

Insurance Policy

Preferred Provider Organization Plan (PPO)



Priority Health Insurance Company,

A subsidiary of Priority Health

CANCELLATION

PROVISIONS

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

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

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

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

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INSURANCE POLICY –

PRIORITY HEALTH INSURANCE COMPANY – PREFERRED PROVIDER ORGANIZATION PLAN

Policy Delivered in Michigan – 2009

Read this entire Policy carefully. It is a contract that 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 Policy.

In some circumstances certain medical services are not Covered or may require prior approval by Priority Health.

NOTE: You are responsible for those Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary listed in the Schedule of Benefits.

SECTION 1. About This Policy

This Policy is part of the Agreement between Priority Health and the Group. The Agreement sets the terms and conditions of Coverage. This Policy describes the health care services that are Covered for Members.

This Policy 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. It replaces and supersedes any Policy we might have issued in the past.

Words that are capitalized in this Policy are special terms that are defined in Section 14. 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. “Group” refers to the Subscriber’s employer or other entity through which you have obtained Coverage under this Policy.

If you have any questions about Coverage, first contact the Group. If you need more help, contact our Customer Service Department at:

Customer Service Department, MS 1165
1231 E. Beltline NE
Grand Rapids, MI 49525-4501
616 464-8830 or 888 389-6645
or
on our website at priorityhealth.com

SECTION 2. Eligibility

As an employee of the Group, or a dependent of an employee of the Group, you may enroll as a Member if you meet certain requirements. First, you must meet the Group’s eligibility and waiting period requirements. You must also meet the other requirements described below and in the Agreement. If there is any conflict between the requirements described below and the terms of the Agreement, the terms of the Agreement will govern eligibility. Eligibility may be limited or expanded by one or more supplemental benefit Addenda.

A. Subscriber.

You may enroll as a Subscriber if you:

- (1) are an Active Employee of the Group; and
- (2) meet any other eligibility requirements listed in the Agreement.

B. Covered Dependents.

You may enroll as a Covered Dependent:

- (1) if you are legally married to the Subscriber who works for the Group the number of hours required for eligibility; or
- (2) if you are the Subscriber’s unmarried 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 one or more of the following applies:
 - (a) You are
 - under age 19 on the effective date of Coverage (or turned 19 in the same calendar year as the effective date of Coverage) and

- dependent on the Subscriber for more than half of your support, as determined by the Internal Revenue Code, as amended. Coverage under this paragraph continues to the end of the calendar year in which you turn 19.

Your Group may end Coverage at the end of the month or day in which you turn 19. If your Group's eligibility requirements are different from those contained in this Policy, your Group's requirements apply.

(b) You are

- between the ages of 19 and 25, and
- dependent on the Subscriber for more than half of your support, as determined under the Internal Revenue Code, as amended, and
- a full-time student attending high school, college or a vocational/technical school. The high school (or equivalent program), college or vocational/technical school must be accredited by the governmental agency, organization or entity that is responsible for accrediting an institution of that kind. "Full-time" means a minimum of 12 credit hours, or as defined by the institution. We reserve the right to ask for proof of attendance at an institution that meets the requirements of this subsection.

Coverage under this subsection continues until (i) you are no longer a full-time student, or (ii) you reach the age of 25, whichever occurs first. This section may be superceded by a Group specific Addendum, which may exclude eligibility under this subsection (2), or change the maximum age for eligibility. Check with your Group if you have any questions about eligibility under this subsection. The Working Families Tax Relief Act of 2004 may impose tax consequences for covering the above stated age groups.

You must tell us when you or your Covered Dependent is no longer eligible for Coverage under this subsection (b). If we learn that your Covered Dependent is no longer eligible because they are no longer a full-time student, we may terminate Coverage retroactively to the date when eligibility ended. You would then be responsible for any services obtained after eligibility ends.

See Section 11.D for information on continuation of Coverage for a dependent student taking a leave of absence from school due to illness or injury.

(c) You are (were) Incapacitated before age 25 or the date the dependent reached Group's maximum age for dependent children, whichever is less. Read Section 11.E to find out about available Coverage.

(Note: Due to a change in the Internal Revenue Code, a Subscriber who enrolls an unmarried child over the age of 23, even a full-time student, may not deduct from the Subscriber's taxes the cost of premiums paid to cover this child. To the extent that the Subscriber's Group pays the premiums for this child, the subscriber may need to pay taxes on the premiums paid by the Group. Please consult your tax advisor for details.)

- (3) if you provide us with a copy of a court or administrative order which requires you to provide health coverage for a child in accordance with state law (a "Qualified Medical Child Support Order" or "QMCSO"), you may enroll the child without regard to any open enrollment restrictions. The child must be otherwise eligible for Coverage as a Covered Dependent except that the child is not required to be dependent on you for more than half of his or her support. (A QMCSO is only applicable regarding the children of an employee and not of an employee's spouse.) If we receive a copy of the QMCSO but you fail to enroll the child for Coverage, the child may be enrolled by the Friend of the Court or by the Child's other parent or guardian through the Friend of the Court. We will not terminate the Coverage of a child who is enrolled under a QMCSO unless the child is no longer eligible as a dependent, Premiums have not been paid as required by the Agreement, or unless we receive satisfactory written proof that the QMCSO is no longer in effect or that the child has or will have comparable health coverage beginning on or before the date the child's Coverage with us is terminated. If we ask you for a copy of a court order to confirm a dependent's eligibility for Coverage, you must provide it to us within 31 days of our request. You and your dependents can obtain, without charge, a copy of Priority Health's procedures governing QMCSO determinations.

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 (such as a court document that states when the child was legally placed in your custody) that satisfies us within 31 days.

You may not enroll as a Covered Dependent if you live outside of the United States unless you reside with the Subscriber who lives 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, or when in the custody of law enforcement officers, or when on release for the sole purpose of receiving medical treatment.

SECTION 3. Enrollment

This Section describes what you need to do to enroll 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 9.C to learn more about termination for cause.

To enroll, you must fill out an enrollment form, sign it, and return it to the Group. On the enrollment 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 the Group permits you to enroll electronically, you still must give us this information. Your Coverage may be limited or expanded by one or more supplemental benefit Addenda.

A. Open Enrollment Period for Employees and Eligible Dependents.

You may apply for Coverage for yourself and your eligible dependents during an Open Enrollment Period. During that time, you may apply regardless of age, health status, or medical needs. Ask the Group when the Open Enrollment Period is for your Group.

B. Special Enrollment of Newly Eligible Employees and Dependents.

You may also apply for Coverage for yourself and your eligible dependents if you become eligible for Coverage between Open Enrollment Periods. In that case, you must apply within 31 days after becoming eligible for Coverage, or within 60 days in the case of Special Enrollment Period under Section 3.B(3). Otherwise, your first day of Coverage will be delayed until the next Open Enrollment Period. Coverage obtained under this Section will become effective without regard to age, health status, or medical needs. If your Coverage is effective retroactively, any care you receive is subject to the terms and provisions of this Policy, including any requirements for prior approval by Priority Health, and use of Network Providers.

(1) New dependents.

If you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself (if not already enrolled), the new dependent, your spouse and other dependents (if not already enrolled), during a Special Enrollment Period. If you are already enrolled and gain a new dependent as a result of marriage, birth, adoption or placement for adoption, you may add your spouse and other dependents (if not already enrolled) and the new dependent to your existing Coverage.

You must fill out and return to the Group a completed enrollment or change form within 31 days after the marriage, birth, adoption, or placement for adoption. You must do this even if the enrollment or changes do not require you to pay a higher Premium. If you submit the enrollment or change form within 31 days, Coverage will be effective on the date of the marriage, birth, adoption or placement for adoption. To enroll with us, you and your dependent(s) must meet the eligibility requirements of the Group and Priority Health.

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 for other than routine care or to continue after discharge, you must fill out and return to Group a change form within 31 days after the child is born.

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.

(2) Loss of Other Coverage.

If you did not previously enroll with us because you had other health insurance coverage, and that coverage is lost, you may enroll yourself and/or your dependents (including your spouse) during a Special Enrollment Period, if the following requirements are met:

- (a) You chose not to enroll for Coverage when it was previously offered because you had other coverage; and
- (b) You stated in writing at the time that you chose not to enroll for Coverage when it was offered that this was because you had other coverage (if your Group required such a statement); and
- (c) The other coverage was COBRA continuation coverage and it ran out; or

The other coverage was not COBRA continuation coverage and it ended because you lost eligibility or because the employer stopped making contributions; and

- (d) You fill out and return to the Group a completed enrollment form within 31 days after the other coverage (as stated above) ends; and
- (e) You provide proof of the loss of other coverage that is acceptable to us.

(3) Medicaid or CHIP Coverage.

CHIP is a state's Children's Health Insurance Plan under the Children's Health Insurance Program Reauthorization Act of 2009.

Beginning April 1, 2009, if you or your eligible dependents (including your spouse) are eligible for, but not enrolled for Coverage, you may enroll yourself and/or your dependents during a Special Enrollment Period if either of the following requirements is met:

- (a) The Medicaid or CHIP coverage of you or your eligible dependent is terminated as a result of loss of eligibility and you request Coverage no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- (b) You or your eligible Dependent become eligible for a premium assistance subsidy for Coverage under a Medicaid plan or CHIP (including any waiver or demonstration project) and you request Coverage no later than 60 days after the date you are determined to be eligible for such assistance.

NOTE: If you lose coverage for the following reasons, you and your dependents are not eligible for Special Enrollment under Section 3.B(2) and 3.B(3):

- (i) You fail to pay your share of the premiums on a timely basis; or
- (ii) Your coverage was terminated for cause such as for making a fraudulent claim or giving false information; or
- (iii) You voluntarily drop your other coverage for any reason, including an increase in premium or change in benefits. **EXCEPTION:** You drop the other coverage during the annual open enrollment period for that other coverage.

If your enrollment is effective retroactively (for example, you send us your enrollment form 31 days after the date of marriage or date of birth), any care you received during such time would be subject to the terms of this Policy, including use of Network Providers and obtaining any required prior approval by us.

C. Late Enrollment.

Anyone who is eligible but does not enroll as described in Sections 3.A or 3.B may only enroll during the next Open Enrollment Period.

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

You or your employer must let us know about any changes that affect Coverage under this Policy. You do that by:

- (1) filling out a change form and returning it to the Group, or
- (2) calling our Customer Service Department.

You or your employer must notify us if any of the following happens to anyone Covered under the Agreement:

- (a) change of address;
- (b) change in Covered Dependent status (including status as a full-time college student);
- (c) eligibility for Medicare, Medicaid and Children's Special Healthcare Services; or
- (d) coverage by any other insurance or health plan.

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

You or your employer must let us know about the change within 31 days after the change happens. Some changes may require prior approval from your employer. If you do not notify us, and we discover the change, we will use the correct information to determine whether or not services you receive are Covered.

E. Loss of Eligibility.

You will lose your eligibility and your Coverage will terminate if you no longer meet the eligibility criteria listed in Section 2 of this Policy, or in the Agreement, or if either of the events described in Section 9.B of this Policy occur.

F. Genetic Testing.

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

SECTION 4. Effective Dates of Coverage

Your Coverage will begin on the latest of:

- (1) The effective date of the Agreement; or
- (2) The first day of the month that the Group has established as the effective date for those enrolling during an Open Enrollment Period, if you enroll during that Open Enrollment Period (unless we agree otherwise with the Group); or
- (3) The date of eligibility stated in the Agreement, if you are a newly eligible employee; or
- (4) The day after your other coverage ended, if you are eligible to enroll during a Special Enrollment Period because you lost coverage (See Section 3.B(2)); or
- (5) The date of marriage, or the date of a dependent's birth, adoption or placement for adoption, if you are eligible to enroll during a Special Enrollment Period because of gaining a dependent (See Section 3.B(1)).

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

SECTION 5. Obtaining Covered Services**I. How The Plan Works.**

This plan is designed as a Preferred Provider Organization ("PPO") group health plan for your medical benefits. The plan provides a network of medical care providers ("Network Providers") who have agreed to provide services for specified fees. Under the plan, you may choose to use either Network services or Non-Network services (as described in Section 5 of this Policy), at the point in time when Covered Services or Supplies are desired. In order to receive Network services, you are responsible to ensure that the Provider participates in the Network at the time of service.

As a Member in the plan you may obtain medical services directly from a Network Provider, allowing you to receive "Network Benefits". You will be responsible for the Copayments, Deductibles, Coinsurance and any amounts over Reasonable and Customary shown under the heading of "Network Benefits" in the Schedule of Benefits. Generally, Network Benefits will cost you less out-of-pocket than Non-Network benefits. If you receive services from a Non-Network provider you will receive "Non-Network Benefits" (except as otherwise specified in this Policy). You will be responsible for the Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary shown under the heading of "Non-Network Benefits" in the Schedule of Benefits. At any time during your course of treatment, you have the option to return to a Network Provider for medical care. If you do, the plan will cover care by a Network Provider at the Network Benefit level.

To verify the current network status of Network Providers, contact the Provider network number listed on your ID card or detailed in the Network Provider attachment. You are responsible for determining whether a provider is part of the Network before receiving services. Unless otherwise specified in this Policy, benefits will be paid based on the network status of the provider as of the day services are received.

Generally, you will have the lowest out-of-pocket amounts and the most cost savings with the Network Benefit option. The Non-Network Benefit option typically involves a higher out-of-pocket expense. But the Non-Network Benefits option allows you to choose any provider, anywhere, and at any time.

Non-Network Benefits are available on a world-wide basis. Prior approval of certain services is required as described in Section 5.II. Penalties for failure to obtain or follow prior approval requirements still apply.

A. Network Providers.

Network Providers can provide your medical care, including your Preventive Health Services, Primary Care and Specialty Care. A Network Provider can provide or coordinate services such as lab tests and x-rays, prescribe medicines or therapies, and arrange

hospitalization. Only those services provided by a Network Provider will be covered as Network Benefits, except as otherwise stated in this Policy.

B. Termination of Provider’s Participation.

A Network Provider, or the Network, can terminate the provider's contract and you will need to change to a different Network Provider to maintain Network Benefits. We do not promise that you will be able to receive services from a specific Network Provider the whole time you are covered by this plan.

If you are being actively treated (or are hospitalized) at the time a Network Provider’s contract with us is terminated, and the provider is able to continue treating you, you may continue to be treated by this provider until your treatment is completed or until the Network has made arrangements for another provider to provide the services. In addition, if, at the time a Network 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, Priority Health will work with you to ensure continuity of care. You may continue to see this provider for up to 90 days, or through completion of postpartum care. This paragraph does not apply if the Network Provider’s contract has been terminated for quality of care reasons.

We will assist you in finding another Network Provider and in receiving care during the transition if your Network Provider’s contract is terminated. If you have any questions, please call our Customer Service Department at 616 464-8830 or 888 389-6645.

C. Referral Care and Second Medical Opinion.

Your Physician, or another health professional, may refer you to a provider who does not participate in the Network. You are responsible to make sure each provider participates with the Network before receiving services in order to receive the Network Benefit level.

A second medical opinion from a specialist may be appropriate for certain health conditions and proposed surgeries. We will Cover second medical opinions from Physicians having skills and training substantially similar to those of the Physician making the original treatment recommendation. Benefits for second opinion services will be based on the Network status of the provider at the time of service. Any tests, procedures, treatments or surgeries recommended by the consulting provider must be performed by a Network Provider to receive benefits at the Network Benefits level.

Note: Sometimes a Provider might refer you for, or suggest, a service that the plan does not cover. The plan will not cover a service that would not be covered otherwise just because a Provider referred you or suggested the service.

D. Review of Health Care Services and Supplies.

Priority Health can review services and supplies that health professionals recommend or provide to decide whether those services and supplies are Covered under this plan. If Priority Health decides that the services and supplies are not Covered, Priority Health will let you know. If you disagree with the decision and want that decision to be reviewed, you must follow the procedures described in Section 10 of this Policy.

E. Additional Information

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

- (1) You may request a current Provider Directory. This lists our current provider network.
- (2) Any prior approval requirements and any limitations, restrictions or exclusions on services, benefits or providers.
- (3) The type of financial relationships between the Network and its providers.
- (4) How we evaluate new technology for inclusion as a Covered Service.
- (5) How we evaluate new drugs for inclusion in our formulary.
- (6) A printed version of this Policy.

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 1165
 1231 E. Beltline NE
 Grand Rapids, MI 49525-4501
 616 464-8830 or 888 389-6645

or

on our website at priorityhealth.com

F. 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.

II. Prior Approval Of Benefits.

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 mental health services and inpatient substance abuse services).
- (2) Certain outpatient services.
- (3) Durable medical equipment over \$1,000.00 and all rentals.
- (4) Prosthetics and orthotics over \$1,000.00, all rentals and all shoe inserts.
- (5) Certain stimulators.
- (6) Certain high-tech radiology examinations, including positron-emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies.
- (7) Selected injectable drugs in certain categories.
- (8) All home health care, including home infusion services and hospice.
- (9) Enteral and parenteral feedings.
- (10) Experimental or investigational services.
- (11) Transplant and evaluations for transplant.
- (12) Genetic testing.
- (13) Clinical trials for cancer care.
- (14) Comprehensive pain and headache programs.

NOTE: Travel outside of the Service Area after 34 weeks gestation also requires prior approval from Priority Health.

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.

See Sections 5.II.A and 5.II.D for the steps of the prior approval process, including how to confirm coverage before receiving services and supplies.

The list of services that require prior approval may be updated from time to time. A current listing is available by calling the Priority Health Customer Service Department at **616 464-8830** or **888 389-6645**.

Other services may be prior approved by you or your provider in order to determine medical/clinical necessity prior to treatment. Prior approval is not a guarantee of coverage or a final determination of benefits under this plan.

A. Prior Approval Must be Obtained:

At least 5 working days before a non-Medical Emergency admission or procedure, including transplants, and outpatient surgical procedures.

In addition, emergency admissions must be reported to our Health Management Department as soon as reasonably possible after the time of admission.

We encourage you to notify us at least 60 days before your due date for delivery in a Hospital to enable us to assist you at that time, however, prior approval is not required for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.

B. Retrospective Review

If approval in advance is not obtained for those services requiring prior approval, we will review the claim after you receive the services. If we determine that care received was Medically/Clinically Necessary and appropriate, the care will be Covered at the applicable Benefits level with a penalty as shown on the schedule of benefits. If we determine that the care received was not Medically/Clinically Necessary and appropriate, the charges will not be Covered.

C. Re-evaluation of Decision on Prior Approval.

At any time, you or your Physician may ask our Health Management Department (or our Behavioral Health Department in the case of mental health and substance abuse services) to re-evaluate our decision on prior approval, or to extend the number of days of Hospital confinement considered Medically/Clinically Necessary for the treatment of a condition. In non-urgent cases, where you ask to extend the number of days of Hospital confinement, we will approve, deny or partially approve your request as soon as reasonably possible, but not later than 24 hours after receipt of the request, provided that you make such a request at least 24 hours prior to the expiration of the prescribed period of time. If the Hospital confinement extends beyond the number of approved days, the additional days will not be Covered unless the extension of days is Medically/Clinically Necessary and we have given approval in advance for the extension before the extension begins.

D. Prior Approval of Certain Health Care Services and Supplies.

As stated in this Section 5.II, 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 partially 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 in writing if the requested services and supplies will be Covered, not Covered or partially Covered. In all cases, if you obtain services that we say are not Covered, you will be responsible for payment for those services. If you want our decision to be reviewed, you must contact us. Section 10 tells you how to do that.

See Section 5.II.E below for the penalty that may apply when prior approval is not requested.

E. Imposition of Penalty.

If prior approval is not obtained before you receive any of the services listed in this Section 5.II, or if prior approval is obtained and not followed, we will impose a penalty by reducing your level of benefits according to the Schedule of Benefits. We will not apply the penalty to the Annual Out-of-Pocket Maximum Expense, but we will apply the penalty to the Maximum Individual Lifetime Benefit. The amount we pay after taking into account any Copayments will be reduced by the penalty even if the Annual Out-of-Pocket Maximum Expense has been reached.

The Maximum Individual Lifetime Benefit and Annual Out-of-Pocket Maximum Expense are shown in the Schedule of Benefits.

III. Services At The Network Benefits Level and The Non-Network Benefits Level.

Covered Services, which may be limited by the Schedule of Benefits, are stated below. For additional Covered Services, please review any Addenda to this Policy.

A. Network Benefits.

You are entitled to the Covered Services at the Network Benefit level described in Section 5.IV when those services meet the following criteria:

- (1) Medically/Clinically Necessary (as defined in this Policy 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) Routine or Preventive Health Services as described in this document; and
- (3) Provided by a Network Provider and approved in advance by us when we consider approval necessary; and
- (4) Not excluded elsewhere in this Policy or in an Addendum or Amendment to this Policy.

For Network Benefits, you are responsible for those Copayments, Deductibles, and Coinsurance as listed in the Schedule of Benefits with this Policy. Deductibles, if any, apply to all Covered Services except as indicated on the Schedule of Benefits.

You are responsible for determining whether a provider is part of the Network before receiving services. Unless otherwise specified in this Policy, benefits will be paid based on the Network status of the provider as of the day that services are received. To verify the current Network status of a provider, contact the Provider Network number listed on your ID card or detailed in the Network Addendum.

B. Non-Network Benefits.

You are entitled to the Covered Services at the Non-Network Benefits level described in Section 5.IV when those services meet the following criteria:

- (1) Medically/Clinically Necessary (as defined in this Policy 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) Routine or Preventive Health Services as described in this document; and
- (3) Approved in advance by us when we consider approval necessary (See Sections 5.II.A and 5.II.D for prior approval requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services. See Section 5.II.E. for the penalty that may apply when prior approval is not obtained.); and
- (4) Not excluded elsewhere in this Policy or in an Addendum or Amendment to this Policy. (Note: Payment for Covered Services will not exceed the Maximum Individual Lifetime Benefit.)

For payment at the Non-Network Benefits level, the Non-Network Provider must be appropriately licensed to perform the Covered Service provided. You are responsible for those Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary listed in the Schedule of Benefits. Deductibles, if any, apply to all Covered Services except as indicated on the Schedule of Benefits. You are also responsible for Charges in excess of Reasonable and Customary Charges.

NOTE: Sometimes a provider may refer you for, or suggest, a service that we do not Cover. Just because a provider 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 acupuncture 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.

You should carefully review the rest of this Policy and any Addenda and Amendments for more information about the extent of your Coverage.

IV. Covered And Non-Covered Services

NOTE: The headings used in Section 5.IV are intended to provide a convenient listing of 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.

A. Professional Services

Allergy Testing and Treatments

Covered Services

Allergy testing, evaluations and injections including serum costs.

Non-Covered Services

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

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.

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 addendum with your Priority Health plan or another plan, drugs for cancer therapy and cancer clinical trials will be Covered by your prescription drug addenda 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 addendum, 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) Diabetic shoes when Medically/Clinically Necessary according to the criteria set form 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 addendum.
- (c) Services and supplies for the convenience of the Member or caregivers.

Dietitian Services

Covered Services

Consultations with a dietitian up to a maximum of 6 visits per Contract Year. Dietitian services must be approved in advance by Priority Health.

Educational Services

Covered Services

- (a) Education to manage chronic disease states such as diabetes or asthma. Education programs must be approved in advance by Priority Health..
- (b) Maternity classes. Services are only Covered at an approved maternity education program.

Non-Covered Services

- (a) Services for remedial education, including school-based services.
- (b) Services, treatment or diagnostic testing related to learning disabilities, apraxias, 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.

Health Maintenance and Preventive Health Services.

Preventive Health Services, which are services routinely needed for all individuals based on their age and sex, shall be covered as detailed in the Schedule of Benefits. Please contact Customer Service with questions on Coverage.

The following 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:

- (a) Well baby care, including routine physical examinations and clinical screenings given at two weeks, one month, two months, four months and six months from the date of birth plus two visits between one year and two years from the date of birth or as directed by your child's physician.
- (b) Periodic physical examinations.

- (c) Pediatric and adult immunizations for infectious diseases identified as a routine vaccine for the general public, as recommended by our Preventive Health Committee. For immunizations that are not Covered, see "Third Party Requirements" under **Not Medically/Clinically Necessary** in this Section 5.IV.I.
- (d) One vision screening during each Contract Year to determine vision loss. Vision screenings do not include refractions, which are tests to determine an eyeglass prescription. See Section 5.IV.H.2 for vision services that are not Covered.
- (e) Hearing tests and one hearing screening during each Contract Year to determine hearing loss. Hearing screenings do not include examinations for hearing aids. See Section 5.IV.H.3 for hearing services that are not Covered.
- (f) One routine "well woman" examination, including a gynecological examination and breast examination, during each Contract Year.
- (g) Breast cancer screening mammography as directed by your physician or as required by state law.
- (h) Maternity care as described in Section 5.IV.G.
- (i) Radiology and laboratory procedures and services identified as routine for the general public.
- (j) Smoking cessation counseling.

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 Physician to determine Coverage for these services:

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

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

Coverage Limitations

Your Coverage for certain procedures, treatments and reconstructive surgeries is limited by the Copayment and Deductible as shown in the Schedule of Benefits and any addendum enclosed with this Policy.

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

Covered Services

- (a) Physical and occupational therapy (including spinal manipulations), including services provided within the scope of practice of osteopathic and chiropractic physicians, for treatment of medical diagnoses are covered if due to:
 - (i) an Injury;
 - (ii) an Illness; or
 - (iii) 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 Benefits. The maximum number of visits per Contract Year for each rehabilitative medicine category is shown in the Schedule of Benefits. The maximum visits applies even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

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. Prolotherapy
- (m) Services outside the scope of practice of the servicing provider.

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 Physician.
- (b) Tobacco cessation drug treatments are covered only if you have a prescription drug addendum.

Non-Covered Services

All related services and supplies for the treatment of tobacco abuse, except for smoking cessation counseling provided by your 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 5.IV.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 Benefits and any addenda to this Policy.

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

Coverage for injectable and infusible drugs administered in a medical office or outpatient facility is limited to selected drugs in certain categories. Prior approval by Priority Health is required. Injectable drugs must be obtained at a Network Pharmacy (including specialty pharmacies for selected drug categories).

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

Non-Covered Services

Self-injectable drugs for certain diseases, including but not limited to, arthritis, growth deficiency, hepatitis, and multiple sclerosis.

Outpatient Prescription Drugs

Covered Services

- (a) Coverage for outpatient prescription drugs is available only if you have a prescription drug addendum to this Policy.
- (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 addendum with your Priority Health plan or another plan, drugs for cancer therapy and cancer clinical trials will be Covered by your prescription drug addenda 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, including hospice services, approved in advance by us and furnished in the home by a Home Health Care Agency's registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist or speech therapist.

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

- (a) Be confined to the home,
- (b) Under the care of a Physician,
- (c) Receiving services under a plan of care established and periodically reviewed by a Physician, and
- (d) 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 members 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.

- (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 Benefits to this Policy.
- (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 Care

Covered Services

- (a) Inpatient Care. Hospital 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 Benefits and any addendum to this Policy. 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 5.IV.

- (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) 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. Preventive health care services are those services described in Priority Health's preventive health care guidelines which are available in the member center on our website at priorityhealth.com, or through our Customer Service Department.
- (c) 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 5.IV.A 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, Subacute, Longterm Acute 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, Longterm Acute, 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 Benefits to this Policy. 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, Longterm Acute 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 Policy.

- (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

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.

Covered Services

- (a) In a Medical Emergency, we will Cover ambulance service to the nearest medical facility that can provide Medical Emergency care.
- (b) We will Cover ambulance transfers between facilities that are approved by us as Medically/Clinically Necessary.

Non-Covered Services

Any other non-emergent transportation is not Covered unless approved in advance by us.

Emergency Care Services and Urgent Care Center Services

A Medical Emergency is 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, serious impairment of bodily functions or serious dysfunction of any bodily organ or part.

If you are confined in a hospital after a Medical Emergency, you (or someone on your behalf) must let Priority Health know about your confinement as soon as it is reasonably possible to provide that notice.

Services and supplies provided at an Urgent Care Center. An “Urgent Care Center” is a licensed facility utilized to treat non-life threatening conditions that require immediate medical attention to limit severity and prevent complications.

Covered Services:

- (a) Facility and Provider Services. Services and supplies that you receive for any condition that Priority Health, following our review of the claim and other information, determines to have been a Medical Emergency or required Urgent Care at the time.
- (b) Follow-Up Care. Services you receive from a provider because of a Medical Emergency or Urgent Care situation after the Medical Emergency or Urgent Care situation has ended.

Non-Covered Services

If you use an emergency facility for non-emergent or routine care, you will be responsible for the cost of that 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 \$1,000.00 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 approved in advance by us, when required. For a complete list of covered DME, go to 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 addendum, as a prescription drug benefit.
- (f) Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.
- (g) Diabetic shoes 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.
- (j) 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 Benefits.
- (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 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 Durable Medical Equipment (DME) 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.

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 short-term mental health conditions when approved by our Behavioral Health Department as Medically/Clinically Necessary. Brief, solution-focused treatment and crisis interventions are Covered.
- (b) Solution-focused treatment, including both individual and/or group sessions, is Covered for up to a maximum number of outpatient sessions per Contract Year as shown in the Schedule of Benefits to this Policy. Each individual session counts as one outpatient visit. Group sessions count as ½ of an outpatient visit. The average course of treatment, which can vary depending upon your condition, is usually 5-6 sessions in length. We Cover services that result in measurable and substantial improvement in mental health status.

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 Medically/Clinically Necessary.

- (a) **Prior Authorization.** You must call our Behavioral Health Department before receiving inpatient mental health services. Call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance or referral. Outpatient mental health services do not require prior authorization from our Behavioral Health Department.
- (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, typically provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day. Services provided over the telephone 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

You must call our Behavioral Health Department before receiving inpatient mental health services. Call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance or referral. Outpatient mental health services do not require prior authorization from our Behavioral Health Department.

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) Behavioral Disorders, including Attention Deficit Hyperactivity Disorder, Attention Deficit Disorder and Oppositional Defiant Disorders, are Covered for outpatient evaluation, and follow-up psychiatric medication management if needed. Children being evaluated for an initial diagnosis are Covered for up to a five-session evaluation, including testing, family consultation and intervention sessions. Adults are Covered for up to a two-session evaluation. After the completed evaluation, both children and adults are Covered for ongoing psychiatric medication management visits deemed Medically/Clinically Necessary. Services for other Behavioral Disorders including but not limited to Impulse Control Disorder, Pathological Gambling and Conduct Disorders are Covered for the initial evaluation and ongoing medication management only.
- (c) Personality Disorders are Covered for specific psychological testing to clarify the diagnosis. Short-term crisis intervention (outpatient or inpatient treatment) is Covered as deemed Medically/Clinically Necessary by our Behavioral Health Department.
- (d) Organic Brain Disorders are Covered only for medication management with a psychiatrist. 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.

- (e) Dissociative Identity Disorder (formerly known as Multiple Personality Disorder) is Covered for medication management only.
- (f) Pervasive Developmental Disorders, Autism, Aspergers, Rett's Disorder, Emotional Impairments, Learning Disabilities, Sensory Integration Disorder and Mental Retardation are Covered for medication management only. 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 limited by the Contract Year maximum number of visits as shown in the Schedule of Benefits to this Policy. The maximum inpatient days and outpatient visits apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum. (Note: Visits for medication checks only do not apply toward this Contract Year maximum.)

Non-Covered Services

- (a) Long-term psychotherapy.
- (b) Residential treatment 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 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 addendum to this Policy.
- (d) Non-medical ancillary services, long-term rehabilitation services, and inpatient care not received in Hospital or 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 long-term 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 Health Professional.
- (h) Non-covered treatments include experimental/investigational or unproven treatments and services, including biofeedback, hypnotherapy, Methadone maintenance and light boxes for phototherapy.
- (i) Scholastic/Educational Testing is not Covered. Intelligence, Developmental Delay 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.

Substance abuse services do not require referral from your Physician, but inpatient services 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 detoxification 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. 24-hour per day supervised care for a substance abuse diagnosis not requiring full nursing and medical services.
- (c) 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.
- (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, typically provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.

Coverage Limitations

Your Coverage is limited by the guidelines of this Policy and the Contract Year maximum as shown in the Schedule of Benefits, but may not be less than required by state law. The maximum benefit applies even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

Non-Covered Services

- (a) **Residential Treatment 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 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 addendum to this Policy.
- (c) Non-medical ancillary services, long-term rehabilitation services, and inpatient care not received in a Hospital or Substance Abuse Treatment Facility.
- (d) Services for nicotine/caffeine abuse or addiction.
- (e) Non-covered treatments include experimental/investigational or unproven treatments and services, including biofeedback, hypnotherapy, and methadone maintenance.
- (f) **Scholastic/Educational Testing** is not Covered. Intelligence, Developmental Delay and Learning Disability testing and evaluations should be requested and conducted by the child's school district.

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

- (a) Diaphragms, including measurement and fittings.
- (b) Intrauterine devices (IUDs), including insertion and removal.
- (c) Implantable contraceptive drugs (including insertion and removal).
- (d) Contraceptive medications and devices are a covered benefit only with an addendum to this Policy.

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 3.B.(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 HealthyEncountersSM-Maternity Care program, our short-term stay maternity program, or if your provider identifies a medical need.
- (e) Maternity education programs. Services are only Covered at an approved maternity education program.

Non-Covered Services

- (a) Prenatal maternity care, delivery services and postpartum care provided while you are outside of the Service Area. Travel out of the Service Area after 34 weeks gestation requires approval by your treating Physician and Priority Health. If you do not obtain approval from us prior to travel, you may be financially responsible for the cost of any care received. 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 Benefits or any addendum to this Policy.

Non-Covered Services

- (a) Birth control pills, implantable contraceptive drugs (including insertion and removal), condoms, contraceptive foams, diaphragms or devices, IUD's (including insertion and removal), 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 addendum to this Policy, dental services are not Covered, including among other things:

(a) Routine dental services.

(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 Physician (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 addendum to this Policy.

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 addendum to this Policu.
- (b) Hearing screenings do not include examinations for hearing aids unless you have a hearing addendum to this Policy.

I. Plan Guidelines

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 according to the terms of this Policy 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 Physician 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 Provider, if you wish) may appeal our determination as described in Section 10. 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 Physician, may choose to go ahead with the

planned treatment at your own expense. You have the option to appeal our denial of your claim for Coverage under our inquiry and grievance procedure as set forth in Section 10.

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 Network or Non-Network 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 Physician,
 - (ii) 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 Physician did not perform, prescribe, or arrange according to the guidelines of this Policy.
 - (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 Policy.
- (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.
- (g) **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 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 6. Limitations

To receive Network benefits, you may only receive services from a Network Provider. Both Network and Non-Network services must be prior approved by Priority Health when required (except as this policy provides otherwise).

You may call our Customer Service Department to find out what services require prior approval. After you have applied for prior approval, our Customer Service Department can also inform you if Priority Health has approved the services. All services received must be Medically/Clinically Necessary.

NOTE: Sometimes your physician may refer you for, or suggest, a service that we do not Cover. Just because your 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 Policy are subject to benefit maximums. The benefit maximums may differ for the Network and Non-Network Benefits levels. The Schedule of Benefits and any Addenda to this Policy lists those maximums.

Once you reach a maximum for a Covered Service, you will be responsible for the cost of additional services received during the Contract Year even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

B. Out-of-Pocket Maximums.

The total amount of Copayments, Coinsurance, and Deductibles that you will pay for certain services may have a limit. This limit is called an Out-of-Pocket Maximum. The Schedule of Benefits and any Addenda to this Policy provide 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 Policy is not intended to replace, duplicate, or substitute for any Worker's Compensation coverage.

This limitation does not apply to a sole proprietor, partner (or spouse, child, or parent of a 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. Reasonable and Customary.

The maximum benefit we will pay for any Covered Services at the Non-Network Benefits level is the Reasonable and Customary Charge as defined in Section 14(57).

E. 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 charges for Covered Services that you receive and we pay for after your Coverage terminated, plus our costs of recovering those charges (including attorney's fees).

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

F. 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.

G. Maximum Individual Lifetime Benefit.

The total amount that will be paid out for any individual while Covered under this Policy (the "Maximum Individual Lifetime Benefit") is listed in the Schedule of Benefits.

H. Physical Examinations And Autopsy.

The insurer, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

I. Right to Amend or Terminate Policy.

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

SECTION 7. 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 Member 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 provider 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 Provider.
- You may register a complaint or file a grievance with us, or with the Commissioner of the Office of Financial and Insurance Services and/or other appropriate state agency, 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 Services.
- You may suggest changes to our Member Rights and Responsibilities policies.

As a Member you also have the following responsibilities:

- You must read the Policy and Member materials, and comply with the requirements.
- You must call us with questions.
- You must obtain prior approval from Priority Health for services as noted in this Policy, and comply with the limits of any approval of services.
- You must notify providers in a timely manner if an appointment must be canceled.
- You must pay Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary 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 16 for additional rights.

SECTION 8. Claims Provisions

I. FOR NETWORK BENEFITS AND NON-NETWORK BENEFITS:

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

Services you receive from Non-Network Providers will be paid at the Non-Network Benefits level. Non-Network Benefits are available worldwide. See Sections 5.II.A and 5.II.D 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 the date and place of service. A statement that shows only the amount owed is not sufficient. If you have questions about what to send us, 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 you receive the services, unless you didn't submit the claim because you are legally incapacitated.

C. Where to Send Your Bills:

Send your itemized medical bills promptly to us at:

The address on the back of your ID card and also referenced on the Network Addendum to this Policy.

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 10 to find out more about that procedure.

II. PROVISIONS REQUIRED BY MICHIGAN INSURANCE CODE

A. Notice Of Claim.

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

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

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

B. Claim Forms.

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

C. Proof Of Loss.

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

D. Time Of Payment Of Claims.

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

E. Payment Of Claims.

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

F. Legal Actions.

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

SECTION 9. Termination of Coverage

A. Termination of Agreement.

We or the Group may terminate the Agreement if we follow the rules of this Policy. If either we or the Group terminate the Agreement, all Coverage under this Policy will terminate at 11:59 p.m. on the effective date of the termination. It is the Group's responsibility to let you know your Coverage has ended if the Agreement is terminated. If we or the Group do not tell you your Coverage has ended, your Coverage will still end on the effective date of the termination.

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

Grace Period.

A grace period of 10 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

B. Loss of Eligibility.

You will lose your eligibility and your Coverage will terminate if:

- (1) You no longer meet the eligibility criteria listed in Section 2 of this Policy or in the Agreement; or
- (2) You enter the military, naval, or air force of any country or international organization on a full-time basis, unless you elect to continue Coverage at your own cost in accordance with federal law (see Section 11.G). Your Coverage will not terminate if you are participating in scheduled drills or other training that does not last longer than one month in any calendar year.

Your Coverage will terminate at 11:59 p.m. on the date you lose your eligibility. If you lose your Coverage, we can collect from you the costs for Covered Services that you received and we paid for after your Coverage terminated, plus our cost of recovering those charges (including attorney's fees).

C. 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 voluntarily refuse or discontinue a service or treatment plan against the advice of a Network Provider(s) and Priority Health that is essential to your health.
 - (b) You fail to pay your share of any required premium.
 - (c) You refuse to cooperate with us as required by the terms of this Policy or the Agreement.
 - (d) You revoke your consent for us to release information to third parties or to receive information regarding your medical care, if your revocation makes it impossible for us to fulfill our responsibilities under this Policy.
 - (e) 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 Provider, including but not limited to verbally or physically threatening us or a Provider.

If we tell you we have terminated or will terminate your Coverage, we will terminate your Coverage on the date stated in the notice. If you file a grievance within 30 days, we will reinstate your Coverage until a determination is made under Step 1 of the Grievance Procedure. (Read Section 10 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 2 of this Policy, 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.

D. Reinstatement.

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

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

E. Time Limit on Certain Defenses.

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

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

F. Cancellation:

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

G. 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 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 1165
1231 East Beltline NE
Grand Rapids, MI 49525-4501
616 464-8830 or 888 389-6645

or use our secure e-mail on our website at priorityhealth.com.

SECTION 10. Inquiry and Grievance Procedures

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 888 389-6645 or 616 464-8830. 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 received the services: Steps 1 and 2 combined must be completed with a final determination made within 30 calendar days after we receive your formal grievance and appeal. 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 Services. You may direct appeals to the Commissioner at the following address and telephone number:

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

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, unless you agree to give us more time.

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 10. 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 11. Continuation, Conversion or Extension of Benefits

A. Continuation of Coverage.

During any year following a calendar year in which your employer had 20 or more employees, federal law (“COBRA”) requires the Group to provide you with the right to continue Coverage under this Policy. This section answers basic questions about your right to continue Coverage. You can obtain complete details of the COBRA continuation provisions from the Group.

The following events (“qualifying events”) provide you with continuation of coverage rights if these events cause you to lose Coverage: termination of employment (other than for gross misconduct), reduction in hours worked, death of the employee, divorce of employee and spouse, coverage under Medicare (Part A, Part B, or both), or a child losing dependent status under the terms of this Policy.

To be eligible for COBRA coverage, you must have been Covered under this Policy on the day before a qualifying event occurs as an employee, as a legal spouse or as a dependent child. However, a child who is born to or placed for adoption with a Covered employee during the COBRA coverage period is also eligible for COBRA coverage. If you are eligible and elect to continue your Coverage under COBRA, you will receive Coverage that is identical to the Coverage provided to similarly situated active employees. Under COBRA, Coverage may be continued for 18 months if the qualifying event was termination (either voluntary or involuntary) or a reduction in work hours.

The other qualifying events (excluding bankruptcy of the Group) allow for 36 months continuation coverage (the continuation coverage time periods run from the date of the qualifying event). Bankruptcy on the part of the Group has special rules that pertain only to the Group’s retirees.

When the qualifying event is a divorce of the employee, the employee or the spouse must notify the Group of the divorce within 60 days after the issuance of the divorce decree. If the Group is not notified of the divorce within the required 60-day period, the spouse and any other dependent losing coverage due to the divorce will not be eligible for continuation coverage.

The Group must also be notified within 60 days of a dependent ceasing to meet eligibility requirements (e.g., age, full-time student status, etc.) in order for the dependent to be eligible for continuation coverage. If the Group is not notified of the dependent ceasing to meet eligibility requirements within the required 60-day period, the dependent losing coverage will not be eligible for continuation coverage.

If a second qualifying event (other than the Group’s bankruptcy) occurs within the initial 18-month continuation coverage period after the date of the covered employee’s termination or reduction in hours, coverage will be available for 36 months from the date of the initial termination or reduction in hours. Qualified beneficiaries who experience more than one qualifying event are not entitled to elect more than a total of 36 months of continuation coverage, beginning after the first qualifying event. A termination of employment following a qualifying event that is a reduction of hours of employment does not expand the maximum coverage period beyond the 18-month period. The extended period of continuation coverage is available only to qualified beneficiaries who were covered under the plan at the time of the covered employee’s termination or reduction in hours. For you to become eligible to elect an extension of continuation coverage beyond the initial 18-month period, you must notify the Group within 60 days of the second qualifying event. If the Group is not notified within 60 days of the second qualifying event, no extension of continuation coverage will be available.

If you are Disabled at the time of a qualifying event involving termination or reduction in hours, or at any time during the first 60 days of COBRA coverage following such a qualifying event, COBRA coverage may be extended up to 29 months from the initial qualifying event date. To receive this additional coverage, the Group must be provided with a Disability determination from the Social Security Administration within 60 days of the latest of:

- (1) the date of the Social Security Administration disability determination;
- (2) the date of the employee qualifying event; or
- (3) the date coverage would be lost under the plan because of the employee qualifying event,

but before the end of the initial 18 months of the COBRA continuation coverage. The Group must also be notified if you are no longer deemed Disabled within 30 days of that determination. If you are no longer disabled, you are no longer eligible for the additional 11 months of COBRA coverage. From the 19th month to the 29th month, the Group is allowed to charge up to 150% of the applicable premium for the extension of coverage.

All notices referenced in this Section 11 must be made in writing within their respective applicable time frames. You must mail or hand-deliver the above notices to the Group. If mailed, your notice must be post-marked no later than the deadlines described above.

Your COBRA continuation coverage through Priority Health will be terminated for any of the following reasons:

- (1) You reach the end of the 18, 29 or 36 month maximum coverage period;
- (2) The Group no longer provides group health coverage to any of its employees, or no longer provides group health coverage through Priority Health;
- (3) The premium for your continuation coverage is not paid on time;
- (4) You are entitled to Medicare (Part A, Part B, or both, unless you were entitled to Medicare prior to becoming eligible for COBRA); or
- (5) You are covered under another group health plan; and
 - (a) the other plan does not contain any exclusion or limitation with respect to any pre-existing condition that you have, or
 - (b) you are not subject to the limitation or exclusion of the other plan because of the crediting of prior coverage or other rules of the Health Insurance Portability and Accountability Act of 1996.

You do not have to show that you are insurable in order to continue your coverage under COBRA. At the end of the 18, 29, or 36 month continuation coverage period, the Group must allow you to enroll in a conversion plan, if such a plan is then available under the Group's health plan.

If you have any questions about your COBRA rights, please contact the Group. Because COBRA notices will be sent to your last known address, you must keep the Group informed of address changes for you and your dependents. Please also notify the Group if you wish to add a dependent to your COBRA coverage.

Your Priority Health benefits under COBRA are limited to those benefits required by law. Only qualified beneficiaries, as defined by federal law, are eligible for COBRA.

ARRA Subsidy Provisions

(For qualifying events on or after February 17, 2009, and on or before December 31, 2009)

Under the American Recovery and Reinvestment Act of 2009 (ARRA) you may be eligible to pay only 35% of your COBRA premium. The other 65% would be government paid for up to 9 months, but only if: (1) you are, and continue to be, eligible for the premium subsidy; and (2) you elect to continue COBRA coverage.

Who is Eligible for the 65% COBRA Premium Subsidy?

Assistance eligible individuals (AEIs) are entitled to elect COBRA coverage and pay only 35% of the applicable premium. An AEI must meet all of the following requirements:

1. You lost group health plan coverage due to a covered employee being *involuntarily terminated from employment* through December 31, 2009.
2. You were entitled to elect COBRA continuation coverage due to that qualifying event.

3. You are not eligible for other group health plan coverage or Medicare.
4. Your modified adjusted gross income (MAGI) in the year in which you receive the subsidy does not exceed \$145,000 (for single individuals) or \$290,000 (for married, filing jointly).
5. You are not currently receiving assistance through the Health Coverage Tax Credit (HCTC) program under the Trade Assistance Act.

AEIs include spouses and dependent children of the covered employee whose coverage was lost due to an *involuntary termination of employment*. Eligibility for the premium subsidy under ARRA does not allow eligibility for the HCTC under the Trade Act.

Subsidy Reduction: For MAGI between \$125,000 and \$145,000 (or between \$250,000 and \$290,000 for married, filing jointly), the subsidy available would be reduced proportionately. An AEI may irrevocably opt out of receiving the subsidy. An AEI who fails to opt out and whose MAGI exceeds these limits would owe an additional tax on the federal tax return equal to the amount of the subsidy.

The Length of Time Premium Subsidy Last:

The subsidy would start as of the first period of COBRA continuation coverage under the Plan and would continue until the earliest of the following:

1. Nine months after the first month in which you would receive the subsidy.
2. When you would become ELIGIBLE for coverage under any other group health plan (other than certain permitted coverage described below) or Medicare.
3. The date on which you would cease to be eligible for COBRA coverage (e.g., failure to pay the premium timely).

Caution: You must notify the plan if you or any related AEI are eligible for any other group health plan coverage or Medicare and NO longer eligible to receive the premium subsidy. A COBRA premium subsidy ineligibility notice is included for this purpose. Failure to notify the plan may result in a penalty in the amount of 110% of the subsidy received for periods during which you were not eligible for the subsidy.

The following types of permitted coverage will not disqualify an AEI from receiving the premium subsidy:

1. Coverage that is only dental, vision, counseling or referral services (or a combination of those services).
2. Coverage under a Health FSA under Section 106(c) (2) of the Code.
3. Coverage through an on-site medical facility maintained by the employer, consisting primarily of first-aid services, prevention and wellness care, or similar care (or a combination thereof).

B. Conversion.

Under certain conditions, you may have the right to obtain Coverage under an individual health care coverage agreement (“Conversion Agreement”). The Coverage available under a Conversion Agreement is called “Conversion Coverage.”

(1) Eligibility for Conversion Coverage.

Your right to obtain Conversion Coverage is limited to each of the following cases:

- (a) You are the Subscriber, and your Coverage under the Agreement (including any Coverage for your Covered Dependents) terminates because your employment terminates or because you are no longer eligible for Coverage.
- (b) You are a Covered Dependent, and although the Subscriber’s Coverage under the Agreement continues, your Coverage terminates because you are no longer a dependent.
- (c) Your Coverage terminates because the Agreement is terminated, except when the terminated Coverage is replaced with group coverage.
- (d) You are a Covered Dependent and your Coverage under the Agreement terminates because of the Subscriber’s death, because of termination of the Subscriber’s employment, or because the Subscriber stops being eligible for Coverage.

In each circumstance, you have the right to obtain Conversion Coverage without giving us evidence of insurability.

The Conversion Agreement contains no limitations based on health status and does not exclude coverage for a pre-existing condition, unless the Conversion Agreement excludes coverage for that condition.

If you want Conversion Coverage, you must apply in writing to us. We must receive your application within 31 days after the termination date of Coverage under the Agreement or the date you are notified of termination by the Group or us, whichever is later. The 31 day period starts running even if you are confined.

We will not issue Conversion Coverage if any of the following applies:

- (a) Coverage under the Agreement ends before you have been continuously enrolled under a group plan for at least three months;
 - (b) On the termination date, you are covered under, eligible for or have coverage available under any individual, group, or governmental health care policy, Certificate, contract, benefit plan or program, whether insured or uninsured and that coverage provides similar benefits to the Conversion Coverage;
 - (c) On the termination date, you are covered under any individual health care policy, Certificate, contract, benefit plan or program, whether insured or uninsured and that coverage provides similar benefits to the Conversion Coverage;
 - (d) You are covered under Medicare; or
 - (e) Your Coverage under the Agreement terminated because:
 - (i) You (or, if you are a dependent, the Subscriber) failed to pay any required Premium contribution;
 - (ii) Your Coverage under the Agreement was replaced by other group coverage; or
 - (iii) You acted to defraud us.
- (2) Terms of Conversion Coverage.

If we issue you Conversion Coverage, it will be our standard Conversion Coverage plan at the time you apply, which may change from time to time. You will receive at least those benefits required by any laws or regulations that apply and your coverage may not contain the same level of coverage that you have had under the Agreement. If you want more details about Conversion Coverage, contact our Customer Service Department.

If we issue you Conversion Coverage, your Conversion Agreement will state that we can ask for information about your, or any covered dependents', coverage under any other plan. We can do this on any date the premium for your Conversion Coverage is due. If you do not give us the information we ask for, we may base any Conversion Coverage benefits on actual expenses incurred. We would then coordinate the benefits under the Conversion Coverage with those other plans (see Section 12 for more information about coordination of benefits).

We must receive payment of the first premium for Conversion Coverage along with your application and authorization for electronic funds transfer (automatic payment). The premium for Conversion Coverage will be our customary rate for your contract status.

If we issue you Conversion Coverage, it will begin on the day after your Coverage under the Agreement ends.

C. Extension of Benefits if You Are Confined.

We will continue Covering your Covered Services if the Agreement is terminated or you lose eligibility while you are confined for medical treatment in a facility other than the home. We will Cover such services only if you are confined, and only for the specific medical condition causing that confinement (a move to an alternative care facility, such as a Skilled Nursing Facility, Hospice Facility or Rehabilitation Facility, is not considered a discharge from confinement under this provision). As soon as one of the following happens, you will stop receiving benefits under this subsection C:

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

If you are eligible for Coverage under this subsection C, your Coverage will be COBRA coverage, or if you are not eligible for COBRA, Conversion Coverage.

You must pay the required Premium to maintain your Coverage. If we extend your benefits, we will not extend the time period in which you can enroll for Conversion Coverage. We also will not expand your benefits.

D. Continuation of Coverage for Dependent Students Taking a Leave of Absence from School due to Illness or Injury.

We will continue to provide Coverage for the Subscriber's and the Subscriber's spouse's Covered dependent if the dependent is a full-time, unmarried student between the ages 19 and 25 taking a leave of absence from school due to illness or injury. Coverage under this section shall continue for 12 months from the last day of attendance in school or until the dependent reaches age 25, whichever occurs first. To qualify for Coverage under this section, the dependent student's attending physician must certify in writing to us that it is Medically/Clinically Necessary for the dependent student to take a leave of absence from school. The dependent child must continue to meet all other eligibility requirements for dependent coverage as described in Section 2.

E. 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, unless we have issued the dependent Conversion Coverage. (For information on the maximum age for dependent children, see Section 2.B.) 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 or meeting the requirements of a full-time student under Section 2.B(2) and unable to independently socialize without assistance because of a mental or physical disability that is incapacitating. Certain diagnoses, including, but not limited to, attention deficit disorder or depression, by themselves, are not evidence of incapacity. Learning disabilities or the inability to "hold a job" in the absence of mental retardation 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 age 25 or the date the dependent reached the Group's maximum age for dependent children, whichever is less; 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 if the child is Covered or within 31 days of initial enrollment. 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 E(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).

F. Extension of Coverage for Family and Medical Leave.

If you are on a qualified leave of absence under the Family and Medical Leave Act of 1993 (the "FMLA"), you may continue Coverage for yourself and any Covered Dependents during that leave. The Coverage will be on the same basis and at the same Premium contribution rate as if you were an Active Employee. If you fail to return from FMLA leave for any reason other than the continuation, recurrence or onset of a serious health condition (as defined in the FMLA) or other circumstance determined by the Group to be beyond your control, the Group may recover the amount the Group paid to maintain Coverage for you during the leave. If you fail to pay your required Premium contribution for Coverage during FMLA leave, Coverage will be suspended, but you will have the right to reinstatement of Coverage upon your return to work from FMLA leave. COBRA coverage is available to you if you were covered under the plan on the day before FMLA leave began even if you were not covered during FMLA leave.

G. Continuation of Coverage for Military Service.

If you are absent from work because of military service, you may elect to continue Coverage for yourself and your eligible dependents; however, to do so, you must give advance notice to your employer of your absence for military service unless providing the notice is impossible, unreasonable or precluded by military necessity. The continuation coverage period will extend for up to 24 months from the first day of the absence (or, if earlier, until the day after the date you are required to apply for or return to reemployment under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")). Your Premium

contribution for the continued Coverage will be the same as for a COBRA beneficiary, except that if you are absent for less than 31 days, the Premium will be the same as for similarly situated Active Employees.

If you do not elect to be Covered during military service, or if your Coverage terminates because the continuation period expires, you may reinstate Coverage when you return to work as required under USERRA. Coverage will be reinstated without regard to any pre-existing condition limitation or waiting period except as would have been applied if Coverage had not terminated because of military service. This waiver of the limitation and waiting period will not apply to any Illness or Injury that we determine was incurred in, or aggravated during, the performance of military service.

If your employer has not adopted its own USERRA procedures, then the following will apply:

Notice of Absence for Military Service. You must give your employer advanced written notice of your absence for military service unless providing the notice is impossible, unreasonable or precluded by military necessity.

Election of Continuation Coverage. You must elect continuation coverage in writing no later than 60 days after you leave work for military service, or if giving advance notice is impossible, unreasonable or precluded by military necessity, then you must give your employer written notice of your absence within 60 days after doing so is no longer impossible, unreasonable or precluded by military necessity. If you make a timely election of continuation coverage and pay any unpaid premium amounts due, then your continuation coverage will be retroactive to your date of absence.

Termination of Coverage. If you do not give your employer notice of your absence for military service, your Coverage will end immediately upon your absence. If you provide your employer notice of your absence but do not elect continuation coverage as provided above, then your coverage will end after you have been absent for military service for 30 days. If you elect continuation coverage but fail to make timely premium payments, then your continuation coverage will be terminated if you fail to make a payment within 30 days of when the payment is due.

H. 2002 Trade Act Information.

TAA Provisions/General Information: The Trade Adjustment Assistance Act (TAA) of 2002 is available only to employees who have lost their jobs or experienced a reduction of hours because of import competition or shifts in product abroad. COBRA amendments made by the TAA of 2002 are effective for individuals with respect to whom petitions for certification to apply to TAA are filed on or after November 4, 2002.

TAA amended COBRA to create a special second COBRA election period for certain workers who did not elect COBRA coverage during the regular COBRA election period. The special second election period is available only in limited circumstances for certain individuals who have been affected by import competition or shifts abroad of production capacity and who are receiving trade adjustment assistance under the Trade Act of 1984. The special second COBRA election period generally runs from the first day of the month in which an individual begins receiving TAA. COBRA coverage elected during the special second election period commences on the first day of that election period. There is no retroactive COBRA coverage for the gap period from the initial COBRA qualifying event to the first day of the special second election period. However, TAA provides that this gap period must be disregarded in determining whether there has been a 63-day break in coverage under HIPAA.

Under HIPAA's creditable coverage rules, if there is a 63-day break in coverage, the coverage that was in effect before the break in coverage may be disregarded when applying creditable coverage to reduce the plan's pre-existing condition exclusion period. Under the TAA of 2002, certain breaks in coverage are not counted for this purpose.

Special Second Election Period: The special second election period assists workers who first become eligible for the TAA new COBRA tax credit sometime after they have lost their jobs, if they did not originally elect COBRA coverage (perhaps because you could not afford COBRA premiums). You are given a second chance to make a COBRA election; the following are details pertaining to the special second election period:

- It is a 60-day period beginning generally on the first day of the month when an individual began receiving TAA (or would be eligible to receive but for the requirement that unemployment benefits be exhausted).
- COBRA election must be made within six months after you lost your group health plan coverage or, if earlier, by the end of the 60-day election period.
- COBRA coverage elected during the special second election period is not retroactive to the date the plan coverage was lost but begins on the first day of the special second election period.

Qualifying Health Insurance:

- COBRA continuation coverage

- Coverage under a group health plan available under your spouse's employer

How to Apply: Once your worker group has been certified by the U.S. Department of Labor, you need to go to the nearest local State Unemployment Insurance (UI) agency and file an application for determination of your individual eligibility for TAA. A staff member of the State UI will take your application and make a determination as to whether you are eligible.

Each state has designated an agency to administer the TAA program. Generally, this agency is the State Employment Security agency; if not, the local office staff of the State Unemployment Insurance agency will be able to direct you to the designated agency.

Establishing Eligibility for TAA: All petitions for TAA are filed with the Division of Trade Adjustment Assistance (DTAA). DTAA has sole responsibility for conducting a fact-finding investigation to determine whether group eligibility criteria have been met and issues an official notice of its decision no later than 60 days after receiving the petition.

In order for the U.S. Department of Labor to issue a Certificate Regarding Eligibility to Apply for Worker Adjustment Assistance, the following requirements must be met:

1. That workers have been totally or partially laid off.
2. That sales or productions have declined.
3. That increased imports have contributed importantly to worker layoffs.

Once the U.S. Department of Labor issues Certification Regarding Eligibility, trade affected workers may apply for benefits under the TAA program.

Appeal Rights: Affected workers whose petitions for TAA are denied by the U.S. Department of Labor may request administrative reconsideration of the U.S. Department of Labor's findings within 30 days after publication of the final determination in the Federal Register.

The request for reconsideration must be in writing, including the TAA investigation number, a description of the group of workers on whose behalf the petition was filed, and must cite specific reasons why the workers consider the decision to be in error, either according to the facts, the interpretations of the facts or the law itself. Request for reconsideration should be mailed to the **U.S. Department of Labor, Division of Trade Adjustment Assistance, 200 Constitution Ave., N.W. Room N-5428, Washington, D.C. 20210, Phone 202-693-3560.**

Refundable Credit: You can claim this credit and get a refund even if you do not owe any taxes.

Advanced Credit: HCTC Program Kits have been created and are being sent to all potentially eligible individuals nationwide. Therefore, you may have or should be receiving the kit if you have properly applied and were approved for the tax credit. The kit includes eligibility and health plan information, questions and answers and a registration form.

To receive the credit in advance, you must register by mailing the registration form or call the HCTC Customer Contact Center at 866-628-4282 to ensure you are eligible and to provide your health plan information. Once you become successfully registered you will send 35% of the eligible health plan premium to the HCTC program. The HCTC program will then add the remaining 65% of your premium and submit the full 100% to your health plan. Until the HCTC program begins making payments to your insurance plan, you should continue to pay 100% of your health insurance coverage and claim the credit by filing Form 8885 with your federal income tax return.

HCTC represents a partnership of federal, state and private industry. For additional information on the Health Coverage Tax Credit, go to www.IRS.gov and enter keyword "HCTC".

SECTION 12. Coordination of Benefits

A. Purpose of Coordination of Benefits.

Coordination of Benefits (COB) is the system that determines how benefits are paid when you are covered by more than one health care plan. The primary plan is responsible for paying the full benefit amount allowed by the Member's contract. The secondary plan is responsible for paying all or part of the benefit not covered by the primary plan as long as the benefit is covered by the secondary plan. The secondary plan adjusts the amount of benefits paid so that the total benefits available to the Member for the considered service will not exceed that to which the Member would otherwise be entitled. The total paid by both plans may provide payment up to, but not exceeding the allowable amount for the service, which may result in member liability even after the secondary plan's payment. The amount that either plan is required to pay is known as its "liability."

We will coordinate benefits with the following types of plans:

- (1) Group insurance, or any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including government programs such as Medicare and Medicaid, but not including specialty plans such as dental, vision or disability insurance, except that we will coordinate with a vision plan if you have Coverage under a vision Addendum, to this Policy; and
- (2) Automobile insurance required by law and provided through arrangements other than those described in subsection (1) above, but only to the extent that automobile insurance law requires benefits. Some automobile insurance is written on a “coordinated” basis in which the health plan must assume primary responsibility for covered benefits. Some automobile insurance is written on a “full medical” basis which assumes the automobile insurance carrier is the primary payer.

B. Information about Coverage from Other Plans.

When you enroll, you must provide us with information about your coverage from other plans. That information is very important and you should give it to us truthfully. If your Coverage from another plan changes in any way, you must fill out and turn in a change form to the Group. Otherwise we can terminate your Coverage. You must cooperate with us to coordinate our Coverage with coverage from other plans, including providing us with copies of court orders and other documents that may determine which plan is primary. All information provided to us will be kept confidential.

C. Guidelines to Determine Primary Coverage If You Are Covered by Two or More Plans.

- (1) A plan without a coordination of benefits provision is always primary.
- (2) A plan covering you other than as a dependent is always primary. But if you also receive Medicare, the Social Security Act of 1965, as amended, may require Medicare to provide its benefits after the plan covering you as a dependent, but before the plan covering you as other than a dependent.
- (3) Dependent children are covered first by the plan of the parent whose birthday falls earlier in the calendar year (month and day only). If the parents’ birthdays are on the same date, the plan that has covered the dependent longer is primary. This subsection (3) does not apply if subsection (4) below applies.

- (4) For children of divorced parents, legally separated parents, or unmarried parents who do not reside in the same household, benefits are coordinated as follows:

If a court order assigns responsibility for providing health care benefits to one parent, that parent’s policy is primary.

If a court order assigns responsibility for providing health care benefits to both parents, health care benefits are determined in the following order:

- (a) Parent with physical custody.
- (b) Stepparent with physical custody.
- (c) Parent without physical custody.
- (d) Stepparent without physical custody.

This order above does not apply, however, when parents have joint physical custody. In such cases, the birthday rule in subsection (3) above applies.

If a court order fails to assign responsibility for providing health care benefits to either parent or if no court order exists, health care benefits are determined according to custody, as described in this subsection (4). However, in cases of joint physical custody, the birthday rule in subsection (3) above applies.

You are required to provide us with a copy of any court order that affects Coverage of your dependents.

- (5) If you are covered under two plans, one as a retiree and the other as an active employee, the plan that covers you as an active employee is primary.
- (6) If you are covered under two plans, and one is COBRA or another right of continuation and the other is not under a right of continuation, the plan that covers you not under a right of continuation is primary.
- (7) If you have prescription drug coverage under an Addendum with your Priority Health plan or another plan, drugs for cancer therapy and cancer clinical trials will be Covered by your prescription drug Addenda before Coverage under your Priority Health base plan will apply.

(8) If none of the above rules determines the order benefits will be paid, the plan that has covered you longer will be primary.

D. Effect on Benefits.

We will follow the above rules to determine which plan is the Primary Payer. If we are the Primary Payer, you are entitled to Covered Services as outlined in this Policy.

If your other plan is the Primary Payer, then we are a Secondary Payer. In that case, the Primary Payer must pay up to its highest benefit level. When the benefits under the Primary Payer's plan are reduced because a covered person did not comply with the provisions of the primary plan, the amount of that reduction will not be considered an Allowable Expense (defined below) for determining our liability. Examples of such provisions include those related to second surgical opinions, pre-approval of admissions or services, and use of Network Providers.

When we are the Secondary Payer, we will not Cover expenses for inpatient services, behavioral health services, prescription services and transplants unless all of the requirements for Coverage under this Policy have been followed. We will pay for such services only when you follow our rules and procedures, including using Network Providers when required and obtaining any approval from us. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you may only be able to receive benefits from the primary plan. Duplicate coverage will never extend your benefits beyond those available under this Policy.

Additional rules for coordination of benefits when we are the Secondary Payer:

- (1) A Primary Payer, as determined above, must provide its covered benefits without considering our Coverage.
- (2) If a Primary Payer does not cover services that we Cover, those services will be Covered as if we are the Primary Payer.
- (3) If we Cover services not fully covered by a Primary Payer, we will coordinate our Coverage with the Primary Payer's coverage to pay up to 100% of Allowable Expenses, the primary plan's contracted rate or our contracted rate, whichever is less, for those services.
- (4) We are not required to pay claims or coordinate benefits for services that are not approved by us (as required by this Policy) or that are not Covered Services under this Policy.

For purposes of this Section 12, "Allowable Expense" means a necessary, reasonable and customary expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless your stay in a private hospital room is Medically/Clinically Necessary.

See Section 13 for information on coordination with Medicare.

E. Release.

We may release to, and obtain from, any other insurer, plan or party, any information that we consider necessary for coordination of benefits or recovery of overpayments. You must cooperate to provide all requested information.

F. Recovery of Overpayments; Conditional Benefit Payments.

A payment made by another plan may include an amount that should have been paid under this Policy. If it does, we may reimburse that amount directly to the other plan. The amount will then be treated as though it were a benefit we had paid, and we will not have to pay that amount again. The term "payment made" includes the reasonable cash value of the benefits provided in the form of services.

If the amount of the payments we made is more than we should have paid under this COB provision, or if we have provided services which should have been paid by a Primary Payer, we may recover the excess or the reasonable cash value of the services, as applicable, from one or more of: (i) the persons we paid or for whom we have paid a provider; (ii) insurance companies; or (iii) other organizations. We can recover those amounts as we choose. If you incur medical expenses for which another party is or may be responsible, we may provide Coverage subject to our right to reimbursement. If we ask, you (or your legal guardian) must sign any agreements or other documents and cooperate with us to make sure that we can recover the overpayments or obtain the reimbursement described in this paragraph. Reimbursement will be made to the extent of, but not exceeding, the total amount of recovery payable to or on your behalf (or on behalf of your guardian or estate) from: (i) any policy or contract from any insurance company or carrier (including your insurer); and (ii) any third party, plan or fund as a result of a judgment or settlement.

G. 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, including the Group. 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 Addenda 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 has a cause of action. You are required, when requested, to acknowledge our rights of recovery in writing. Our right of recovery, however, is not dependent upon this acknowledgement. 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 or reimbursement rights. We will then have the right to immediately collect the present value of our right to reimbursement, as described above. Our claim will be the first priority claim from the settlement fund. If you receive any proceeds of settlement or judgment, and if we have a right of reimbursement in those proceeds, you must hold those proceeds in trust for us. Transfer of such funds to a third party does not defeat our right of reimbursement if the funds were or are intended for your benefit. We can recover from you expenses we incur because you failed to cooperate in enforcing our rights under this Section.

For purposes of this subsection 12.G, the term "you" includes you and any person claiming through or on behalf of you, including relatives, heirs, assigns and successors.

H. Provisions Required by Michigan Insurance Code.

(1) Insurance with Other Insurers.

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

(2) Unpaid Premium.

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

SECTION 13. Medicare and Other Federal or State Government Programs

A. Nonduplication of Benefits.

Your benefits under this Policy cannot be doubled up with any benefits you are, or could be, eligible for under Medicare or any other federal or state government program. If we Cover a service that is also covered by one of those programs, any sums payable under that program for that service must be paid to us.

We will apply the rules for Coordination of Benefits described in Section 12 after your benefits from us have been calculated under the rules in this Section. We will reduce Allowable Expenses by any benefits available for those expenses under Medicare or any other federal or state governmental program. You must fill out and return to us any documents we ask for to make sure we receive reimbursement by those programs.

B. Coordination with Medicare.

The following rules apply with respect to coordination with Medicare, except as required otherwise by applicable law:

(1) Election Against Coverage.

Despite any other provision of this Policy, if you elect not to be Covered under this plan, Medicare will be the Primary Payer and the Coverage provided under this plan will not be available.

(2) Members Age 65 and Over.

If you are a full-time employee who is at least age 65 (or a full-time employee's spouse who is at least age 65): (i) Medicare will be primary if the Group has less than 20 employees; and (ii) this plan will be primary if the Group has 20 or more employees. (Whether the Group has 20 or more or less employees will be determined by looking at a typical business day during the previous calendar year.) If you are covered by Medicare because of your age and if your Coverage under this plan is not due to your (or your spouse's) current employment, Medicare will be primary.

(3) Disabled Members Under Age 65.

If you are disabled and your Coverage under this plan is due to the current employment status of you, your spouse or parent: (i) this plan will be primary, if this plan is a Large Group Health Plan; and (ii) Medicare will be primary, if this plan is not a Large Group Health Plan. A Large Group Health Plan is one that had at least 100 employees on a typical business day during the previous calendar year. If you are covered by Medicare because of disability and if your Coverage under this plan is not due to the current employment status of you, your spouse or parent, Medicare will be primary.

(4) Members Eligible for Medicare ESRD Benefits.

Except as provided below, if you are entitled to or eligible for end-stage renal disease (ESRD) Medicare benefits, this plan will be primary for the first 30 months of eligibility for Medicare ESRD benefits plus any applicable waiting period for those benefits. After that time, Medicare will be primary. If you have primary coverage under Medicare by reason of age or disability and you later become eligible for Medicare ESRD coverage, Medicare will remain primary.

(5) Eligibility for Medicare.

In determining benefits payable under Medicare, you will be considered to be enrolled for and covered by all Medicare (both Parts A and B) and other governmental benefits to which you are eligible, whether or not you are actually enrolled.

NOTE: To obtain the highest level of benefits under this plan, if you are eligible for Medicare and Medicare would be primary for you, you must also enroll in and become covered by Medicare (both Parts A and B). If you are eligible for Medicare and Medicare is primary, we will pay as if Medicare is primary, even if you have not enrolled in Medicare. If you are eligible for Medicare and Medicare is primary, you may incur large out of pocket expenses if you do not purchase Part B.

(6) Statutory and Regulatory Changes.

Despite any other provision of this Policy, if any existing statute or regulation is amended or altered, or if any new statute or regulation is enacted or adopted, further permitting this plan to be secondary to Medicare, this plan will be secondary to Medicare as permitted by that statute or regulation.

C. State Medical Assistance Plan.

When we enroll a person or determine or make any payment for a person's benefits, we will not consider the fact that the person is eligible for or is provided medical assistance under a state medical assistance plan approved under Title XIX of the Social Security Act ("Medicaid"). To the extent that payment has been made under Medicaid when we are legally responsible to pay for health care benefits, we will pay for benefits according to any state law that provides that the state has acquired the rights to such payment with respect to a Member. We will pay benefits with respect to a Member in accordance with any assignment of rights made by or on behalf of the Member as required by Medicaid.

D. Coordination with CHIP.

This plan will be primary to any CHIP coverage that supplements this plan.

SECTION 14. Definitions

- (1) **Active Employee.** The Subscriber is an Active Employee when the Subscriber is doing his or her regular job for the Group on a regularly-scheduled work day at the place where he or she normally works or is on an authorized FMLA leave. The Subscriber must work the required number of hours, as set forth in the Agreement, to be considered an Active Employee.
- (2) **Addendum.** Attachment to this policy which specifies additional covered services.
- (3) **Agreement.** The Group Agreement between the Group and us. The Agreement is a contract for health benefits. The Agreement includes this Policy, the enrollment form, the Schedule of Benefits, any Addenda, any Amendments and any attachments. A copy of the Agreement is available on request from us and may also be available from the Group.
- (4) **Allowable Expense.** A necessary, reasonable and customary expense for health care, when the item of expense is Covered at least in part by one or more plans covering the person for whom the claim is made.
- (5) **Amendment.** The Group Agreement may be changed at any time; these changes would be reflected in an additional document called an Amendment which would be attached to this Policy.
- (6) **Balance Billing.** Priority Health will pay for services received under your Non-Network Benefits, subject to a limit of the Reasonable and Customary Charges (as defined below). A Non-Network Provider may bill you for amounts in excess of the Reasonable and Customary Charges, as these charges are not Covered by Priority Health.
- (7) **Behavioral Health Department.** The department that assesses and arranges inpatient mental health and substance abuse services for Members. The department is available for assessment 24 hours a day.
- (8) **Certificate of Creditable Coverage.** A Certificate issued to you and/or your Covered Dependents upon termination of Coverage under this Policy.
- (9) **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.
- (10) **Congenital Birth Defect.** A condition that is present at birth.
- (11) **Contract Year.** The period of time that starts on the day the Agreement is effective (the “renewal date”) and ends 365 days later (unless the Agreement says otherwise). The Contract Year often begins on the date eligibility is effective after an Open Enrollment Period.
- (12) **Coinsurance.** The portion of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often, coinsurance applies after first meeting a deductible requirement.
- (13) **Copayments.** The amount you must pay directly to a provider of Covered Services for those services and supplies; usually this is a flat dollar amount. You must pay this amount when you receive Covered Services. Copayments are listed in the Schedule of Benefits.
- (14) **Covered Dependent.** Any of your dependents: (a) who meet the eligibility requirements explained in Section 2 and in the Agreement; (b) who have been enrolled as required by this Policy; and (c) for whom we have been paid all required Premiums.
- (15) **Covered Services, Coverage, Cover or Covered.** Those services and supplies that you are entitled to under this Policy, if they are Medically/Clinically Necessary and you have met all other requirements of the Agreement and this Policy. The Agreement, this Policy and the Schedule of Benefits limit what we will pay for some services and supplies. When we say we will “Cover” a service or supply, this means we will treat the service or supply as a Covered Service.
- (16) **Deductible.** An amount that you must pay before Priority Health will pay for Covered Services under this Policy. Deductibles, if any, are listed on the Schedule of Benefits or any Addendum to this Policy.
- (17) **Disabled or Disability.** Under the Social Security Act, you are Disabled or have a Disability if, taking into account your age, education and past work experience, you are unable to perform any substantial gainful activity by reason of a medically determinable physical or mental impairment, or a combination of impairments, which can be expected to result in death or which has lasted or can be expected to last at least 12 consecutive months.
- (18) **Group.** The Subscriber’s employer.
- (19) **Health Professional.** An individual licensed, certified or authorized under state law to practice a health profession.

- (20) Home Health Care Agency. An agency or organization that is licensed to provide skilled nursing services and other therapeutic services in an outpatient setting.
- (21) Hospice Care. Services for the terminally ill and their families including pain management and other supportive services.
- (22) 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.
- (23) ID Card. The Member Identification Card you receive from us as evidence of your enrollment with us.
- (24) Ill or Illness. A sickness or a disease, including congenital defects or birth abnormalities.
- (25) Incapacitated. A dependent is eligible for Coverage as an Incapacitated dependent if the dependent meets the requirements of Section 11.E.
- (26) Injury or Injured. Accidental bodily Injury.
- (27) Maximum Eligible Benefit. A necessary, reasonable, and customary expense for health care or a provider's contracted rate, (minus any member deductibles, copayments or coinsurance) when the item of expense is covered at least in part by one or more policies covering the member for whom the claim is made.
- (28) Maximum Individual Lifetime Benefit. The Maximum Individual Lifetime Benefit is the total amount that will be paid out for a Member while Covered under this Policy.
- (29) Medical Director. A Michigan-licensed Physician we have designated to supervise and manage the medical aspects of our health care delivery system.
- (30) 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.
- (31) 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 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.
- (32) Medicare. Title XVIII of the Social Security Act, as amended.
- (33) Member. A person enrolled with us as a Subscriber or Covered Dependent.
- (34) 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.

- (35) Motorized vehicle. Any self-propelled vehicle, designed for use on or off public roads, waterways or in the air.
- (36) Network. An organization that contracts with providers to provide discounted services to members.
- (37) Network Benefits. The benefits provided by Priority Health under this Policy when a Member receives Covered Services from a Network Provider.
- (38) Network Hospital. A Hospital that contracts with a Network to provide Covered Services to Members.
- (39) Network Mental Health Treatment Facility. A Mental Health Treatment Facility that contracts with a Network to provide Covered Services to Members.
- (40) Network Physician. A Physician who contracts with a Network to provide Covered Services to Members.
- (41) Network Provider. A Health Professional or other entity that contracts with a Network to provide Covered Services.
- (42) Network Substance Abuse Treatment Facility. A Substance Abuse Treatment Facility that contracts with a Network to provide Covered Services to Members.
- (43) Newborn. A child 30 days old or younger.
- (44) Non-Network Benefits. The benefits provided when a Member uses Non-Network Providers. Benefits are paid according to the Schedule of Benefits to this Policy.
- (45) Non-Network 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.
- (46) 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. If we obtain proof that you are covered under a Worker's Compensation law or similar law, but 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.
- (47) Nurse Midwife. An individual licensed as a registered professional nurse under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, who has been issued a specialty certification in the practice of nurse midwifery by the Michigan Board of Nursing under section 17210 of the public health code, 1978 PA 368, MCL 333.17210 for those with Michigan Networks. Nurse midwives in other Networks must be appropriately licensed by the state in which they practice.
- (48) Open Enrollment Period. A period of time established by the Group and us during which eligible employees and their eligible dependents may be enrolled as Members.
- (49) Out-of-Pocket Maximums. The total amount any member will pay toward covered services as described in the Schedule of Benefits.
- (50) Physician. An appropriately licensed physician or surgeon.
- (51) Policy. The document that describes your and our rights and duties. It includes the enrollment form, the Schedule of Benefits, and any Addenda, Amendments and attachments to this document. The Policy is a part of the Agreement.
- (52) Premium. The total payment, including any contributions by Subscribers, from the Group to us for Coverage.
- (53) Preventive Health Services. Routine care described in Priority Health's preventive health care guidelines that are designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability. These guidelines are available in the member center on our website at priorityhealth.com or from our Customer Service Department.
- (54) Primary Care. Medical care received from a Physician practicing in any of the following fields: Family Practice, General Practice, Gynecology, Internal Medicine, Obstetrics & Gynecology, Pediatrics, and Internal Medicine Pediatrics.
- (55) Priority Health. Priority Health Insurance Company, the Michigan corporation and licensed insurance company providing benefits under this Policy.

- (56) **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 policy.
- (57) **Reasonable and Customary Charges.** Except as otherwise specified in this policy, the maximum benefit Priority Health will pay for Non-Network Providers for any covered service is the Reasonable and Customary charge which is 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.
- (58) **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.
- (59) **Skilled Nursing, Subacute or Rehabilitation Facility.** A facility that is appropriately licensed to provide services in lieu of hospitalization including skilled nursing care and related services, subacute services and short-term rehabilitative therapy on an inpatient basis.
- (60) **Special Enrollment Period.** A period, other than an Open Enrollment Period, in which you and your Covered Dependents are permitted to enroll with us (see Section 3.B).
- (61) **Specialty Care.** Medical care received from a Physician practicing in a specialty field other than those listed under Primary Care as defined in this Section of the Policy.
- (62) **Subscriber.** An employee of the Group: (a) who meets all applicable eligibility requirements of the Agreement; (b) who has enrolled for Coverage; and (c) on whose behalf the Group has paid us any applicable Premium payments under the Agreement.
- (63) **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.
- (64) **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.
- (65) **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.
- (66) **We, us or our.** Priority Health Insurance Company.
- (67) **You, your or yourself.** The Member, whether enrolled with Priority Health as a Subscriber or Covered Dependent.

SECTION 15. General Provisions

A. Independent Contractors.

We do not directly provide any health care services under the Agreement or this Policy, and we have no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by Health Professionals in consultation with you. We are only obligated under the Agreement and this Policy to provide Members a Network of health care services.

We are responsible for making benefit determinations under the Agreement, this Policy and our contracts with Network 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 and you may appeal any of our benefit decisions. Any appeal must follow the inquiry and grievance procedure explained in Section 10.

B. Entire Agreement.

The Agreement, including this Policy, the enrollment form, the Schedule of Benefits, any Addenda, and any Amendments or attachments, is the entire Agreement between the Group and us. Beginning on the effective date of Coverage, the Agreement supersedes all other Agreements for health care services and benefits between you, the Group, and us.

No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

C. Non-assignment.

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

D. Conformity with State and Federal Law.

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

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

If any part of this Policy does not agree with state or federal laws or regulations, we will change our procedures to agree with the laws and regulations.

E. 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 Policy 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.

F. Governing Law and Severability.

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

G. Notices.

Any notice required or permitted under this Policy 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 enrollment form or to any more recent address of which the sending party has received written notice.

H. Third Parties.

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

I. Waiver.

In the event a party waives any provision of this Policy, 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 Policy shall not operate as a waiver of such right.

SECTION 16. 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 personal 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 personal 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, or to assist Priority Health in its health care operations relating to the time that you were still covered.

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, and Priority Health’s business planning. For example, your health information may be released to Priority Health 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

Priority Health may share information with the sponsor of your group plan 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 personal health information to help the sponsor run the group health plan and to seek available subsidies.

Other Uses of Health Information - By Authorization Only

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us with an authorization to use or release medical information about you, you may end that authorization, in writing, at any time. If you end your authorization, we will no longer use or release medical 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 if you cannot provide an authorization. Authorization is needed for certain releases of information dealing with mental health issues, substance abuse issues, HIV/AIDS and grievances/appeals. We can provide you with a Sample Authorization Form. You may also end an authorization by writing to Priority Health’s Legal Department. (See Contact Information section.)

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.

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 Customer Service.

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 Legal 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 about you that we keep in medical or billing information 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 Legal 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 Legal 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 Legal 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, and of the restrictions Priority Health has put in place.

Right to Request Confidential Communications

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

To request confidential communications, you must make your request in writing to Priority Health's Legal 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. Otherwise, you may also print a copy of this Notice from our website at priorityhealth.com.

Changes to this Notice

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

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Priority Health and/or the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS). To file a complaint with Priority Health, please send a written explanation of the issue to Priority Health's Legal 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
Attn: Legal Department
1231 East Beltline NE , MS 1340
Grand Rapids, MI 49525

616 942-0954
800 942-0954

This Privacy Practices Notice is effective April 14, 2003

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