

# Individual Agreement



## TABLE OF CONTENTS

<b>INDIVIDUAL AGREEMENT</b>	<b>1</b>
<b>Individual Agreement</b>	<b>3</b>
<b>SECTION 1. ABOUT THIS AGREEMENT</b>	<b>3</b>
<b>SECTION 2. OBTAINING COVERED SERVICES</b>	<b>4</b>
<b>SECTION 3. ELIGIBILITY</b>	<b>9</b>
<b>SECTION 4. ENROLLMENT</b>	<b>10</b>
<b>SECTION 5. EFFECTIVE DATES OF COVERAGE</b>	<b>11</b>
<b>SECTION 6. COVERED AND NON-COVERED SERVICES</b>	<b>11</b>
<b>SECTION 7. LIMITATIONS</b>	<b>35</b>
<b>SECTION 8. MEMBER RIGHTS AND RESPONSIBILITIES</b>	<b>36</b>
<b>SECTION 9. CLAIMS PROVISIONS</b>	<b>37</b>
<b>SECTION 10. TERMINATION OF COVERAGE</b>	<b>38</b>
<b>SECTION 11. INQUIRY AND GRIEVANCE PROCEDURE</b>	<b>39</b>
<b>SECTION 12. CONTINUATION AND CONVERSION</b>	<b>41</b>
<b>SECTION 13. SUBROGATION AND REIMBURSEMENT</b>	<b>42</b>
<b>SECTION 14. NON-DUPLICATION OF BENEFITS</b>	<b>42</b>
<b>SECTION 15. PREMIUMS</b>	<b>42</b>
<b>SECTION 16. RENEWAL</b>	<b>43</b>
<b>SECTION 17. DEFINITIONS</b>	<b>43</b>
<b>SECTION 18. GENERAL PROVISIONS</b>	<b>46</b>
<b>SECTION 19. NOTICE OF PRIVACY PRACTICES</b>	<b>47</b>

---

## Individual Agreement

Agreement Delivered in Michigan 2011

### SECTION 1. About This Agreement

This Agreement has been applied for as Individual Coverage. Read this entire Agreement carefully. It sets the terms and conditions of Coverage and describes the health care services that are Covered for Members. The Agreement describes the rights and obligations of Members and Priority Health. It is your responsibility to understand the terms and conditions of your health benefits contained in this Agreement.

This Agreement only Covers Non-Occupational Injuries and Non-Occupational Illnesses, and it only Covers Medically/Clinically Necessary services or supplies that are furnished while a person is a Member. In some circumstances certain medical services are not Covered or may require prior approval by Priority Health. It replaces and supersedes any Agreement we might have issued in the past.

This Agreement is renewable at Premium rates set by us on each renewal. Please see the "Premiums" and "Renewal" sections of this Agreement for more information. Coverage will not be continued beyond the termination date stated in the "Termination of Coverage" section.

Coverage under this Agreement is available to the Subscriber and the Subscriber's Covered Dependents, as defined in this Agreement. For Coverage to become effective, the Subscriber, on behalf of himself or herself and his or her Covered Dependents, must submit to us a completed application form and the required Premium.

Newborns must be enrolled and any additional Premium paid within 31 days from birth if Coverage is to continue beyond the 31-day period.

#### **RIGHT OF CONTRACT EXAMINATION**

The Subscriber may return this Agreement to us within 10 days after the date of delivery if he or she is not satisfied. If the Subscriber returns this Agreement, it will be void from its effective date and any Premium paid will be returned. This provision or the fact of its existence will not be used to defeat or reduce any other right of the Subscriber.

#### **IMPORTANT NOTICE. YOUR AGREEMENT MAY NOT APPLY! PLEASE READ!**

This Agreement was issued based on the information in your application form, which has become part of this Agreement. If, to the best of your knowledge and belief, there is any misstatement in your application form, you must let us know immediately about the incorrect or omitted information; otherwise, your Agreement may not be valid.

If any information on your application form is incorrect or incomplete, please write to us at 1231 East Beltline, NE, P.O. Box 269, Grand Rapids, MI 49501, within 10 days of receiving the Agreement.

NOTE: You are responsible for those Copayments and Deductibles listed in the Schedule of Copayments and Deductibles.

Words that are capitalized in this Agreement are special 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:

Customer Service Department, MS 1105  
PO Box 269  
Grand Rapids, MI 49501-0269  
or  
1231 E. Beltline NE  
Grand Rapids, MI 49525-4501  
616 942-1221 or 800 446-5674

or use our secure e-mail form in the member center on our website at [priorityhealth.com](http://priorityhealth.com).

## SECTION 2. Obtaining Covered Services

### A. Primary Care Provider (PCP).

#### **Your PCP arranges your medical care.**

Your PCP may be a family practitioner, a general practitioner, an internal medicine specialist, a pediatrician, an obstetrician/gynecologist, a nurse practitioner or a physician assistant. He or she provides your primary health care, and coordinates such services as, among other things, ordering of lab tests and x-rays, prescribing medicines or therapies, and arranging hospitalization. Members may seek services from a Participating Provider without referral from their PCP. For example, women can see a participating obstetrician/gynecologist without referral from their PCP. We will only Cover Non-Participating Provider services that your PCP provides or refers and that we approve, unless we tell you otherwise in this Agreement.

We recommend you talk with your PCP about any issues concerning your medical care, and contact your PCP before you receive medical services, except in a Medical Emergency. Your PCP also refers you to and consults with Specialist Providers, Participating Providers, and Non-Participating Providers when necessary. If the standard of care treatment (medically appropriate treatment) for your condition is not available from a Participating Provider, your PCP will ask Priority Health for approval to refer you to a Non-Participating Provider. All referrals to or services received from Non-Participating Providers (providers not listed in our provider directory) must be prior approved by us. Referral by your PCP is not sufficient for Coverage of services received from Non-Participating Providers. If you do not receive written approval from Priority Health prior to obtaining services from a Non-Participating Provider, you will be responsible for payment.

A copy of the Priority Health Provider Directory is available by calling our Customer Service Department or on our website at [priorityhealth.com](http://priorityhealth.com).

#### **Choosing a PCP**

When you enroll, we will give you a list of PCPs to choose from. You will also find a list of PCPs to choose from on our website at [priorityhealth.com](http://priorityhealth.com). If you are the Subscriber, you must choose a PCP for yourself from that list. If you are a Covered Dependent, the Subscriber must choose a PCP for you from that list. Each member of the Subscriber's family may have a different PCP, if desired. Until a PCP is chosen, you will only have Coverage for Medical Emergencies. If you need help choosing a PCP, call our Customer Service Department at 800 446-5674 or 616 942-1221. If you do not choose a PCP, we will select one for you.

#### **Changing a PCP**

You can voluntarily change your PCP (and the Subscriber may change the PCP of a minor or a Member who is incapable of choosing a PCP) by filling out and turning in a change form to us. If you need a change form, or you need help filling it out, contact our Customer Service Department. You can also change your PCP by contacting our Customer Service Department by phone or in the member center on our website at [priorityhealth.com](http://priorityhealth.com). The change will take effect on the first day of the month after we receive your request except for a change to a pediatrician, which will be effective immediately. A PCP change cannot be made while you are in the Hospital.

When you change your PCP, your medical treatment must be re-approved by your new PCP.

### B. Establishing and Maintaining a Provider-Patient Relationship.

It is important that you establish and maintain a good relationship with your PCP and other Health Professionals. We require your PCP and other Participating Providers to discuss with you all treatment options available to you, regardless of benefit coverage limitations. Don't expect your PCP and other Participating Providers to inform you when services have limitations or are excluded from Coverage. Your Agreement provides you with this information and our Customer Service Department can help you with any questions.

If you do not choose a PCP (or if you are a minor or incapacitated Member and do not have a PCP selected for you), or if you cannot maintain a satisfactory provider-patient relationship with Participating Providers after repeated attempts, we can terminate your Coverage "for cause." Termination for cause is explained in Section 10.D.

### C. Referrals.

At times you may need services from another Participating Provider, including a Specialist Provider, or a Non-Participating Provider. Participating providers are those listed in the Priority Health Provider Directory; a provider is a Non-Participating Provider if he or she is not listed in the provider directory.

You do not need approval from your PCP or from Priority Health to seek services at a Participating Physician's office. Participating Physician's are listed in the provider directory.

Your PCP does not need approval from Priority Health to refer to a Participating Provider, except for a few specific services that are listed at the end of this subsection. Services with a Non-Participating Provider are Covered when the standard of care treatment (medically appropriate treatment) for your condition is not available from a Participating Provider. All referrals to or services received from Non-Participating Providers (providers not listed in our provider directory) must be prior approved by us. Referral by your PCP is not sufficient for Coverage of services received from Non-Participating Providers. If you do not receive written approval from Priority Health prior to obtaining services from a Non-Participating Provider, you will be responsible for payment. You also must pay for services you receive in excess of the services that we approved. You may call our Customer Service Department at 800 446-5674 or 616 942-1221 to find out if a provider is participating or non-participating and to find out if we have approved a referral to a Non-Participating Provider.

NOTE: Sometimes your PCP or other Participating Physician may refer you for or suggest a service that we do not Cover. Just because your PCP or other Participating Physician refers you or suggests the service does not mean you will have Coverage for that service. For example: Bite splints used for dental purposes are excluded from Coverage. If your doctor recommends a bite splint for a dental purpose, Coverage for a bite splint will not be provided even if the bite splint could prevent the need for more costly Covered Services. Remember – If you receive services that we do not Cover, you must pay for those services.

#### **A Second Medical Opinion**

A second medical opinion from a specialist may be appropriate for certain health conditions and proposed surgeries. We will Cover second medical opinions from Participating Providers having skills and training substantially similar to those of the Physician making the original treatment recommendation.

If no Participating Provider is available and your PCP documents the need for a second opinion, we may Cover a second medical opinion from a Non-Participating Provider if approved by us before the second opinion is obtained. Any tests, procedures, treatments or surgeries recommended by the consulting provider must be performed by a Participating Provider unless we approve the services in advance.

Priority Health may also require a second opinion from a specialist chosen by Priority Health. A second medical opinion may be needed to assist us in determining whether services or supplies are Medically/Clinically Necessary according to Priority Health's medical and behavioral health policies or adopted criteria.

#### **Required Prior Approval from Priority Health**

Certain services and supplies that Health Professionals recommend or provide to you must receive prior approval from Priority Health before they can be Covered.

General Services categories for which prior approval from Priority Health is required:

- (1) All inpatient services (including inpatient hospice services, inpatient mental health services and inpatient substance abuse services).
- (2) Certain outpatient services.
- (3) Referrals to Non-Participating Providers (Participating Providers are those listed in the Priority Health Provider Directory; a provider is Non-Participating if he or she is not listed in the Provider Directory).
- (4) Durable medical equipment over \$1,000 and all rentals.
- (5) Prosthetics and orthotics over \$1,000, all rentals and all shoe inserts.
- (6) All behavioral health services (including mental health services, substance abuse services, feeding and eating disorders).
- (7) Certain stimulators.
- (8) Certain high-tech radiology examinations, including positron-emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies.

- (9) Selected injectable drugs in certain categories.
- (10) Home health care, including home infusion services. (Hospice services in the home setting do not require prior approval.)
- (11) Enteral and parenteral feedings.
- (12) Experimental or investigational services.
- (13) Transplant and evaluations for transplant.
- (14) Genetic testing.
- (15) Clinical trials for cancer care.
- (16) Comprehensive pain and headache programs.

The list of services that require prior approval from Priority Health may be updated frequently throughout the Contract Year as new technology and standards of care emerge. A current detailed list is available by calling our Customer Service Department or on our website at [priorityhealth.com](http://priorityhealth.com).

See Section 2.G for the steps of the prior approval process, including how to confirm coverage before receiving services and supplies.

**D. Termination of Provider's Participation.**

Priority Health or a Participating Provider, can terminate a Participating Provider's contract or limit the number of Members a Participating Provider will accept as patients. We do not promise that you will be able to receive services from a specific Participating Provider the whole time you are Covered by us. But we will notify you if your PCP or Specialty Care Physician is no longer a Participating Provider. In such cases, you must agree to choose another PCP, and we can help if needed. If you choose or are assigned another PCP, you must have your medical treatment re-approved by your new PCP.

If you are receiving on-going care from a Participating Provider whose contract with us is terminated, and the provider is able to continue treating you, 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 Participating Provider. If at the time a Participating Provider's contract with us is terminated, you are undergoing treatment for a chronic or disabling condition, or are in the second or third trimester of pregnancy, you may continue to see this provider for up to 90 days, or through completion of postpartum care. In addition, if at the time a Participating Provider's contract with us is terminated, you are undergoing treatment for a terminal illness, you may continue to be treated by that provider for the remainder of your life. This paragraph does not apply if the Participating Provider's contract with Priority Health has been terminated for quality of care reasons.

Any provider you use in addition to your PCP may also stop being a Participating Provider. If that happens, we recommend you contact your PCP for another referral. Otherwise, we may not Cover any services you receive from the provider.

We will assist you in finding another Participating Provider and in receiving care during the transition if your Participating Provider's contract with us is terminated. If you have any questions please call our Customer Service Department at 800 446-5674 or 616 942-1221.

**E. Non-Emergent Care After Regular Office Hours.**

Your PCP must have telephone coverage 24 hours a day, 7 days a week. If you become Ill or are Injured after regular office hours, we recommend you call your PCP's office and tell them you are a Member of Priority Health. Your PCP or a Participating Provider who is taking calls for your PCP may give advice over the phone, prescribe medicine or therapy, ask you to come into the office, or refer you to an emergency room or another Participating Provider to receive care.

**F. Medical Emergency or Urgent Care.**

You have Coverage for Medical Emergency care and Urgent Care services. The rules for that Coverage depend on whether you receive care inside or outside of the Service Area and whether the care is for a Medical Emergency or an Urgent Care situation.

NOTE: If you are confined in a Hospital after a Medical Emergency, you (or someone on your behalf) must let your PCP and Priority Health know about your confinement as soon as it is reasonably possible. If you do not notify us, you may only have Coverage until your condition has stabilized and not for follow-up care.

(1) Inside the Service Area.

If you have a Medical Emergency, seek medical help immediately. You can receive emergency room Coverage in any Medical Emergency. But if you use an emergency room for care your PCP could have given, or for a medical condition that is not a Medical Emergency, we will not Cover the cost.

When you need Urgent Care services, you must try to contact your PCP's office before you obtain those services. Otherwise, you will be responsible for any of the services you receive. Your PCP will tell you either to go to his or her office or to another Participating Provider's office. If you cannot reach your PCP's office and your problem requires Urgent Care, go to a participating Urgent Care Center or Participating Hospital emergency room. Present your ID Card at the Urgent Care Center and be prepared to pay the required Copayment or Deductible. Afterward, contact your PCP's office for follow-up care.

Remember, if you use an emergency room or an Urgent Care Center for care that is not for a Medical Emergency or Urgent Care or that could have been provided by your PCP, you must pay for the services. Do not return to the emergency room for follow-up care that can be provided by your PCP.

The following are Covered Services within the Service Area:

- (a) Services and supplies that you receive for a Medical Emergency (see the definition in Section 17(20)).
- (b) Services and supplies that you receive for any condition that, following our review of the proper medical records, we determine to have required Urgent Care at the time you received the services and supplies.
- (c) Hospitalization for a Medical Emergency in a facility that is a Non-Participating Provider, until, in our determination, it is appropriate for you to be transferred to a Participating Provider.

We will not Cover services or supplies you receive from a Non-Participating Provider for a situation that is not a Medical Emergency or does not require Urgent Care unless we have given approval for those services or supplies. This includes any follow-up care after a Covered emergency.

If you receive Medical Emergency or Urgent Care services, you must contact your PCP's office as soon as reasonably possible after you receive the services to allow your PCP to arrange follow up treatment with a Participating Provider. If you do not tell your PCP about the Medical Emergency or Urgent Care services, we will not Cover follow up care, unless you can show it was not reasonably possible to notify your PCP. Except for emergency services, any services received from a Non-Participating Provider must be prior approved by us and your PCP or you will be financially responsible for the services.

(2) Outside the Service Area.

- (a) If you are temporarily out of the Service Area.

If you become Ill or are Injured while you are temporarily away from the Service Area, we will Cover care for Medical Emergencies and Urgent Care.

Services and supplies for Medical Emergencies and Urgent Care situations that you receive outside the Service Area are Covered, if:

- (i) You could not reasonably have expected, before you left the Service Area, to need the services and supplies; and
- (ii) It would be hazardous to your health to wait for those services and supplies until you could reasonably return to receive them from your PCP or a Participating Provider.

If you have a Medical Emergency, seek medical help immediately at the nearest facility. You can receive emergency room Coverage in any Medical Emergency.

If you need Urgent Care services when you are outside of the Service Area, you must try to contact your PCP's office before you obtain those services. Otherwise, you may be financially responsible for the services you receive. If you cannot reach your PCP's office and your problem requires Urgent Care, go to an Urgent Care Center or a Hospital emergency room.

We will not Cover services and supplies you receive during travel outside the Service Area if the only reason for the travel is to obtain medical services or supplies, unless we state in writing that we will Cover them.

If you receive Medical Emergency or Urgent Care services while you are outside of the Service Area, you must contact your PCP's office as soon as reasonably possible after you receive the services to allow your PCP to arrange follow up treatment. If you do not tell your PCP about the Medical Emergency or Urgent Care services, we will not Cover follow up care, unless you can show it was not reasonably possible to notify your PCP. Services received from a Non-Participating Provider (other than emergency services) must be prior approved by us, as well as by your PCP.

Remember, your PCP must provide or arrange all follow up and continuing care outside the Service Area, and obtain prior approval from Priority Health if the services are to be received from a Non-Participating Provider. Otherwise, you will not have Coverage for the services you receive.

- (b) If you live outside the Service Area.

If you permanently live outside the Service Area or are outside of the Service Area for an extended period of time, you are Covered for Medical Emergencies and Urgent Care only. See Section 3. for additional information if you live outside the Service Area or if you are planning to spend an extended period outside of the United States.

- (3) Ambulance Services.

“Ambulance” includes a motor vehicle or rotary 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 ambulance service to the nearest medical facility that can provide Medical Emergency care.

We will Cover ambulance transfers between facilities that are approved by your PCP or us as Medically/Clinically Necessary. Any other non-emergent transportation is not Covered unless approved in advance by us .

#### **G. Prior Approval of Certain Health Care Services and Supplies.**

As stated in Section 2.C above, certain services and supplies that Health Professionals recommend or provide to you must receive prior approval from Priority Health before they can be Covered. In most cases, Priority Health will approve, deny or partially approve or deny a request for prior approval within 15 days of receipt. However, in urgent cases, the determination period is reduced to 72 hours. In some cases we may ask you for additional information or additional time in which to make our determination. Once a decision is made, we will let you know if the requested services and supplies will be Covered, not Covered or partially Covered. In the case that your PCP is requesting that you receive services from a Non-Participating Provider, you and your PCP will receive a letter from us indicating whether or not the services will be Covered. Watch for this letter. You may also contact our Customer Service Department to find out whether or not the services will be Covered. In all cases, if you obtain services that we say are not Covered or if you obtain services in excess of what has been approved, you will be responsible for payment for those services. If you want our decision to be reviewed, you must contact us. Section 11 tells you how to do that.

#### **H. Additional Information.**

We will provide you with the following additional information when you request it by calling or writing our Customer Service Department:

- (1) Our current Provider Directory. This lists our current provider network, including: names and locations of participating providers by specialty, and names of providers who are not accepting new Members. You may also find our Provider Directory in the member center on the website at [priorityhealth.com](http://priorityhealth.com).
- (2) The professional credentials of our Participating Providers, including, but not limited to, Participating Providers who are board certified in the specialty of pain medicine and the evaluation and treatment of intractable pain and have reported that certification to us, and the Participating Hospitals where they have privileges.
- (3) The telephone number of the Michigan Department of Consumer and Industry Services where you can call to find out information regarding disciplinary actions or formal complaints filed against a provider.
- (4) Any 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) How we evaluate new drugs for inclusion in our formulary.
- (8) A printed version of this Agreement.

You may request this information by calling or writing to our Customer Service Department at the phone numbers or address below.

Priority Health  
Customer Service Department, MS 1105  
P. O. Box 269  
Grand Rapids, MI 49501-0269  
616 942-1221 or 800 446-5674

or use our secure e-mail form in the member center on our website at [priorityhealth.com](http://priorityhealth.com).

**I. Items or Services Received from or Ordered by any Provider Included on the Office of Inspector General's List of Excluded Individuals/Entities.**

Consistent with the federal guidelines for payment of sanctioned providers, Priority Health 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. The basis for exclusion may include convictions for program-related fraud and patient abuse, licensing board actions and 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](http://www.hhs.gov/oig).

**SECTION 3. Eligibility**

Any person and his or her dependents who have met the eligibility requirements stated in this Section and this Agreement will be eligible for enrollment as Members.

**A. Subscriber**

You may enroll as a Subscriber if you:

- (1) Are not eligible for, or have coverage under any individual or group health insurance;
- (2) Are not eligible for Medicare under Title XVIII of the Social Security Act;
- (3) Reside within the Service Area;
- (4) Are 18 years of age or older; and
- (5) Elect Coverage under Priority Health by submitting a completed and signed application form and the required Premium.

**B. Covered Dependents.**

You may enroll as a Covered Dependent:

- (1) if you are legally married to the Subscriber and reside in the Service Area.
- (2) if you are the 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 (other than a temporary guardian). In addition, you can only enroll as a Covered Dependent if:
  - (a) you are under age 26 on the effective date of Coverage; or
  - (b) you are (were) unmarried and Incapacitated before age 26.

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. When we say "physical custody" we mean 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 proof that satisfies us within 31 days.

A child who enrolls as a Covered Dependent and who resides outside of the Service Area will have Coverage outside of the Service Area only for Medical Emergencies and Urgent Care as described in Section 2.F(2) of the Agreement. All other care must be received inside the Service Area according to the requirements of this Agreement, unless we approve otherwise.

You may not enroll as a Covered Dependent if you live outside of the United States.

**C. Incarceration or Detention.**

You or your dependents are not eligible for Coverage 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 when on release for the sole purpose of receiving medical treatment.

**SECTION 4. Enrollment**

This section describes what you need to do to enroll as a Subscriber or to enroll your eligible dependents. If your Coverage has been terminated for cause, you may not re-enroll even if you do these things. Read Section 10.D to learn more about termination for cause.

To enroll as a Subscriber, you must fill out an application form, sign it, and return it to us with the applicable Premium payment plus authorization for electronic funds transfer for future Premium payments. On the application form, you must list every person being enrolled, and give the information asked for about each person, including information about any other insurance coverage (including Medicare and Medicaid) that you or your dependents carry. If you or your dependents have other insurance, including Medicare or Medicaid, you or your dependent(s) are not eligible to enroll in this health plan.

In addition, eligible dependents may be enrolled as described below.

**A. Enrollment of Newly Eligible Dependents.**

- (1) As Subscriber, you may apply for Coverage as a Covered Dependent for anyone who becomes your eligible dependent. You must apply for Coverage for a newly eligible dependent within 31 days of the date the dependent first becomes eligible for Coverage. You must do this even if the enrollment or change does not require you to pay a higher Premium. Otherwise, that dependent will not be eligible for Coverage. Coverage will become effective without regard to age, health status or medical needs (except for the age limit for eligible dependents as described in Section 3.B). As Subscriber, you must complete and submit a change form to us along with any additional required Premium payment.
- (2) We will Cover routine inpatient care for the Subscriber's Newborn child from the date of birth to the date the child or the mother is discharged, whichever comes first, if the mother is a Member. If you want Coverage to continue after discharge, you must fill out and return to us a change form within 31 days after the child is born.
- (3) We will Cover a Subscriber's Newborn child for Injury or Illness (including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities) for the first 31 days from birth. 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.
- (4) A legally adopted child or a child for whom the Subscriber or the Subscriber's spouse is a court-appointed legal guardian (other than a temporary guardian) may be enrolled as a Covered Dependent regardless of health status, age (except for the age limit for eligible dependents as described in Section 3.B) or medical needs if you complete and submit to us a signed change form, with any additional required Premium payment, within 31 days from the date of the child's placement in your physical custody.
- (5) If Coverage is effective retroactively (for example, you send us a change form 31 days after the date of marriage or date of birth), any care you or your Covered Dependents received during such time would be subject to the terms and provisions of this Agreement, including any requirements for prior approval by Priority Health, and use of Participating Providers.

**B. Special Enrollment as a Result of a Court or Administrative Order.**

If you provide us with a copy of a court judgment, decree or order (including approval of a settlement agreement) that provides for benefit coverage with respect to a child of a Subscriber, and is made pursuant to a State domestic relations law, you may enroll the child without regard to any enrollment season restrictions. The child must be otherwise eligible for Coverage as a Covered Dependent except that the child is not required to be a dependent on you for more than half of his or her support. Coverage will become effective without regard to age, health status or medical needs (except for the age limit for eligible dependents as described in Section 3.B).

As Subscriber, you must complete and submit a change form to us along with any additional required Premium payment. 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 due to the fact that this is not a group health plan.

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

You must let us know about any changes that affect Coverage under this Agreement. You do that by filling out a change form and returning it to us or by calling our Customer Service Department. You must notify us if any of the following happens to anyone Covered under this Agreement:

- (1) change of PCP;
- (2) change of address;
- (3) change in Covered Dependent's state of residence;
- (4) eligibility for Medicare, Medicaid and Children's Special Health Care Services; or
- (5) coverage by any other insurance or health plan.

These are just examples, and you must let us know about any other change that, according to this Agreement, affects your Coverage or Coverage for your Covered Dependents.

You must let us know about the change within 31 days after the change happens. If you do not, and we discover the change, we will use the correct information to determine whether or not services you receive are Covered.

**D. Loss of Eligibility.**

You will lose your eligibility and your Coverage will terminate if you no longer meet the eligibility criteria listed in Section 3 of this Agreement, or if you lose your eligibility as described in Section 10.C.

**E. Genetic Testing**

Enrollment under this Section 4 is not contingent on undergoing genetic testing or disclosing results of any genetic testing to us.

**SECTION 5. Effective Dates Of Coverage**

Your Coverage under this Agreement will become effective on the later to occur of

- (a) the effective date of this Agreement; and
- (b) the date dependent status is established (marriage, birth, adoption, guardianship) if all other requirements of the Agreement are met.

If Coverage is effective retroactively, any care you or your Covered Dependents receive is subject to the terms and provisions of this Agreement, including any requirements for prior approval by Priority Health, and use of Participating Providers.

**SECTION 6. 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 organized alphabetically within the following categories:

- A. Professional Services
- B. Pharmacy Services
- C. Hospitals, Labs And Other Facilities Services
- D. Medical Emergency And Urgent Care Services
- E. Durable Medical Equipment (DME) And Supplies
- F. Behavioral Health Services
- G. Family Planning And Maternity Care Services
- H. Dental, Vision And Hearing Services
- I. Plan Guidelines

The information following each heading provides a description of *Covered Service* and *Non-Covered Services*, as applicable.

You are responsible for those Copayments and Deductibles listed in the Schedule of Copayments and Deductibles.

You are entitled to the Covered Services described in this Section 6 when those services meet the following criteria:

- (1) Medically/Clinically Necessary (as defined in this Agreement and according to Medical and Behavioral Health policies established by Priority Health with the input of physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health); and
- (2) Provided by your PCP; or  
Provided by a Participating Physician and approved in advance by us when we consider approval necessary; or  
Provided by a Participating Provider and approved in advance by us when we consider approval necessary; or  
Provided by a Non-Participating Provider (one not listed in our Provider Directory) upon referral from your PCP and approved in advance by us (See Sections 2.C and 2.G for prior approval requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services); and
- (3) Not excluded elsewhere in this Agreement or in an amendment to this Agreement.

NOTE: Sometimes your PCP or other Participating Physician may refer you for or suggest a service that we do not Cover. Just because your PCP or other Participating Physician refers you or suggests the service does not mean you will have Coverage for that service. For example: Acupuncture is excluded from Coverage. If your doctor recommends acupuncture as a treatment for a medical condition, Coverage for acupuncture will not be provided even if the acupuncture could prevent the need for more costly Covered Services. Remember – If you receive services that we do not Cover, you must pay for the services.

Some referral care must be approved in advance by us when we consider approval necessary, including all non-emergency referral care provided by Non-Participating Providers. For a list of referral care that must be approved by us, see our website at [priorityhealth.com](http://priorityhealth.com) or call our Customer Service Department.

You should carefully review the rest of this Agreement and any amendments for more information about the extent of your Coverage.

## **A. Professional Services**

### **1. Preventive Health Care Services**

Preventive Health Care Services are described in Priority Health's preventive health care guidelines available in the member center on our website at [priorityhealth.com](http://priorityhealth.com), or you may request a copy from our Customer Service Department.

Preventive Health Care Services are Covered Services for each Member even though they are not provided in connection with the diagnosis and treatment of an Illness or Injury. Covered Preventive Health Care Services include:

- (a) Immunization (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**

Other Provider Care Services include:

- (a) All services listed in this Section 6 provided by a Participating Provider or Non-Participating Provider during an office, home or Hospital visit for the diagnosis and treatment of a Covered Illness or Injury. Referral by your PCP and prior approval by us is required if the referral Provider is a Non-Participating Provider. See Section 2.C and 2.G to review the prior approval process, including how to confirm Coverage before receiving services.
- (b) Services necessary to treat a Medical Emergency or Urgent Care situation.
- (c) Services and supplies received from a participating obstetrician/gynecologist for an annual well-woman examination or routine pregnancy services upon self-referral by you.

### **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.

### **Cancer Drug Therapy and Clinical Trials**

#### *Covered Services*

Drugs for cancer therapy and the reasonable cost of administering them 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, as required by state law. Certain drugs may not be Covered if a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety or efficacy of the drugs. Limitations apply.

Routine patient costs in connection with certain Phase II and Phase III cancer clinical trials may be Covered if approved in advance by our Medical Director.

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

### **Clinical Ecology and Environmental Medicine**

#### *Non-Covered Services*

Services and supplies provided to effect changes in or treatment to you and/or your physical environment. "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.

### **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 the proper self-management and treatment of their diabetic condition.
- (d) Certain diabetic supplies, such as syringes, needles, lancets, and blood glucose test strips, may be purchased at a participating durable medical equipment (DME) provider. Your DME Copayment will apply. If you have a prescription drug rider, these supplies may also be purchased at a participating pharmacy and your prescription drug Copayment will apply.
- (e) Insulin pumps may be Covered under the DME benefit.
- (f) Shoe inserts for members with peripheral neuropathy, including diabetic neuropathy.
- (g) Special shoes prescribed for a person with diabetes when Medically/Clinically Necessary according to the criteria set forth in our medical policies.

#### *Non-Covered Services*

- (a) Alcohol and gauze pads.
- (b) Insulin and other medications for Members with diabetes are not Covered unless you have a prescription drug rider.
- (c) Services and supplies for the convenience of the Member or caregivers.

### **Dietitian Services**

#### *Covered Services*

- (a) Consultations with a Participating dietitian, upon referral from your PCP, up to a maximum of 6 visits per Contract Year. Dietitian services must be obtained from a dietitian employed by a Participating Provider.
- (b) See Priority Health's preventive health guidelines for additional dietitian services Covered under Preventive Health Care Services.

### **Educational Services**

#### *Covered Services*

- (a) Education to manage chronic disease states such as diabetes or asthma conducted by Participating Providers.
- (b) Maternity classes conducted by Participating Providers.

#### *Non-Covered Services*

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

### **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.

### **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.

### **Intractable Pain**

#### *Covered Services*

Evaluation and treatment of intractable pain.

### **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 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. We will do that even if the treatment takes longer than two years.

Necessary surgery following cancer surgery (such as following a mastectomy) and major trauma (severe lacerations and burns) is a Covered Service as required by law.

- (b) Reconstructive Surgery Following Breast Cancer

In compliance with the Women's Health and Cancer Rights Act of 1998, Priority Health will consult with your PCP or other Participating Provider 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*

Your Coverage for certain procedures, treatments and reconstructive surgeries is limited by the Copayment and Deductible as shown in the Schedule of Copayments and Deductibles and any rider enclosed with this Agreement.

*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 lower lids.
- (b) Breast augmentation except when provided as part of post-mastectomy reconstructive services.
- (c) Chemical peel for acne.
- (d) Collagen implants.
- (e) Diastasis recti repair.
- (f) Removal for excessive hair growth by any method, even if caused by an underlying medical condition.
- (g) Excision or repair of excess or sagging skin except panniculectomy.
- (h) Fat grafts, unless an integral part of another Covered procedure.
- (i) Hair transplants or repair of any congenital or acquired hair loss, including hair analysis.
- (j) Liposuction, unless an integral part of another Covered procedure.
- (k) Spider vein removal.
- (l) Rhytidectomy (wrinkle removal).
- (m) Rhinophyma treatment.
- (n) Salabrasion.
- (o) Tattoo removal.
- (p) Orthodontic treatment, even when provided along with reconstructive surgery.

**Rehabilitative Medicine Services**

Short-term rehabilitative medicine services are Covered if:

- you receive them as an outpatient or in the home, and
- the services cannot be provided by any federal or state agency or by any local political subdivision, including school districts, when a Member is not liable for the costs in the absence of insurance, and
- the therapy is restorative in nature and there is meaningful improvement within 90 days in the Member's ability to perform functional day-to-day activities that are significant in the Member's life roles, and
- a Participating Physician refers, directs, and monitors the services.

*Covered Services*

- (a) Physical and occupational therapy including:
- (i) spinal manipulations by a chiropractor; and
  - (ii) all manipulations by osteopathic physicians
- for treatment of medical diagnoses are Covered if due to:

- an Injury;
- an Illness; or
- a congenital defect for which you have received corrective surgery.

Biofeedback for treatment of medical diagnoses when Medically/Clinically Necessary, as determined according to our medical policies.

- (b) Speech therapy for treatment of medical diagnoses is Covered if due to:
- (i) an Injury;
  - (ii) an Illness; or
  - (iii) a congenital defect for which you have received corrective surgery.

- (c) Cardiac and pulmonary rehabilitation when Medically/Clinically Necessary, as determined according to our medical policies.

The rehabilitative medicine benefits are categorized in the Schedule of Copayments and Deductibles. The maximum number of visits per Contract Year for all rehabilitative medicine categories combined is shown in the Schedule of Copayments and Deductibles. The visit maximum applies even when continued care is Medically/Clinically Necessary beyond the benefit maximum. **Note:** Rehabilitative medicine services provided in the home are Covered, subject to the Copayments and visit maximums under the rehabilitative medicine services categories shown in the Schedule of Copayments and Deductibles and not the home health care category.

*Non-Covered Services*

- (a) Therapy is not Covered if there is not meaningful improvement in the Member's ability to perform functional day-to-day activities that are significant in the Member's life roles within 90 days of therapy initiation.
- (b) 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.
- (c) Physical, speech or occupational 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.
- (d) Cognitive rehabilitative therapy. Cognitive rehabilitative therapy is defined as neurological training or retraining.
- (e) Strength training and exercise programs.
- (f) Visual training and sensory integration therapy.
- (g) Rehabilitation services obtained from non-Health Professionals, including massage therapists.
- (h) Summer programs meant to maintain physical condition or developmental status during periods when school programs are unavailable.
- (i) All therapies for developmental delays, cognitive disorders, including physical, occupational, speech, cognitive and sensory integration therapy.
- (j) Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluation and all return to work programs.
- (k) 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 inpatient Hospital service.
- (l) Craniosacral therapy.

- (m) Prolotherapy
- (n) Services outside the scope of practice of the servicing provider.
- (o) Notwithstanding item (n) above, extra-spinal manipulation 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 PCP or other Participating Physician.
- (b) Tobacco cessation drug treatments are Covered if you have a prescription drug rider. See Priority Health's preventive health care guidelines for tobacco cessation drug treatments Covered under Preventive Health Care Services.

#### *Non-Covered Services*

Any other related services and supplies for the treatment of tobacco abuse, except for smoking cessation counseling provided by your PCP or other Participating Physician.

### **Transplants**

#### *Covered Services*

Evaluations for transplants and transplants of the following organs at a facility approved by us, but only when we have approved the transplant as, Medically/Clinically Necessary and non-experimental:

- (a) Cornea.
- (b) Heart.
- (c) Lung.
- (d) Kidney.
- (e) Bone marrow or stem cell.
- (f) Liver.
- (g) Pancreas.
- (h) Small bowel.

We will Cover the following expenses:

- (a) Typing or screening of a potential donor only if the person proposed to receive the transplant is a Member and the potential donor is a parent, child or sibling of the Member proposed to receive the transplant.
- (b) Computer organ bank searches and any subsequent testing necessary after a potential donor are identified, unless Covered by another health plan.
- (c) Donor's medical expenses if the person receiving the transplant is a Member and the donor's expenses are not Covered by another health benefit plan.
- (d) One comprehensive evaluation per transplant.

*Non-Covered Services*

- (a) Community wide searches for a donor.
- (b) All donor expenses, even those of Members, for transplant recipients who are not Members.
- (c) Transplants of artificial organs.

This provision is not intended to conflict with the Coverage of drugs for cancer therapy, which is Covered as described in **Pharmacy Services** in this Section 6.B.

**Weight loss services**

*Covered Services*

Medical and surgical treatment of obesity is Covered when Medically/Clinically Necessary, as determined according to our medical policies. All treatment for obesity must be approved by us in advance and provided by a provider or facility approved by us.

- (a) Physician-supervised weight loss programs are Covered if obtained from a program approved in advance by Priority Health.
- (b) Surgical treatment is limited to specific procedures outlined in our medical policy. In most cases, co-morbid health conditions must exist and all reasonable non-surgical options must have been tried before surgical treatment will be Covered. Surgical treatment will only be considered with evidence of compliance with medical treatment in a Priority Health approved program, along with other criteria set forth in our medical policies. Noncompliance with treatment regimens may limit future benefits.
- (c) Surgical treatment is limited to once per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.

Note: Coverage for a pre-approved surgery is limited by the Copayment and Deductible as shown in the Schedule of Copayments and Deductibles and any rider to this Agreement.

*Non-Covered Services*

Weight loss services, supplies, equipment or facilities in connection with weight control or reduction, whether or not prescribed by a physician or associated with an Illness, including, but not limited to: food, food supplements, gastric balloons, certain weight loss surgeries, jaw wiring, liposuction, physical fitness or exercise programs.

**B. Pharmacy Services**

**Injectable Drugs.**

*Covered Services*

In general, the following Covered drugs are treated as medical benefits. Exceptions are outlined in our medical policies.

- (a) Injectable and infusible drugs administered in an inpatient or emergency setting.
- (b) Injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility.

We may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.

Note: Coverage for selected injectable drugs in certain categories is available only if you have a prescription drug rider to this Certificate.

*Non-Covered Services*

Drugs that are not primarily intended to be administered by a Health Professional as defined by the federal Food and Drug Administration. This includes, for example, self-administered drugs for certain diseases for arthritis, growth deficiency, hepatitis, and multiple sclerosis.

Note: Coverage for drugs that are not primarily intended to be administered by a Health Professional is available only if you have a prescription drug rider to this Certificate.

## **Outpatient Prescription Drugs**

### *Covered Services*

- (a) Coverage for outpatient prescription drugs not listed in Preventive Health Care Services is available only if you have a prescription drug rider to this Agreement.
- (b) Drugs for cancer therapy and the reasonable cost of administering them 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, as required by state law. Certain drugs may not be Covered if a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety or efficacy of the drugs.
- (c) Routine patient costs in connection with certain Phase II and Phase III cancer clinical trials may be Covered if approved in advance by our Medical Director.

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

## **C. Hospitals, Labs, And Other Facilities 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. Services and tests performed in an outpatient or ambulatory surgical center will be subject to the Copayment and Deductible, if any, applicable to Hospital services.

### **Home Health Care.**

#### *Covered Services*

Intermittent skilled services approved in advance by us and furnished in the home by a participating Home Health Care Agency's registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist or speech therapist. (Hospice services in the home setting do not require prior approval.)

**Note:** Rehabilitative medicine services provided in the home are Covered, subject to the Copayments and visit maximums under the rehabilitative medicine services categories shown in the Schedule of Copayments and Deductibles and not the home health care category.

To qualify for home health benefits, we may require that you meet the following:

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

#### *Non-Covered Services*

- (a) Custodial care. Any 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. Custodial and maintenance 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. Custodial care is not Covered, even if you receive home health care services or Skilled Services along with 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.

## **Hospice Care**

### *Covered Services*

Inpatient and outpatient hospice care is Covered when your Physician informs Priority Health that your condition is terminal and when Medically/Clinically Necessary according to the criteria set forth in applicable medical policies. Inpatient Hospice Care must be approved in advance by us. Hospice services in the home setting do not require prior approval.)

- (a) **Inpatient.** Short-term inpatient care is Covered when Medically/Clinically Necessary for skilled nursing needs that cannot be provided in other settings. Your Coverage for inpatient hospice care is limited by the Contract Year maximum number of days as shown in the Schedule of Copayments and Deductibles enclosed with this Agreement.
- (b) **Outpatient.** Outpatient care is Covered when intermittent skilled 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.
- (c) **Respite.** 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) **Inpatient Care.** Hospital and longterm acute inpatient services and supplies including services performed by Health Professionals, room and board, general nursing care, observation care and related services and supplies. Non-emergency inpatient hospital stays, other than hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section, must be approved in advance by us.
- (b) **Outpatient Care.** Hospital services and supplies listed under Inpatient Care above that you receive on an outpatient basis.
- (c) Certain surgeries and treatments may be subject to an additional Copayment as set forth in the Schedule of Copayments and Deductibles and any rider to this Agreement. In all cases, these surgeries and treatments are Covered only when Medically/Clinically Necessary according to the criteria set forth in applicable medical policies.

### *Non-Covered Services*

Leave of Absence. Charges incurred when you are on an overnight or weekend pass during an inpatient stay.

## **Radiology Examinations and Laboratory Procedures**

### *Covered Services*

Diagnostic and therapeutic radiology services and laboratory tests not excluded elsewhere in this Section 6..

- (a) Certain radiology examinations, including positron-emission tomography (PET scans), magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies, require prior approval by Priority Health.
- (b) Non-emergency laboratory tests must be performed at a participating laboratory selected by your PCP.
- (c) Except for preventive and maternity care, services and tests may be subject to a Deductible even if the service or test was ordered and performed in a provider's office. See the summary of Preventive Health Care Services in Section 6.A.1. Priority Health's complete preventive health care guidelines are available in the member center on our website at [priorityhealth.com](http://priorityhealth.com), or through our Customer Service Department.
- (d) Services and tests performed in a Hospital (either as an inpatient or outpatient) are subject to the Copayment and Deductible, if any, applicable to Hospital services even if the service or test was ordered and partially performed in a provider's office.

## **Rehabilitative Medicine Services**

See. Rehabilitative Medicine Services under Section 6.A.2. above.

## **Respite Care**

### *Coverage Limitations*

Respite care is not Covered except when provided by a hospice program for a member enrolled in a hospice program.

## **Skilled Nursing Services – Skilled Nursing, Subacute and Inpatient Rehabilitation Facility Care**

### *Covered Services*

- (a) Care and treatment, including therapy, and room and board in semi-private accommodations, at a Skilled Nursing, Subacute or Inpatient Rehabilitation Facility when we have approved a treatment plan in advance. The treatment plan will be approved based on our determination of Medical/Clinical Necessity and appropriateness.
- (b) Your Coverage is limited by the Contract Year maximum number of days as shown in the Schedule of Copayments and Deductibles enclosed with this Agreement. The maximum days applies even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

### *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. Priority Health's admission criteria for Coverage are not the same as Medicare's, therefore, just because Medicare is covering your stay does not mean the services are Covered under this Agreement.
- (b) Care provided in a facility required to protect you against self-injurious behavior is not Covered. Examples include care in a facility to prevent you from using alcohol or illicit drugs or to insure your compliance with recommended treatment such as medication use, dietary intake or a behavioral care plan.
- (c) Custodial care is not Covered, even if you receive skilled nursing services or therapies along with custodial care. Custodial care and services include room and board, therapies, nursing care, home health aids 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 members of your family.
- (d) Leave of Absence. Charges incurred when you are on an overnight or weekend pass during an inpatient stay.

## **D. Medical Emergency and Urgent Care Services**

See Section 2.F for information about your Covered for a Medical Emergency and Urgent Care.

## **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. DME over \$1,000 must be approved in advance by us. Some examples of DME are manual wheelchairs, CPAP machines and glucose monitoring devices.

### *Covered Services*

- (a) DME is Covered by Priority Health when:
  - (i) prescribed by your PCP or by a Participating Provider upon referral from your PCP;
  - (ii) approved in advance by us, when required; and
  - (iii) obtained from a Participating Provider.

For a complete list of Covered DME, go to [priorityhealth.com](http://priorityhealth.com) or call our Customer Service Department.

- (b) Repairs or maintenance of DME required as a result of normal use. We reserve the right to limit replacement of DME to the expected life of the equipment.
- (c) Training or education on the use of DME
- (d) Disposable supplies necessary for the proper functioning or application of the DME.

- (e) Inhaler assist devices and some diabetic supplies such as syringes, needles, lancets and blood glucose test strips are covered as a DME benefit or, if you have a prescription drug rider, as a prescription drug benefit.
- (f) Shoe inserts for members with peripheral neuropathy, including diabetic neuropathy.
- (g) Special shoes prescribed for a person with diabetes when Medically/Clinically Necessary according to the criteria set forth in our medical policies.
- (h) Shoes when attached to a Medically/Clinically Necessary brace according to criteria set forth in our medical policies.

*Coverage Limitations*

- (a) Coverage is for standard DME only; equipment that is not conventional or not Medically/Clinically Necessary as determined by us or for the convenience of the Member or caregivers will not be Covered. Equipment must be appropriate for home use.
- (b) Coverage for DME, including wheelchairs and insulin pumps, is limited to one piece of same-use equipment. Priority Health may substitute one type or brand of DME for another when the items are comparable in meeting your medical needs. Wheelchair Coverage is generally limited to a manually operated wheelchair unless 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 at our discretion. We will Cover the repair or replacement, fitting and adjustment of Covered DME that is the result of normal use, body growth or body change. We reserve the right to limit replacement of DME to the expected life of the equipment.

*Non-Covered Services*

- (a) Equipment and devices solely for the convenience of you or your caregiver,
- (b) The purchase or rental of personal comfort items, convenience items, or household equipment that have customary non-medical purposes, such as, among other things: protective beds, chair lifts, air purifiers, water purifiers, exercise equipment, non-allergenic pillows, mattresses or waterbeds, spas, tanning equipment, and other similar equipment.
- (c) Modifications to your home or living area and equipment installation, such as, central or unit air conditioners, escalators, elevators, and swimming pools.
- (d) Car seats and modifications to motorized vehicles.
- (e) Self-help, communication or adaptive aids, designed for self-assistance or safety. Examples include, among other things, reachers, feeding, dressing and bathroom aids, augmentive communication devices, car seats, and protective beds.
- (f) Non-standard items.
- (g) Services and supplies not directly related to your care, such as, among other things: guest meals and accommodations, telephone charges, travel expenses, take-home supplies and similar costs.
- (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) Enteral feedings may be Covered if Medically/Clinically Necessary according to the criteria set forth in our medical policies.
- (b) Parenteral nutrition through an IV may be Covered if Medically/Clinically Necessary according to the criteria set forth in our medical policies.

*Non-Covered Services*

All food, formula and nutritional supplements including, but not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements are not Covered, 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 as set forth in the Schedule of Copayments and Deductibles.
- (b) Some medical supplies are Covered under your Durable Medical Equipment Copayment, including such supplies as catheters, syringes, ostomy supplies, feeding tubes, and lancets. For a complete list of Covered items go to [priorityhealth.com](http://priorityhealth.com) or contact our Customer Service Department.

### *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.

## **Prosthetic and Orthotic/Support Devices**

### *Covered Services*

- (a) Surgically implanted prosthetic devices, such as replacement hip or heart pacemaker if Medically/Clinically Necessary according to the criteria set forth in our medical policies.
- (b) Externally worn prosthetic devices if Medically/Clinically Necessary according to the criteria set forth in our medical policies.
- (c) Purchased, repaired or replaced prosthetics and orthotics if Medically/Clinically Necessary according to the criteria set forth in our medical policies.
- (d) Repairs or maintenance of prosthetic and orthotic/support devices required as a result of normal use.

### *Non-Covered Services*

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

You may call our Customer Service Department to find out if the Prosthetic or Orthotic/Support Device you need is Covered or go to [priorityhealth.com](http://priorityhealth.com).

## **F. Behavioral Health Services**

### **Mental Health Services**

#### *Covered Services*

- (a) Evaluation, consultation and treatment to determine a diagnosis and treatment plan for acute crisis intervention and other mental health conditions when approved by our Behavioral Health Department as Medically/Clinically Necessary and received from a Participating Provider. Solution-focused treatment and crisis interventions are Covered.
- (b) Solution-focused treatment, including both individual and/or group sessions, is Covered as shown in the Schedule of Copayments and Deductibles to this Certificate. The average course of treatment, which can vary depending upon your condition, is usually 5-6 sessions in length. We Cover services that: 1) result in measurable and substantial improvement in mental health status within 90 days; and 2) follow evidence-based standards of care.

The main goals of solution-focused treatment are:

- (i) to stabilize your current situation through an emphasis on personal strengths and coping skills, and
- (ii) to intervene in ways that will have a positive, lasting impact beyond treatment's end.

*Additional Coverage Information*

Care is Covered when it is:

- approved in advance by our Behavioral Health Department as Medically/Clinically Necessary, and
  - received from a Participating Provider, including a Participating Substance Abuse Treatment Facility.
- (a) Prior Authorization. Mental Health services do not require referral from your PCP, but, except in an emergency, inpatient services (including partial hospitalization) do require prior approval from our Behavioral Health Department. Call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance.
- (b) Covered Treatment Settings. Mental health services may be provided in a variety of settings as approved by our Behavioral Health Department, generally the least restrictive for the particular condition. Covered treatment settings include:
- (i) Acute Inpatient Hospitalization. The highest level of intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers.
  - (ii) Partial Hospitalization. An intensive, non-residential level of service where multidisciplinary, medical and nursing services are required. This care is provided in a structured setting, similar in intensity to inpatient, meeting for more than four hours (and, generally, less than eight hours) daily.
  - (iii) Intensive Outpatient Treatment. Multidisciplinary, structured services provided at a greater frequency and intensity than routine outpatient treatment. These are generally up to four hours per day, up to five days per week. Common treatment modalities include individual, family, group and medication therapies.
  - (iv) Outpatient Treatment. The least intensive level of service, provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day by a Participating Provider who is a licensed behavioral health professional. Services provided via telephone, e-mail or Internet are not Covered.
  - (v) 23-Hour Observation. "23-hour beds" are defined as a period of up to 23 hours during which services are provided at less than an acute level of care. It is indicated for those situations where full criteria for inpatient hospitalization are not met because of external factors relative to information gathering or risk assessment yet the patient clearly is at risk for harm to self or others.

*Coverage Limitations*

Mental health services do not require referral from your PCP, but, except in an emergency, inpatient services (including partial hospitalization) do require prior approval from our Behavioral Health Department. Call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance.

The following Coverage limitations apply with respect to certain conditions:

- (a) Eating Disorders, including Anorexia Nervosa, Bulimia Nervosa, and feeding disorders of infancy or childhood, are Covered for outpatient, Intensive Outpatient Programming (IOP), partial hospitalization, and inpatient hospitalization levels of care based on Priority Health's determination that the requested services are Medically/Clinically Necessary. Residential care is not Covered for the treatment of eating disorders. Treatment for any related medical complications is Covered under your medical benefits.
- (b) Impulse Control Disorders, including but not limited to Impulse Control Disorder, Unspecified, Pathological Gambling and Intermittent Explosive Disorder, are Covered for initial evaluation and follow-up psychiatric medication management deemed Medically/Clinically Necessary by our Behavioral Health Department.
- (c) Attention Deficit Hyperactivity Disorders are Covered for initial evaluation, and follow-up psychiatric medication management.
- (d) Personality Disorders are Covered for specific psychological testing to clarify the diagnosis. Crisis intervention (outpatient or inpatient treatment) is Covered as deemed Medically/Clinically Necessary by our Behavioral Health Department.
- (e) Organic Brain Disorders are Covered for initial evaluation to clarify the diagnosis and for follow-up psychiatric medication management. Treatment for any related medical complications requiring services, including but not limited to neuropsychological testing, are Covered under your medical benefit. Services for Members with Illnesses such as Closed Head Injuries, Alzheimer's and other forms of dementia, who meet our inpatient or partial hospitalization criteria are Covered for Medically/Clinically Necessary medical and behavioral health services.

- (f) Dissociative Identity Disorder (formerly known as Multiple Personality Disorder) is Covered for initial evaluation and follow-up psychiatric medication management.
- (g) Pervasive Developmental Disorders, including but not limited to Autism, Aspergers, Rett's Disorder, Emotional Impairments, Learning Disabilities, Sensory Integration Disorder and Mental Retardation are Covered for initial evaluation and follow-up psychiatric medication management. Treatment for any related medical complications, including but not limited to neuropsychological testing, are Covered under your medical benefits.

Your Coverage for Mental Health benefits is shown in the Schedule of Copayments and Deductibles to this Certificate.

*Non-Covered Services*

- (a) Transitional living centers, non-licensed programs, therapeutic boarding schools, and services typically provided by community mental health services program settings.
- (b) Custodial care or basic care provided in a residential, institutional or assisted living setting. 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) Prescription drug Coverage is only available when you are confined as an inpatient unless you have a prescription drug rider to this Certificate.
- (d) Non-medical ancillary services and inpatient care not received in a Hospital or Participating Mental Health Treatment Facility.
- (e) Services for nicotine/caffeine abuse or addiction, sexual/gender identity issues, antisocial personality, and insomnia and other sleep disorders. Services and treatment related to sex therapy.
- (f) Services for adoption adjustment issues, such as treatment for reactive attachment disorder and other treatment for adoptive children with special needs or a history of sexual abuse or neglect.
- (g) Counseling for marital and relationship enhancement and religious purposes including counseling provided by a religious counselor who is not a Participating Provider.
- (h) Experimental/investigational or unproven treatments and services, including biofeedback, hypnotherapy, Methadone maintenance, neurofeedback and light boxes for phototherapy.
- (i) Scholastic/Educational Testing is not Covered. Intelligence and Learning Disability testing and evaluations should be requested and conducted by the child's school district.

**Substance Abuse Services**

*Covered Services*

Care is Covered when it is:

- approved in advance by our Behavioral Health Department as Medically/Clinically Necessary; and
- received from a Participating Provider, including a Participating Substance Abuse Treatment Facility.

Substance abuse services do not require referral from your PCP, but, except in an emergency, inpatient substance abuse services (including partial hospitalization) do require prior approval from our Behavioral Health Department. Call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance.

Counseling, medical testing, diagnostic evaluation and prescription drugs for detoxification and treatment of substance abuse are Covered as described below:

- (a) Inpatient Detoxification. Detoxification services provided in a 24-hour hospital setting with full nursing and medical care. Generally provided on inpatient or subacute units, services can also be received on a medical/surgical unit when needed for safety or in the absence of adequate services elsewhere. Services received on a medical/surgical unit are managed jointly by our Behavioral Health and Health Management Departments.
- (b) Inpatient Rehabilitation. Care provided at an inpatient facility or subacute level with 24-hour per day medically monitored skilled nursing care following full or partial recovery from acute detoxification symptoms.

- (c) **Partial Hospitalization.** An intensive, non-residential level of service where multidisciplinary, medical and nursing services are required. This care is provided in a structured setting, similar in intensity to inpatient, meeting for more than four hours (and, generally, less than eight hours) daily.
- (d) **Intensive Outpatient Programs.** Multidisciplinary, structured services provided at a frequency of up to four hours daily, up to five days per week for the treatment of a substance dependence disorder.
- (e) **Outpatient Treatment.** The least intensive level of service, provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.
- (f) **Outpatient/Ambulatory Detoxification.** Detoxification services delivered within a structured program having medical and nursing supervision where physiological consequences of withdrawal have non-life-threatening potential. This is Covered under your medical benefits.

*Coverage Limitations*

Your Coverage for Substance Abuse Care benefits is shown in the Schedule of Copayments and Deductibles.

*Non-Covered Services*

- (a) Residential treatment, institutional care, non-licensed programs, half-way houses or assisted living settings. 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.
- (b) Prescription drug Coverage is only available when you are confined as an inpatient unless you have a prescription drug rider to this Certificate.
- (c) Non-medical ancillary services and inpatient care not received in a Hospital or Participating Substance Abuse Treatment Facility.
- (d) Services for nicotine/caffeine abuse or addiction.
- (e) Experimental/investigational or unproven treatments and services, including biofeedback, hypnotherapy, neurofeedback and methadone maintenance.

**G. Family Planning And Maternity Care Services**

**Abortions**

*Non-Covered services*

All services and supplies relating to elective abortions.

**Contraceptive Medications and Devices**

*Covered Services*

Contraceptive medications and devices are a Covered benefit only with a rider to this Agreement.

**Maternity and Newborn Care**

*Covered Services*

- (a) **Hospital and Provider Care.** Services and supplies furnished by a Hospital or Provider for prenatal care, including genetic testing, postnatal care, Hospital delivery, and care for the complications of pregnancy.
- (b) The mother and Newborn have the right to stay no less than 48 hours following a normal vaginal delivery or no less than 96 hours following a cesarean section. If the mother and her attending Physician agree, the mother and the Newborn may be discharged from the Hospital sooner and these restrictions would not apply.
- (c) **Newborn Child Care.**
  - (i) Routine inpatient care for a Newborn child of a Subscriber from the date of birth until the discharge of the Newborn or of the mother, whichever happens first, so long as the mother is a Member. Routine inpatient care rendered for the Newborn before the mother's discharge will be Covered, subject to the same Copayment and individual and family maximums as under the mother's plan.

- (ii) Coverage for a Newborn child's Injury or Illness (including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities) for the first 31 days.

To continue Coverage for the Newborn beyond the first 31 days, you must properly enroll the Newborn within 31 days after the date of birth. Section 4.A(1) explains the proper enrollment procedures.

- (d) Home Care Services. . Telephone assessment and home visits by a registered nurse within three days after the date of the mother's discharge for evaluation of the mother, Newborn and family. These services are only available if you are discharged within the guidelines of the HealthyEncounters<sup>SM</sup>-Maternity Care program, our short-term stay maternity program, or if your provider identifies a medical need.
- (e) Maternity education programs provided by a participating provider.

*Non-Covered Services*

- (a) Prenatal maternity care, delivery services and postpartum care provided while you are outside of the Service Area. We do not consider a routine delivery to be an emergency.
- (b) Services and supplies received in connection with an obstetrical delivery in the home.

**Reproductive Services.**

*Covered Services*

- (a) Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility. Examples of Covered services are sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.
- (b) Advice on contraception and family planning, including childbirth education.
- (c) Certain genetic counseling, testing and screening services when approved in advance by us.
- (d) Sterilization procedures such as tubal ligations, tubal obstructive procedures and vasectomy. Vasectomy is Covered when performed in a Physician's office or when performed in connection with another Covered inpatient or outpatient surgery.

Note: Voluntary sterilization may be excluded or limited as shown in the Schedule of Copayments and Deductibles or any rider to this Agreement.

*Non-Covered Services*

- (a) Birth control pills, implantable contraceptive drugs (including insertion and removal), condoms, contraceptive foams, diaphragms or devices, IUD's and contraceptive jellies and ointments.
- (b) Services to reverse voluntary sterilization.
- (c) 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**

*Covered Services*

- (a) Facility, ancillary and anesthesia services may be Covered for pediatric Members under the age of 18 as follows:
  - (i) Multiple extractions or multiple restorations for children under the age of seven.
  - (ii) A total of six or more teeth are extracted in various quadrants.
  - (iii) Dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
  - (iv) Extensive oral-facial and/or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
  - (v) Patients with a concurrent hazardous medical condition.
  - (vi) Medical services that are Medically/Clinically Necessary such as suturing of lacerations required in connection with an accident.

- (b) Facility, ancillary and anesthesia services for adults require prior approval by Priority Health.
- (c) Removal of sound natural teeth required in preparation for other medical procedures.

*Non-Covered Services*

Unless you have a dental rider to this Agreement, dental services are not Covered, including among other things:

- (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, even when provided in conjunction with other treatment or surgery.
- (d) Orthodontia and orthodontic x-rays, even when provided in conjunction with other treatment or surgery,
- (e) Orthognathic surgery (except as specifically Covered above),
- (f) Dental prostheses, including implants and dentures and preparation of the bone to receive implants or dentures.
- (g) Rebuilding or repair of soft tissues of the mouth or lip except as specifically above.
- (h) Bite splints used for dental purposes or for temporomandibular joint dysfunction or syndrome.
- (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) Reduction or manipulation of fractures of facial bones.
- (b) Removal of tumors or cysts of the jaw, other facial bones, soft tissues of the mouth, lip, tongue, accessory sinuses, salivary glands, or the 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.
- (d) Medical services such as suturing of lacerations required in connection with a dental accident.

*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**

*Covered Services*

"Orthognathic surgery" is defined as oral surgical therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment to correct bodily dysfunction. We will only Cover the following orthognathic surgery services, and only when the services are approved in advance by us in consultation with your PCP (and, if necessary, a dental consultant) as Medically/Clinically Necessary:

- (a) Referral care for evaluation and orthognathic treatment.
- (b) Cephalometric study and x-rays.
- (c) Orthognathic surgery and post-operative care.
- (d) Hospitalization.

*Non-Covered Services*

Orthodontic treatment, even when provided along with orthognathic surgery.

**Temporomandibular Joint Dysfunction or Syndrome**

*Covered Services*

Medical care or services to treat temporomandibular joint dysfunction or temporomandibular joint syndrome resulting from a medical cause or Injury are Covered. "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. You have Coverage for the following 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, but not dental x-rays.
- (d) Myofunctional therapy.
- (e) Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

*Non-Covered Services*

Bite splints, orthodontic treatment, or other dental services to treat temporomandibular joint dysfunction or syndrome are not Covered.

**2. Vision Care Services**

*Covered Services*

- (a) One vision screening during each Calendar Year to determine vision loss.
- (b) Coverage is limited to treatment of medical conditions and diseases of the eye.

*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 an eyeglass prescription).
- (e) Vision care unless you have a vision care rider attached to this Agreement.

**3. Hearing Care Services**

*Covered Services*

Hearing tests and one hearing screening during each Contract 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, unless you have hearing care rider attached to this Agreement.
- (b) Hearing screenings do not include examinations for hearing aids unless you have a hearing rider to this Agreement.

## I. Plan Guidelines

### Referral Care

Referral care is care provided by a Specialist Provider, including Participating Providers and Non-Participating Providers. See Sections 2.C and 2.G for the requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services.

Some referral care must be approved in advance by us when we consider approval necessary, including all non-emergency referral care provided by Non-Participating Providers. A current detailed list of referral care that must be approved in advance by us is available by calling our Customer Service Department or on our website at [priorityhealth.com](http://priorityhealth.com).

### Against Medical Advice/Noncompliance

#### *Non-Covered Services*

You are not Covered for those services or supplies determined by Priority Health medical committees to be ineffective, unproductive or compromised because:

- (a) You have voluntarily discharged yourself against the advice of a provider from a facility where you are receiving treatment,
- (b) You have been discharged from a facility because of your noncompliance with treatment, or
- (c) You have been noncompliant with treatment directed by your provider and agreed to by you, regardless of service setting.

Priority Health may also deny Coverage of services or supplies when discharging yourself from a facility against medical advice, your being discharged from a facility for noncompliance, or your noncompliance with treatment you and your provider have agreed to in any setting is determined to be a major contributing factor to requiring the follow-up service or supply (e.g., an emergency room visit shortly following your leaving against medical advice from a facility for a related Illness or Injury).

Noncompliance with treatment includes but is not limited to:

- (a) Failure to take prescribed medication.
- (b) Failure to follow through with outpatient treatment after inpatient or other intensive level of care.
- (c) Failure to comply with treatment plans or care contracts between you and a Provider or you and us

### Court Ordered Services

#### *Covered Services*

We will Cover services ordered by a court according to the terms and conditions of this Agreement only if they are Medically/Clinically Necessary and you have not exhausted your benefits for the Contract Year.

#### *Non-Covered Services*

Services required by court order and services required to file or respond to an action with a court, including evaluations and testing, or services required as a condition of parole or probation.

### Domestic Violence

#### *Covered Services*

Medically/Clinically Necessary 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 clinical meaningful outcomes.
- (e) Evidence that clinically meaningful outcomes can be attained at a reasonable cost.

*Covered Services*

- (a) Coverage is available for routine patient costs in connection with certain Phase II and Phase III cancer clinical trials. For information about which trials are Covered, your PCP should contact Priority Health's Medical Management Department.
- (b) The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is 1) a terminal disease, or 2) a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration. Individual case review may allow Coverage for care or treatment that is investigational, yet promising for the conditions described. Medical Coverage policy applies.

*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 cannot be lawfully marketed in the United States without the approval of the Food and Drug Administration (FDA) and that approval has not been granted.
- (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 research, experimental study, or 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.

**Illegal Acts**

*Non-Covered Services*

Treatment, services and supplies in connection with any Injury or Illness caused by your:

- (a) commission of, or attempt to commit, a felony or other serious illegal act; or
- (b) engagement 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.

### **Not Medically/Clinically Necessary**

Services and supplies that we determine are not Medically/ Clinically Necessary according to our medical and behavioral health policies established by Priority Health with the input of physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health. If you disagree with us about Medical/ Clinical Necessity, you (or your Participating Provider, if you wish) may appeal our determination as described in Section 11. But unless and until we agree with you that the services and supplies will be Covered Services, they will be excluded from Coverage.

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 Participating Provider, 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 under our inquiry and Grievance Procedure as set forth in Section 11.

### **Services Not Covered**

#### *Non-Covered Services*

- (a) **No Legal Obligation to Pay.** Any service or supply that you would not have a legal obligation to pay for without this Coverage, including, among other things, any service performed or item supplied by a relative of yours if, in the absence of this Coverage, you would not be charged for the service or item.
- (b) **No Show Charges.** Any missed appointment fee charged by a Participating or Non-Participating Provider because you failed to show up at an appointment, except in the case of a Medical Emergency.
- (c) **Third Party Requirements.** Services required or recommended by Third Parties, including, but not limited to:
  - (i) Physical examinations in excess of one per year performed by your PCP,
  - (ii) Physical examinations performed by a Physician other than your PCP, and
  - (iii) Diagnostic services and immunizations 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.
- (d) **Unauthorized Services and Supplies.**
  - (i) Services and supplies that your PCP or other Participating Physician did not perform, prescribe, or arrange according to the guidelines of this Agreement.
  - (ii) Services and supplies that were provided without any required advance approval by us,
  - (iii) Services and supplies sought solely for the purpose of obtaining benefits under this Agreement.
- (e) **Providers Barred from Reimbursement.** Services and supplies received from providers who either have been terminated from our provider network for failing to meet Priority Health's credentialing criteria, or providers who we have identified as being noncompliant with Priority Health's quality standards and programs.
- (f) **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](http://www.hhs.gov/oig).
- (g) **Non-Participating Providers.** Non-Participating Providers are those not listed in our provider directory. For the most complete directory, call our Customer Service Department or visit our member center on our website at [priorityhealth.com](http://priorityhealth.com). Services and supplies received from Non-Participating Providers are not Covered, except in the case of a Medical Emergency or if approved by us in writing prior to obtaining the services and supplies. See Sections 2.C and 2.G for the requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services.
- (h) **Treatment in a Federal, State, or Governmental Entity.** The following are excluded to the extent permitted by law:
  - (i) Services and supplies provided in a Non-Participating 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

You may only receive services from a Non-Participating Provider if your PCP or other Participating Physician has referred you and the services have been approved by us in advance when we consider approval necessary. See Sections 2.C and 2.G for requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services. Do not go to a Non-Participating provider unless your PCP has referred you and we have approved the referral first. Otherwise, you must pay for the services. You also must pay for services you receive in excess of services approved. You may call our Customer Service Department to find out if Priority Health has approved the services. This limitation does not apply to an annual well-woman examination or to routine obstetrical services with Participating Providers as described in Section 6.A.

NOTE: Sometimes your PCP or other Participating Physician may refer you for or suggest a service that we do not Cover. Just because your PCP or other Participating Physician refers you or suggests the service does not mean you will have Coverage for that service. Remember -- if you receive services that we do not Cover, you must pay for the services.

### A. Benefit Maximums.

Some of the Covered Services described in this Agreement are subject to benefit maximums. The Schedule of Copayments and Deductibles lists those maximums. Once you have reached a maximum for a Covered Service, you will be responsible for the cost of additional services received during that Contract Year even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

### B. Out-of-Pocket Maximums.

The total amount of Copayments that you will pay for certain inpatient and outpatient hospital services and non-hospital facility services may have a limit. This limit is called an out-of-pocket maximum. The Schedule of Copayments and Deductibles provides more information about out-of-pocket maximums that may apply to you.

### C. Work-Related Illness or Injury.

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 Agreement 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 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.

### D. Services Received While a Member.

We will only pay for Covered Services you receive while you are a Member and Covered under the Agreement. 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 costs for Covered Services that you receive and we pay for after your Coverage terminated, plus our cost 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 offices, 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.

### E. Uncontrollable Events.

A national disaster, war, riot, civil insurrection, epidemic or other event we cannot control may make our offices, personnel or financial resources unable to provide or arrange for the provision of Covered Services. To the extent that happens, we will not be liable if you do not receive those services or if they are delayed. But we will make a good faith effort to see that services are provided, considering the impact of the event.

## SECTION 8. Member Rights And Responsibilities

As a Member of Priority Health you have the following rights:

- You may receive prompt medical care appropriate for your condition, including emergency care if necessary.
- You may receive information regarding appropriate or medically necessary treatment options, which will enable you to make an informed decision about the treatment you receive, regardless of cost or benefit Coverage.
- You may receive information about us, our services, our providers and your rights and responsibilities.
- You may participate in decisions regarding your health care.
- We will treat you with respect.
- We will protect your privacy.
- We will keep your medical and financial records maintained by us confidential, whether in electronic or written form. We will not disclose information from your medical records without your consent, except when permitted or required by law, in connection with the administration of Priority Health, or for anonymous use in statistical studies and medical research.
- You may inspect your medical records and those of your minor dependents at the office of the proper PCP or other Participating Physician during normal business hours. The provider may limit a parent's or legal guardian's access to a minor's medical records without the minor's consent, as provided by law.
- You may contact us to discuss concerns about the quality of care you have received from a Participating Provider.
- You may register a complaint or file a grievance with us, or the Commissioner of the Office of Financial and Insurance Regulation, if you experience a problem with us, or a provider.
- You may initiate a legal proceeding if you experience a problem with us or providers after you have exhausted the Grievance Process.
- We will notify you in a timely manner if we release personal information about you in response to a court order.
- You may review a summary of Priority Health's annual report, and inspect the full report on file with the Office of Financial and Insurance Regulation.
- You may suggest changes to our Member Rights and Responsibilities policies.

As a Member you also have the following responsibilities:

- You must read the Agreement and accompanying member materials, and comply with the requirements.
- You must call us with questions.
- You must coordinate all medical services through your PCP or other Participating Physician except in the case of a medical emergency.
- You must obtain prior approval from your PCP and Priority Health for services as noted in this Agreement, including all services from providers who are not listed in Priority Health's Provider Directory, and comply with the limits of any approval of services.
- We recommend you receive a physical examination from your PCP within one year of joining Priority Health.
- You must use Participating Providers for all services and supplies not requiring prior approval.
- You must contact Participating Providers to arrange for medical appointments, and notify providers in a timely manner if an appointment must be canceled.
- You must pay Copayments and Deductibles at the time service is provided.
- You must present your ID Card to the provider before you receive a service.
- You must participate in your health care as much as possible by working to understand your health problems.
- You must follow the treatment goals and other instructions given to you by your provider. You may participate in developing your treatment goals when possible. Priority Health or your providers may ask you to enter into an explicit written agreement setting forth your treatment plan to ensure you understand the instructions.

- You must supply, to the extent possible, information needed by us and health care professionals to provide proper care.
- You must notify providers and us if you have other health insurance coverage.
- You must provide truthful information on your application, your enrollment form and in any other information provided to us.
- You must promptly notify us of any change in address.
- You must promptly notify us if your ID card is stolen.
- You must cooperate with us to prevent the unauthorized use of your ID Card and to prevent anyone from obtaining benefits in your place.
- You must treat providers and their staff with respect.

See Section 19 for additional rights.

## SECTION 9. Claims Provisions

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

You are responsible for the cost of any services you receive from Non-Participating Providers unless those services were arranged by your PCP and approved in advance by us, or unless you need them to treat a Medical Emergency or Urgent Care situation. See Sections 2.C and 2.G for the requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services.

### A. If You Pay for Covered Services:

When you must pay a health care provider for Covered Services, ask us in writing to be reimbursed for those services. 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 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, you may call our Customer Service Department.

### B. Reimbursement Request Time Limit:

We ask that you make your request 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 of service, 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:

Priority Health  
Claims Department  
P.O. Box 232  
Grand Rapids, MI 49501-0232

### D. Information May Be Required for Payment:

Before we pay health care 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. We will not be liable for a claim or reimbursement request if we ask for additional information from you and you do not respond within 60 days after we request the additional information, unless you didn't submit the additional information or respond to us because you are legally incapacitated. Our right to that information or documentation may be limited by state or federal law.

### E. Satisfaction With Benefit Determination:

If you are not satisfied with any benefit determination we have made, you can dispute it under the Grievance Procedure. Read Section 11 to find out more about that procedure.

## SECTION 10. Termination Of Coverage

### A. Termination of Agreement.

As Subscriber, you may terminate the Agreement at the end of any month by giving us 30 days written notice of such termination. All Coverage through this Agreement will terminate at 11:59 p.m. on the date of the termination of this Agreement.

### B. Termination Due to Non-Payment of Premium.

If we do not receive payment from you for the entire Premium due under this Agreement on or before the 30<sup>th</sup> day following the payment due date, we will terminate this Agreement. Should you fail to pay Premium due to us during this 30-day grace period, we can collect from you all costs of Covered services that you received and we paid for during the grace period, plus our cost of recovering those charges (including attorney's fees). The grace period is not an extension of benefits.

### C. Loss of Eligibility.

Your Coverage will terminate if you fail to continue to meet the eligibility criteria listed below. If you lose your eligibility, your Coverage will automatically terminate at 11:59 p.m. on the day the loss of eligibility occurred and we can collect from you the costs of Covered Services that you received and we paid for after your Coverage terminated, plus our cost of recovering those charges (including attorney's fees).

You will lose your eligibility on the earliest to occur of the following:

- (1) The date you no longer meet the eligibility criteria listed in Section 3 of this Agreement.
- (2) The end of the month in which you become divorced from the Subscriber, if you were Covered as a Covered Dependent.
- (3) The date you become 18 years of age if you have enrolled as a Covered Dependent because the Subscriber or the Subscriber's spouse is your court-appointed guardian. If you are the unmarried and incapacitated child of the Subscriber, your Coverage may be continued past age 18 as described in Section 12.A.
- (4) The date you become 26 years of age if you have enrolled as a Covered Dependent child.
- (5) If you are the Subscriber, the date you become covered by any group medical expense contract, whether insured or uninsured.
- (6) The date the Subscriber no longer resides in the Service Area.
- (7) The date you enter the military, naval, or air force of any country or international organization on a full time active-duty basis. Your Coverage will not terminate if you are just participating in scheduled drills or other training that does not last longer than one month in any calendar year.

### 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) You fail, after repeated attempts, to establish or maintain a satisfactory provider-patient relationship with a Participating Provider.
  - (b) You voluntarily refuse or discontinue a service or treatment plan against the advice of your Participating Provider(s) and Priority Health that is essential to your health.
  - (c) You fail to pay any required premium.
  - (d) You refuse to cooperate with us as required by the terms of this Agreement.
  - (e) 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 Agreement.
  - (f) You refuse to comply with treatment plans, including but not limited to:
    - (i) Refusal to take prescribed medication,
    - (ii) Refusal to follow through with outpatient treatment after inpatient or other intensive level of care.
    - (iii) Repeated substance abuse detoxification.
    - (iv) Voluntarily discharging yourself from a hospital against the advice of a provider.

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

- (a) We find out you have committed or attempted to commit fraud against us or you have been dishonest with us about some important or material matter. For example, we may terminate your Coverage if we find out you gave us wrong or misleading information or you let someone else use your ID Card or receive benefits in your place.

If we choose, termination can be effective the day you committed the fraud or were dishonest with us. Also, 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); or

- (b) You act so disruptively that you upset our ordinary operations or those of a Participating Provider, including but not limited to verbally or physically threatening us or a Participating 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 a grievance within 30 days, we will reinstate your Coverage until a determination is made under Step 1 in the Grievance Procedure. (Read Section 11 to learn more about the Grievance Procedure.) If the Grievance Committee determines that your Coverage should be terminated for cause under this Section, we will again 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. If you file an appeal under Step 2 of the Grievance Procedure within 30 days, we will reinstate your Coverage until the Appeal Committee makes a final determination. If the Appeal Committee determines that your Coverage should be terminated for cause under this Section, we will again terminate your Coverage back to the date stated in the original termination notice. If we terminate your Coverage retroactively, we will refund any Premiums you paid for the period after the termination date, offset by the amount of any Covered Services you received during that period. Also, Priority Health is entitled to reimbursement for any payments made for Covered Services you received after your termination date not offset by Premiums you paid.

NOTE: If you are still eligible for Coverage under Section 3 of this Agreement, we will not terminate your Coverage based on your health or your health care needs. Also, we will not terminate your Coverage just because you used the grievance procedure to file a complaint against us.

**E. Certificate of Creditable Coverage.**

After we are notified of your termination of Coverage, you and/or your Covered Dependent(s) will receive a Certificate of Creditable Coverage that will provide proof of the Coverage you had under the Agreement. In addition, you have the right to receive a Certificate of Creditable Coverage if you request one for yourself or your dependent(s) within 24 months after the Coverage under this Agreement 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 1105  
P.O. Box 269  
Grand Rapids, MI 49501-0269  
800 446-5674 or 616 942-1221

or use our secure e-mail form in the member center on our website [priorityhealth.com](http://priorityhealth.com).

**SECTION 11.  
Inquiry And Grievance Procedure**

We hope that you are always happy with the services you receive from Priority Health. 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 about Priority Health, please call our Customer Service Department at 800 446-5674 or 616 942-1221. Our Customer Service Department will try to resolve your problem as soon as possible.

If you have a complaint or problem that our Customer Service Department cannot resolve informally or you are unhappy with our resolution, you may initiate formal grievance proceedings about any of the following:

- Benefits (including services determined to be experimental or investigational or not Medically/Clinically Necessary or appropriate)
- Eligibility
- 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 Priority Health and denied, reduced or terminated. It also may include a slow response to a request for a decision from us.

Here is a summary of the steps of the Grievance Procedure:

**A. Grievance Procedure.**

**Step 1:** Contact our Customer Service Department to file a formal grievance with us. You must file a formal grievance within 2 years of an adverse determination or within 2 years of learning of an adverse determination, whichever is later. Our Grievance Committee will meet to discuss your grievance and we will mail you a written response. Our Grievance Committee is comprised of Priority Health employees and may include senior managers and a physician, none of whom were involved in the initial determination or are subordinates of someone who made the initial determination.

**Step 2:** If your grievance has not been resolved to your satisfaction, you may request a hearing before our Appeal Committee. The Appeal Committee may be comprised of community physicians, Priority Health members, employers who offer Priority Health to their employees, and Priority Health employees, none of whom were involved in the initial determination or the decision of the Grievance Committee or are subordinates of someone who served on the Grievance Committee.

We will let you know the date and time for the hearing. You may attend the portion of the Appeal Committee hearing that applies to your grievance. Immediately after the hearing, we will send you a written decision.

If you have not yet received the services: Steps 1 and 2 combined must be completed with a final determination made within 30 calendar days after we receive your grievance and appeal forms. The 30-day count does not include any days you or your representative may delay the process. Neither Step 1 nor Step 2 may take more than 15 days, respectively.

If you have already received the services: Steps 1 and 2 combined must be completed with a final determination made within 35 calendar days after we receive your grievance and appeal forms. The 35-day count does not include any days you or your representative may delay the process. Neither Step 1 nor Step 2 may take more than 30 days, respectively.

**Step 3:** If you are not satisfied with the resolution of your problem or complaint after completing all the steps of the Priority Health Grievance Procedure, you may request a review by the Office of Financial and Insurance Regulation. You may direct appeals 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](http://www.michigan.gov/ofir)

**B. Expedited Grievance Procedure.**

If the time it takes for us to review your concern under the normal Grievance Procedure would put your life in serious danger, interfere with your full recovery or delay treatment for severe pain, we will follow an "expedited grievance" procedure. Steps 1 and 2 in an "expedited grievance" procedure must be completed within 72 hours of receipt of your request.

**C. Obtaining Information about the Grievance Procedure.**

To obtain a complete copy of our Grievance Procedure and Grievance Filing Form, or to find out more about your appeal rights, please contact our Customer Service Department.

**D. Obtaining Information about your Grievance.**

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 under Section 502 of ERISA. However, before filing a lawsuit against us, you must complete our Grievance Procedure as described in this Section 11. In addition, 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 (3) three years after the time written proof of loss is required to be furnished.

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. Continuation and Conversion**

**A. Continuation of Coverage for Unmarried and Incapacitated Dependents.**

We will continue to provide Coverage for the Subscriber's and the Subscriber's spouse's unmarried and incapacitated dependent past the maximum age for dependent children, except as described below. A dependent is Incapacitated if all of the following apply:

- (1) The dependent is the child of the Subscriber or the Subscriber's spouse;
- (2) The dependent is not capable of self-sustaining employment and is unable to independently socialize without assistance because of a mental or physical disability that is incapacitating. Certain diagnosis, including but not limited to attention deficit disorder or depression, by themselves, are 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 the date the dependent reached the maximum age for dependent children; and
- (4) The dependent relies on the Subscriber for more than half of his or her support, as determined under Section 152 of the Internal Revenue Code, as amended.

We must receive proof from you that the dependent is incapacitated within 31 days after the dependent reaches the maximum age for dependent children. After that, 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 not be continued after any of the following happens:

- (a) The dependent is no longer a dependent of the Subscriber or the Subscriber's 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; or
- (d) The dependent's Coverage as a dependent ends for any reason other than reaching the maximum age for dependent children (such as marriage).

**B. Conversion**

This subsection does not continue Coverage under this Agreement. It permits the issuance of a separate Individual Agreement under certain conditions.

An Individual Agreement may be issued, subject to the terms of this subsection, only if the Coverage under this Agreement for a Subscriber's Covered Dependents terminates because of the death of the Subscriber, divorce or legal separation from the Subscriber, or because of the Member's loss of eligibility as a Covered Dependent.

The Covered Dependent will have the right to convert to an Individual Agreement without providing evidence of good health to us, and without regard to health status or requirements for health care services.

To obtain coverage under a separate Individual Agreement, a completed application and the applicable Premium payment must be submitted to us within 31 days after the termination date of Coverage under this Agreement. The Individual Agreement will become effective on the day after the termination date of Coverage under this Agreement.

We will not issue an Individual Agreement if either of the following is true:

- (1) The application is made in a jurisdiction in which we are not authorized to issue or deliver the Individual Agreement.
- (2) The person who would be covered under the Individual Agreement is, on the conversion date, covered, eligible for or entitled to coverage under:

- (a) Any group health care benefit plan, whether insured or uninsured; or
- (b) Any federal or state governmental program.

### **SECTION 13. 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 a right to subrogation (which means that we can stand in your or your estate's shoes and sue a third party directly for an Illness or Injury for which we are providing services) and a right of reimbursement (which 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 for which we are providing services). These rights include recoveries from tort-feasors, underinsured/uninsured motorist coverage, worker's compensation, other substitute coverage, any other group or non-group policy of insurance providing health and/or accident coverage (including, but not limited to, any insurance policy having to do with payment of medical benefits that result from an automobile accident, and any riders or attachments to that policy), or 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 had 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. You must tell us immediately, in writing, about any situation that might let us invoke our rights under this section.

You must 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 and 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 13, the term "you" includes you and any person claiming through or on behalf of you, including relatives, heirs, assigns and successors.

### **SECTION 14. Non-Duplication of Benefits**

The benefits under this Agreement are not intended to duplicate any benefits to which Members are, or would be, entitled under any other federal or state government program, nor are they intended to duplicate any "no fault" benefits. All sums payable under such programs or policies for services provided pursuant to this Agreement shall be payable to and retained by us. Each Member shall complete and submit to us such consents, releases, assignments and other documents as may be requested by us in order to obtain or assure reimbursement in connection with any governmental program or "no fault" benefits for which Members are eligible.

### **SECTION 15. Premiums**

Premiums for Covered Services to be provided under this Agreement are as disclosed to you at the time you filed your initial application with us.

The initial Premium will be effective for the initial term of this Agreement. We may change the Premium upon 30 days written notice to you prior to the renewal of this Agreement or a change in any applicable law or regulation having a direct and material impact upon the cost of providing Coverage to Members (such as an increase in the premium tax applicable to such Coverage or revision of the Covered Services provided under this Agreement to include benefits mandated by applicable laws). You may terminate this Agreement as of the date that the revised Premium would become effective, by providing written notice of termination not less than 10 days prior to such effective date.

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 a quarterly basis. Each Premium period, whether monthly or otherwise, shall end at 11:59 p.m. E.S.T.

Premium payments to Priority Health are subject to a 30-day grace period, during which time Premiums may be made to us without lapse of Coverage. If the Premium is not paid within that grace period, your Coverage will, at our discretion, be terminated as of the end of that 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 these charges (including attorney's fees).

## SECTION 16. Renewal

The initial term of this Agreement is from 12:01 a.m. of the day Coverage becomes effective through December 31 of that year. Following the initial term, this Agreement will renew automatically for an additional 12 months, subject to all terms and provisions of this Agreement, unless otherwise terminated as provided for in this Agreement. We will give you advance written notice of any change in the Premium or material changes in Covered Services or other provisions of this Agreement that will be effective on the renewal date. Payment of the applicable Premium on and after that date will constitute acceptance of those changes by you, individually and on behalf of all of the Members enrolled under this Agreement. You may terminate this Agreement as of its renewal date by providing written notice of non-renewal not less than 10 days prior to the renewal date, if such changes are not acceptable to you.

We will not refuse to renew this Agreement, if validly in force, except for the discontinuance of this entire class of agreements. We will not refuse to renew this Agreement based on your medical condition or health care needs.

## SECTION 17. Definitions

- (1) **Agreement.** This Agreement between the Subscriber and us. The Agreement is a contract for health benefits. The Agreement includes this document, the application form, the Schedule of Copayments and Deductibles, any amendments and any attachments.
- (2) **Behavioral Health Department.** The department that assesses and arranges all mental health and substance abuse services for Members. The department is available for assessment 24 hours a day.
- (3) **Certificate of Creditable Coverage.** A certificate issued to you and/or your Covered Dependents upon termination of Coverage under this Agreement.
- (4) **Child Placed for Adoption.** A child of whom the Subscriber has custody and for whom the Subscriber has assumed and retains a legal obligation for partial or total support in anticipation of adoption.
- (5) **Congenital Birth Defect.** A condition that is present at birth.
- (6) **Contract Year.** The period of time that starts on the day the Agreement is effective and ends 365 days later (unless the Agreement says otherwise).
- (7) **Copayments.** The amount you must pay directly to a provider of Covered Services for those services and supplies. You must pay this amount when you receive Covered Services. The Copayments are listed in the Schedule of Copayments and Deductibles.
- (8) **Covered Dependent.** Any of your dependents: (a) who meet the eligibility requirements set forth in Section 3 and in the Agreement; (b) who have been enrolled as required by this Agreement; and (c) for whom we have been paid all required Premiums.
- (9) **Covered Services, Coverage, Cover or Covered.** Those services and supplies that you are entitled to under this Agreement, if they are Medically/Clinically Necessary and you have met all other requirements of this Agreement. The Agreement and the Schedule of Copayments and Deductibles limit what we will pay for some services and supplies. When we say we will "Cover" a service or supply, that means we will treat the service or supply as a Covered Service.
- (10) **Deductible.** An amount that you must pay before Priority Health will pay for Covered Services under this Agreement. Deductibles, if any, apply to those Covered Services as indicated on the Schedule of Copayments and Deductibles or any rider to this Agreement.
- (11) **Health Professional.** An individual licensed, certified or authorized under state law to practice a health profession.
- (12) **Home Health Care Agency.** An agency or organization that is licensed to provide skilled nursing services and other therapeutic services in an outpatient setting.
- (13) **Hospice Care.** Services for the terminally ill and their families including pain management and other supportive services.

- (14) Hospital. An appropriately licensed acute care institution (including a longterm acute care facility) that provides inpatient 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.
- (15) ID Card. The Member Identification Card you receive from us as evidence of your enrollment with us.
- (16) Ill or Illness. A sickness or a disease, including congenital defects or birth abnormalities.
- (17) Incapacitated. A dependent is eligible for Coverage as an Incapacitated dependent if the dependent meets the requirements of Section 12.A.
- (18) Injury or Injured. Accidental bodily Injury.
- (19) Medical Director. A Michigan-licensed Physician we have designated to supervise and manage the medical aspects of our health care delivery system.
- (20) Medical Emergency. The sudden onset of a medical condition with signs and symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.
- (21) Medically/Clinically Necessary. The services or supplies needed to diagnose, care for or treat your physical or mental condition. The Medical Director, or anyone acting at the Medical Director's direction, in consultation with your PCP or other Participating Physician, or, for Mental Health or Substance Abuse services, the Behavioral Health Department, determines whether services or supplies are Medically/Clinically Necessary according to Priority Health's medical and behavioral health policies or adopted criteria that have been approved by community physicians and other providers. Medically/Clinically Necessary services and supplies must be widely accepted professionally by Priority Health's network physicians as effective, appropriate, and essential, based upon nationally accepted evidence-based standards.  
  
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 service or supply beyond those services sufficient to safely and adequately diagnose or treat your physical or mental condition; and
  - (e) An alternative procedure of no demonstrated additional benefit.
- (22) Medicare. Title XVIII of the Social Security Act, as amended.
- (23) Member. A person enrolled with us as a Subscriber or Covered Dependent.
- (24) Mental Health Treatment Facility. A Mental Health Treatment Facility is a facility that (a) meets applicable licensing standards; (b) provides a generally accepted as effective program for diagnosis, evaluation and treatment of multiple mental health conditions; (c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; (d) provides all normal infirmity-level medical services or arranges with a Hospital for any other medical services that may be required; (e) is under the supervision of a psychiatrist; and (f) provides skilled nursing care by licensed nurses, who are directed by a registered nurse.
- (25) Motorized vehicle. Any self-propelled vehicle, designed for use on or off public roads, waterways or in the air.
- (26) Newborn. A child 30 days old or younger.
- (27) Non-Occupational Illness and Non-Occupational Injury. An Illness or Injury that does not arise out of (or in the course of) any work for pay or profit, and does not in any way result from an Illness or Injury that arose from work for pay or profit. But, if we obtain proof that you are covered under a Worker's Compensation law or similar law, but that you are not covered for a particular Illness or Injury under that law, that Illness or Injury will be considered "non-occupational" regardless of cause.

- (28) Non-Participating Provider. A Health Professional or other entity, including a hospital or outpatient facility, that has not contracted with us to provide Covered Services to Members. Health Professionals who practice outside of our Service Area are Non-Participating Providers. Non-Participating Providers are not listed in the Priority Health Provider Directory.
- (29) Out-of-Area Services. Those services and supplies provided outside our Service Area by Non-Participating Providers.
- (30) Out-of-Pocket Maximums. The total amount of Copayments that you will pay for certain Covered Services as described in the Schedule of Copayments and Deductibles.
- (31) Participating Hospital. A Hospital that contracts with us to provide Covered Services to Members. Participating Hospitals are located within our Service Area and are listed in our Provider Directory.
- (32) Participating Mental Health Treatment Facility. A Mental Health Treatment Facility that contracts with us to provide Covered Services to Members.
- (33) Participating Physician. A Physician who contracts with us to provide Covered Services to Members. Participating Physicians are listed in our Provider Directory.
- (34) Participating Provider. A Health Professional or other entity that contracts with us to provide Covered Services to Members and is listed in Priority Health's Provider Directory. Most Participating Providers practice within Priority Health's Service Area.
- (35) Participating Substance Abuse Treatment Facility. A Substance Abuse Treatment Facility that contracts with us to provide Covered Services to Members.
- (36) Physician. An appropriately licensed physician or surgeon.
- (37) Premium. The total payment from Subscriber to us for Coverage.
- (38) Preventive Health Care Services. Routine care described in Priority Health's preventive health care guidelines that are designed to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability. See Section 6.A.1 for the summary of Covered Preventive Health Care Services. Priority Health's complete preventive health care guidelines are available in the Member Center on our website at [priorityhealth.com](http://priorityhealth.com) or from our Customer Service Department. Our guidelines are based on federal requirements for Coverage of preventive health care services contained in Section 1001 of the Patient Protection and Affordability Act (PPACA) available at [healthcare.gov](http://healthcare.gov).
- (39) Primary Care Provider ("PCP"). The Participating Provider, as chosen under Section 2.A, who is responsible to provide, arrange, and coordinate all aspects of your health care.
- (40) Priority Health. The Michigan nonprofit corporation and licensed health maintenance organization providing benefits under this Agreement.
- (41) QMCSO. A Qualified Medical Child Support Order is an order meeting certain requirements that is issued by a State court and directs one or both parents to cover a child under his/her health insurance carrier.
- (42) Reasonable and Customary Charges. The charge for a Covered Service that is the lower of: (a) the provider's usual charge for furnishing the service; and (b) the charge we determine to be the prevailing charge level made for the service or supply in the geographical area where it is furnished. In determining the reasonable charge for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, we may consider things like the complexity of the service, the degree of skill needed, the type or specialty of the provider, the range of services provided by a facility, and the prevailing charge in other areas.
- (43) Residential Treatment. 24 hour services provided in a facility where the focus of care is custodial, and inpatient Medically/Clinically Necessary criteria are not met.
- (44) Service Area. A geographical area, designated by us and approved by the State of Michigan's Office of Financial and Insurance Regulation, in which we are authorized to offer Covered Services. In general, our Service Area is located in West Michigan and Northwest Michigan. We publish precise Service Area boundaries and you may obtain that information on our website [priorityhealth.com](http://priorityhealth.com) or from our Customer Service Department.
- (45) Skilled Nursing, Subacute, or Inpatient Rehabilitation Facility. A facility that is appropriately licensed to provide services in lieu of acute care in a hospital, including skilled nursing care and related services, subacute services and short-term rehabilitative therapy care on an inpatient basis.

- (46) **Specialist Provider.** A Participating Provider, other than a PCP, under contract with us to provide Covered Services upon referral by the PCP and approval in advance by us.
- (47) **Specialty Drug.** Drugs listed in the Medication Formulary meeting certain criteria, such as drugs or drug classes whose cost on a per-month or per-dose basis exceeds the threshold established by the Centers for Medicare and Medicaid Services; or drugs that require special handling or administration; or drugs that have limited distribution; or drugs in selected therapeutic categories.
- (48) **Specialty Pharmacy.** A Pharmacy that specializes in the handling, distribution, and patient management of Specialty Drugs.
- (49) **Subscriber.** A person: (a) who meets all applicable eligibility requirements of the Agreement; (b) who has enrolled for Coverage; and (c) has paid us any applicable Premium payments under the Agreement.
- (50) **Substance Abuse Treatment Facility.** A Substance Abuse Treatment Facility is a facility that (a) meets licensing standards; (b) provides a program for diagnosis, evaluation and treatment of substance abuse; (c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; and (d) provides, on its premises, 24 hours a day, detoxification services, infirmary-level medical services or arranges with a Hospital for any other medical services that may be required, supervision by a staff of Physicians, and skilled nursing care by licensed nurses who are directed by a registered nurse.
- (51) **Urgent Care.** Services provided at a licensed facility other than a Hospital emergency room to treat non-life threatening conditions that require immediate medical attention to limit severity and prevent complications.
- (52) **Urgent Care Center.** A licensed facility, not including a Hospital emergency room, that provides Urgent Care for the immediate treatment only of an Injury or Illness. An Urgent Care Center may include a Physician's office when urgent care is provided after normal office hours.
- (53) **We, us or our.** Priority Health.
- (54) **You, your or yourself.** The Member, whether enrolled with Priority Health as a Subscriber or Covered Dependent.

## SECTION 18. General Provisions

### A. Independent Contractors.

We do not directly provide any health care services under this Agreement, 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. We are only obligated under this Agreement to provide Members a network of health care services.

We are responsible for making benefit determinations under this Agreement and our contracts with Participating Providers. Health Professionals are responsible for making independent medical judgments.

Health Professionals and you may choose to continue medical treatment even if we deny Coverage for those treatments. In such event, you will be responsible for the cost of those treatments. Health Professionals, on your behalf, and you may appeal any of our benefit decisions. Any appeal must follow the inquiry and grievance procedure explained in Section 11.

### B. Entire Agreement.

The Agreement, including the application form, the Schedule of Copayments and Deductibles, and any amendments or attachments, is the entire Agreement between the Subscriber and us. Beginning on the effective date of Coverage, the Individual Agreement 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 Agreement, whether as a Subscriber or a Covered Dependent.

### D. Conformity with State and Federal Law.

Priority Health will apply this Agreement in accordance with state and federal laws and regulations. If any part of this Agreement does not conform with state or federal laws or regulations, we will change our procedures to agree with the laws and regulations.

### E. Amendments.

This Agreement may be amended by either party upon written notice to the other if the amendment is necessary in order to comply with applicable laws and regulations. It may also be amended for any reason upon written agreement by the Subscriber 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 effective dates, termination dates, or erroneous mailings, will not change the rights or obligations of you or us under this Agreement and will not operate to grant additional benefits to Members, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

**G. Execution of Agreement.**

This Agreement shall be executed by the Subscriber and Priority Health by signing the application form that is made a part of this Agreement.

**H. Governing Law and Severability.**

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

**I. Notices.**

Any notice required or permitted under this Agreement shall be in writing and shall be considered to have been given on the date when delivered in person; or if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Member's application form or to any more recent address of which the sending party has received written notice.

**J. Third Parties.**

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

**K. Waiver.**

In the event a party waives any provision of this Agreement, that party will not be considered to have waived that provision at any other time or to have waived any other provision. The failure to exercise any right under this Agreement shall not operate as a waiver of such 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 or 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. In addition, Priority Health will not share any member information with an employer without specific authorization from the member.

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](http://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:

Priority Health  
1231 East Beltline NE  
Grand Rapids MI 49525

616 942-0954  
800 942-0954

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.

Filed in Michigan: 2011

Doc\_2520