

PriorityPPOSM Group Conversion Insurance Policy



Priority Health Insurance Company,
A subsidiary of Priority Health

CANCELLATION

PROVISIONS

Cancellation during first 10 days. During a period of 10 days after the date the policyholder receives the policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to such notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

Cancellation after 10 days. A policyholder may cancel the policy after the first 10 days following receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer shall promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

Cancellation during the first 30 days. During a period of 30 days after the date the policyholder receives the policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to such notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

Cancellation after 30 days. A policyholder may cancel the policy after the first 30 days following receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer shall promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

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**PriorityPPOSM GROUP CONVERSION INSURANCE POLICY –
PRIORITY HEALTH INSURANCE COMPANY – PREFERRED PROVIDER ORGANIZATION
(PPO) PLAN**

Delivered in Michigan – 2012

YOUR RIGHT TO CANCEL

Please read this Policy right away. If you are not satisfied with it for any reason, you may return it within 10 days. If returned, this Policy will be void. We will refund all Premiums paid. We can collect from you all costs for Covered Services that you received and we paid, plus our costs of recovering those charges, including attorney's fees.

IMPORTANT NOTICE. YOUR POLICY MAY NOT APPLY! PLEASE READ!

This Policy was issued based on the information in your Application, which has become part of this Policy. If there is any misstatement in your Application, you must let us know immediately. Otherwise, your agreement may not be valid.

If any information on your Application is incorrect or incomplete, please write to us within 10 days of receiving the Policy, at:

1231 East Beltline, NE
P.O. Box 269
Grand Rapids, MI 49501

SECTION 1. About This Policy

This Policy is a contract between you and Priority Health. It describes your benefits and explains your rights and responsibilities. It also describes the rights and responsibilities of Priority Health. This Policy sets the terms and conditions of Coverage. It replaces and supersedes any Agreement we might have issued in the past.

Your Coverage may be renewed annually. Your Premiums may change each year at the time of renewal. Please see Section 12, Premium Payments and Renewal Terms, of this Policy for more information. Coverage will not be continued beyond the termination date as stated in Section 10.

NOTE: The Schedule of Benefits lists the cost sharing between you and Priority Health for Covered Services.

Coverage under this Policy is available to individuals eligible under Section 2.

Words that are capitalized in this Policy are terms that are defined in Section 17. The terms "we," "us" and "our" refer to Priority Health. The terms "you," "your" and "yourself" refer to the Member, whether enrolled with Priority Health as a Subscriber or Covered Dependent.

If you have any questions about Coverage, contact our Customer Service Department at:

Priority Health
Customer Service Department, MS FH 5
34505 West Twelve Mile Road
Farmington Hills, MI 48331
800 528-8762

or

Use our secure e-mail form in the Member Center on our website at priorityhealth.com

SECTION 2. Eligibility

To be eligible for Conversion Coverage with Priority Health Insurance Company, you must submit to us a completed Application. This must be submitted no more than 31 days after you lose coverage under a Group agreement with us. You must also meet the eligibility requirements described in this Section 2. The Subscriber and any Covered Dependent(s) have the right to obtain Conversion Coverage without evidence of good health.

A. Subscriber.

You are eligible to enroll in Conversion Coverage as a Subscriber when:

- (1) You are a Subscriber or Covered Dependent under a Group agreement with us and that coverage terminates because the subscriber's employment terminates or the subscriber no longer meets the eligibility requirements of that coverage.
- (2) You are the subscriber or covered dependent under a group agreement and your coverage terminates because the agreement is terminated, unless the terminated coverage is replaced with other group coverage.
- (3) You are a covered dependent, and although the subscriber's coverage under the Group agreement continues, your coverage terminates because you no longer meet the eligibility requirements to be a covered dependent.
- (4) You are a covered dependent under a Group agreement with us and your coverage under that agreement terminates because of the subscriber's death.

B. Covered Dependents.

If you were a Subscriber under a Group agreement with us and lost your Group coverage as stated above, you may also apply for Conversion Coverage for those dependents who were covered under the Group agreement.

You are eligible to enroll as a Covered Dependent if:

- (1) you are legally married to the Subscriber; or
- (2) you are a Subscriber's child (including a stepchild, legally adopted child, natural child or Child Placed for Adoption), or have the Subscriber or the Subscriber's spouse as your court-appointed permanent or limited guardian. You may not enroll as a Covered Dependent if the Subscriber or Subscriber's spouse has been appointed as your temporary guardian.

In addition, you may only enroll as a Covered Dependent child if:

- (a) you are under age 26 on the effective date of Coverage; or
- (b) you are an Incapacitated Dependent, and your incapacitation began before you reached age 26; and
- (c) you are unmarried if over age 26 and Covered as an Incapacitated Dependent.

Court or Administrative Order

The Subscriber's child is eligible to enroll in this plan even if it has been more than 31 days since you lost your coverage under a Group agreement with us if you provide us with a copy of a court judgment, decree or order, including approval of a settlement agreement. The judgment, decree or order must provide for benefit coverage with respect to a child of a Subscriber, and be made pursuant to a State domestic relations law. The child must be otherwise eligible for Coverage as a Covered Dependent. Coverage will become effective upon receipt of the court or administrative order, the Change Form and any required Premium payment.

This special enrollment option is not subject to the Qualified Medical Child Support Order (QMCSO) requirements because this is not a group health plan.

Court-Appointed Guardianship

Special rules apply to a child for whom the Subscriber or the Subscriber's spouse is the court-appointed permanent or limited guardian. The child may be enrolled from the moment he or she is in your physical custody. We will not Cover any expenses incurred for the child's care before he or she is in your physical custody. "Physical custody" means that the child is legally and physically placed in your home. If we ask for proof that the child meets the above requirements, you must give us acceptable proof, such as a court order, within 31 days. The child is eligible for Coverage until the end of the day on which he or she turns 18 years of age.

C. When you are Not Eligible for Conversion Coverage

You are not eligible for Conversion Coverage as a Subscriber or Covered Dependent if any of the following applies:

- (1) Your coverage under the Group agreement with us terminated because:
 - (a) You, or if you are a covered dependent, the Subscriber, failed to pay any required premiums;
 - (b) Your coverage under the Group agreement was replaced by other group coverage; or
 - (c) Your coverage under the Group agreement was terminated for cause.
- (2) Coverage under the Group agreement with us ended before you had been continuously enrolled under any group agreement for at least three months;
- (3) You are covered under or eligible for any group or governmental health care policy, certificate, contract, benefit plan or program, such as through an employer, union or association, Medicaid, Medicare or SCHIP, whether insured or self-insured and that coverage provides similar benefits to the Coverage under this Policy;
- (4) You are Covered under any individual health care policy, certificate, contract, benefit plan or program, whether insured or self-insured and that coverage provides similar benefits to the Coverage under this Policy.
- (5) You are in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or when on release for the sole purpose of receiving medical treatment;
- (6) You are covered under or eligible for Medicare.
- (7) You live outside of the United States.

D. Full Time Participation in the Military, Navy, or Air Force.

You or your dependents will no longer be eligible for Coverage if you enter the military, navy, or air force of any country or international organization on a full time basis. You are eligible for Coverage if you are participating in scheduled drills or other training that does not last longer than one month in any calendar year.

SECTION 3. Enrollment

A. Initial Enrollment

To enroll as a Subscriber, you must fill out an Application, sign it, and return it to us within 31 days of the loss of Coverage under a Group agreement with us. The applicable Premium, plus authorization for electronic funds transfer for Premium payments, must accompany the Application. On the Application, you must list each person being enrolled, and give the information asked for about each person. If you are the Subscriber and under the age of 18, you must have your parent or guardian fill out and sign the Application on your behalf. The parent or guardian must agree, in a signed statement provided to us, to assume your obligations as Subscriber under this Policy.

You may enroll regardless of age, health status or medical needs, except for the age limit for Covered Dependent children stated in Section 2.B(2) above.

B. Special Enrollment of Newly Eligible Dependents

Certain events may qualify you to enroll a new Covered Dependent even if it has been more than 31 days since you lost coverage under a Group agreement with us. You are entitled to a 31 day Special Enrollment Period when you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption.

Fill out and return to us a completed Change Form and any additional required Premium payment within 31 days of the marriage, birth, adoption, or placement for adoption. You must do this even if the addition or change does not require you to pay a higher Premium. If you submit the Change Form within 31 days, Coverage will be effective on the date of the marriage, birth, adoption or placement for adoption. All terms and provisions of this Policy, such as Prior Approval requirements and use of Network Providers, apply for services to be Covered during that time.

NOTE: A legally adopted child, or child, or a child for whom the Subscriber or the Subscriber's spouse are a court-appointed permanent or limited guardian, may be enrolled as a Covered Dependent within 31 days from the date of the child's placement in your physical custody.

This plan Covers a Subscriber's Newborn child, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, for the first 31 days from birth even if you do not submit a Change Form. If you want the Newborn's Coverage to continue beyond the first 31-day period, fill out and return to us a Change Form within 31 days after the child is born.

C. Notification of Change in Status or Other Changes that Affect Coverage and Eligibility

Notify us about any changes that affect your Coverage under this Policy by:

- (1) filling out a Change Form and returning it to us, or
- (2) visiting the Member Center on our website at *priorityhealth.com*, or
- (3) calling our Customer Service Department.

For example, notify us if any of the following happens to anyone Covered under this plan:

- (1) change of address or state of residence;
- (2) eligibility for Medicare, Medicaid, and Children's Special Health Care Services; or
- (3) coverage by any other individual, group or association health plan.

These are examples only. Let us know about any change that, according to this Policy, affects your Coverage or Coverage for your Covered Dependents.

Tell us about the change, such as acquiring coverage under another plan, within 31 days. This allows us to make sure you and your eligible dependents are enrolled correctly. We will review services you have received since the effective date of the change to determine if the services are Covered and how they should have been paid.

D. Loss of Eligibility

Your Coverage will terminate if you no longer meet the eligibility criteria listed in Section 2 of this Policy.

E. Genetic Testing

Enrollment under this Section 3 and continuation of Coverage under this plan is not contingent on undergoing genetic testing or disclosing results of any genetic testing to us.

SECTION 4. Effective Dates of Coverage

Your Coverage begins on the latest of:

- A. the effective date of this Agreement, which is the date of termination of coverage under the Group agreement with us.
- B. the date of marriage if you are a newly eligible dependent spouse or the date of birth, adoption, or placement for adoption if you are newly eligible dependent child.
- C. the date we receive a court or administrative order if you are a newly eligible dependent as the result of a court judgment, decree or order and all other requirements of the Agreement are met.
- D. the date a child is placed in your physical custody if Coverage is being provided as a result of a court or administrative order or a court-appointed permanent or limited guardianship.

SECTION 5. Obtaining Covered Services

This plan is designed as a Preferred Provider Organization ("PPO") health plan. With this type of plan, Priority Health provides you a Network of Physicians and other Health Professionals who have contracted with us to provide Covered Services for Members. These Providers are listed in our Provider Directory. The directory is available on our website as part of the Find a Doctor tool or by calling our Customer Service Department.

A. Network and Non-Network Providers

You may choose to seek services from Network Providers or Non-Network Providers, including preventive health care services, primary care and specialty care. Network and Non-Network Providers can order lab tests and x-rays, prescribe medicines or therapies and arrange hospitalization when necessary.

Services provided by Network Providers are Covered at the Network Benefits Level, and services provided by Non-Network Providers are Covered at the Non-Network Benefits Level, unless it is a Medical Emergency. If you are receiving services from a Non-Network Provider, you have the option to return to a Network Provider for medical care at any time during your course of treatment. If you do, the Covered Services provided by a Network Provider will be Covered at the Network Benefits level.

NOTE: The services listed in Section 5.D require Prior Approval from us when provided by Network or Non-Network Providers.

Generally, Network Benefits will cost you less than Non-Network Benefits. In addition to higher Coinsurance and Deductibles, you may also be responsible for the cost of Covered Services about the Reasonable and Customary charge when you seek services from a Non-Network Provider. See your Schedule of Benefits for additional information.

To determine if a Health Professional is a Network or Non-Network Provider, contact our Customer Service Department at 800 528-8762 or visit our website at priorityhealth.com. Unless this Policy states otherwise, services will be Covered based on the Network status of the Provider at the time you receive the services. You are responsible for determining whether a Provider is part of the Network before receiving services.

Non-Network Benefits are available world-wide. Prior Approval requirements apply.

B. Referral Care.

Your Physician, or a Health Professional, may refer you to another Provider when it would be more appropriate for you to receive care from a different type of Health Professional or Specialist. The Provider to whom you are referred may or may not participate in the Network. If you want to receive the Network Benefits Level, ask your Provider to refer you to a Network Provider. You may also contact our Customer Service Department or visit our website at priorityhealth.com to find a Network Provider who can provide the referral care.

Sometimes a Provider may refer you for or suggest a service that we do not Cover. This referral or suggestion does not mean the services will be Covered.

A Second Medical Opinion.

It is often appropriate to ask for a second medical opinion before receiving certain treatments for health conditions and before many proposed surgeries. You may request a second medical opinion from a Specialist Provider who has skills and training substantially similar to those of the Physician making the original treatment recommendation without Prior Approval. Benefits for second opinion services will be based on the Network status of the Provider at the time of service. Any tests, procedures, treatments or surgeries recommended by the consulting Provider must be performed by a Network Provider to receive benefits at the Network Benefits Level.

C. Your Treatment Options.

We require Network Providers to discuss all treatment options available to you whether the treatment or services are Covered or not Covered. Providers are not expected to know when services have limitations or are excluded from Coverage. Your Policy provides you with this information. Our Customer Service Department can help you with any questions.

Your Physician or other Health Professional may recommend, and you may choose, treatment options even if they are not Covered or are limited by this Policy. You are required to pay for any services you receive that are not Covered or that exceed your maximum benefit.

D. Prior Approval Requirements.

Some services and supplies require Prior Approval by Priority Health in order to be Covered under this plan. The complete and detailed list of these services is available by calling our Customer Service Department or on our website at priorityhealth.com. This list may change throughout the Contract Year as new technology and standards of care emerge. Below are the general categories of services and supplies that require Prior Approval by Priority Health:

- (1) All inpatient services.

You do not need Prior Approval from Priority Health in order to seek care in a Medical Emergency or when Urgent Care is needed.

- (2) Outpatient services as outlined on our website.
- (3) Durable Medical Equipment (DME) charges over \$1,000 and all rentals.
- (4) Prosthetics and orthotics charges over \$1,000 and all shoe inserts.

- (5) Stimulators.
- (6) High-tech radiology examinations, including but not limited to:
 - (a) positron-emission tomography (PET) scans
 - (b) magnetic resonance imaging (MRI)
 - (c) computed tomography (CT scans)
 - (d) nuclear cardiology studies.
- (7) Home Health Care, including home infusion services and intermittent skilled services.
- (8) Supplemental feedings administered via tube or IV.
- (9) Genetic testing.
- (10) Clinical trials for cancer care.
- (11) Comprehensive pain and headache programs.
- (12) Additional items as outlined on our website.

Non-Urgent Requests

Contact Priority Health as soon as a Provider recommends a service or supplies that require Prior Approval. In most cases, we will approve, partially approve or deny a request for Prior Approval within 15 days of receipt. In some cases we may ask you for additional information or additional time in which to make a determination. Based on our approval or denial, you and your Provider can decide if you want to go forward with the proposed services or obtain the supplies.

Urgent Requests

For urgent requests, we must respond within 72 hours. A request is considered urgent if delaying treatment would put your life in serious danger, interfere with your full recovery or delay treatment for severe pain.

For both urgent and non-urgent requests you may contact our Customer Service Department to find out our decision. You and the Provider recommending the services will receive a letter from us if the services will not be Covered.

If you obtain services that we say are not Covered, or services in excess of what we say is Covered, you are responsible for payment for those services. If you want our decision to be reviewed, you may contact us. Section 11 tells you how to do that.

Retrospective Review

It is important to get Prior Approval so you know ahead of time if the services or supplies you seek will be Covered. If the required Prior Approval is not obtained, we may review the claim after you receive the services. If we determine that care received was Medically/Clinically Necessary, the care will be Covered at the appropriate benefits level. If we determine that the care received was not Medically/Clinically Necessary, the services will not be Covered.

Re-evaluation of Decision on Prior Approval.

At any time, your Physician may ask us to reevaluate a Prior Approval decision we have made.

E. Termination of Provider's Participation.

A Network Provider's contract may be terminated at any time. We cannot guarantee that you will be able to receive services from a specific Network Provider while you are covered under this Policy. If your Provider terminates his or her participation in the Network, you will need to select a different Network Provider in order to continue receiving Network Benefits. Our Customer Service Department is available to assist you in finding another Network Provider and in receiving care during the transition to a new Provider. If you have any questions, please call our Customer Service Department at 800 528-8762.

If you are being treated by a Network Provider whose contract with us is terminated, you may be allowed to continue seeing that Provider for a limited time. So long as the Provider is able to continue treating you, you can receive services at the Network Benefits Level if at the time of the Provider's contract termination:

- (1) you are receiving on-going care. You may continue to see this Provider for up to 90 days or until Priority Health makes other arrangements for you to receive the same services from another Network Provider.

- (2) you are undergoing treatment for a chronic or disabling condition. You may continue to see this Provider for up to 90 days.
- (3) you are undergoing treatment for a terminal illness. You may continue to be treated by this Provider for the remainder of your life.

NOTE: If the Network Provider's contract with Priority Health has been terminated for quality of care reasons, we will Cover any care you receive from him or her at the Non-Network Benefits Level.

F. Medical Emergency or Urgent Care.

Medical Emergency care and Urgent Care services are Covered under this Policy. You do not need Prior Approval from Priority Health to seek care in a Medical Emergency or when Urgent Care is needed.

If you use an emergency room facility for non-emergent or routine care, the services will not be Covered.

(1) Urgent Care

When you have an illness or injury that needs immediate attention, such as cuts or sprains, but it is not as serious as a Medical Emergency, go to an Urgent Care Center or Hospital emergency room. Present your ID card and be prepared to pay the required Copayment or Deductible. Urgent Care benefits will be based on the Network status of the Provider at the time of service.

Do not return to the Urgent Care Center or emergency room for follow-up care unless it is an urgent situation or Medical Emergency. If you receive services from a Non-Network Provider, you have the option to return to a Network Provider for any necessary follow-up care. Any follow-up care that is provided by a Non-Network Provider will be Covered at the Non-Network Benefits level.

(2) Medical Emergency

If you have a Medical Emergency, seek help immediately. All care needed to treat a Medical Emergency will be Covered at the Network Benefits Level. This includes care provided by Non-Network Providers. If you are treated by a Non-Network Provider, at either a Network or Non-Network facility, you may be responsible for charges over the Reasonable and Customary amount.

If you are confined to a Hospital as an inpatient after a Medical Emergency, you (or someone on your behalf) must let us know about your confinement as soon as it is reasonably possible. Once your inpatient stay is no longer a Medical Emergency, Priority Health must approve your continued inpatient stay in order for it to be Covered.

Following a Medical Emergency, you may choose to seek all follow-up care from a Network Provider. Any follow-up care that is provided by a Non-Network Provider will be Covered at the Non-Network Benefits level.

(3) Ambulance Services.

"Ambulance" includes a motor vehicle or aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

In a Medical Emergency, we will Cover EMT and ambulance service to the nearest medical facility that can provide Medical Emergency care.

We will Cover ambulance transfers between facilities that we approve in advance. Any other non-emergent transportation is not Covered unless approved in advance by us.

G. Review of Health Care Services and Supplies.

Priority Health can review services and supplies that Health Professionals recommend to decide whether those services and supplies will be Covered under this plan. If Priority Health decides that the services and supplies will not be Covered, Priority Health will let you know. If you disagree with the decision and want that decision to be reviewed, you must follow the procedures described in Section 11 of this Policy. Our decision is a benefit determination only. You may still elect to receive the suggested services at your own expense.

H. Additional Information

The following information is available from our Customer Service Department:

- (1) our current Provider Directory.

- (2) The professional credentials of our Network Providers. This includes, but is not limited to, Network Providers who are board certified in the specialty of pain medicine and the evaluation and treatment of chronic or acute pain.
- (3) The telephone number of the Michigan Department of Licensing and Regulatory Affairs, where you can call to find out information regarding disciplinary actions or formal complaints filed against a Provider.
- (4) Prior Approval requirements and any limitations, restrictions or exclusions on services, benefits or Providers.
- (5) The type of financial relationships between us and our Provider Network.
- (6) How we evaluate new technology for inclusion as a Covered Service.
- (7) A printed version of this Policy.

Request this information by calling or writing to our Customer Service Department at the phone number or address below.

Priority Health
Customer Service Department, MS FH 5
34505 West Twelve Mile Road
Farmington Hills, MI 48331
800 528-8762

or

use our secure e-mail form in the Member Center on our website at priorityhealth.com

I. Providers Included on the Office of Inspector General’s List of Excluded Individuals/Entities.

As required by law, we will not pay claims for items or services furnished, ordered, or prescribed by any Provider listed on the Office of Inspector General’s (OIG) List of Excluded Individuals/Entities. A Provider or entity may be on this exclusion list due to convictions for program-related fraud and abuse, licensing board actions or default on Health Education Assistance Loans.

You will be responsible for the full payment of items or services furnished, ordered, or prescribed by any provider included on the OIG List of Excluded Individuals/Entities. This includes items or services such as prescriptions written by or medical equipment ordered by a provider included on this list. This list is available on the OIG website at www.hhs.gov/oig.

SECTION 6. Covered and Non-Covered Services

Covered and Non-Covered Services are listed in subsection II below. The benefits level (Network or Non-Network) at which a Covered Service is paid is determined by the criteria listed in subsection I below. The Schedule of Benefits specifies the applicable benefit limits, Copayments, and Deductible amounts. Deductibles, if any, apply to all Covered Services except as indicated on the Schedule of Benefits. There may be additional Covered Services and limitations described in Addenda or amendments to this Policy. Benefit limits and maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

IMPORTANT NOTE

This Policy only Covers services that are Medically/Clinically Necessary as defined in this Policy and according to medical and behavioral health policies established by us, with the input of Physicians not employed by us, or according to criteria developed by reputable external sources and adopted by Priority Health. Additionally, certain services require Prior Approval from us before they will be Covered. See Section 5.D For detailed information about Prior Approval requirements. If you do not follow the necessary steps in the Prior Approval process or obtain services in excess of what is approved, certain services may not be Covered. You are responsible for paying for services we do not Cover, whether received from Network or Non-Network Providers. Complications to non-Covered Services described in this Policy are Covered if they result in a Medical Emergency.

I. BENEFIT LEVELS

A. Network Benefits.

Services described in Section 6.II are Covered at the Network Benefits Level when those services are:

- (1) Routine or preventive health care services or Medically/Clinically Necessary health care services as described in this Section 6 ; and
- (2) Provided by a Network Physician or Network Provider and with Prior Approval from us when required; and
- (3) Not excluded elsewhere in this Policy or in an Addendum or Amendment to this Policy.

NOTE: If you seek services at a Network facility, you may also receive radiology, anesthesiology, pathology, emergency or special diagnostic services provided by Non-Network Providers. Covered Services provided by Non-Network Providers in a Network facility are paid at the Network Benefits Level. You may be responsible for the difference between the Provider's charge and the Reasonable and Customary charge in addition to Network Benefits, including Copayments, Deductibles and Coinsurance amounts applicable to these services.

B. Non-Network Benefits.

Services described in Section 6.II are Covered at the Non-Network Benefits Level when those services are:

- (1) Routine or preventive health care services or Medically/Clinically Necessary health care services as described in this Policy and with Prior Approval from us when required; and
- (2) Not excluded elsewhere in this Policy or in an Addendum or amendment to this Policy.
- (3) Not in excess of the Maximum Individual Annual Benefit for Network and Non-Network Benefits per Contract Year as shown in the Schedule of Benefits.

NOTE: You are responsible for any amount over Reasonable and Customary charges.

II. COVERED AND NON-COVERED SERVICES

NOTE: The headings used in Section 6 are intended to provide a convenient listing of Covered and Non-Covered Services. If you cannot find a particular service, please contact our Customer Service Department. The services are organized alphabetically within each of the following categories:

- A. Professional Services
 1. Preventive Health Care Services
 2. Other Services Provided by Health Professionals
- B. Prescription Drugs and Supplies
- C. Hospitals, Diagnostic Tests and Other Facilities Services
- D. Medical Emergency and Urgent Care Services
- E. Durable Medical Equipment (DME) and Supplies
- F. Behavioral Health Services
 1. Mental Health Services
 2. Substance Abuse Services
- G. Family Planning and Maternity Care Services
- H. Dental, Vision and Hearing Services
- I. Additional Coverage Information

A. Professional Services

1. Preventive Health Care Services

Preventive health care services are listed in Priority Health's Preventive Health Care Guidelines available in the Member Center on our website at priorityhealth.com, or you may request a copy from our Customer Service Department. We recommend you receive a physical examination from a Network Provider within one year of joining Priority Health.

Covered preventive health care services include:

- (a) Immunizations (doses, recommended ages, and recommended populations vary)
 - Certain vaccines – children from birth to age 18
 - Certain vaccines – all adults

(b) Certain Drugs

- Aspirin – men and women of certain ages
- Folic Acid supplements – women who may become pregnant
- Fluoride Chemoprevention supplements – children without fluoride in their water source
- Gonorrhea preventive medication – all Newborns
- Iron supplements – children ages 6 to 12 months at risk for anemia

(c) Screening and Counseling Services for Adults

- Abdominal Aortic Aneurysm – men of specified ages who have ever smoked (one-time only)
- Alcohol Misuse – all adults
- Blood Pressure – all adults
- Cholesterol – adults of certain ages or adults at higher risk
- Colorectal Cancer – adults over 50
- Depression – all adults
- Type 2 Diabetes – adults with high blood pressure
- Diet counseling – adults at higher risk for chronic disease
- HIV – all adults at higher risk
- Obesity – all adults
- Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk
- Tobacco Use – all adults (includes cessation interventions for tobacco users)
- Syphilis – all adults at higher risk

(d) Screening and Counseling Services for Women Only (Including Pregnant Women)

- Anemia – on a routine basis for pregnant women
- Bacteriuria (urinary tract or other infection screening) – pregnant women
- BRCA (counseling about genetic testing) – women at higher risk
- Breast Cancer Mammography – every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention – women at higher risk
- Breast Feeding – interventions to support and promote breast feeding
- Cervical Cancer – sexually active women
- Chlamydia Infection – younger women and other women at higher risk
- Gonorrhea – all women at higher risk
- Hepatitis B – pregnant women at their first prenatal visit
- Osteoporosis – women over age 60 depending on risk factors
- Rh Incompatibility – all pregnant women and follow-up testing for women at higher risk
- Tobacco Use – all women, and expanded counseling for pregnant tobacco users
- Syphilis – all pregnant women or other women at increased risk

(e) Assessments and Screenings for Children

- Alcohol and Drug Use Assessments – adolescents

- Autism Screening – children at 18 and 24 months
- Behavioral Assessments – children of all ages
- Cervical Dysplasia Screening – sexually active females
- Congenital Hypothyroidism Screening – Newborns
- Developmental Screening – children under age 3, and surveillance throughout childhood
- Dyslipidemia Screening – children at higher risk of lipid disorders
- Hearing Screening – all Newborns
- Height, Weight and Body Mass Index Measurements – children of all ages
- Hematocrit or Hemoglobin Screening – children of all ages
- Hemoglobinopathies or Sickle Cell Screening – all newborns
- HIV Screening – adolescents at higher risk
- Lead Screening – children at risk of exposure
- Medical History – all children throughout development
- Obesity Screening and Counseling – children of all ages
- Oral Health Risk Assessment – young children
- Phenylketonuria (PKU) Genetic Disorder Screening – all newborns
- Sexually Transmitted Infection (STI) Prevention Counseling – adolescents at higher risk
- Tuberculin Testing – children at higher risk of tuberculosis
- Vision Screening – all children

2. Other Provider Care Services

Allergy Testing and Treatments

Covered Services

Allergy testing, evaluations and injections including serum costs.

Non-Covered Services

Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine autoinjections, bronchial or oral allergen sensitization and provocative and neutralization testing for allergies.

Clinical Ecology and Environmental Medicine

Non-Covered Services

"Clinical ecology" and "environmental medicine" means medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems. This plan does not cover services or supplies needed to make changes to your physical environment even when those changes are recommended as treatment for an illness or injury.

Diabetic Services, Supplies, and Medications

Covered Services

- (a) Blood glucose monitors and diabetes test strips.
- (b) Syringes and lancets.
- (c) Diabetes educational classes to ensure that persons with diabetes are trained as to proper self-management and treatment of their diabetes.

- (d) Certain diabetic supplies, such as syringes, needles, lancets, and blood glucose test strips, may be purchased at a Network Durable Medical Equipment (DME) Provider. Your DME Copayment will apply.
- (e) Insulin pumps.
- (f) Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.
- (g) Specialty shoes prescribed for a person with diabetes.

Non-Covered Services

- (a) Alcohol and gauze pads.
- (b) Services and supplies for the convenience of the Member or caregivers.

Dietitian Services

Covered Services

See Priority Health's Preventive Health Care Guidelines for dietitian services that are Covered as preventive health care services

Non-Covered Services

Dietitian services are not Covered except those Covered as a preventive health care service.

Educational Services

Covered Services

Education about managing chronic disease states such as diabetes or asthma.

Non-Covered Services

- (a) Maternity classes.
- (b) Services for remedial education, including school-based services.
- (c) Services, treatment or diagnostic testing related to learning disabilities, cognitive disorders and developmental delays.
- (d) Education testing or training, including intelligence testing. Necessary testing and evaluations should be requested from and conducted by the child's school district.
- (e) Classes covering such subjects as stress management, parenting and lifestyle changes.

Eye Care

Covered Services

Treatment of medical conditions and diseases of the eye.

Coverage Limitations

Vision Care Services are Covered as described later in this Section 6.

Foot Care

Non-Covered Services

- (a) Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care.
- (b) Cleaning, soaking, and skin cream application for the feet.
- (c) Shoes unless attached to a brace or prescribed for a person with diabetes.

Home Health Care

Covered Services

Intermittent skilled services furnished in the home by a physical therapist, occupational therapist, respiratory therapist, speech therapist, licensed practical nurse or registered nurse.

Home Health Care is Covered when you are:

- (a) confined to the home,
- (b) under the care of a Physician,
- (c) receiving services under a plan of care established and periodically reviewed by a Physician, and
- (d) in need of intermittent skilled nursing care or physical, speech, or occupational therapy.

Non-Covered Services

- (a) Custodial Care is not Covered, even if you receive Home Health Care services or Skilled Nursing Services at the same time you receive the custodial care.
- (b) Private Duty Nursing.
- (c) Residential or Assisted Living. Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aides, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.

Homeopathic and Holistic Services

Non-Covered Services

Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy.

Pain Management

Covered Services

Evaluation and treatment of chronic and/or acute pain as specified in our medical policies.

Outpatient and Inpatient Care

Non-Covered Services

Certain surgeries and treatments performed on an outpatient or inpatient basis are not Covered. These include but are not limited to bariatric surgery, blepharoplasty of upper lids, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty, surgical treatment of male gynecomastia, certain skin disorder treatments, genetic testing and sleep apnea treatment procedures.

Reconstructive Surgery

Covered Services

- (a) Reconstructive surgery to correct congenital birth defects and/or effects of Illness or Injury, if:
 - (i.) The defects and/or effects of Illness or Injury cause clinical functional impairment. "Clinical functional impairment" exists when the defects and/or effects of Illness or Injury:
 - causes significant Disability or major psychological trauma (psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the Illness or Injury for which the reconstructive surgery is requested),
 - interfere with employment or regular attendance at school,
 - require surgery that is a component of a program of reconstructive surgery for a congenital deformity or trauma, or
 - contribute to a major health problem, and
 - (ii.) We reasonably expect the surgery to correct the condition, and

(iii.) The services are approved in advance by us and you receive them within two years of the event that caused the impairment, unless either of the following applies:

- The impairment caused by Illness or Injury was not recognized at the time of the event. In that case, treatment must begin within two years of the time that the problem is identified, or
- Your treatment needs to be delayed because of developmental reasons.

We will Cover treatment to correct the functional impairment even if the treatment needs to be performed in stages as long as that treatment begins within two years of the event causing the impairment and as long as you remain a Member.

(b) Reconstructive Surgery Following Breast Cancer

In compliance with the Women's Health and Cancer Rights Act of 1998, we will consult with your Physician to determine Coverage for these services:

- (i.) Reconstruction of the breast on which a mastectomy was performed;
- (ii.) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (iii.) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

The requirement to receive services within two years of the event that caused the impairment does not apply to reconstructive surgery following breast cancer.

Coverage Limitations

See your Schedule of Benefits and any Addenda to this Policy for additional information about limitations on certain procedures, treatments and reconstructive surgeries.

Non-Covered Services

Cosmetic services, prescription drugs, treatment, therapies or procedures done primarily to improve the way any part of the body looks. Coverage is excluded for, among other things:

- (a) Blepharoplasty of upper or lower lids.
- (b) Breast augmentation except when provided as part of post-mastectomy reconstructive services.
- (c) Breast reduction.
- (d) Chemical peel for acne.
- (e) Collagen implants.
- (f) Diastasis recti repair.
- (g) Excision of lipomas.
- (h) Excision of seborrheic keratoses.
- (i) Excision of skin tags.
- (j) Excision or repair of excess or sagging skin.
- (k) Fat grafts, unless an integral part of another Covered procedure.
- (l) Hair transplants or repair of any congenital or acquired hair loss, including hair analysis.
- (m) Liposuction, unless an integral part of a Covered procedure.
- (n) Orthodontic treatment, even when an integral part of reconstructive surgery.
- (o) Panniculectomy.
- (p) Port wine stains and hemangioma treatment.
- (q) Removal for excessive hair growth by any method, even if caused by an underlying medical condition.
- (r) Rhinoplasty or septorhinoplasty.

- (s) Rhinophyma treatment.
- (t) Rhytidectomy (wrinkle removal).
- (u) Salabrasion.
- (v) Scar revision or keloid scar treatment.
- (w) Spider vein removal.
- (x) Surgical treatment of male gynecomastia.
- (y) Tattoo removal.
- (z) Treatment of hyperhidrosis.
- (aa) Treatment of vitiligo.

Rehabilitative Medicine Services

Covered Services

Therapy and /or Rehabilitative Medicine Services that result in meaningful improvement in your ability to perform functional day-to-day activities that are significant in your life roles, including:

- (a) Cardiac and pulmonary rehabilitation
- (b) Physical and occupational therapy
- (c) Speech therapy for treatment of medical diagnoses
- (d) Biofeedback for treatment of medical diagnoses when Medically/Clinically Necessary, as determined according to our medical policies.

NOTE: Covered physical and occupational therapy services include spinal manipulations by a chiropractor and all manipulations by osteopathic Physicians.

Short-term Rehabilitative Medicine Services are Covered if:

- Treatment is provided in an outpatient setting or in the home, and
- You cannot receive those services from any federal or state agency or any local political subdivision, including school districts, and
- They result in meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 90 days of starting treatment, and
- A Physician refers, directs and monitors the services.

Non-Covered Services

- (a) Therapy is not Covered if there has been no meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 90 days of starting treatment.
- (b) All therapies for developmental delays, cognitive disorders, including physical, occupational, speech, cognitive and sensory integration therapy.
- (c) Cognitive rehabilitative therapy (neurological training or retraining).
- (d) Craniosacral therapy.
- (e) Prolotherapy.
- (f) Rehabilitation services obtained from non-Health Professionals, including massage therapists.
- (g) Relational, educational and sleep therapy and any related diagnostic testing. This exclusion does not apply to therapy or testing provided as part of a Covered Hospital Inpatient or Outpatient Care.
- (h) Services outside the scope of practice of the servicing provider.

- (i) Strength training and exercise programs.
- (j) Summer programs meant to maintain physical condition or developmental status during periods when school programs are unavailable.
- (k) Therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition including, but not limited to, cerebral palsy and developmental delays.
- (l) Therapy to correct an impairment, when the impairment is not due to Illness, Injury or a congenital defect for which you have received corrective surgery.
- (m) Visual training and sensory integration therapy.
- (n) Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluation and all return to work programs.
- (o) Notwithstanding item (h) above, extra-spinal manipulations and related services performed by a chiropractor are not Covered.

Sex Change or Transformation

Non-Covered Services

Any procedure or treatment, including hormone therapy, designed to change your physical characteristics from your biologically determined sex to those of the opposite sex. This exclusion applies despite any diagnosis of gender role or psychosexual orientation problems.

Tobacco Cessation Treatment

Covered Services

- (a) Smoking cessation services provided by your Network Physician.
- (b) See Priority Health's Preventive Health Care Guidelines for tobacco cessation drug treatments Covered under preventive health care services.

Coverage Limitations

Smoking cessation services are Covered at the Network Benefits Level only.

Non-Covered Services

Any other related services and supplies for the treatment of tobacco abuse.

Transplants

Non-Covered Services

- (a) Evaluations for transplants,
- (b) transplant procedures,
- (c) any professional or facility charges related to transplants
- (d) any other costs relating to transplants.

Weight loss services

Non-Covered Services

- (a) Neither Medical nor surgical treatments of obesity are Covered under this Policy, even when Medically/Clinically Necessary.
- (b) Coverage is excluded for, among other things, food, food supplements, gastric balloons, weight loss surgeries, jaw wiring, liposuction, physical fitness or exercise programs, even when prescribed by a Physician or associated with an Illness.

B. Prescription Drugs and Supplies

Prescription Drugs Received While You Are an Inpatient

Covered Services

Drugs and supplies that are prescribed and received during a Covered inpatient stay are Covered as medical benefits.

Cancer Therapy Drugs

Covered Services

As required by state law, drugs for cancer therapy and the reasonable cost of administering them are Covered. These drugs are Covered regardless of whether the federal Food and Drug Administration (FDA) has approved the cancer drugs to be used for the type of tumor for which the drugs are being used.

Coordination of Benefits for drugs for cancer therapy and cancer clinical trials: If you have prescription drug coverage under another plan, drugs for cancer therapy and cancer clinical trials will be Covered by your prescription drug plan before Coverage under your Priority Health medical plan will apply.

Non-Covered Services

Experimental, investigational or unproven services are not Covered. Additionally, certain drugs for which a majority of experts believe further studies or clinical trials are needed to determine toxicity, safety or efficacy, of the drug are not Covered.

Injectable Drugs

Covered Services

Injectable and infusible drugs administered in an inpatient or emergency setting are Covered as medical benefits. Exceptions are outlined in our medical policies.

Outpatient Prescription Drugs

Covered Services

Drugs listed in Section 6.II.A.1(b) under "Preventive Health Care Services."

Non-Covered Services

Prescription drugs are not Covered under this Policy, including:

- (a) drugs obtained at a retail pharmacy, except those listed in Section 6.II.A.1(b) above,
- (b) drugs requiring administration by a Health Professional in a medical office, home or outpatient facility, and
- (c) drugs that are intended to be self-administered as defined by the federal Food and Drug Administration. This includes self-administered drugs for certain diseases, such as growth deficiency, hepatitis and multiple sclerosis and for certain other Illnesses or Injuries.

C. Hospitals, Diagnostic Tests, and Other Facilities Services

NOTE: If you seek services at a Network facility, you may also receive radiology, anesthesiology, pathology, emergency or special diagnostic services provided by Non-Network Providers. Covered Services provided by Non-Network Providers in a Network facility are paid at the Network Benefits Level. You may be responsible for the difference between the Provider's charge and the Reasonable and Customary Charge in addition to Network Benefits, including Copayments, Deductibles and Coinsurance amounts applicable to these services.

Ambulatory Surgical Services and Supplies

Covered Services

Outpatient services and supplies furnished by a surgery center along with a Covered surgical procedure on the day of the procedure.

Hospice Care

Covered Services

The following Hospice Care services, provided as part of an established Hospice Care program, are Covered when your Physician informs Priority Health that your condition is terminal and Hospice Care would be appropriate:

- (a) Inpatient Hospice Care. Short-term inpatient care in a licensed hospice facility is Covered when Skilled Nursing Services are required and cannot be provided in other settings. Prior Approval for inpatient Hospice Care is required.
- (b) Outpatient Hospice Care. Outpatient care is Covered when Skilled Nursing Services by a registered nurse or a licensed practical nurse are required or when medical social services under the direction of a Physician are required. Outpatient Hospice Care is any Hospice Care provided in a setting other than a licensed hospice facility. Hospice Care provided while you are in a Hospital or skilled nursing facility is considered outpatient Hospice Care.
- (c) Respite Care. Respite care in a facility setting is Covered as outlined in our medical policies.

Non Covered Services

Custodial Care is not Covered even if you receive inpatient or outpatient Hospice Care along with Custodial Care.

Hospital and Longterm Acute Care

Covered Services

- (a) Hospital Inpatient Care. Hospital and longterm acute inpatient services and supplies including services performed by Physicians and Health Professionals, room and board, general nursing care, drugs administered while you are confined as an inpatient, and related services and supplies. Non-emergency inpatient Hospital stays must be approved in advance by us.
- (b) Hospital Outpatient Care. Hospital services and supplies listed under Hospital Inpatient Care above that you receive on an outpatient basis. Hospital Observation Care received after an emergency room visit is considered Hospital Outpatient Care.

Non-Covered Services

- (a) Pre-natal, delivery and post-partum Maternity Care services are not Covered under this Policy. Complications of a Pregnancy, as defined in Section 17, are Covered under the terms and conditions of this Policy.
- (b) Certain surgeries and treatments, including Hospital, Physician and any other related charges, are not Covered as specified in the Schedule of Benefits to this Policy.
- (c) Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.

Private Duty Nursing

Non Covered Services

Nursing services provided in a facility or private home, usually to one patient. Private duty nursing services are generally provided by independently contracted nurses, rather than through an agency, such as a Home Health Care agency.

Radiology Examinations and Laboratory Procedures

Covered Services

Diagnostic and therapeutic radiology services and laboratory tests not excluded elsewhere in this Section. See Section 5.D For Prior Approval requirements.

- (a) To receive Network Benefits, all non-emergency laboratory tests, including high-tech radiology examinations, must be performed at a Network laboratory or facility.
- (b) Except for preventive health care services, radiology services and laboratory tests may be subject to a Deductible even if ordered and performed in a Provider's office. Services and tests performed in a Hospital (either as an inpatient or outpatient) are subject to any Copayment, Coinsurance and Deductible, applicable to Hospital services even if the service or test was ordered and partially performed in a provider's office.

Skilled Nursing Services - Skilled Nursing, Subacute, and Inpatient Rehabilitation Facility Care.

NOTE: Our admission criteria for Coverage are not the same Medicare's, therefore, just because Medicare is covering your stay does not mean the services are Covered under this Policy. Only services listed in this Section 6.II are Covered.

Covered Services

Care and treatment, including therapy, and room and board in semi-private accommodations, at a skilled nursing, subacute or inpatient rehabilitation facility is Covered when we have approved a treatment plan in advance.

Coverage Limitations

See the Non-Hospital Facility Services category of your Schedule of Benefits and for the number of days Covered under your plan.

Non-Covered Services

- (a) Admission to a skilled nursing, subacute or inpatient rehabilitation facility is not Covered if the necessary care or therapies can be provided safely in a less intensive setting, including the home or a Provider office.
- (b) Care provided in a facility required to protect you against self-injurious behavior is not Covered.
- (c) Custodial Care is not Covered, even if you receive Covered Skilled Nursing Services or therapies along with Custodial Care.
- (d) Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.
- (e) Residential Facility or Assisted Living Facility Care. Non-skilled care received in a residential facility or assisted living facility on a temporary or permanent basis is not Covered. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.

D. Medical Emergency and Urgent Care Services

Medical Emergency Care and Urgent Care Services are Covered under this Policy. You do not need Prior Approval from Priority Health to seek care in a Medical Emergency or when Urgent Care is needed.

See Section 5.F for detailed information about Medical Emergency and Urgent Care benefits.

E. Durable Medical Equipment (DME) and Supplies

Durable Medical Equipment (DME)

DME is equipment intended for repeated use in order to serve a medical need, is generally not useful to a person in the absence of Illness or Injury, and is appropriate for use in the home. Examples of Covered DME are manual wheelchairs, CPAP machines and glucose monitoring devices. DME charges over \$1,000 must be approved in advance by us. For a complete list of Covered DME, go to priorityhealth.com or call our Customer Service Department.

Covered Services

- (a) DME prescribed by a Physician or Health Professional and obtained from a Network DME Provider.
- (b) Repairs or replacement, fitting and adjustment of Covered DME needed as the result of normal use, body growth or body change.
- (c) Training or education on the use of DME.
- (d) Disposable supplies necessary for the proper functioning or application of the DME.
- (e) Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.
- (f) Specialty shoes according to the criteria set forth in our medical policies.
- (g) Shoes when attached to a Medically/Clinically Necessary brace according to criteria specified in our medical policies.
- (h) Inhaler assist devices and some diabetic supplies such as syringes, needles, lancets and blood glucose test strips.

Coverage Limitations

- (a) Coverage is for standard DME only. Equipment must be appropriate for home use.

- (b) Coverage is limited to one piece of same-use equipment. We may substitute one type or brand of DME for another when the items are comparable for meeting your medical needs. Wheelchair Coverage is generally limited to a manually operated, standard wheelchair unless another model is Prior Approved by us according to our medical policies.
- (c) DME may be rented, purchased or repaired. The decision to rent, purchase, repair or replace DME is made by Priority Health. We may limit replacement of DME to the expected life of the equipment.

Non-Covered Services

- (a) DME provided by a Non-Network Provider.
- (b) Equipment that is not conventionally used for the medical need for which it was prescribed.
- (c) Equipment and devices solely for the convenience of you or your caregiver.
- (d) The purchase or rental of personal comfort items, convenience items, or household equipment that have customary non-medical purposes, such as: protective beds, chair lifts, air purifiers, water purifiers, exercise equipment, non-allergenic pillows, mattresses or waterbeds, spas, tanning equipment, and other similar equipment even if they are Medically/Clinically Necessary.
- (e) Modifications to your home, living area or motorized vehicles. This includes equipment and the cost of installation of equipment, such as central or unit air conditioners, escalators, elevators, swimming pools, and car seats.
- (f) Items designed for self-assistance, safety, communication assistance and other adaptive aids. This include, but is not limited to, reachers, feeding, dressing and bathroom aids, augmentive communication devices, car seats, and protective beds.
- (g) Non-standard DME unless we approve the non-standard equipment in advance.
- (h) All repairs and maintenance that result from misuse or abuse.
- (i) Replacement of lost or stolen DME.

Food, Supplements and Formula

Covered Services

- (a) Supplemental feedings administered via tube. This type of nutrition therapy is also known as enteral feeding. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy are Covered.
- (b) Supplemental feedings administered via an IV. This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies and equipment needed to administer this type of nutrition are Covered.

Non-Covered Services

Except for formula specifically intended for tube feeding and nutrients necessary for IV feeding, all food, formula and nutritional supplements are not Covered. This includes, but is not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the FDA.

Medical Supplies

Covered Services

- (a) Medical supplies received while an inpatient or in connection with a home health visit are Covered at your Hospital benefit level.
- (b) Some medical supplies are Covered under your Durable Medical Equipment benefit, including such supplies as catheters, syringes, ostomy supplies, feeding tubes, and lancets.

Non-Covered Services

Certain outpatient medical supplies that are consumable or disposable supplies, including, among other things, gloves, diapers, adhesive bandages, elastic bandages, and gauze.

You may call our Customer Service Department or go to priorityhealth.com to find out if the medical supplies you need are Covered.

Prosthetic and Orthotic/Support Devices

Covered Services

- (a) Surgically implanted prosthetic devices, such as a replacement hip or heart pacemaker.
- (b) Externally worn prosthetic devices.
- (c) Purchased, repaired or replaced prosthetics and orthotics.
- (d) We will Cover the repairs or replacement, fitting and adjustment of Covered prosthetic and orthotic/support devices that is needed as a result of normal use, body growth or body change.

Coverage Limitations

Prosthetic and Orthotic/Support Devices are Covered when provided by Network Providers only.

Non-Covered Services

- (a) Prosthetic and Orthotic/Support Devices provided by a Non-Network Provider.
- (b) All repairs and maintenance that result from misuse or abuse.
- (c) Appliances that have been lost or stolen.
- (d) Prosthetic or orthotic devices that are not conventional, not Medically/Clinically Necessary according to the criteria set forth in our medical policies, or are for the convenience of the Member or caregivers.

You may call our Customer Service Department or go to priorityhealth.com to find out if the prosthetic or orthotic/support device you need is Covered.

F. Behavioral Health Services

Mental Health Services

A Mental Health Condition means a clinically significant behavioral or psychological condition or syndrome causing distress, disability or functional impairment, regardless of the cause. Mental Health Conditions include: psychosis, depression, schizophrenia, bipolar affective disorder and other psychiatric illnesses listed in the current Diagnostic and Statistical Manual (DSM) of Mental Disorders of the American Psychiatric Association.

Non-Covered Services

Evaluation, consultation and treatment (in any setting) for a Mental Health Condition, including acute crisis interventions, are not Covered under this Policy. Prescription drugs used primarily to treat mental health disorders are not Covered under this Policy.

Substance Abuse Services

Covered Services

Substance abuse services, including counseling, medical testing, diagnostic evaluation and detoxification are Covered in a variety of settings. You may be treated in an inpatient or outpatient setting, depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know what the most appropriate treatment setting is for your condition, call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance. Priority Health follows the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Inpatient substance abuse services (including partial hospitalization) require Prior Approval from our Behavioral Health Department, except in a Medical Emergency. Outpatient substance abuse services do not require referral from us.

Covered treatment includes:

- (a) Inpatient Detoxification. These are detoxification services that are provided while you are an inpatient in a Hospital or subacute unit. When provided in a medical setting, services are managed jointly by our Behavioral Health and Health Management Departments.
- (b) Medically Monitored Intensive Inpatient Treatment. Following full or partial recovery from acute detoxification symptoms, this type of care is provided at an inpatient facility or subacute unit.

- (c) **Partial Hospitalization.** This is an intensive, non-residential level of service provided in a structured setting, similar in intensity to inpatient treatment. You are generally in treatment for more than four hours but generally less than eight hours daily.
- (d) **Intensive Outpatient Programs.** These are outpatient services provided by a variety of Health Professionals at a frequency of up to four hours daily, and up to five days per week.
- (e) **Outpatient Treatment.** This is the least intensive level of service. It is provided in an office setting generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.
- (f) **Outpatient/Ambulatory Detoxification.** These detoxification services may be provided on an outpatient basis within a structured program when the consequences of withdrawal are non-life-threatening. These services are Covered under your medical benefits.

Coverage Limitations

Prescription Drug Coverage is only available when you are confined as an inpatient.

Non-Covered Services

- (a) The costs of residential treatment programs without medical monitoring, institutional care, non-licensed programs, half-way houses or assisted living settings.
- (b) Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.
- (c) Services for caffeine abuse or addiction.
- (d) Experimental/investigational or unproven treatments and services.

G. Family Planning And Maternity Care Services

Abortions

Non-Covered services

All services and supplies relating to elective abortions.

Contraceptive Medications and Devices

Non-Covered Services

Contraceptive medications and devices.

Complications of a Pregnancy

Covered Services

Complications of a Pregnancy, as defined in Section 17 of this Policy, are Covered as any other Illness under the terms and conditions of this Policy.

Maternity Care Services

Non-Covered Services

Prenatal, delivery and post-partum Maternity Care services for the mother and well newborn are not Covered under this Policy.

Newborn Care for Injury or Illness

Covered Services

This plan Covers a Subscriber's Newborn child, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, for the first 31 days. If you want the Newborn's Coverage to continue beyond the first 31 day period, you must fill out and return to us a Change Form within 31 days after the child is born. Section 3.B explains the proper enrollment procedures.

Covered Services include telephone assessment and home visits by a registered nurse shortly after the date of the Newborn's discharge for evaluation of the Newborn. These services are only Covered if Medically/Clinically Necessary.

Reproductive Services.

Non-Covered Services

- (a) Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility including, but not limited to, sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.
- (b) Advice on contraception and family planning, including childbirth education.
- (c) Genetic counseling, testing and screening services
- (d) Contraceptives, including birth control pills, implantable contraceptive drugs (including insertion and removal), diaphragms or devices, and IUD's.
- (e) Condoms, contraceptive foams, contraceptive jellies and ointments.
- (f) Sterilization procedures such as tubal ligations, tubal obstructive procedures and vasectomy.
- (g) Services to reverse voluntary sterilization.
- (h) All services and supplies relating to treatments for infertility including, among other things, artificial insemination, in-vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, fees to a surrogate parent, prescription drugs designed to achieve pregnancy, harvest preservation and storage of eggs or sperm.

H. Dental, Vision And Hearing Services

1. Dental Services

Non-Covered Services

The following dental services are not Covered, even when needed due to an underlying medical condition or in conjunction with other treatment or surgery:

- (a) Routine dental services not listed in Priority Health's Preventive Health Care Guidelines.
- (b) Dental x-rays.
- (c) Dental surgery, such as root canals and tooth extractions.
- (d) Facility, ancillary and anesthesia services for dental services.
- (e) Orthodontia and orthodontic x-rays.
- (f) Orthognathic surgery.
- (g) Dental prostheses, including implants and dentures and preparation of the bone to receive implants or dentures.
- (h) Bite splints used for dental purposes.
- (i) Treatment of congenital dental defects, such as missing or abnormally developed teeth.
- (j) Treatment, services and supplies related to periodontal/ inflammatory gum disease.
- (k) Dental services required due to accidents.

Oral Surgery

Covered Services

- (a) Treatment of fractures of facial bones.
- (b) Biopsy and removal of tumors or cysts of the jaw, other facial bones, soft tissues of the mouth, lip, tongue, accessory sinuses and salivary glands and ducts.
- (c) Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury. This includes treatment for abnormalities such as cleft lip or cleft palate, among other things.
- (d) Medical and surgical services required to correct accidental Injuries including emergency care to stabilize dental structures.

- (e) Treatment of oral and/or facial cancer.
- (f) Treatment for conditions affecting the mouth, other than the teeth.

Non-Covered Services

- (a) Rebuilding or repair for cosmetic purposes.
- (b) Orthodontic treatment, even when provided along with oral surgery.
- (c) Dental surgery in preparation for implants or dentures, including preparation of the bone, or dental surgery done in connection with any of the Covered Services listed above.

Orthognathic Surgery

“Orthognathic surgery” is surgical treatment to restructure the bones or other parts of the jaw to correct a congenital birth defect, the effects of an Illness or Injury, or to correct other functional impairments.

Non-Covered Services

Orthognathic surgery is excluded from Coverage. The following orthognathic surgery services and any other orthognathic services are excluded from Coverage, even if deemed Medically/Clinically Necessary:

- (a) Referral care for evaluation and orthognathic treatment.
- (b) Cephalometric study and x-rays.
- (c) Orthognathic surgery and post-operative care, including hospitalization, if necessary.
- (d) Orthodontic treatment, even when provided along with orthognathic surgery.

Temporomandibular Joint Dysfunction or Syndrome

"Temporomandibular Joint Syndrome" or "TMJS" means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction. Medical care or services to treat temporomandibular joint dysfunction or TMJS resulting from a medical cause or Injury are not Covered.

Non-Covered Services

- (a) Office visits for medical evaluation and treatment.
- (b) Specialty referral for medical evaluation and treatment.
- (c) X-rays of the temporomandibular joint including contrast studies.
- (d) Myofunctional therapy.
- (e) Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.
- (f) Bite splints, orthodontic treatment, or other dental services to treat temporomandibular joint dysfunction or syndrome.

2. Vision Care Services

Covered Services

One vision screening, performed as part of a physical exam, during each calendar year to determine vision loss.

Non-Covered Services

- (a) Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses.
- (b) Eye exercises, visual training, orthoptics, sensory integration therapy.
- (c) Radial keratotomy, laser surgeries and other refractive keratoplasties.
- (d) Refractions (tests to determine if eyeglasses are needed, and if so, what prescription).
- (e) All other vision care services.

3. Hearing Care Services

Covered Services

One hearing screening, performed as part of a physical exam, during each calendar year to determine hearing loss.

Non-Covered Services

- (a) Services and supplies related to hearing care, including ear plugs, external BAHA devices, hearing aids and adjustments.
- (b) Examinations for hearing aids, including examination performed during a Covered hearing screening.

I. Additional Coverage Information

Against Medical Advice/Noncompliance

Non-Covered Services

Services that are needed because you left a facility against medical advice or because you are noncompliant with treatment are not Covered.

Examples of services that may not be Covered include, but are not limited to:

- (a) Emergency room services shortly after you left a facility against medical advice;
- (b) A Hospital stay to treat complications caused by leaving a facility against medical advice;
- (c) A Hospital stay to treat complications caused by not taking prescribed medications such as insulin or blood pressure medication.

Court Ordered Services

Covered Services

If a court orders services that are otherwise Covered under this Policy, they will be Covered. All provisions of this Policy, such as Prior Approval requirements, still apply when services are ordered by a court.

Non-Covered Services

Services required by court order, when filing or responding to an action with a court, including evaluations and testing, or services required as a condition of parole or probation, if those services are not otherwise Covered under this Policy.

Domestic Violence

Covered Services

Treatment, services and supplies for Injuries resulting from domestic violence.

Experimental, Investigational or Unproven Services

Priority Health uses the following criteria when evaluating new technologies, procedures and drugs:

- (a) Evidence of clear therapeutic effectiveness when used in the general population as demonstrated in peer-reviewed clinical trials.
- (b) Evidence of patient safety when used in the general population.
- (c) Evidence that the medical community in general accepts the safety and effectiveness of the service outside of investigational setting.
- (d) Evidence of clinically meaningful outcomes.
- (e) Evidence that clinically meaningful outcomes can be attained at a reasonable cost.

Non-Covered Services

Any drug, device, treatment or procedure that is experimental, investigational or unproven. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:

- (a) The drug or device has not been approved by the Food and Drug Administration (FDA) and, therefore, cannot be lawfully marketed in the United States.

- (b) An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy.
- (c) The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy.
- (d) Reliable Evidence shows that the drug, device, treatment or procedure is:
 - (i.) The subject of on-going Phase I or Phase II clinical trials; or
 - (ii.) The subject of research, experimental study, or the investigational arm of on-going Phase III clinical trials; or
 - (iii.) Otherwise under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or
 - (iv.) Believed by a majority of experts to require further studies or clinical trials to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis.

"Reliable Evidence" includes any of the following:

- Published reports and articles in authoritative medical and scientific literature, or technology assessment and cost effectiveness analysis; or
- A written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same or a similar drug, device, treatment or procedure; or
- Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device, treatment or procedure.

Not Medically/Clinically Necessary

Non-Covered Services

Services and supplies that we determine are not Medically/Clinically Necessary according to medical and behavioral health policies established by us with the input of Physicians not employed by us or according to criteria developed by reputable external sources and adopted by us are not Covered.

All of the following are considered not to be Medically/Clinically Necessary:

- (a) Those services rendered by a Health Professional that do not require the technical skills of such a Provider;
- (b) Those services and supplies furnished mainly for the personal comfort or convenience of you, anyone who cares for you, or anyone who is part of your family;
- (c) Those services and supplies furnished to you as an inpatient on any day on which your physical or mental condition could safely and adequately be diagnosed or treated as an outpatient;
- (d) Any services or supplies beyond those services sufficient to safely and adequately diagnose or treat your physical or mental condition;
- (e) Additional or repeated services or treatments of no demonstrated additional benefit.

NOTE: If we exclude Coverage because a service or supply is not Medically/Clinically Necessary, that decision is a determination about benefits and not a medical treatment determination or recommendation. You, with a Physician, may choose to go ahead with the planned treatment at your own expense. You have the option to Appeal our denial of your claim for Coverage as described in Section 11.

Other Non-Covered Services

Non-Covered Services

- (a) **Illegal Acts.** Priority Health shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

We reserve the right to recover the cost of services and supplies that were initially Covered by us and later determined to be excluded as described in this **Illegal Acts** section.

- (b) **No Legal Obligation to Pay.** Services and supplies are not Covered if you would not be required to pay for them if you did not have this Coverage. This includes, among other things, services and supplies performed or provided by a family member.
- (c) **No Show Charges.** Any missed appointment fee charged by a Provider because you failed to show up at an appointment, except in the case of a Medical Emergency.
- (d) **Third Party Requirements.** Services required or recommended by third parties, such as courts, schools, employers, or accrediting/licensing agencies, related to getting or keeping a job, getting or keeping any license issued by a governmental body, getting insurance coverage, foreign travel, adopting children, obtaining or maintaining child custody, school admission or attendance and participation in athletics. Non-Covered Services include but are not limited to:
 - (i.) physical examinations in excess of one per year performed by your Physician or other Health Professional,
 - (ii.) diagnostic services; and
 - (iii.) immunizations.
- (e) **Unauthorized Services and Supplies.** The following are not Covered:
 - (i.) Services and supplies that are not performed, prescribed, or arranged according to the guidelines of this Policy; and
 - (ii.) Services and supplies that are provided without any required Prior Approval by us.
- (f) Services and supplies not directly related to your care, such as guest meals and accommodations, telephone charges, travel expenses, take-home supplies and similar costs.
- (g) **Items or Services Furnished, Ordered or Prescribed by any Provider included on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities.** This list is available on the OIG website at www.hhs.gov/oig.
- (h) **Treatment by a Federal, State, or Governmental Provider.** The following are excluded to the extent permitted by law:
 - (i) Services and supplies provided in a Non-Network Hospital owned or operated by any federal, state, or other governmental entity.
 - (ii) Services and supplies provided for conditions relating to military service, if you are legally entitled to the services and supplies and if you have reasonable access to the services and supplies at a governmental facility.
 - (iii) Services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment.

SECTION 7. Limitations

A. Benefit Maximums.

Some of the Covered Services described in this Policy are Covered for a limited number of days or visits per Contract Year. This is known as a benefit maximum.

The Schedule of Benefits and any Addenda to this Policy list the maximums that apply to certain benefits. The schedule will specify the benefit maximum for services received at the Network Benefits Level and at the Non-Network Benefits Level. The benefit maximums are reached by combining benefits received under the Network and Non-Network Benefits levels. For example, under both the Network and Non-Network Benefits Level, Skilled Nursing Services may be Covered for no more than 45 days per Contract Year. The Network Benefits Level provides 45 days and the Non-Network Benefits Level also provides 45 days. You may receive services at the Network Benefits Level, Non-Network Benefits Level or both, but the benefit maximum is 45 days, not 90.

Once you reach a maximum for a Covered Service, you will be responsible for the cost of additional services received during the Contract Year even when continued care is Medically/Clinically Necessary. The cost of those additional services will not count toward your Deductible or Out-of-Pocket Maximum.

B. Out-of-Pocket Maximums.

There may be a limit to the total amount of percentage Copayments that you have to pay for Covered Services in a Contract Year. This limit is called an Out-of-Pocket Maximum. After meeting this maximum, you are still responsible for flat-dollar Copayments. The Schedule of Benefits and any Addenda to this Policy provide more information about Out-of-Pocket Maximums that may apply to you.

C. Maximum Individual Annual Benefit for Network and Non-Network Benefits.

The Maximum Individual Annual Benefit is the total amount that will be paid for all Covered Services, received at the Network and Non-Network Benefits Level, combined for any Member during the Contract Year while Covered under this Policy. The maximum, if any, that applies to your Coverage is listed in the Schedule of Benefits.

D. Work-Related Illness or Injury; Other Activities.

We will not pay for any expenses incurred because of Illness or Injury arising out of or in the course of gainful employment. This is true whether or not you apply for Worker's Compensation benefits. Coverage under this Policy is not intended to replace, duplicate, or substitute for any Worker's Compensation coverage.

This limitation does not apply to a sole proprietor, partner (or spouse, child, or parent of a sole proprietor or partner), or corporate officer (who is an officer and stockholder owning at least 10% of the stock of a corporation that has 10 or fewer stockholders) if that person has been excluded from Coverage as an "employee" under the Michigan Worker's Compensation Act. If this limitation applies to you, please provide information directly to us.

We will not pay for charges for treatment of an Injury received while engaging in any dangerous activity for which compensation or prize money is received, including, but not limited to the following:

- a) Participating, instructing, demonstrating, guiding, or accompanying others in parachute jumping, hang gliding, bungee jumping, competing with any motorized vehicle, skiing, or horse riding; or
- b) Practicing, exercising, conditioning, or other physical preparation for any such compensated activity.

E. Motorized Vehicle.

We will not pay for Covered Services you receive for treatment of Injury arising out of ownership, operation, maintenance or use of a motorized vehicle as a motorized vehicle.

F. Reasonable and Customary.

Network Providers contract with us to provide Covered Services to Members at negotiated rates. We do not have contracts or negotiated rates with Non-Network Providers. If we haven't negotiated a rate with a Non-Network Provider, the maximum benefit we will pay for any Covered Services at the Non-Network Benefits Level is the Reasonable and Customary charge as defined in Section 17. A Non-Network Provider may bill you for the difference between the Provider's charges and the Reasonable and Customary charge.

G. Services Received While a Member.

We will only pay for Covered Services you receive while you are a Member and Covered under the Policy. A service is considered to be received on the date on which services or supplies are provided to you. We can collect from you all charges for Covered Services that you receive and we pay for after your Coverage terminated, plus our costs of recovering those charges (including attorney's fees).

Because you lose your eligibility when in detention or incarcerated in a facility such as a youth home, jail or prison or otherwise in the custody of law enforcement officers, services received under such circumstances, or when on release for the sole purpose of receiving treatment, are not Covered. If you are admitted to a Hospital while in custody, the entire inpatient stay will not be Covered.

H. Uncontrollable Events.

A national disaster, war, riot, civil insurrection, epidemic or other similar event we cannot control may make our offices, personnel or financial resources unable to provide or arrange for the provision of Covered Services. If any of these events occur, Priority Health will not be liable if you do not receive those services or if they are delayed. We will make every effort to ensure necessary services are provided.

I. Physical Examinations And Autopsy.

We have the right and opportunity (at our own expense) to examine the person of the Member when and as often as it may reasonably require when reviewing and paying all outstanding claims and to require an autopsy in case of death where it is not forbidden by law.

J. Right to Amend or Terminate Policy.

You do not have any vested right to any current or future benefits under this Policy. Your right to benefits is limited to claims you incur before any of the following occurs: amendment of the Policy, termination of the Policy, expiration of the applicable limitations period, or termination of your participation (including termination of any extension period for which you have properly elected and paid). We may change this Policy and any benefits provided under it at any time. We will promptly notify you of any change or termination.

SECTION 8. Your Rights and Responsibilities

As our Member, you have the right to:

- receive prompt medical care appropriate for your condition, including emergency care if necessary.
- discuss all treatment options available to you regardless of Coverage limitations.
- receive information about us, our services, our Providers and your rights and responsibilities.
- Collaborate with Physicians and Health Professionals to make informed decisions about the care you receive.
- be treated with respect.
- have your privacy protected.
- have your medical and financial records maintained by us kept confidential, whether in electronic or written form. We will not disclose information from your medical records without your consent, except as allowed in accordance with our Notice of Privacy Practices which is included as Section 19 of this Policy.
- be notified in a timely manner if we release personal information about you in response to a court order.
- inspect your medical records and those of your minor dependents. Your right as a parent or legal guardian to access your minor dependent's medical records, without the minor's consent, may be limited by state or federal law.
- contact us to discuss concerns about the quality of care you have received from a Provider.
- register a complaint or file an Appeal with us, or with the Commissioner of the Office of Financial and Insurance Regulation and/or other appropriate state agency, if you experience a problem with us, or a Provider.
- initiate a legal proceeding if you experience a problem with us or Providers after you have exhausted the Appeal Process.
- register a complaint, file an Appeal, or initiate legal proceedings without retaliation by us.
- review a summary of our annual report, and inspect the full report on file with the Office of Financial and Insurance Regulation.
- suggest changes to our Rights and Responsibilities policies for Members.

As our Member, you are responsible for:

- reading the Policy and accompanying Member materials.
- understanding and complying with the terms and conditions of your health benefits contained in this Policy.
- calling us with questions.
- obtaining Prior Approval from us as specified in this Policy, except in Medical Emergencies, and complying with the limits of any approval of services.
- contacting Providers to arrange for appointments, and notifying Providers in a timely manner if an appointment must be canceled.
- paying Copayments at the time service is provided and Deductibles, Coinsurance and any amount over Reasonable and Customary when billed by the Provider.
- presenting your ID card to the Provider before you receive a service.
- collaborating with Physicians and Health Professionals to make informed decisions about the care you receive and to understand your health risks.

- following instructions and working toward treatment goals that you and your provider agree upon. You may participate in developing your treatment goals when possible. We or your Providers may ask you to enter into an explicit written agreement describing your treatment plan to ensure you understand it.
- supplying us and Health Professionals with accurate and complete information to ensure you receive proper care.
- notifying Providers and us if you have other health insurance coverage.
- providing accurate information on your Application and in any other information provided to us.
- promptly notifying us of any change in address.
- promptly notifying us if your ID card is stolen.
- cooperating with us to prevent the unauthorized use of your ID card and to prevent anyone from obtaining benefits in your place.
- treating Providers and their staff with respect

SECTION 9. Claims Provisions

I. FOR NETWORK BENEFITS AND NON-NETWORK BENEFITS

When you receive Covered Services from a Network Provider, you will not be required to pay any amounts except for applicable Copayments, Deductibles, and Coinsurance as shown in the Schedule of Benefits. You will not be required to submit any claim forms for Covered Services received from Network Providers.

A. If You Pay for Covered Services:

If you pay a Provider for Covered Services, ask us in writing to be reimbursed for those services. A Reimbursement Request Form is available in the Member Center on our website or by calling our Customer Service Department. With your request, you must give us proof of payment that is acceptable to us. You must send a bill that shows exactly what services were received, including applicable diagnosis and CPT codes, and the date and place of service. A statement that shows only the amount owed is not sufficient. If you have questions about what to send us, please call our Customer Service Department.

B. Reimbursement Request Time Limit:

- We ask that you make your request for reimbursement within 60 days of the date you obtained the services. If you do not ask for reimbursement within 60 days, we can limit or refuse reimbursement. But we will not limit or refuse reimbursement if it is not reasonably possible for you to give us proof of payment in the required time, as long as you give us the required information as soon as reasonably possible.
- We will only be liable for a claim or reimbursement request if we receive it within one year after the date you receive the services, unless you didn't submit the claim because you are legally incapacitated.

C. Where to Send Your Bills:

Send your itemized medical bills promptly to us at the address on the back of your ID card.

D. Information May Be Required for Payment:

Before we pay Providers or reimburse you for services you receive, we may require you to give us more information or documentation to prove they are Covered Services. Unless you are legally incapacitated and, therefore, unable to respond, we will not be liable for a claim or reimbursement request if we ask for additional information from you and you do not respond to our request within 60 days. Our right to that information or documentation may be limited by state or federal law.

II. PROVISIONS REQUIRED BY MICHIGAN INSURANCE CODE

A. Notice Of Claim.

Written notice of a claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible.

Notice given by or on behalf of the Member or the beneficiary to the insurer at Priority Health Claims Department, P.O. Box 232, Grand Rapids, MI, 49501-0232, or to the address referenced on your ID card, or to any authorized agent of the insurer, with information sufficient to identify the Member, shall be deemed notice to the insurer.

Subject to the qualifications set forth below, if the Member suffers loss of time due to a disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the Member or any payment by the insurer due to such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the Member's right to any indemnity which would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given.

B. Claim Forms.

We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which a claim is made.

C. Proof Of Loss.

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

D. Time Of Payment Of Claims.

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid weekly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

E. Payment Of Claims.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Member. Any other accrued indemnities unpaid at the Member's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Member.

F. Legal Actions.

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

SECTION 10. Termination of Coverage

A. Termination of Policy.

The Subscriber may terminate the Policy by giving at least 10 days notice. Notice may be given in writing or by calling our Customer Service Department. The termination will be effective on the last day of the month, following the 10 day notice period. Coverage under this Policy will terminate at 11:59 p.m. on the effective date of termination of this Policy.

If you lose your Coverage, we can collect from you all costs for Covered Services that you receive after your Coverage terminated and we paid for, plus our cost of recovering those charges (including attorney's fees).

B. Non-Payment of Premium

If Premiums are not paid in full on or before the first of the month, you are in default. As outlined in Section 12, you have a 30-day grace period during which time you may make payment and your Coverage will not be terminated. The termination will be effective at the end of the last Premium period for which we have received payment. That means we can collect from you all costs for Covered Services that you received after your Coverage terminated and we paid for, plus our cost of recovering those charges (including attorney's fees).

C. Loss of Eligibility.

If you no longer meet the eligibility requirements described in Section 2 of this Policy or in Addenda or amendments to this Policy, your Coverage will terminate.

Your Coverage will terminate at 11:59 p.m. on the date you lose your eligibility.

D. Termination For Cause.

(1) We can terminate your Coverage for cause 30 days after we notify you in writing if any of the following happens:

- (a) Multiple Network Providers ask you to leave their practices due to disruptive behavior.
- (b) You fail to pay any required Premium before the end of the grace period.
- (c) You refuse to cooperate with us as required by the terms of this Policy.
- (d) You revoke your consent for us to release information to third parties or to receive information regarding your medical care, if your revocation makes it impossible for us to fulfill our responsibilities under this Policy.

(2) We can terminate your Coverage for cause immediately if either of the following happens:

- (a) You commit or attempt to commit fraud against us or you are dishonest with us about some important or material matter. For example, we may terminate your Coverage if:
 - (i.) you give us wrong or misleading information that affects the Coverage we provide to you and/or your Covered Dependents,
 - (ii.) you allow someone else to use your ID card or receive benefits in your place.
 - (iii.) you enroll someone in this plan who is not eligible for Coverage.

Termination may be effective the day you committed the fraud or were dishonest with us. We can collect from you the costs for Covered Services that you received after the effective date of termination and we paid for, plus our cost of recovering those charges (including attorney's fees).

We will only rescind your Coverage as permitted by federal law, which allows rescission for fraud or material misrepresentation. Rescission means terminating your Coverage retroactively to your original effective date with us, with the effect that your Coverage never existed; or

- (b) You act so disruptively that you upset our ordinary operations or those of a provider, including but not limited to verbally or physically threatening us or a provider.

If we tell you we have terminated or will terminate your Coverage, we will terminate your Coverage on the date stated in the notice. If you file an Appeal within 30 days of the date of the notice, we will reinstate your Coverage until a determination is made under Step 1 of the Appeal Procedure. If the Appeal Committee determines that your Coverage should be terminated for cause under this Section, we will terminate your Coverage back to the date stated in the original termination notice. We will only reinstate your Coverage if your Premium is paid up to that time. Section 11 provides more information about the Appeal Procedure.

Priority Health is entitled to reimbursement for any payments made for Covered Services you received after your termination date.

E. Reinstatement.

If your Coverage was terminated under this Policy because you no longer meet the Dependent Eligibility requirements described in Section 2.B, you are eligible to apply for a Priority Health Insurance Company Individual plan as a Subscriber.

If your Coverage was terminated under this Policy for any reason other than those stated above, you are not eligible to enroll for Coverage under any Priority Health Insurance Company Individual plan following your date of termination under this Policy.

If any renewal premium is not paid within the time granted you for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy, provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified you in writing of its disapproval of such application.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the Member and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

F. Time Limit on Certain Defenses.

After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such 3-year period.

(The foregoing policy provisions shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 3-year period, nor to limit the application of sections 3432 (change of occupation), 3434 (misstatement of age), 3436 (other insurance – same insurer), 3438 (insurance with other insurers – provision of service or expense incurred basis), and 3440 (insurance with other insurers) in the event of misstatement with respect to age or occupation or other insurance.)

G. Cancellation:

We may cancel this Policy at any time by written notice delivered to the Subscriber, or mailed to the Subscriber, stating when, not less than 5 days thereafter, the cancellation shall be effective; and after the Policy has been continued beyond its original term, you the Subscriber may cancel this Policy at any time by written notice delivered or mailed to us, effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, we may retain the pro rata premium for the expired time or \$25.00, whichever is greater. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

H. Certificate of Creditable Coverage.

After your Coverage is terminated for any reason, you and/or your Covered Dependent(s) will receive a Certificate of Creditable Coverage that will provide proof of the Coverage you had with us. In addition, you have the right to receive a Certificate of Creditable Coverage if you request one for yourself or your dependent(s) at any time within 24 months after the Coverage terminates. If you become covered by other health insurance, a Certificate of Creditable Coverage may help you to receive the new coverage without a pre-existing condition exclusion or with a shorter exclusion period.

You or your Covered Dependents may request a Certificate of Creditable Coverage by writing or calling Customer Service at:

Priority Health
Customer Service Department, MS FH 5
34505 West Twelve Mile Road
Farmington Hills, MI 48331
800 528-8762

or use our secure e-mail form in the Member Center on our website at priorityhealth.com.

SECTION 11. Inquiry, Appeal and Expedited Review Procedure

We hope that you are always happy with the services you receive from us. We know, however, that from time to time you may have a problem or concern that you want us to address. If you have a question, concern or complaint, please call our Customer Service Department at 800 528-8762 or use our secure e-mail form in the Member Center on our website. Our Customer Service representatives will help you with your problem as soon as possible.

If you are not happy with answers that our representative has provided or you are unhappy with our decision, you can start the formal Appeal Procedure about any of the following:

- Benefits (including services determined to be experimental or investigational or not Medically/Clinically Necessary or appropriate);
- Eligibility;
- Rescission of your Coverage;
- Payment of claims (in whole or in part);
- How we've handled payment or coordination of health care services;
- Contracts with our Providers;
- Availability of care or Providers;
- Delivery or quality of health care services; or
- A decision not in your favor. This may include services that have been reviewed by us and denied, reduced or terminated. It also may include a slow response to a request for a decision from us.

A. Appeal Process.

Here is a summary of the Appeal process:

Step 1: Filing an Appeal with Priority Health

Contact our Customer Service Department or go to our website to file a formal Appeal with us. After we receive your Appeal, the Appeal Committee reviews your case. The members of the Appeal Committee may include Priority Health employees, Priority Health members, local employers who offer Priority Health coverage to their employees, and Physicians from the Priority Health Network. When a medical issue is being reviewed, the Appeal Committee always receives an opinion from a Physician.

You may attend your Appeal. You may participate via telephone or have someone act as your authorized representative at the Appeal, if necessary. We will let you know the date, time and location of the review after we receive your request for Appeal. We will explain what will happen during the review and give you, free of charge, a copy of the material that will be reviewed by the Appeal Committee. During the review, you or your representative will have the chance to talk to the Appeal Committee.

After this review, the Appeal Committee will make a decision, and we will mail you a written response within five full business days of the review.

If you have not yet received the services for which you are requesting Coverage: The review must be completed with a final determination made within 30 calendar days after we receive your Appeal Form. The 30 calendar days do not include any days you or your representative may delay the process.

If you have received the services for which you are requesting Coverage: The review must be completed with a final determination made within 35 calendar days after we receive your Appeal Form. The 35 calendar days do not include any days you or your representative may delay the process.

Step 2: External Review

If you are not satisfied with the resolution of your problem or complaint after completing the Priority Health Appeal Process, you may ask for an external review by the Michigan Office of Financial and Insurance Regulation (OFIR). You may also request a review by OFIR if we do not meet the timeline requirements of our internal Appeal process, as explained above. However, if you have agreed to give us more time to make a decision, you may not request an external review until we have made our decision.

You may direct your request for external review to the Commissioner at the following address and telephone number:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, Third Floor
P. O. Box 30220
Lansing, Michigan 48909-7720
877 999-6442
www.michigan.gov/ofir

B. Expedited Appeal Procedure.

Priority Health will follow a faster review process if your Physician tells us, verbally or in writing, that the normal time it takes for us to complete step 1 of the Appeal process would:

- put your life in serious danger,
- interfere with your full recovery or
- delay treatment for severe pain.

We will make a decision within 72 hours (three days) from the time we get your request. This timeline begins when we receive your request. During non-business hours, you can leave a message at 877 954-1035 (toll free) to make a request.

As soon as the expedited review is finished, we will contact you by telephone to tell you our decision. We will also send a letter no more than two business days later with our decision.

If you are not happy with the outcome, you may appeal to OFIR within 10 days after you receive the final decision about your expedited review. You may also ask OFIR for an expedited review if:

- You have already asked for an expedited review by Priority Health, and
- Your Physician tells OFIR, either in writing or by telephone, that waiting for Priority Health's decision before requesting an expedited external review would put your life in danger or would interfere with your full recovery.

OFIR's expedited review will be done within 72 hours (three days) from the time OFIR gets it from you.

C. Obtaining Information about the Appeal Procedure.

To obtain a complete copy of our Inquiry, Appeal and Expedited Review Procedure and Appeal Filing Form, or to find out more about your rights under this section, please contact our Customer Service Department or go to our website.

D. Obtaining Information about your Appeal.

You have the right to receive, free of charge, access to and copies of all documents relevant to a claim denial.

E. Filing a Lawsuit against Priority Health.

You have the right to bring an action for benefits. However, before filing a lawsuit against us, you must complete our Inquiry, Appeal and Expedited Review Procedure as described in this Section 11. In addition, you must file suit no later than three years after the date of service or receiving notice that Coverage for the requested service is denied.

SECTION 12. Premium Payments and Renewal Terms

Your enrollment packet includes information about Premiums due in exchange for Coverage under this Policy. These Premiums are effective for your initial term of Coverage, which begins on the effective date of the Policy and ends on December 31st of that year. Premiums are due in full at Priority Health on or before the first day of each month for the following month's Coverage unless arrangements have been made with us to make payments on other than a monthly basis. Each Premium period, whether monthly or otherwise, shall end at 11:59 p.m. E.S.T.

Excluding your first Premium payment, all payments are subject to a 30-day grace period. During this time, Premiums must be paid to us without lapse of Coverage. If the Premium is not paid within that grace period, your Coverage will be terminated at the end of that Premium period. If you fail to pay the required Premium and Coverage is terminated, we can collect from you all costs of Covered services that you received and we paid for during the 30-day grace period, plus our costs of recovering those charges (including attorney's fees).

By giving you 30 days written notice, we may change the Premium mid-year or following a change in law or regulation that directly impacts the cost of providing Coverage under this Policy, such as an increase in premium tax or additional mandated coverage to be Covered under this Policy. Additionally, if there is a change in law or regulation that directly impacts the cost of providing Coverage under this Policy; we may change the Premium before the renewal of this Policy.

Following the initial term, this Policy will renew automatically for an additional 12 months as long as all terms and provisions continue to be satisfied and the Policy is not otherwise terminated. Prior to the renewal date, we will notify you of any benefit or Premium changes or any changes to other provisions of this Policy. Payment of the applicable Premium on and after that date will be considered acceptance of those changes by you and your Covered Dependents.

We will not refuse to renew this Policy based on your medical condition or health care needs. We will not refuse to renew this Policy unless this entire class of Policies is discontinued.

If there is a benefit or Premium change, you may terminate this Policy by providing at least 10 days written notice. The termination will be effective on the date of renewal or the date the Premiums change mid-year or as a result of change in law or regulation.

SECTION 13. Successor Subscriber

If the Subscriber dies or his or her Coverage terminates due to loss of eligibility, the Subscriber's spouse, if enrolled as a Covered Dependent at that time, will become the Subscriber. If, at the end of a Premium period, there is no Subscriber, this Policy will terminate.

SECTION 13. Continuation of Coverage and Extension of Benefits

A. Continuation of Coverage for Unmarried and Incapacitated Dependents.

We will continue to provide Coverage for your or your spouse's unmarried and Incapacitated Dependent past the age of 26, except as described below. A Covered Dependent is incapacitated if all of the following apply:

- (1) The Covered Dependent is the child of you or your spouse;
- (2) The Covered Dependent is not capable of self-sustaining employment and unable to independently socialize without assistance because of a mental or physical disability that is incapacitating. Certain diagnoses, including but not limited to attention deficit disorder or depression, by themselves, are not evidence of incapacity. Learning disabilities or the inability to "hold a job" alone is not evidence of incapacity. Examples of diagnoses that may constitute an incapacitating condition include Down Syndrome and traumatic brain injury.
- (3) The incapacity must have started before age 26; and
- (4) The Covered Dependent relies on you for more than half of his or her support, as determined under Section 152 of the Internal Revenue Code, as amended.

You must provide proof to us that the Covered Dependent is incapacitated no more than 31 days after the Covered Dependent reaches the age of 26. If your Covered Dependent is over the age of 26 at the time of enrollment, proof must be provided within 31 days of initial enrollment. After that the initial proof of incapacitation, you must give us proof when we ask for it, from time to time, but not more often than once each year.

Coverage for an Incapacitated Dependent will end if any of the following events occur:

- (a) The dependent is no longer a dependent of you or your spouse as described in subsection A(4) above;
- (b) The dependent's incapacity ends;
- (c) We do not receive proof that the dependent is incapacitated within 31 days of requesting such information;
- (d) The dependent no longer meets eligibility requirements for any reason other than reaching 26 years of age; or
- (e) The dependent is married after reaching 26 years of age.

B. Extension of Benefits if You Are Confined.

If you are confined for medical treatment in a facility, other than your home, at the time the Policy is terminated or you lose eligibility, we will continue to be responsible for certain Covered Services. We will only Cover services that are necessary to treat the medical condition for which you are confined and which would otherwise be Covered under this Policy. A move to an alternative care facility, such as a skilled nursing facility, hospice facility or rehabilitation facility, is not considered a discharge from confinement under this provision. As soon as one of the following happens, you will stop receiving benefits under this subsection B:

- (1) The confinement is no longer Medically/Clinically Necessary;
- (2) You reach the maximum benefit limits for the Covered Services available for that confinement or condition;
- (3) You become eligible for similar coverage from another health plan, whether individual, group or governmental; or
- (4) 12 months passes from the day your Coverage under the Policy ended.

You must pay the required Premium to maintain your Coverage.

SECTION 14. Subrogation and Reimbursement.

When you receive payment for Covered Services, you assign (or transfer) to us all of your rights of recovery from any third party. These rights of recovery include recoveries from tort-feasors, underinsured/uninsured motorist coverage, Worker's Compensation, other substitute coverage, any group or non-group policy of insurance providing health and/or accident coverage, including automobile insurance. Additionally, we have a right:

- (1) to subrogation. This means that we can stand in your or your estate's shoes and sue a third party directly for an Illness or Injury that we Covered.
- (2) of reimbursement. This means that we have a right to be reimbursed out of any recoveries you or your estate receives in the future or may have received in the past from third parties relating to your Illness or Injury that we Covered.
- (3) to pursue any other right of recovery, whether based in tort, contract, or any other body of law.

This assignment is to the fullest extent permitted by law. Our rights of recovery shall not be limited to recoveries from third parties designated for medical expenses, but shall extend to any and all recovered amounts. In the case of both subrogation and reimbursement, we will be permitted to pursue a recovery amount equal to the total amount paid by us, or the cost of services provided by us, as applicable, plus reasonable collection costs, because of an Illness or Injury for which you (or your estate or guardian) have or has a cause of action. You are required, when requested, to acknowledge our rights of recovery in writing. Our right of recovery, however, is not dependent upon this acknowledgement. Tell us immediately, in writing, about any situation that might let us invoke our rights under this Section.

You are expected to cooperate with us to help protect our rights under this Section. You agree that these rights will be considered the first priority claim with a first priority lien of 100% of the proceeds of any full or partial recovery against anyone else. Our claim will be paid before any other claims are paid, whether or not you have recovered your total amount of damages. We must be reimbursed in full before any amounts (including attorney's fees incurred by you or your guardian or estate) are deducted from the policy proceeds, judgment or settlement.

Neither you, nor anyone acting for you, will do anything to harm our rights under this Section. If you settle a claim or action against a third party, you will be considered to have been made whole by the settlement. We expressly reject the application of any "make whole," common fund or other claim or defense to Priority Health's subrogation or reimbursement rights. We will then have the right to immediately collect the present value of our right to reimbursement, as described above. Our claim will be the first priority claim from the settlement fund. If you receive any proceeds of settlement or judgment, and if we have a right of reimbursement in those proceeds, you must hold those proceeds in trust for us. Transfer of such funds to a third party does not defeat our right of reimbursement if the funds were or are intended for your benefit. We can recover from you expenses we incur because you failed to cooperate in enforcing our rights under this Section.

For purposes of this Section, the term "you" includes you and any person claiming through or on behalf of you, including relatives, heirs, assigns and successors.

SECTION 15. Provisions Required by Michigan Insurance Code

(1) Insurance with Other Insurers.

If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of a loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(2) Unpaid Premium.

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

SECTION 16. Non-Duplication of Benefits

Your benefits under this Policy cannot be doubled up with any benefits you are or could be eligible for under any other federal or state government program, including Medicare. Additionally, your benefits under this Policy are not intended to duplicate any “no fault” benefits. All sums payable under such governmental or “no fault” programs or policies for services that would otherwise be Covered by this Policy must be paid to us. Complete and submit to us any consents, releases, assignments or other documents that we request so that we may obtain or be assured reimbursement as described in this Section 16.

SECTION 17. Definitions

- (1) **Addendum.** A legal document that is part of your Policy, that explains any additional benefits, limitations or other modifications to the Coverage outlined in the Policy.
- (2) **Allowed Amount.** Maximum amount on which payment is based for Covered Services. The Allowed Amount is determined by us. If a Non-Network Provider charges more than the Allowed Amount, you may have to pay the difference. See Balance Billing for addition information.
- (3) **Appeal.** A formal complaint. You may file an Appeal if you want us to review a benefit or payment decision. A more detailed explanation of the Appeal procedure is available in Section 11 of this Certificate.
- (4) **Balance Billing.** When a Non-Network Provider bills you for the difference between the Provider’s charge and the Allowed Amount. For example, if a Non-Network Provider’s charge is \$100 and the Allowed Amount is \$70, the Non-Network Provider may bill you for the remaining \$30. A Network Provider may not Balance Bill you.
- (5) **Certificate of Creditable Coverage.** Information about the Certificate of Creditable Coverage is available in Section 10.G of this Policy.
- (6) **Child Placed for Adoption.** A child in your custody for whom you have assumed and retain a legal obligation to provide partial or total support in anticipation of adoption.
- (7) **Coinsurance.** The percentage of the cost of a Covered Service that you must pay directly to a Provider at the time you receive Covered Services and supplies. This percentage may also be called a Copayment.
- (8) **Complications of Pregnancy.** Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency cesarean sections are not Complications of Pregnancy.
- (9) **Contract Year.** The period of time that starts on the effective date of the Policy and ends on December 31st of that year. Each following Contract Year will begin on January 1st and end on December 31st of that year.
- (10) **Copayments.** The amount you must pay directly to a Provider for Covered Services at the time you receive the services and supplies. A Copayment may be either a flat dollar amount or a percentage, such as \$20.00 for a PCP office visit or 20% of the costs of outpatient surgery. A percentage Copayment may also be called Coinsurance.
- (11) **Covered Dependent.** An individual eligible to enroll in this plan as outlined in Section 2.B of this Policy.
- (12) **Covered Services, Coverage, Cover or Covered.** Services and supplies for which this plan will pay all or part of the costs, as listed in your Schedule of Benefits, so long as you meet the eligibility requirements outlined in Section 2 of this Policy. The services or supplies must be preventive or Medically/Clinically Necessary and not otherwise excluded by this Policy. When we say we will “Cover” a service or supply, that means we will treat the service or supply as a Covered Service.
- (13) **Custodial Care.** Care you receive if, in our opinion, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. This type of care includes room and board, therapies, nursing care, home health aides and personal care designed to help you in the activities of daily living and home care and adult day care that you receive, or could receive, from a member of your family.
- (14) **Deductible.** An amount that you must pay before Priority Health will pay for certain Covered Services under this Policy. For example, if your Deductible is \$1,000, we won’t pay anything for Covered Services that are subject to the Deductible until you’ve paid \$1,000 for those services. If you have a Deductible, it is shown on your Schedule of Benefits or an Addendum to this Policy.
- (15) **Disabled or Disability.** As determined by the Social Security Act, we will consider you to be Disabled or to have a Disability if a Health Professional has diagnosed a physical or mental impairment or combination of impairments that, based on your age, education and past work experience, prohibit you from performing any substantial gainful activity. The impairment or combination of impairments must have lasted or can be expected to last at least 12 consecutive months or result in death.

- (16) Durable Medical Equipment (DME). Information about DME is available in Section 6.E of this Policy.
- (17) Group. The employer or other entity through which you previously obtained health coverage from Priority Health Insurance Company.
- (18) Health Professional. An individual licensed, certified or authorized under state law to practice a health profession.
- (19) Home Health Care. Information about Home Health Care is available in Section 6.II of this Policy.
- (20) Hospice Care. Services for the terminally ill and their families, including pain management and other support services.
- (21) Hospital. An appropriately licensed acute care institution (including a long-term acute care facility) that provides inpatient and outpatient medical care and treatment for ill and injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24-hour-a-day nursing and Physician service.
- (22) Hospital Inpatient Care. Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for Hospital Observation Care may be considered outpatient care.
- (23) Hospital Observation Care. Short-term treatment and monitoring that is provided on an outpatient basis. This type of care is commonly provided after you visit an emergency room to allow Health Professionals to determine if you can be discharged or if you need to be admitted as an inpatient for additional treatment. Hospital Observation Care is typically limited to 24-48 hours. Even when you are required to stay at the Hospital overnight, if you are receiving Observation Care, you have not been admitted as an inpatient. See your Schedule of Benefits for information about your Hospital Outpatient Care benefit.
- (24) Hospital Outpatient Care. Care in a Hospital that usually doesn't require an overnight stay.
- (25) Ill or Illness. A sickness or a disease, including congenital defects or birth abnormalities.
- (26) Incapacitated Dependent. A dependent is eligible for Coverage as an Incapacitated Dependent if the dependent meets the requirements of Section 13.A.
- (27) Injury or Injured. Accidental bodily harm.
- (28) Maximum Individual Annual Benefits. Information about your Maximum Individual Annual Benefit is available in Section 7.C of this Policy and your Schedule of Benefits.
- (29) Medicaid. Title XIX of the Social Security Act, as amended.
- (30) Medical Director. A Michigan-licensed Physician, employed by Priority Health, who oversees the plan's medical delivery system.
- (31) Medical Emergency. The sudden onset of an Illness or Injury, symptom or condition serious enough that not seeking immediate medical attention could reasonably be expected to result in serious harm to your health, serious jeopardy to a pregnancy, or death.
- (32) Medically/Clinically Necessary. The services or supplies needed to diagnose or treat your physical or mental condition. Whether services or supplies are Medically/Clinically Necessary is determined in accordance with Priority Health's medical and behavioral health policies or adopted criteria that have been approved by community Physicians and other Providers. The determination is made by Priority Health's Medical Director, or anyone acting at the Medical Director's direction, in consultation with other Physicians. Medical/Clinical Necessity of mental health and substance abuse services is determined by our Behavioral Health Department. In order to be considered Medically/Clinically Necessary, the services or supplies must be widely accepted as effective, appropriate, and essential, based upon nationally accepted evidence-based standards.
- (33) Medicare. Title XVIII of the Social Security Act, as amended.
- (34) Member. A person enrolled with us as a Subscriber or Covered Dependent.
- (35) Network or Network Provider. The Physicians, Health Professionals, Hospitals and other facilities that have contracted with Priority Health to provide Covered Services to you at the Network Benefits Level. The Providers that make up our Network are considered Network Providers and are listed in our Provider Directory.
- (36) Network Benefits or Network Benefits Level. The benefits you receive when you receive Covered Services from Network Providers. Your Schedule of Benefits provides more information about how Network Benefits will be paid.
- (37) Newborn. A child 30 days old or younger.
- (38) Non-Covered or Excluded Services. Health care services that this plan does not pay for or Cover.

- (39) Non-Network Benefits or Non-Network Benefits Level. The benefits you receive when you receive Covered Services from a Non-Network Provider. Your Schedule of Benefits provides more information about how your Non-Network Benefits will be paid.
- (40) Non-Network Provider. The Physicians, Health Professionals, Hospitals and other Providers and facilities that have not contracted with Priority Health to provide Covered Services to Members. Non-Network Providers are not listed in the Priority Health Provider Directory. Covered Services and supplies you seek from a Non-Network Provider are Covered at the Non-Network Benefits Level.
- (41) Nurse Midwife. An individual licensed as a registered professional nurse under article 15 of the Michigan public health code, who has been issued a specialty certification in the practice of nurse midwifery by the Michigan Board of Nursing for those with Michigan Networks. Nurse midwives in other Networks must be appropriately licensed by the state in which they practice.
- (42) Out-of-Area Services. Those services and supplies provided outside of the Service Area.
- (43) Out-of-Pocket Maximums. The maximum amount of percentage Copayments you will pay for certain Covered Services. Once you reach this maximum, many Covered Services will be Covered at 100% with no cost to you. Some Copayments, usually flat dollar amounts, are not limited by your Out-of-Pocket Maximum. You will still be required to pay these costs after reaching your maximum. Your Schedule of Benefits specifies which Copayments count toward your Out-of-Pocket Maximum.
- (44) Physician. A licensed medical doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) or surgeon.
- (45) Policy. The agreement between the Subscriber and us. The Policy is a legal contract for health benefits that describes the rights and responsibilities of both you and Priority Health. It includes this document, the **PriorityPPOSM** Conversion Coverage Application, the Schedule of Benefits, and any Addenda, amendments and attachments to this document.
- (46) Premium. The total amount paid to us for Coverage under this plan.
- (47) Preventive Health Care Guidelines. A list of immunizations, screenings, lab tests and other services that we Cover to help you maintain optimum health and prevent unnecessary Injury, Illness or Disability. Our guidelines are developed by Health Professionals who are Network Providers or employed by us, and are based on federal requirements for coverage of preventive health care services contained in Section 1001 of the Patient Protection and Affordable Care Act (PPACA), available at www.healthcare.gov.
- (48) Primary Care. Medical care received from a Physician practicing in any of the following fields: Family Practice, General Practice, Gynecology, Internal Medicine, Obstetrics & Gynecology, Pediatrics, and Internal Medicine Pediatrics. Primary Care may also be provided by licensed nurse practitioners and Physician assistants in accordance with state law.
- (49) Prior Approval. A decision made by Priority Health as to whether a service or supply is Covered or not Covered under the plan. It may also include a decision to partially Cover a service. See Section 5.D for more information about when and how to obtain Prior Approval.
- (50) Priority Health. Priority Health Insurance Company.
- (51) Provider. A licensed Health Professional or facility that provides health care services.
- (52) Provider Directory. The names and locations of Network Providers who comprise our Network. Also included, among other things, are whether the Provider is accepting new Members and quality and performance information. You may call our Customer Service Department to obtain a list of Providers in your area, or you can go to the Member Center on our website at www.priorityhealth.com.
- (53) Reasonable and Customary. Except as otherwise specified in this plan, the maximum amount Priority Health will allow for Non-Network Providers for any Covered Service, will be the lesser of: (a) the Provider's usual charge for furnishing the service; or (b) the charge we determine to be the prevailing charge level for the service or supply. Criteria considered in setting the Reasonable and Customary Charge for a particular service or supply may include the complexity of the service, the degree of skill required, the range of services provided by a facility, and regional variations.
- (54) Rehabilitative Medicine Services. Services that are restorative in nature and result in a meaningful improvement in our ability to perform functional day-to-day activities that are significant in your life role. These services may include physical, occupational and speech therapy, cardiac and pulmonary rehabilitation, and osteopathic and chiropractic manipulations.
- (55) Schedule of Benefits. The legal document that outlines how benefits will be paid for Covered Services received at either the Network or Non-Network Benefits Level, including Copayments, Coinsurance and Deductibles. It also lists any maximum limitations that apply to your health care benefits.
- (56) Service Area. The state of Michigan.
- (57) Skilled Nursing Services. Information about Skilled Nursing Services is available in Section 6.II.C of this Policy.

- (58) **Special Enrollment Period.** A period more than 31 days after initial enrollment, during which you are entitled to enroll a dependent you have gained as a result of marriage, birth, adoption, or placement for adoption. Additional information about a Special Enrollment Period is available in Section 3.B of this Policy.
- (59) **Specialist or Specialist Provider.** A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
- (60) **Subscriber.** An individual eligible to enroll in this plan as outlined in Section 2.A of this Policy and in the Agreement.
- (61) **Urgent Care or Urgent Care Center.** Care provided at an Urgent Care Center, instead of a Hospital emergency room, when you need immediate care to treat a non-life threatening Illness or Injury to limit severity and prevent complications.
- (62) **We, us or our.** Priority Health Insurance Company.
- (63) **You, your or yourself.** The Member, whether enrolled with us as a Subscriber or Covered Dependent.

SECTION 18. General Provisions

A. Independent Contractors.

Priority Health does not directly provide any health care services under this Policy, and we have no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by Health Professionals in consultation with you. Network Providers and other Health Professionals provide health care services as independent contractors.

We are obligated under this Policy to provide you with a Network of health care Providers. We are also responsible for making benefit determinations under this Policy and our contracts with Network Providers.

B. Entire Policy.

The Policy, including this document, the Application, the Schedule of Benefits, any Addenda, and any amendments or attachments, is the entire Policy between you and us. Beginning on the effective date of Coverage, the Policy supersedes all other agreements for health care services and benefits between you and us.

C. Non-assignment.

You may not assign or transfer any of your rights to benefits or services under this Policy, whether as a Subscriber or a Covered Dependent.

D. Conformity with State and Federal Law.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Member resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

We will also apply this Policy in accordance with federal laws and regulations.

If any part of this Policy does not comply with state or federal laws or regulations, the language of this Policy will be read to comply with such laws and regulations.

E. Amendments.

This Policy may be amended to comply with applicable laws and regulations. The amendment may be made by either party so long as written notice is provided. The Policy may also be amended for any reason if written agreement is made between you and an authorized representative of Priority Health. No agent has the authority to modify this Agreement, waive any of its provisions or restrictions, extend the time for making a payment, or bind us by making any other commitment or representation

F. Clerical Errors.

Clerical errors, such as incorrect transcriptions of Premiums, effective dates, termination dates, or mailings, with incorrect information, will not change the rights or obligations of you or us under this Policy. These errors will not operate to grant additional benefits, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

G. Execution of Agreement.

This Policy will be considered fully executed (complete) after the Application, which is made a part of this Policy, is signed by the Subscriber.

H. Governing Law and Severability.

This Policy is governed by Michigan law and any applicable federal law. If any provision of this Policy is held to be invalid or unenforceable, the remaining provisions of this Policy will remain in full force and effect.

I. Notices.

Any notice required or permitted under this Policy shall be in writing. A notice is considered to be received by you either on the date when delivered in person or by e-mail at an e-mail address given to us by you; or if delivered by first-class United States mail, on the date mailed, proper postage prepaid, to the address listed on your Application. Notify us of any change in address, and we will send all notices to your most current address.

J. Third Parties.

This Policy shall not give or create any rights, remedies, claims or obligations on third parties except as specifically provided in this Policy.

K. Waiver.

In the event that you or we waive any provision of this Policy, you or we will not be considered to have waived that provision at any other time or to have waived any other provision. Failure to exercise any right under this Policy does not act as a waiver of that right.

SECTION 19. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to You

Priority Health understands the importance of handling protected health information with care. We are committed to protecting the privacy of our members' health information in every setting. State and federal laws require us to make sure that your health information is kept private.

When you enroll with Priority Health or use services provided by one of the Priority Health plans, your protected health information may be released to Priority Health and by Priority Health. This information is used and disclosed to coordinate and oversee your medical treatment, pay your medical claims and assist in health care operations. The use and disclosure of your health information ends when your Coverage ends, except to pay for services received relating to the time that you were Covered or for certain health care operations of Priority Health or our providers.

Federal law requires that we provide you with this Notice of Privacy Practices. This Notice states our legal duties and privacy practices regarding your protected health information. It also states your rights under these laws with respect to the use and disclosure of your health information. Priority Health is required by law to follow the terms of the Notice currently in effect.

Use and Release of Your Health Information

The sections below describe the ways Priority Health uses and releases your health information. Your health information is not shared with anyone who does not have a "need to know" to perform one of the tasks below.

Treatment

We may use your health information or disclose it to third parties to coordinate and oversee your medical care. For example, we may use your health information to help you find a doctor or a hospital that can treat your specific health needs.

Payment

We may use your health information or disclose it to third parties to pay for your medical care. For example, we may use your health information when we receive a claim for payment. Your claim tells us what services you received and may include a diagnosis. We may also disclose this information to another insurer if you are covered under more than one health plan.

Health Care Operations

Priority Health may use your health information and disclose it to third parties in order to assist in Priority Health's everyday work activities such as looking at the quality of your care, carrying out utilization review, confirming benefit eligibility, employee training and review processes, monitoring and auditing activities, and Priority Health's business management and general administrative duties. For example, your health information may be released to members of Priority Health's staff to review the quality of care and outcomes. Your health information may also be released to doctors or doctor groups involved in your care to improve patient care.

Other Permitted or Required Uses and Disclosures

Priority Health may also use or release your health information:

- When required by state or federal law and the use or disclosure complies with and is limited to the requirements of such law
- When permitted for law enforcement purposes
- When permitted to be released to government authorities in cases of abuse, neglect or domestic violence (in which case, you will be notified unless the notification would place you at risk of serious harm)
- When permitted for certain public health activities, such as disease control or public health investigations
- When permitted to be released to public health authorities in child abuse and neglect investigations
- When permitted to be released for certain FDA investigations and activities, such as investigations of product defects or to permit product recalls, repairs or replacements
- When permitted to prevent a serious threat to an individual or a community's health and safety
- When permitted by certain court proceedings (either judicial or administrative)
- When permitted for health oversight activities led by governmental agencies and authorized by law
- When permitted to be released about an inmate to a correctional facility, or otherwise permitted for release in law enforcement custodial situations
- When information about a deceased individual is required by a coroner, medical examiner, law enforcement official or funeral director to carry out their legal duties
- When permitted to be released to cadaveric organ, eye or tissue donation and transplant organizations
- For research purposes when the research has been approved by an institutional review board that has reviewed proposals and established protocols to ensure the privacy of your health information
- When authorized by and to the extent necessary to comply with workers' compensation laws
- When permitted for purposes of providing you with treatment alternatives or other health-related benefits and services
- When permitted to be released to the Armed Forces for active personnel
- When permitted to be released to the Veterans Administration for determining if you are eligible for benefits
- When permitted to be released to Intelligence Agencies for national security
- When permitted to be released to the Department of State for foreign services reasons (e.g. security clearance)
- When permitted to be released to Government Agencies for protection of the President

In order to use or disclose your health information in the above ways, Priority Health may have to follow additional state and federal requirements. Also, in some cases, Priority Health may share your information with one of its "business associates," a person or company that provides certain services to Priority Health. In those cases, Priority Health will have a contract with the business associate, as needed. This contract will require the business associate to confirm they will keep your health information private.

Disclosures to Health Plan Sponsors

(This section of the Notice of Privacy Practices applies to group plans only.)

Priority Health may share information with the sponsor of your group plan (your employer) about whether you are enrolled or disenrolled in the plan. Priority Health may also share summary health information with the sponsor. Summary health information has most identifying information (such as your name, your age and address, except for zip code) removed, and provides the sponsor with information about the amount, type and history of claims paid under the sponsor's group health plan. The sponsor may use this information to obtain premium bids for health insurance coverage or to decide whether to modify, amend to terminate the plan. If the sponsor of your group health plan has agreed to follow federal privacy regulations, Priority Health may also share your protected health information to help the sponsor run the group health plan or to seek available subsidies.

Other Uses of Health Information - By Authorization Only

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. Some common examples of when Authorization is typically needed for certain releases of information concern mental health issues, substance abuse issues, prenatal and pregnancy related services, venereal disease or HIV/AIDS and grievances/appeals. We can provide you with a Sample Authorization Form.

If you provide us with an authorization to use or release health information about you, you may end that authorization at any time by writing to Priority Health's Compliance Department. (See Contact Information section.) If you end your authorization, we will no longer use or release health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization.

A parent, legal guardian, or properly named patient advocate may represent you and provide us with an authorization (or may end an authorization) to use or release health information about you if you cannot provide an authorization. Court documents may be required to verify this authority.

Confidentiality in all Settings

We have policies and procedures in place that protect the privacy of your information.

- Every employee signs a statement when they are hired that they understand they are required to keep member information private. They also learn about the actions the company will take if the privacy policies are not followed.
- Priority Health has strict control of access to electronic and paper information specific to members. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for members or for administrative purposes.

Priority Health tells all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours.

Priority Health reviews our confidentiality policies and procedures every year. Priority Health also reviews how we collect, use, dispose of and disclose your information. Members (or prospective members) and providers have the right to review Priority Health's confidentiality policies and procedures. You may get copies by contacting Priority Health's Compliance Department. (See Contact Information section.)

Your Rights Regarding Your Health Information

You have the following rights:

Right to Inspect and Copy

You have a right to look at and get a copy of health information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. There are other limited circumstances in which we may deny your request to inspect and copy under federal and state law. If you are denied access to health information, you may request that the denial be reviewed.

To inspect and copy health information, contact Priority Health's Compliance Department in writing. (See Contact Information section.)

If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

Right to Amend

You have the right to request that Priority Health amend any health information (medical or billing) we have about you. However, Priority Health will not amend any record that:

- it did not create (unless there is a reasonable basis to believe that the creator of the information is no longer available to act on the requested amendment)
- is not part of the medical or billing information we have about you
- is not part of information which you would be permitted to inspect and copy
- is determined by Priority Health to be accurate and complete

To request that we amend your health information, you must write to Priority Health's Compliance Department (see Contact Information section) and include a reason to support the change.

Right to Know About Disclosures

You have the right to know when your health information is disclosed to third parties. You can request a list of disclosures going back six years from the date of your request. This list will not include disclosures:

- to carry out treatment, payment or health care operations
- that were made to you
- for national security or intelligence purposes
- to correctional institutions or law enforcement officials
- that were incidental to a use or disclosure that was permitted or required
- that were made with an authorization by the individual
- of a subset of information called a “limited data set”
- that were prior to April 14, 2003

To request a list of disclosures, you must send your request in writing to Priority Health’s Compliance Department. (See Contact Information section.) Your request must specify the time period desired. There will be no charge for the first list you request within a 12-month period. There may be a small charge for any further requests. We will let you know of the cost involved and you may choose to stop or change your request at that time before any costs occur.

Right to Request Restrictions

You have the right to request a limit on the health information that we use or disclose about you. We are not required by law to agree to your request. If we do agree to your request for restriction, we will comply with it unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to Priority Health’s Compliance Department. (See Contact Information section.) In your request, you must tell us:

- what information you want to limit
- whether you want to limit our use, disclosure or both
- to whom you want the limits to apply

Priority Health will notify you of receiving your request, either in writing or by telephone, of the restrictions Priority Health has put in place.

Right to Request Confidential Communications

Priority Health will agree to any reasonable request asking that you receive information from the health plan by different means or at a different location. For Priority Health to honor this request, you must clearly state that the disclosure of all or part of that information without the change could be a risk to you.

To request confidential communications, you must make your request in writing to Priority Health’s Compliance Department. (See Contact Information section.)

Right to a Paper Copy of This Notice

You have the right to a paper copy of Priority Health’s current Notice upon request. To obtain a paper copy of this Notice, please call our Customer Service Department. (See Contact Information section.) Otherwise, you may also print a copy of this Notice from our website at priorityhealth.com.

Changes to this Notice

Priority Health has the right to change the terms of this Notice. We have the right to make these changes apply to health information we already have about you as well as any we receive in the future. We will always post a copy of the current Notice on Priority Health’s website. You will also receive materially revised Notices within 60 days of their effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Priority Health and/or the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS). To file a complaint with Priority Health, please call or send a written explanation of the issue to Priority Health’s Compliance Department. (See Contact Information section.) You will not be penalized for filing a complaint.

Contact Information

If you have any questions or complaints, please contact Priority Health’s Compliance Department or Customer Service Department as noted above at:

Compliance Department

Priority Health
1231 East Beltline NE
Grand Rapids MI 49525

616 942-0954
800 942-0954

Customer Service Department

Priority Health
34505 West Twelve Mile Road
Farmington Hills, MI 48331

800 528-8762

If this information is unclear or if you do not understand it, please call Priority Health for assistance at 888 975-8102 (for TDD services, please call 616 464-8485).

This Privacy Practices Notice is effective: April 14, 2003

The term “Priority Health” refers to four corporations: “Priority Health Government Programs, Inc. (a Michigan non-profit corporation), “Priority Health” (a Michigan non-profit corporation), “Priority Health Insurance Company (a Michigan non-profit corporation) and “Priority Health Managed Benefits, Inc.” (a Michigan business corporation).

Priority Health is a registered trademark and is used by the permission of the owner.

Priority Health is an Equal Opportunity Employer.

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