



**HEALTHPLUS
INSURANCE COMPANY**

CERTIFICATE OF COVERAGE

TABLE OF CONTENTS

SECTION I – INTRODUCTION	1
SECTION II -- DEFINITIONS.....	1
SECTION III – ELIGIBILITY FOR BENEFITS	7
3.1 Subscribers	7
3.2 Dependents	8
3.3 Return from Active Military Duty.....	8
3.4 Ineligibility	8
SECTION IV – ENROLLMENT.....	8
4.1 Open Enrollment	8
4.2 Special Enrollment	8
4.3 Notification of Changes that Affect Coverage	9
SECTION V – EFFECTIVE DATE OF COVERAGE	10
5.1 Effective Date	10
5.2 Inpatient on Effective Date	10
SECTION VI – ACCESSING COVERED SERVICES	10
6.1 PPO Plans and Members’ Responsibilities.....	10
6.2 Provider of Choice.....	10
6.3 Termination of a Provider’s Participation	11
6.4 Member Identification Cards	11
6.5 Forms and Applications.....	12
SECTION VII – PRIOR AUTHORIZATION FOR BENEFITS	12
7.1 Obtaining Prior Authorization	12
7.2 Review of HPI’s Prior Authorization Decisions	13
7.3 Time for Making Prior Authorization Decisions	13
7.4 Services Requiring Prior Authorization	13
SECTION VIII – SCHEDULE OF COVERED SERVICES.....	15
8.1 Immunizations and Preventive Services	15
8.2 Physician and Professional Services	17
8.3 Emergency Health Services	17
8.4 Outpatient Laboratory and Diagnostic Services.....	18
8.5 Maternity Services Provided by a Physician or Certified Nurse Midwife	18
8.6 Hospital Care.....	18
8.7 Alternatives to Hospital Care.....	19
8.8 Organ and Tissue Transplants.....	20

8.9	Mental Health Services	21
8.10	Substance Abuse Treatment.....	22
8.11	Short-Term Outpatient Rehabilitative Therapy	22
8.12	Durable Medical Equipment (“DME”)	23
8.13	Prosthetic Devices and Orthotic Appliances (“P&O”).....	23
8.14	Family Planning and Infertility Services	23
8.15	Therapeutic Services.....	23
8.16	Diabetic Services.....	23
8.17	Other Services.....	24
SECTION IX – LIMITATIONS AND EXCLUSIONS.....		26
9.1	Coverage Limitations.....	26
9.2	Services Covered by Rider Only	28
9.3	Exclusions from Coverage	28
SECTION X – PAYMENT AND CLAIMS PROVISIONS		33
10.1	Prepayment of Premium	33
10.2	Changes in Prepayment Rates	33
10.3	Coverage; Grace Period	33
10.4	Termination Based on Late Payment.....	33
10.5	Payment for Services by Member	33
10.6	Physical Examination and Autopsy	34
SECTION XI – COORDINATION OF BENEFITS AND SUBROGATION		34
11.1	Coordination of Benefits	34
11.2	Subrogation	36
11.3	Member Consent.....	37
SECTION XII – MEMBER RIGHTS AND RESPONSIBILITIES		37
12.1	Member Rights – Grievance Process	37
12.2	Other Members Rights	37
12.3	Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act.....	38
12.4	Member Responsibilities	38
SECTION XIII – RECORDS		39
13.1	Membership Records	39
13.2	Inspection of Records by Member	39
13.3	Accuracy of Information.....	39
13.4	Confidentiality of Members’ Personal Health Information	39
SECTION XIV – TERM AND TERMINATION		39
14.1	Term	39
14.2	Termination	39

SECTION XV – CONVERSION AND CONTINUATION.....	41
15.1 Conversion Option.....	41
15.2 Continuation of Group Coverage Option.....	42
SECTION XVI – GENERAL TERMS AND CONDITIONS.....	42
16.1 Interpretation and Construction.....	42
16.2 Entire Agreement	43
16.3 Amendments	43
16.4 Notices	43
16.5 Governing Law	43
16.6 Reinstatements	43
16.7 Identification Cards.....	43
16.8 Policies and Procedures	43
16.9 Adjustments and Refunds	44
16.10 Assignment.....	44
16.11 Independent Contractors.....	44
16.12 Provider Disclaimer	44
16.13 Headings	44
16.14 Severability.....	44
16.15 Waiver	44
16.16 Recovery of Payments.....	44
16.17 ERISA.....	44
HEALTHPLUS INSURANCE COMPANY MEMBER SATISFACTION PLAN.....	46
SECTION I -- HPI ROUTINE (NON-EXPEDITED) GRIEVANCE PROCESS	46
SECTION II -- OFIR ROUTINE EXTERNAL REVIEW OF ADVERSE DETERMINATIONS...49	
SECTION III -- HPI EXPEDITED GRIEVANCE PROCESS	50
SECTION IV -- OFIR EXPEDITED EXTERNAL REVIEW OF ADVERSE DETERMINATIONS	50
SECTION V -- MEMBER SATISFACTION REPORTS.....	51
SECTION VI -- MISCELLANEOUS.....	52

HEALTHPLUS INSURANCE COMPANY GROUP CERTIFICATE OF COVERAGE

THIS CERTIFICATE OF COVERAGE MUST BE READ TOGETHER WITH THE ASSOCIATED SCHEDULE OF BENEFITS AND ANY APPLICABLE RIDERS.

THIS POLICY IS EXEMPT FROM THE FILING REQUIREMENTS OF SECTION 2236 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.2236.

SECTION I – INTRODUCTION

- 1.1 This Certificate of Coverage (“Certificate”) is between HealthPlus Insurance Company (“HPI”), a Michigan for-profit corporation authorized to operate a health insurance company, the Subscriber’s Group and each Subscriber (and Dependent(s), if applicable). The Certificate includes: this document, the Schedule of Benefits, the Group Enrollment and Coverage Agreement (the agreement between HPI and a Subscriber’s Group), the Member’s HPI Identification Card, the Application, all forms, questionnaires and other documents completed by the Subscriber (and Dependents, if applicable) and any amendments, Riders, or endorsements to this Certificate.
- 1.2 By enrolling with HPI, accepting this Certificate, and using the HPI Identification Card, Subscribers (and Dependent(s), if applicable) agree to be bound by the terms and conditions of this Certificate.
- 1.3 This Certificate provides the terms and conditions for enrollment, membership, payment, and Coverage related to Covered Services for Members. Covered Services a Member may be entitled to are included in Section VIII of this document, the Schedule of Benefits, and the Rider(s) (if any). Covered Services are subject to certain limitations and exclusions, as provided in Section IX of this document, the Schedule of Benefits, and any applicable Rider(s).

SECTION II -- DEFINITIONS

- 2.1 “Act” means Public Act 368 of 1978, Michigan Public Health Code, as amended by Act 354 of 1982, as amended.
- 2.2 “Adverse Determination” means a determination by HPI (or its designee) that an admission, availability of care, continued stay, or other health care service or benefit has been reviewed and denied, reduced, or terminated. Failure by HPI (or its designee) to respond in a timely manner to a request for a determination constitutes an Adverse Determination. Whenever an Adverse Determination is made, a written statement containing the reasons for the Adverse Determination will be provided to the Member (or his or her Authorized Representative) along with any written notifications that may be required by state or federal law.
- 2.3 “Allowed Amount” means the maximum amount HPI will pay for a Covered Service furnished by a Preferred or Non-Preferred Provider. For a Non-Preferred Provider, the Allowed Amount is what HPI reasonably determines is usual and customary for the services provided.
- 2.4 “Ambulance” means a licensed motor vehicle or rotary aircraft operated by licensed and certified personnel and used to provide transportation and life support services.
- 2.5 “Application” means those documents each person must complete in order to become eligible to become a Member.
- 2.6 “Authorized Representative” means any of the following:

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- A. A person to whom a Member has given express written consent including a Practitioner, to represent him/her in a Grievance or an external review;
 - B. A person authorized by law to provide substituted consent for a Member; or
 - C. For Urgent Care Claims or if the Member is unable to provide consent, a family member of the Member or the Member's treating health care professional.
- 2.7** "Certificate" means the description of Covered Services including the Application, HPI Identification Card, the Group Enrollment and Coverage Agreement, this document, the attached Schedule of Benefits, and Rider(s), and any other document issued by Group or HPI that is necessary for the administration of benefits.
- 2.8** "Child" means an unmarried child of the Subscriber or the Subscriber's Spouse (whether by birth, legal adoption, or legal guardianship) whom the Subscriber or the Subscriber's Spouse may claim as a dependent under the Internal Revenue Code of the United States, as amended, or for whom the Subscriber is required to provide coverage under a divorce decree or qualified medical child support order.
- 2.9** "Claim" means any request for benefits made by a Provider, a Member, or his or her Authorized Representative, that complies with HPI's procedures for making benefit claims. Claims include Pre-Service Claims, Post-Service Claims, and Urgent Care Claims.
- 2.10** "Clinical Trial" means an organized study conducted in people with a specific disease to answer specific questions about vaccines, a new treatment, or new ways of using known treatments. Clinical trials (also called medical research and research studies) are used to determine whether new drugs or treatments are both safe and effective.
- 2.11** "COBRA" means the Consolidated Omnibus Reconciliation Act of 1985, as it may be amended from time to time, and any successor legislation.
- 2.12** "Coinsurance" means the percentage of the fee or cost of a Covered Service that a Member must pay. A Member's Coinsurance is listed in the Schedule of Benefits.
- 2.13** "Copayment" means the amount each Member must pay per Visit to a treating Provider for certain Covered Services. A Member's Copayments are listed in the Schedule of Benefits and any applicable Riders.
- 2.14** "Cosmetic" means to improve appearance or self-perception.
- 2.15** "Coverage" means payment for the Health Care Benefits identified by this Certificate.
- 2.16** "Covered Services" means a service(s) for which Health Care Benefits are available under this Certificate, the Schedule of Benefits, and any applicable Rider(s).
- 2.17** "Day Treatment Mental Health/Substance Abuse Program" means a program providing generally accepted therapeutic services and/or ancillary services which last four (4) or more consecutive hours.
- 2.18** "Deductible" means the annual amount a Member must pay in advance for Covered Services before HPI Coverage for health care services begins. A Member's Deductible is included in the Schedule of Benefits and any applicable Rider(s).
- 2.19** "Dental Care" means services or procedures that concern maintenance or repair of the teeth and/or gums or are performed to prepare the mouth for dentures or implants.

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- 2.20** “Dentist” means an individual licensed under the Act or any licensing statute or law of the applicable governing state or governmental unit to engage in the practice of dentistry.
- 2.21** “Dependent” means the Subscriber’s Spouse, or a Child of the Subscriber or the Subscriber’s Spouse. HPI reserves the right to demand proof of dependency from a Subscriber.
- 2.22** “Durable Medical Equipment” means equipment of the type approved by HPI that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury.
- 2.23** “Emergency Health Service” means Medically Necessary services rendered by Providers for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such 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 to bodily functions; or serious dysfunction of any bodily organ or part.
- 2.24** “Excess Charges” means charges for Covered Services beyond the Allowed Amount.
- 2.25** “Expedited Grievance” means a Grievance for Urgent Care Claims.
- 2.26** “Experimental” means that a service is of doubtful medical usefulness or effectiveness to the Member, as assessed by local medical community standards. The final determination of experimental procedures shall be made by HPI.
- 2.27** “Formulary” means a list of selected or preferred drug products and supplies available to a Member pursuant to relevant HPI organizational policies and procedures.
- 2.28** “Freestanding Emergency Center” means a facility that is licensed, certified, or otherwise authorized pursuant to the Act or any similar licensing statute or law of its governing state or governmental unit to provide services in emergencies or after hours.
- 2.29** “Grace Period” means a period of thirty (30) days beyond the date on which Premiums are due and during which the Subscriber or Remitting Agent may make payments to HPI without a lapse of Coverage under this Certificate.
- 2.30** “Grievance” means a dispute on behalf of a Member, presented (orally or in writing) by the Member or his/her Authorized Representative, including a Practitioner, regarding:
- A. The availability, delivery, or quality of health care services (including an Adverse Determination concerning utilization review);
 - B. Pre-Service Claims or Post-Service Claims;
 - C. Payment, handling or reimbursement for health care services; or
 - D. Matters pertaining to the contractual relationship between a Member and HPI.
- 2.31** “Group” means the legal entity located in Michigan that has contracted with HPI for Health Care Benefits for Subscribers and Dependents in return for prepayment of Premiums.
- 2.32** “Group Enrollment and Coverage Agreement” means the agreement between the Group and HPI for the provision of Health Care Benefits to eligible Subscribers and Dependents.

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- 2.33** “Group Open Enrollment” means the time period when eligible Group employees and their eligible Dependents may enroll or disenroll from HPI Coverage.
- 2.34** “Health Care Benefits” mean the benefits provided by this Certificate for health care services rendered to Members.
- 2.35** “Hearing Aid” means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if Medically Necessary.
- 2.36** “Home Health Agency” means a facility or program which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit and approved to provide home health services.
- 2.37** “Hospice” means a Provider which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit to supply pain relief, symptom management, and supportive services to individuals suffering from a disease or condition with a terminal prognosis.
- 2.38** “Hospital” means an acute care general facility which: (1) provides inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of duly licensed Physicians; (2) is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit; and (3) which is not, other than incidentally, a place of rest, a place for the aged, a nursing home, or a facility for the treatment of substance abuse or pulmonary tuberculosis.
- 2.39** “HPI” means HealthPlus Insurance Company, a Michigan corporation and wholly-owned subsidiary of HealthPlus of Michigan, Inc., with its principal office located at 2050 South Linden Road, Flint, Michigan 48532.
- 2.40** “Identification Card” means the card issued to a Member upon approval of an Application by HPI.
- 2.41** “Inpatient Mental Health Hospitalization” means hospitalization in a setting providing psychiatric services and twenty-four (24) hour medical care and nursing in a structured environment.
- 2.42** “In Network Benefit” means any Covered Services furnished by a Preferred Provider.
- 2.43** “Intermediate Care” means, as it applies to mental health and substance abuse services, the use of a full or partial residential therapy setting (also known as Day Treatment or partial hospitalization programs), and shall include generally accepted therapeutic techniques and other therapeutic and ancillary services.
- 2.44** “Intermittent Skilled Nursing Care” means services provided by a licensed nurse to a Member who has a medically predictable recurring need for skilled care at least once in every sixty (60) day period.
- 2.45** “Medically Necessary” (or “Medical Necessity”) means services or supplies provided to Members that are determined by HPI or its designee to be medically required and appropriate to diagnose or treat a Member’s physical or mental condition. Also, such services or supplies must: (1) meet widely accepted criteria and professionally recognized standards of health care; (2) not be used primarily for the comfort or convenience of the Member, the Member’s family or caregiver, or the Member’s treating Physician; (3) not be excessive in cost as compared to alternative services or supplies effective for the diagnosis or treatment of the Member’s physical or mental condition;

and (4) not be provided to the Member as an inpatient when the services or supplies could be safely and appropriately provided to the Member on an outpatient basis.

- 2.46** "Medicare" means the federal program of medical care benefits, generally for those over age sixty five (65) comprised of Medicare Part A (hospital services, extended care facilities, hospices) and Medicare Part B (physician and other types of care not covered under Part A).
- 2.47** "Member" means the Subscriber and his/her Dependents covered under this Certificate.
- 2.48** "Non-Covered Services" means those health care services that are not covered or excluded from Coverage by HPI under this Certificate, any Excess Charges, or services that were rendered at a time when the Member was not eligible for Coverage under this Certificate.
- 2.49** "Non-Preferred Provider" means a Provider who has not entered into a written agreement with HPI, or otherwise agreed, to provide services to Members.
- 2.50** "OFIR" means the Office of Financial and Insurance Regulation of the State of Michigan.
- 2.51** "Orthotic Appliance" means an apparatus of the type approved by HPI which is used to support, align, prevent, or correct deformities, or to improve the function of moveable parts of the body.
- 2.52** "Out of Network Benefit" means any Covered Services furnished by a Non-Preferred Provider.
- 2.53** "Out of Pocket Costs" means all costs that a Member must pay based on this Certificate as described in the Schedule of Benefits and any applicable Riders, including: Copayments, Coinsurance, Deductibles, and any Excess Charges or penalties for failing to obtain Prior Authorization when required.
- 2.54** "Out of Pocket Maximum" means the total amount of Out of Pocket Costs a Member must pay for Covered Services during each benefit year. Out of Pocket Costs that do and do not count towards meeting a Member's Out of Pocket Maximum are described in the Schedule of Benefits.
- 2.55** "Personal Health Information" includes medical information (i.e., claims, health assessments, etc.) and other administrative data (i.e., names, addresses, social security numbers, etc.) that are personally identifiable.
- 2.56** "Pharmacy" means a business licensed under the Act or other similar licensing statute or law of the applicable governing state or governmental unit to engage in the practice of pharmacy.
- 2.57** "Physician" means an individual licensed under the Act or other similar licensing statute or law of the applicable governing state or governmental unit to engage in the practice of allopathic medicine, osteopathic medicine, chiropractic, or podiatric medicine and surgery.
- 2.58** "Plan" means the health insurance policy or plan that provides Coverage for Health Care Benefits under this Certificate.
- 2.59** "Post-Service Claim" means any Claim that is not a Pre-Service Claim.
- 2.60** "Practitioner" means a licensed professional who provides health care services.
- 2.61** "Pre-Service Claim" means any Claim that, under the terms of the Member's Certificate of Coverage, requires Prior Authorization before medical care is obtained.
- 2.62** "Preferred Provider" means a Provider who has entered into a written agreement with HPI, or otherwise agreed, to provide services to Members.

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- 2.63** “Preferred Provider Organization” (or “PPO”) means HPI’s preferred provider organization product. Participating providers are afforded “preferred status” within PPO plans. Generally, if a Member in a PPO plan utilizes a Preferred Provider, the Member is responsible for lower Copayments, Coinsurance and/or Deductibles than if the Member had obtained health services from a Non-Preferred Provider.
- 2.64** “Premium” means the monthly prepayment rate charged by HPI for the Health Care Benefits provided in this Certificate.
- 2.65** “Preventive Services” means those services aimed at prevention, early detection, and early treatment of health conditions. This includes routine physical examinations, routine gynecological services, immunizations, preventive diagnostic screenings, and well person care.
- 2.66** “Prior Authorization” means the process of obtaining any necessary prior approval from HPI or its designee. Services that require prior approval are subject to the clinical review criteria of HPI or its designee to ensure quality and efficiency in health care services.
- 2.67** “Prosthetic Device” means a device of the type approved by HPI that replaces all or part of an internal body organ or external body member, or that replaces all or a part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.
- 2.68** “Provider” means a health professional, facility, or agency complying with the Act or other similar licensing statute of the applicable governing state or governmental unit.
- 2.69** “Reconstructive” means to affect a substantial improvement or restoration of bodily function or to correct deformities resulting from disease, injury, or congenital, or developmental abnormalities.
- 2.70** “Remitting Agent” means the person or corporation designated by the Group to collect and remit to HPI the prepayment rate.
- 2.71** “Reside” means the physical presence of a Member at a particular address with the intention to permanently remain at that address. For purposes of this definition, “permanently remain” at an address shall refer to a period of time longer than nine (9) months and shall be evidenced by notice of forwarding address, voter registration, driver’s license address, or other such verification.
- 2.72** “Residential Mental Health/Substance Abuse Treatment” means non-Medically Necessary, primarily custodial treatment provided in a facility that provides services twenty-four (24) hours a day.
- 2.73** “Rider” means an addition to this Certificate that provides for additional, different, or reduced Coverage for Covered Services and Members’ responsibility for Out of Pocket Costs.
- 2.74** “Schedule of Benefits” means the document issued with this Certificate containing a brief summary of benefits, and the Copayment, Coinsurance, and Out of Pocket Costs (including Out of Pocket Maximum Costs) a Member is responsible for paying related to Covered Services. Although a benefit is listed in the Schedule of Benefits, it may require Prior Authorization or may not be a Covered Service. Benefits are subject to any exclusions and/or limitations contained in this Certificate or in any Rider.
- 2.75** “Semi-Private Room” means a room containing two (2) or more patient beds in an inpatient facility.
- 2.76** “Short-Term” means service for a condition that HPI determines can be expected to significantly improve within a period of sixty (60) days.

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- 2.77** “Skilled Nursing Care” means concentrated observation, monitoring, evaluation, and intervention by licensed and trained personnel under the direction of a Physician and usually does not require daily intervention for conditions that are stable or stabilizing.
- 2.78** “Skilled Nursing Facility” means a facility licensed to provide Skilled Nursing Care in accordance with the Act or other similar licensing statute or its governing state or governmental unit.
- 2.79** “Specialist Physician” means a Physician who specializes in an area of medicine, other than family practice, internal medicine, or pediatrics.
- 2.80** “Spouse” means the person to whom a Subscriber is legally married. HPI reserves the right to demand proof of legal marriage from a Subscriber.
- 2.81** “Subscriber” means the person so designated in the Application who is entitled to enroll for Coverage.
- 2.82** “Terminal Illness” means a medical or surgical condition for which an individual has a medical prognosis that his/her life expectancy is six (6) months or less if the illness runs its normal course.
- 2.83** “Termination Date” means that date that Coverage for Health Care Benefits under this Certificate ends.
- 2.84** “Urgent Care Center” means a facility that provides Urgent Care Services.
- 2.85** “Urgent Care Claim” means a Claim for which resolution within HPI’s normal time frames, due to the medical status of the Member, would seriously jeopardize the life or health of a Member or his/her ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately. Only Pre-Service Claims, and not Post-Service Claims, can be Urgent Care Claims.
- 2.86** “Urgent Care Services” means Medically Necessary services furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition.
- 2.87** “Visit” means a meeting between a Member and Provider for the purpose of rendering Covered Services, without regard to the frequency of meetings if such meeting is separated by any period of time.

SECTION III – ELIGIBILITY FOR BENEFITS

3.1 SUBSCRIBERS

To be eligible to enroll as a Subscriber, a person must:

- A. Reside in one of the fifty (50) United States;
- B. Be a member of a Group, and be eligible to receive Health Care Benefits arranged by that Group on the person’s behalf and not by virtue of dependency, except as otherwise specifically allowed pursuant to the Group Enrollment and Coverage Agreement between HPI and the Group;
- C. Complete an Application for enrollment for himself/herself and any eligible Dependents; and
- D. Meet any other specific eligibility criteria specified by the Group and HPI.

3.2 DEPENDENTS

To be eligible to enroll as a Dependent of a Subscriber under this Certificate, a person must be:

- A. The Spouse or legally separated Spouse of a Subscriber (excluding a person who marries a Subscriber who has Coverage as a surviving Spouse);
- B. An unmarried Child of the Subscriber or the Subscriber's Spouse until the end of the month in which he/she reaches nineteen (19) years of age, or until the age specified in an HPI Family Continuation Rider if such Rider is purchased by the Subscriber's Group; or
- C. A Child of any age that is totally and permanently disabled by any physical or mental condition that prevents the Child from engaging in substantial, gainful activity and can be expected to result in death or to be of long, continued, or indefinite duration. A Member must provide proof to HPI that a Dependent is incapacitated as of the date that the Dependent reaches nineteen (19) years of age. Such proof must be submitted to HPI within thirty-one (31) days after the Dependent reaches nineteen (19) years of age, or within thirty-one (31) days of enrollment of the Dependent. HPI also reserves the right to periodically require medical certification satisfactory to HPI of a Dependent's total and permanent disability.

HPI will not deny enrollment to a Child on any of the following grounds: (a) the Child was born out of wedlock, (b) the Child is not claimed as a dependent on the Subscriber's or Subscriber's Spouse's federal income tax return, or (c) the Child does not Reside with the Subscriber or the Subscriber's Spouse.

A Child over eighteen (18) years of age is not eligible for Coverage through HPI if he/she is employed full-time and/or has health benefit coverage through another medical benefits plan of any kind.

3.3 RETURN FROM ACTIVE MILITARY DUTY

A Subscriber and his/her previously enrolled Dependents may be eligible for immediate reinstatement of previous health care Coverage upon return from active military duty. Reinstatement of Coverage requires that: (1) the Subscriber's cumulative length of absence was less than five (5) years, (2) the Subscriber submits a new Application to HPI within ninety (90) days of re-employment, and (3) the Subscriber and Dependent(s) meet all other eligibility requirements.

3.4 INELIGIBILITY

No person shall be entitled to enroll as either a Subscriber or a Dependent who has had a prior HPI Certificate of Coverage terminated based on his/her violation of the terms of the Certificate.

SECTION IV – ENROLLMENT

4.1 OPEN ENROLLMENT

At least once a year, there will be a Group Open Enrollment period during which eligible Group employees and their eligible Dependents may enroll by submitting a completed Application.

4.2 SPECIAL ENROLLMENT

Individuals newly eligible to enroll as Subscribers or Dependents may be added between Open Enrollment periods if they submit a completed Application to HPI within thirty-one (31) days after

becoming eligible for Coverage. The following requirements must be met to enroll during a special enrollment period:

- A. The individual was covered under another group health plan or had other health benefit coverage when HPI was previously offered to the individual;
- B. The individual stated in writing at the time Coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment (this only applies if the Group informed the individual of the requirements and the consequences of waiving Coverage); and
- C. The individual's coverage described in subsection 4.2A above: (1) was under a COBRA continuation policy and the coverage under that policy was exhausted, or (2) was not under a COBRA policy and the coverage was terminated as a result of loss of eligibility or termination of the Group's contributions towards that other coverage.

If an individual failed to apply for Coverage when eligible or during an Open Enrollment period, he/she may enroll himself/herself and his/her eligible Dependents (including his/her Spouse) when a new individual becomes a Dependent of the individual through marriage, birth, adoption, or placement for adoption. The individual is required to request such enrollment within thirty-one (31) days of the marriage, birth, or adoption.

The effective date of such Coverage is the date of birth, the date of adoption or placement for adoption if enrolled within thirty-one (31) days from the date of birth, adoption, or placement for adoption. Placement for adoption means the assumption and retention of a legal obligation for total or partial support of a child by the Subscriber with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with the Subscriber terminates upon the termination of the legal obligation.

4.3 NOTIFICATION OF CHANGES THAT AFFECT COVERAGE

A Subscriber must notify the Group in writing, within thirty-one (31) days, of any of the following events that may affect Coverage under this Certificate:

- A. Change in address or phone number;
- B. Change in marital status;
- C. Change in status of a Dependent;
- D. New Dependent becomes eligible for Coverage;
- E. Eligibility of Subscriber or Dependent for Medicare, Medicaid, or Children's Special Healthcare Services;
- F. Change in disability status of an adult Child;
- G. Change in Subscriber's employment;
- H. Death of a Member; or
- I. Health care coverage by any other insurance or health plan.

The Group and the Subscriber are responsible for notifying HPI of any such changes. Failing to timely notify HPI of any of these changes may affect Coverage or result in the Subscriber and/or

his/her Dependents losing HPI Coverage. HPI is not responsible for any lapse in Coverage because of failure to notify HPI of any change in status.

SECTION V – EFFECTIVE DATE OF COVERAGE

5.1 EFFECTIVE DATE

Except as provided in Paragraph 5.2, below, the Effective Date of Coverage begins on the latest of:

The effective date of the Group Enrollment and Coverage Agreement;

- A. The first day of the month established by the Group as the Effective Date of Coverage for those enrolling during the Group Open Enrollment Period;
- B. The date agreed to by the Group and HPI (in the Group Enrollment and Coverage Agreement) for newly eligible individuals; or
- C. For individuals eligible to enroll during a special enrollment period: (1) the day after coverage under another health benefit plan ends; or (2) the date of a Dependent's birth, adoption, or placement for adoption.

5.2 INPATIENT ON EFFECTIVE DATE

In the case of a Member who is an inpatient on the Effective Date of Coverage specified in Paragraph 5.1, above, Coverage for inpatient benefits will be provided only if the eligible individual has no other coverage provided or available on a continuing or extended basis through any other carrier, program, or insurance.

SECTION VI – ACCESSING COVERED SERVICES

6.1 PPO PLANS AND MEMBERS' RESPONSIBILITIES

This is a Preferred Provider Organization ("PPO") group health plan. A PPO plan consists of a network of health care providers ("Preferred Providers") who are given "preferred" status within the plan. Preferred Providers agree to provide services to the plan's Members. Generally, a Member who receives Covered Services from a Preferred Provider is responsible for lower Copayments, Coinsurance and/or Deductibles than if the Member had received Covered Services from a Provider who has not agreed to provide services to the plan's Members ("Non-Preferred Providers"). Whether a Member obtains Covered Services from a Preferred Provider or a Non-Preferred Provider, the Member is responsible for paying any applicable Copayments, Deductibles, and Coinsurance.

Providers may bill Members for Out of Pocket Costs, Non-Covered Services, or the difference between the amount HPI pays for Covered Services provided by a Non-Preferred Provider and the Non-Preferred Provider's rate for the Covered Service.

It is a Member's responsibility to verify whether an HPI Preferred Provider continues to be an HPI Preferred Provider before receiving services from such Provider.

6.2 PROVIDER OF CHOICE

- A. Members may receive Health Care Benefits from any Provider the Member chooses. However, if a Member receives Health Care Benefits from a Non-Preferred Provider, the Member will be responsible for paying higher Copayments, Coinsurance, and

Deductibles. Members should refer to the Schedule of Benefits and any applicable Riders for further information.

- B. HPI cannot guarantee the continued availability or participation of any particular Provider.

6.3 TERMINATION OF A PROVIDER'S PARTICIPATION

A Preferred Provider (or the Provider's network) may choose to terminate his/her (its) contract or arrangement with HPI. Therefore, HPI cannot guarantee that a given Preferred Provider will be available to treat a Member during the entire time the Member is covered by HPI. If a Preferred Provider informs a Member that the Provider will no longer be contracting with HPI, the Member should contact HPI's Customer Service Department (at 1-888-212-1512) as soon as possible. If a Preferred Provider terminates his/her contract or arrangement with HPI, a Member receiving services from the terminating Provider will be required to select a different Provider in order to continue receiving In Network Benefits. However, a Member who is undergoing an ongoing course of treatment with the terminating Preferred Provider may be eligible to continue to be treated by this Provider if:

- A. The Provider is not leaving HPI's PPO network because of failing to meet HPI's quality standards or based on fraudulent conduct;
- B. The Provider is still available to continue treating Members;
- C. The continuation period is approved by HPI;
- D. The Provider agrees to continue to meet HPI's quality standards and comply with HPI's policies and procedures; and
- E. The Provider agrees to accept, as payment in full, reimbursement from HPI at the rates applicable prior to the Provider's termination.

This continuation of treatment with the Provider will continue, as applicable:

- A. For up to ninety (90) days after the Member receives notice that the Provider is leaving HPI's PPO network;
- B. Through the second and third trimester of a pregnancy (in the case of a pregnant woman) and through the completion of post-partum care; or
- C. In the case of a Member with a Terminal Illness, through the remainder of the Member's life for treatment related to the Terminal Illness.

6.4 MEMBER IDENTIFICATION CARDS

- A. A Member is required to present his/her Member Identification Card to a Provider before receiving Covered Services. Merely possessing an Identification Card does not entitle the holder to Health Care Benefits under this Certificate unless all required Premiums have been paid.
- B. A Member shall not allow any other person to use his/her Identification Card. A Member who allows another person to use his/her Identification Card may have his/her Identification Card confiscated and be immediately terminated by HPI, at HPI's direction. Additionally, any person who receives Health Care Benefits through the unauthorized use of an Identification Card will be required to repay the costs of such Health Care Benefits

at prevailing rates. A Member shall immediately notify HPI, in writing, of any loss or theft of his/her Identification Card.

- C. A Member's use of his/her Identification Card is subject to the terms of this Certificate of Coverage, the attached Schedule of Benefits, and any Rider(s), including the user's agreement to permit the release of medical and other information to HPI and its designees.

6.5 FORMS AND APPLICATIONS

Individuals applying for HPI Coverage and HPI Members must complete all documents required by HPI including, but not limited to, Application forms and related materials and medical questionnaires. In completing such forms, individuals applying for HPI Coverage and Members warrant that the information they provide is true, correct and complete to the best of their knowledge, information, and belief. If a Member or an individual refuses to complete a required form or intentionally submits false, misleading information, or omits material information, HPI may refuse or terminate enrollment and/or Coverage, or deny payment of individual Claims.

SECTION VII – PRIOR AUTHORIZATION FOR BENEFITS

7.1 OBTAINING PRIOR AUTHORIZATION

- A. Medical Prior Authorization

Members may be required to obtain Prior Authorization from HPI or its designee for certain services and/or supplies. If required, Prior Authorization must be obtained from HPI (or its designee) at least five (5) days before a Member receives the service requiring such Prior Authorization. If a Member does not obtain Prior Authorization, the Member will be responsible for the entire cost of the service if HPI or its designee, in its sole discretion, determines that the service was not Medically Necessary. If HPI determines that the service for which Prior Authorization was required but not obtained was Medically Necessary, the Member will be charged a penalty of the lesser of the cost of the service or the amount specified in the Member's Schedule of Benefits. However, for certain services, if the Member has not obtained Prior Authorization if required, there will be no HPI Coverage for the service even if the service is Medically Necessary (see Section 8.4C). Neither the costs a Member pays for non-Medically Necessary Services obtained without required Prior Authorization nor the "lesser of the cost" or the penalty amount for obtaining Medically Necessary Services without required Prior Authorization will be applied to the Member's Deductible or Out of Pocket Maximum, as described in the Schedule of Benefits.

- B. A list of services and supplies requiring Prior Authorization are contained in this Certificate, on the HPI website at www.healthplus.org, or may be obtained by calling HPI's Customer Service department at 1-888-212-1512.

C. Pharmacy Prior Authorization

HPI requires Prior Authorization for selected drug products or certain quantity limits. To prescribe a Prescription Drug that requires Prior Authorization from HPI, a Member's Physician (or office staff) contacts the HPI Pharmacy Department to complete a request for Prior Authorization. If a Member presents a prescription to a Pharmacy without Prior Authorization, when it is required, the Pharmacy will contact the Member's Physician. The treating Physician must submit the request for Prior Authorization to HPI, and the Member must meet the established Prior Authorization criteria for the Prescription Drug to receive Prior Authorization for Coverage.

If a Member obtains a Prescription Drug requiring Prior Authorization without receiving Prior Authorization from HPI, there will be no Coverage for such medication. Members may obtain an updated list of medications that require Prior Authorization by visiting the HPI website, www.healthplus.org, or if a Member has questions about HPI's pharmacy Prior Authorization program, he/she may call the HPI Customer Service Department at 1-888-212-1512.

7.2 REVIEW OF HPI'S PRIOR AUTHORIZATION DECISIONS

If a Member disagrees with the decision regarding Prior Authorization, the Member or his/her treating Physician may contact HPI or its designee to request a re-evaluation of the decision. A Member may also use HPI's grievance process as provided in Section XII of this Certificate and the HPI Member Satisfaction Plan.

7.3 TIME FOR MAKING PRIOR AUTHORIZATION DECISIONS

For most non-urgent Prior Authorization decisions, HPI or its designee will make its decision within fifteen (15) calendar days after receiving the request. For most urgent Prior Authorization decisions, HPI or its designee will make its decision within seventy-two (72) hours of receiving the request.

7.4 SERVICES REQUIRING PRIOR AUTHORIZATION

A Member's Plan may require Prior Authorization for the services listed below (these services must also meet Medical Necessity criteria to be Covered Services):

A. Consultations and procedures for:

1. Plastic (Cosmetic and Reconstructive) surgery of skin (face and body).
2. Botox injections.
3. Orthognathic surgery (jaw reconstruction).
4. Eye or eyebrow lifts.
5. Removal of excessive skin due to weight loss.
6. Surgery to reduce breast size.
7. Surgery to increase breast size (implants) or to make breasts the same size.
8. Removal of breast implants.

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9. Heat, cold or chemical therapy for acne.
 10. Bariatric (weight loss) surgery.
 11. Surgical treatments for sleep apnea. (e.g., uvulopalatopharyngoplasty).
 12. Transplant and evaluations for transplant (including autologous chondrocyte transplantation for knee trauma).
 13. Outpatient pulmonary rehabilitation.
 14. General anesthesia for outpatient dental procedures.
 15. Genetic counseling, testing, and screening (e.g., breast and colon cancer genetic predisposition testing).
 16. Covered infertility Services.
 17. Surgery of the jaw or gums.
 18. Removal of skin tags.
 19. Varicose vein treatments.
 20. Clinical Trials and associated routine medical care.
 21. Non-emergency Ambulance transportation between facilities.
- B. Inpatient Care
1. Elective (non-emergent) admissions.
 2. Inpatient skilled nursing, sub acute, long-term acute and rehabilitation care.
 3. Mental health and substance abuse admissions, including detoxification, intensive outpatient/Intermediate Care (including Day Treatment (partial hospitalization)).
 4. Skilled Nursing Facility care.
 5. Inpatient Hospice care.
- C. Outpatient Services
1. Durable Medical Equipment costing three thousand dollars (\$3,000.00) or more.
 2. Prosthetic Devices and Orthotic Appliances.
 3. Imaging services, including but not limited to: Magnetic Resonance Imaging (MRI), Computed Axial Tomography (CAT), Positron Emission Tomography (PET) scans, Computed Tomography (CT), Computed Tomography Angiography (CTA), Magnetic Resonance Angiography (MRA), nuclear cardiac studies and virtual studies (such as virtual colonoscopy and capsule endoscopy).

4. Home health services beyond thirty (30) Visits per benefit year.
 5. Residential Hospice or home Hospice care beyond one hundred eighty (180) days.
 6. Specialty injectible medications (such as growth hormones, injectible drugs for rheumatoid arthritis and multiple sclerosis) provided in a Physician's office or outpatient facility.
- D. Mental Health Services
1. Psychological testing for Attention Deficit Hyperactivity Disorder, Attention Deficit Disorder and Oppositional Defiant Disorder.

This list may be updated from time to time. Members should carefully review this Certificate of Coverage, Schedule of Benefits, and any applicable Rider(s). A Member may obtain a list of services and supplies requiring Prior Authorization by visiting HPI's website, www.healthplus.org, or by contacting HPI's Customer Service department. If a Member has specific questions regarding whether the Member's Plan requires Prior Authorization for a particular service or supply, the Member should contact HPI's Customer Service department at 1-888-212-1512.

SECTION VIII – SCHEDULE OF COVERED SERVICES

The following is a general list of Covered Services. To be covered, the service must be Medically Necessary according to generally accepted standards of practice as determined by HPI or its designee. This list of Covered Services is subject to all other requirements in this Certificate (including, but not limited to, the Prior Authorization requirements in Section VII and the Limitations and Exclusions in Section IX), the Schedule of Benefits, applicable Riders, and HPI policies and procedures. Covered Services listed in this Section VIII of the Certificate may or may not be covered under a Member's particular Plan. Members must review the Schedule of Benefits and Rider(s) to determine Coverage. Members are required to pay for any services that are Non-Covered Services. Members should note that even if they receive a referral for a Non-Covered Service from a Preferred Provider, this does not mean that such service becomes a Covered Service, and the Member will still be responsible for payment for the service.

Members should also carefully review the Schedule of Benefits to determine Out of Pocket Costs they are responsible for paying. Members will be required to pay higher Out of Pocket Costs if they receive Covered Services from a Non-Preferred Provider instead of a Preferred Provider, even if a Preferred Provider has referred the Member to a Non-Preferred Provider.

8.1 IMMUNIZATIONS AND PREVENTIVE SERVICES

Preventive Services are routine health care services including screenings, immunizations and examinations that are provided based on a Member's age and sex. Preventive Services are not subject to Deductibles, but may be subject to office Visit Copayments (Members should refer to the Schedule of Benefits for details).

Immunizations that are Covered Services may include:

- A. For children: childhood immunizations through the age of eighteen (18).
- B. For adults:
 - Influenza vaccine – every year.

- Pneumonia vaccine – once at age sixty-five (65) or any age if Medically Necessary.
- Tetanus/diphtheria – booster at age twenty five (25), then every ten (10) years, or if injured.

HPI may choose to add or remove immunizations from the above list based on new vaccines becoming available, new studies in the efficacy of vaccines, or available vaccine supplies.

Travel-related immunizations are not covered.

Preventive Services that are Covered Services may include:

- A. Routine health maintenance examination and assessment for adults: one (1) per benefit year.
- B. “Well Baby” and “Well Child” Visits and associated screenings:
 - Six (6) Visits per benefit year through age twenty-three (23) months.
 - Two (2) Visits per benefit year for ages twenty-four (24) through forty-seven (47) months.
 - One (1) Visit per benefit year for ages four (4) through seventeen (17).
- C. Childhood screenings:
 - Lead testing – infants/early childhood (no limit on number of screenings).
 - Urinalysis – once at age five (5), and once between ages eleven (11) and seventeen (17).
 - Hemoglobin/hemocrit – once before age one (1), and once between ages eleven (11) and seventeen (17).
- D. “Well Woman” services:
 - Gynecological examination – one (1) per benefit year.
 - Cervical cancer screening Pap smear (laboratory and pathology services) - one (1) per benefit year beginning at age eighteen (18).
 - Chlamydia screening – one (1) per benefit year for women ages sixteen (16) through twenty-five (25).
 - Breast cancer screening mammography – one (1) between ages thirty-five (35) and forty (40), and one (1) per benefit year thereafter.
- E. Colorectal cancer screenings beginning at age fifty (50):
 - Fecal occult blood test – once every benefit year; or
 - Sigmoidoscopy – once every five (5) years; or
 - Double contrast barium enema – once every five (5) years; or

- Colonoscopy – once every ten (10) years.
- F. Cholesterol screening: once every five (5) years beginning at age twenty (20).
- G. Diabetes screening: once every three (3) years beginning at age forty-five (45).
- H. Prostate cancer screening: routine PSA test once per benefit year beginning at age forty-five (45).

Members should note that preventive diagnostic screenings furnished more than once a benefit year and/or done before the age indicated (except as otherwise noted above for “Well-Baby” and lead testing of children) are not deemed to be Preventive Services and the Member will be responsible for paying any applicable Copayment and Deductible for such services.

Members should consult HPI's website, www.healthplus.org, for a current list of covered immunizations and Preventive Services.

8.2 PHYSICIAN AND PROFESSIONAL SERVICES

- A. Office and home Visits and consultations provided by non-Specialist Physicians (General or Family Practitioner, Internist, or Pediatrician) for the diagnosis of illness or injury.
- B. Office and home Visits and consultations provided by Specialist Physicians (Physician specialties other than those listed in Paragraph 8.2(A)) for the diagnosis and/or treatment of illness or injury).
- C. Inpatient and outpatient Visits and consultations provided by a Physician or Specialist Physician.
- D. Surgical and anesthesiology services provided by a Physician or Specialist Physician.
- E. Other Physician services provided for the diagnosis and/or treatment of an illness or injury including those services associated with Emergency Health Services.
- F. Other professional Practitioner services provided for the diagnosis and/or treatment of an illness or injury including those services associated with Emergency Health Services.

8.3 EMERGENCY HEALTH SERVICES

- A. Hospital emergency department Visits.
- B. Physician and Practitioner services in a Hospital emergency department for Emergency Health Services.
- C. Follow-up care by a Physician or Practitioner after the emergency has ended.
- D. Ambulance services (air or ground), not including Ambulance services from a Hospital to a Member's home, when Medically Necessary. No Coverage if a Member receives treatment by Ambulance personnel but is not transported to a Hospital. Prior Authorization is required for Ambulance transfers between facilities. All other non-emergency Ambulance transportation is not covered.
- E. Freestanding Emergency Center or Urgent Care Center Visits.

8.4 OUTPATIENT LABORATORY AND DIAGNOSTIC SERVICES

- A. Clinical laboratory and pathology tests ordered by a Physician.
- B. Diagnostic and therapeutic radiological services such as:
 - Electrocardiogram.
 - Electroencephalogram.
 - Diagnostic x-rays.
 - Therapeutic procedures including such services related to pregnancy.
 - Physician services when required to read and/or administer certain radiological tests.
- C. Imaging services, including but not limited to: MRI, CAT scan, CT, CTA, MRA, PET scan, and nuclear cardiac studies and virtual studies are covered only if Member, or his/her Physician acting on Member's behalf, obtains Prior Authorization from HPI or its designee.

If a Member fails to obtain Prior Authorization from HPI or its designee (including if the Member's treating Physician refuses to comply with HPI's Prior Authorization requirements even after HPI or its designee has contacted the Physician), then imaging services are not covered.

8.5 MATERNITY SERVICES PROVIDED BY A PHYSICIAN OR CERTIFIED NURSE MIDWIFE*

- A. Pre-natal and post-natal office Visits.
- B. Delivery and post-partum care, miscarriage, and other related obstetrical services (*no Coverage for home births*).

The mother and newborn have a right to stay in the Hospital following childbirth without obtaining Prior Authorization for no less than forty-eight (48) hours after a normal vaginal delivery, or no less than ninety-six (96) hours after a cesarean section. However, HPI may pay for a shorter stay if the mother and attending Physician agree to the earlier discharge.

**Coverage for Certified Nurse Midwife only if he/she has an interdependent and formal relationship established for supervision, consultation, collaboration and referral to an obstetrician/gynecologist in the event that further and/or immediate medical attention is required. Services performed by a Certified Nurse Midwife without this relationship are not covered.*

8.6 HOSPITAL CARE

(other than mental health and substance abuse services (see Sections 8.9 and 8.10 below))

- A. Inpatient care including:
 - Room and board in Semi-Private Room or in a private room for medical reasons (when authorized by a Physician).
 - Inpatient Physician services.
 - General nursing care.

- Hospital services and supplies.
 - Therapeutic and support care.
 - Care in specialized units as Medically Necessary.
 - Fees for use of operating, delivery, recovery, and treatment rooms and equipment.
 - Special diets.
 - Short-Term inpatient rehabilitation services.
 - Maternity care and routine newborn nursery care during an eligible mother's Hospital stay.
- B. Hospital services and supplies for procedures performed on an outpatient basis.
- C. Surgical services including appropriate professional services, anesthesia, and all related surgical services and supplies.

Elective hospitalizations (both In Network and Out of Network) require Prior Authorization from HPI or its designee. **If Prior Authorization is required, a Member must obtain Prior Authorization at least five (5) days before the surgery is scheduled.** Emergency admissions require authorization and should be reported to HPI or its designee within twenty-four (24) hours of admission or as soon as possible.

See Sections 7.1 through 7.4 for Prior Authorization requirements including lists of services that require Prior Authorization and Member financial responsibility if the Prior Authorization process is not followed.

8.7 ALTERNATIVES TO HOSPITAL CARE

A. SKILLED NURSING FACILITY

Skilled Nursing Care provided at a Skilled Nursing Facility, including drugs and related medical supplies, and room and board in a Semi-Private Room, when necessary on a Short-Term, intermittent basis and expected to lead to rehabilitation and increased ability to function. Coverage is limited to one hundred twenty (120) days per Member per benefit year (In Network and Out of Network combined). Non-skilled custodial or convalescent care are not Covered Services. Prior Authorization from HPI or its designee is required.

B. HOSPICE

Hospice care for pain relief, symptom management, and supportive services to individuals suffering from a disease or condition with a terminal prognosis (up to a maximum of three hundred sixty (360) days) including:

1. inpatient care for pain and/or symptom control that cannot be done safely in another location, and/or up to five (5) days of respite care in a thirty (30) day period. Prior Authorization from HPI or its designee is required.
2. residential care in a freestanding Hospice facility. No Prior Authorization is required for the first one hundred eighty (180) days. Prior Authorization from HPI or its designee is required for up to an additional one hundred and eighty (180) days thereafter.

3. Hospice care in the Member's/family member's home. No Prior Authorization is required for the first one hundred eighty (180) days. Prior Authorization from HPI is required for up to one hundred and eighty (180) additional days thereafter.

Hospice Coverage includes room and board charges for inpatient and residential care, intermittent skilled services, medical supplies, drugs, and medical-social services when required.

C. HOME HEALTH CARE

Intermittent skilled care provided to a Member in his/her home on a Short-Term basis when the Member is confined at home as a result of an illness or injury and is unable to obtain necessary medical care on an outpatient basis, including:

1. Intermittent Skilled Nursing Care.
2. Short-Term physical therapy.
3. Short-Term speech therapy in conjunction with Skilled Nursing Care.
4. medical-social services in conjunction with Skilled Nursing Care.
5. Short-Term occupational therapy in conjunction with Skilled Nursing Care.

Custodial care or general housekeeping services are not covered. Covered home health services do not require Prior Authorization for the first thirty (30) Visits per benefit year. Any subsequent Visits require Prior Authorization from HPI or its designee.

8.8 ORGAN AND TISSUE TRANSPLANTS

Transplants require Prior Authorization from HPI or its designee, must be Medically Necessary and not considered Experimental, and must be performed at HPI-approved facilities. No Coverage for transplant services provided by Non-Preferred Providers.

- A. Human organ transplants: liver, heart, lung, pancreas, heart/lung, small bowel/liver, and kidney.
- B. Bone marrow transplants.
- C. Cornea and skin transplants.
- D. Organ/tissue donor expenses

The following donor expenses are covered:

1. typing or screening of a potential donor only if the proposed transplant recipient is a Member and the potential donor is a parent, child or sibling of the Member proposed to receive the transplant.
2. computer organ bank searches and any subsequent testing necessary after a potential donor is identified, unless covered by other insurance.
3. donor's medical expenses if the person receiving the transplant is a Member and the donor's expenses are not covered by other insurance.

The following donor expenses are not covered:

1. community wide searches for a donor.
2. all donor expenses, even those for donors who are Members, for transplant recipients who are not Members.

There is a one million dollar (\$1,000,000.00) limit per transplant type. Included in this limit are:

1. costs associated with evaluation of the transplant (professional and facility fees).
2. costs for the transplant (professional fees and all charges incurred at an inpatient, HPI-approved Preferred Provider facility, including anti-rejection drugs while the Member is an inpatient).
3. any donor medical costs covered for the specific transplant.

Anti-rejection drugs received after a transplant on an outpatient basis and covered by a Prescription Drug Rider are covered but are not included in the one million dollar (\$1,000,000.00) limit per transplant type.

8.9 MENTAL HEALTH SERVICES

Coverage for treatment of Short-Term, acute mental health conditions as listed below.

- A. Inpatient Mental Health Hospitalization, limited to thirty (30) days per benefit year.
- B. Intensive outpatient/Intermediate Care, including Day Treatment Mental Health/partial hospitalization Program instead of inpatient care at the rate of two (2) days of intensive outpatient/Intermediate Care for one (1) inpatient day, limited to thirty (30) days total (sixty (60) days of intensive outpatient/Intermediate Care) per benefit year.

Prior Authorization from HPI or its designee is required for all mental health admissions, including: Inpatient Mental Health Hospitalization and intensive outpatient/Intermediate Care.

- C. Outpatient mental health Visits, limited to thirty (30) Visits per benefit year, including psychiatric evaluations and not including medication management/reviews.
- D. Behavioral Disorders

For Attention Deficit Hyperactivity Disorder, Attention Deficit Disorder and Oppositional Defiant Disorder: Coverage for mental health evaluation and a maximum of eight (8) hours per benefit year for psychological testing, and Medically Necessary psychiatric medication management on an outpatient basis thereafter. Prior Authorization is required by HPI or its designee for psychological testing.

- E. Developmental Disorders and Autism (including Aspergers, Rett's Disorder, and Sensory Integration Disorder), organic brain disorder, Dissociative Identity Disorder, emotional impairments, and learning disabilities

Coverage for one (1) mental health evaluation per benefit year, and Medically Necessary psychiatric medication management on an outpatient basis thereafter. No Coverage for: any other outpatient mental health services, Inpatient Mental Health Hospitalization, or Intensive outpatient/Intermediate Care.

No Coverage for long-term psychotherapy or for Covered Services beyond the stated limitation even if the services remain Medically Necessary.

HPI will cover the above listed mental health services if provided to a Member by a mental health care provider operated by or under contract with the Michigan Department of Community Health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if such a provider is designated by a court order, provided that the mental health care provider meets HPI's standards for all other such Providers.

8.10 SUBSTANCE ABUSE TREATMENT

Coverage for treatment of substance abuse as listed below until the benefit maximum, as provided in the Schedule of Benefits, has been reached.

- A. Inpatient substance abuse treatment, including detoxification (and any Medically Necessary medical services).
- B. Intensive outpatient/Intermediate Care, including Day Treatment Substance Abuse/partial hospitalization Programs.

Prior Authorization from HPI or its designee is required for all substance abuse admissions, including: inpatient detoxification, and intensive outpatient/Intermediate Care.

- C. Outpatient substance abuse Visits.

In each benefit year, HPI's Coverage for intensive outpatient/Intermediate Care and Outpatient substance abuse treatment will be limited to the annual monetary minimum for Coverage required by Michigan law.

8.11 SHORT-TERM OUTPATIENT REHABILITATIVE THERAPY

Coverage for Short-Term outpatient therapy including:

- A. Physical, speech, and occupational therapy to restore function.

Coverage is limited to one hundred and twenty (120) Visits total consisting of physical therapy, speech therapy, and/or occupational therapy per benefit year for treatment of an illness, injury or congenital birth defect if the Member has surgery to correct such defect.

Coverage is limited to one hundred and twenty (120) Visits per benefit year, even if the services remain Medically Necessary after one hundred and twenty (120) Visits. No Coverage for developmental delays or learning disabilities; or for treatment of congenital birth defects, unless the Member has had surgery to correct such a condition. No Prior Authorization is required.

- B. Stage 1 and Stage 2 cardiac rehabilitation following a heart transplant, bypass surgery, myocardial infarction, congestive heart failure, stable angina, or heart valve repair/replacement.

Coverage for outpatient Hospital or Physician clinic Visits (Stage 2 cardiac rehabilitation) following an inpatient Hospital stay are limited to three (3) sessions per week for six (6) weeks, or eighteen (18) sessions total. No Coverage for Stage 3 or Stage 4 cardiac rehabilitation.

- C. Outpatient pulmonary rehabilitation services with a maximum benefit of twelve (12) weeks per lifetime. Prior Authorization from HPI or its designee is required.

8.12 DURABLE MEDICAL EQUIPMENT (“DME”)

Coverage for Medically Necessary equipment obtained from Preferred Providers including urological and ostomy supplies, and diabetic management supplies, if the Member does not have Prescription Drug Coverage.

Members should contact HPI's Customer Service department for more information regarding specific Coverage questions. Prior Authorization from HPI or its designee is required for individual DME items costing three thousand dollars (\$3,000.00) or more. No Coverage for DME obtained from a Non-Preferred Provider.

8.13 PROSTHETIC DEVICES AND ORTHOTIC APPLIANCES (“P&O”)

Coverage for Medically Necessary devices or appliances obtained from Preferred Providers. Coverage for Medically Necessary breast prosthesis following mastectomy obtained from either a Preferred or Non-Preferred Provider.

Prior Authorization by HPI or its designee is required for all P&O items. No Coverage for P&O obtained from a Non-Preferred Provider (except for breast prosthesis following mastectomy).

8.14 FAMILY PLANNING AND INFERTILITY SERVICES

- A. Medically indicated genetic testing and counseling according to generally accepted medical practices.
- B. Voluntary adult sterilization procedures (reversal of voluntary sterilization is not covered).
- C. Insertion and removal of contraceptive devices.
- D. Contraceptive injections.
- E. Termination of pregnancy in accordance with locally accepted medical practices.
- F. Diagnosis, counseling, and treatment of infertility when Medically Necessary (except as excluded in Section IX, Paragraph 9.3(Z) of this Certificate or an applicable Rider) in accordance with generally accepted medical practices and when Prior Authorization is obtained in advance from HPI or its designee. Treatment is limited to four (4) artificial insemination attempts per lifetime.

8.15 THERAPEUTIC SERVICES

Therapeutic services/procedures including radiation therapy, inhalation therapy and chemotherapy.

8.16 DIABETIC SERVICES

- A. HPI will cover the following equipment, supplies and educational training related to the treatment of diabetes if determined to be Medically Necessary and prescribed by the Member's treating Physician:
 - 1. blood glucose monitors and blood glucose monitors for the legally blind.

2. test strips for glucose monitors, visual reading and urine treating strips, lancets, and spring-powered lancet devices.
3. insulin pumps and medical supplies required for the use of an insulin pump.*
4. insulin syringes.
5. diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management and treatment of their condition.

*Insulin pumps costing three thousand dollars (\$3,000.00) or more require Prior Authorization from HPI or its designee.

B. With regard to Coverage for diabetes self-management training, the following conditions apply:

1. it is limited to completion of a certified diabetes education program only if:
 - considered Medically Necessary upon the diagnosis of diabetes by the Member's treating Physician who is managing the Member's diabetic condition and if the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or
 - the Member's treating Physician diagnoses a significant change with long-term implications in the Member's symptoms or conditions that requires changes in the Member's self-management or a significant change in medical protocol or treatment modality.
2. it shall be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Department of Community Health. This training shall be conducted in group settings whenever available.

8.17 OTHER SERVICES

A. Allergy (skin) testing for food, eye and nose allergies; and allergy injections. No Coverage for Cytotoxicity testing (Bryan's Test), urine autoinjection and provocative and neutralization testing for allergies.

B. Prosthetic Devices and reconstructive therapy after mastectomy:

Coverage for Prosthetic Devices (including costs for fitting the prosthetic device) to maintain or replace the body parts of a Member who has undergone a mastectomy, and for medical care and attendance during Reconstructive surgery following a mastectomy.

C. Drugs used in antineoplastic therapy provided the following are met:

1. the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
2. the drug is approved by the federal Food and Drug Administration ("FDA") for use in antineoplastic therapy;
3. the drug is used as part of an antineoplastic drug regimen;

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4. current medical literature substantiates the drug's efficacy and recognized oncology organizations generally accept the treatment; and
 5. the Physician has obtained informed consent from the Member for the treatment regimen that includes FDA-approved drugs for off-label indications.
- D. Vision care Coverage for: (1) medical conditions and diagnoses related to vision loss, (2) one (1) pair of glasses post-cataract surgery, and (3) one (1) retinal eye exam per benefit year for diabetics.
- E. Pain management services including Coverage for the evaluation and treatment of intractable pain.
- F. Oral surgery and related services when Medically Necessary for the following conditions:
1. prompt repair and treatment of fractures and dislocation of the jaw immediately following an accident or traumatic injury.
 2. prompt repair of injury to the jaw, tongue, cheeks, lips, and roof/floor of the mouth immediately following an accident or traumatic injury (implants and repair/restoration of the teeth are not a Covered Service).
 3. orthognathic surgery prior to age twenty-one (21) for congenital defects directly affecting the growth, development, and ability to chew or maintain nourishment.
 4. treatment of tumors, cysts, and lesions on or in the mouth except when in connection with an extraction.
 5. hospitalization for: (a) multiple extractions which must be performed in a Hospital due to a concurrent hazardous medical condition, or (b) when general anesthesia is required due to: (i) Member's physical or mental condition, (ii) significant trauma in the facial area, (iii) the nature of a special procedure requires general anesthesia, or (iv) the Member's age along with other contributing factors necessitates the use of general anesthesia in a hospital setting. Members are required to obtain Prior Authorization from HPI or its designee for dental hospitalizations.

Routine Dental Care is not a Covered Service.

- G. Medically Necessary Reconstructive surgery to correct congenital birth defects or the effects of illness/injury. Prior Authorization from HPI or its designee is required. Treatment must begin within two (2) years following the occurrence necessitating treatment.
- H. Medically Necessary neuropsychological testing/assessment, limited to no more than two (2) per twelve (12) month period.
- I. Specialty injectible medications

Medications that are injected or infused at a Physician's Office or outpatient facility (such as growth hormones, injectible drugs for rheumatoid arthritis and multiple sclerosis) are covered as a medical benefit (rather than as a Prescription Drug) and subject to any applicable Deductibles or Coinsurance as provided in the Member's Schedule of Benefits. These medications are not covered at retail pharmacies or through mail order, and are not eligible for reimbursement through a Member's Prescription Drug benefit.

- J. Dietician services/nutritional counseling with a Registered Dietician, up to a maximum of two (2) Visits per benefit year.
- K. A Member's participation in either treatment or palliative Clinical Trials only if all of the following conditions are met:
1. there is no clearly superior, non-investigational treatment alternative relative to established therapies;
 2. the available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative;
 3. the Member, the Member's treating Physician and an HPI Medical Director conclude that the Member's participation in the Clinical Trial is Medically Necessary and appropriate pursuant to procedures established by HPI or its designee; and
 4. the Member's treating Physician is involved in the coordination of care.

Covered Services include items and services that are Covered Services absent a Clinical Trial and/or are Medically Necessary to diagnose and treat complications arising from the Member's participation in the Clinical Trial.

SECTION IX – LIMITATIONS AND EXCLUSIONS

9.1 COVERAGE LIMITATIONS

A. Benefit maximums

Certain Covered Services, such as, but not limited to, transplants, substance abuse and mental health treatment, and Short-Term outpatient therapies (physical, speech, and occupational), have benefit maximums. These maximums may be a monetary maximum or number of Visits/services maximums. Members should carefully review Section VIII of this Certificate, the Schedule of Benefits, and any Rider(s) to determine what Covered Services are subject to maximums. Once the maximum benefit level has been reached, HPI will no longer provide Coverage for the service and a Member will be responsible for paying for all costs beyond the maximum level, even if the service(s) remains Medically Necessary.

The maximum lifetime benefit for Covered Services paid by HPI for an individual Member is five million dollars (\$5,000,000.00). Only benefits paid by HPI over the Member's lifetime apply towards the five million dollar (\$5,000,000.00) limit. This five million dollar (\$5,000,000.00) limit is the total limit per a Member's lifetime, even if the Member is covered under more than one HPI plan.

The maximum lifetime benefit for Covered Services per transplant type (as provided in Section 8.8) paid by HPI for an individual Member is one million dollars (\$1,000,000.00). Only benefits paid by HPI over the Member's lifetime apply towards the one million dollar (\$1,000,000.00) limit. This one million dollar (\$1,000,000.00) limit is the total limit per a Member's lifetime per transplant type, even if the Member is covered under more than one HPI plan.

B. Services covered by another party

HPI does not provide Coverage for any illness, injury, examination, evaluation, treatment or other medical services:

1. covered under a workers' compensation policy, no fault or other auto policy, Medicare, CHAMPUS, or any other state or federal program, other insurance plan, or by any other third party payor.
2. for educational or sports-related purposes.
3. pursuant to a court order to determine competency or as a condition of parole or probation (including mental health or substance abuse evaluation and/or treatment).

C. Major disasters

In the event of any major disaster, epidemic, or other circumstances beyond its control, HPI shall attempt to arrange Covered Services in so far as is practical, according to its best judgment, within the limitations of facilities and personnel then available. However, no liability or obligations shall be incurred by HPI for delay or failure to provide any such benefits due to lack of available facilities or personnel, if such lack is the result of such disaster, epidemic, or other circumstances beyond HPI's control. Such circumstances include complete or partial disruption of facilities, war, riot, civil insurrection, acts of terrorism, disability of a significant part of a Preferred Provider's or Plan's personnel, or similar causes.

D. Emergency Health Services

HPI reserves the right not to pay for treatment at emergency facilities if the presenting symptoms were not severe enough to suggest the need for immediate medical attention. In making such a determination, HPI will use the standard of a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

E. Durable Medical Equipment, Orthotic Appliances, and Prosthetic Devices

Coverage shall be provided for non-deluxe items determined by HPI to be eligible for reimbursement. Orthotic Appliances are covered only when they are used to support, align, prevent, correct, or improve a defect of body form or function. Prosthetic devices are covered only when they replace a limb or other part of the body after accidental or surgical removal and/or when the Member's body growth necessitates a replacement. Comfort and convenience equipment, exercise and hygiene equipment, dental appliances, Experimental or research equipment, and self-help devices not medical in nature are not a Covered Service. Any equipment, appliance, or device ordered before the Effective Date of Coverage will not be covered, even if delivered after the Effective Date of Coverage. Equipment, appliances, or devices ordered while a Member, but delivered after the Effective Date of Termination, will not be covered. Equipment, appliances, or devices (other than breast prosthesis following mastectomy) are not covered if furnished by a Non-Preferred Provider.

F. Inappropriate and unnecessary services

Benefits shall be limited to providing Coverage for necessary treatment as determined by reviewing the intensity of service, severity of illness, appropriateness of services rendered, and appropriateness of placement in special units and selected clinical support facilities. Services may be reviewed prospective, concurrent, or retrospective to the time

of service. Such review shall impact only the level of Coverage provided by HPI and shall not serve, or be construed as, any limitation or infringement of any Member's right to select and pay for any level of care desired in any location.

9.2 SERVICES COVERED BY RIDER ONLY

Additional services may be covered if the Member's Group has purchased a separate Rider providing such Coverage. All Riders are subject to the terms and conditions of this Certificate and the attached Schedule of Benefits.

9.3 EXCLUSIONS FROM COVERAGE

Coverage for services and products not specifically identified by this Certificate or any applicable Rider are not Covered Services (even if Medically Necessary) including, but not limited to:

- A. Services determined not to be Medically Necessary for which Prior Authorization was required but not obtained.
- B. Services and supplies to the extent not Medically Necessary for the diagnosis and treatment of injury, illness, or pregnancy.
- C. Excess Charges.
- D. Services performed before the Effective Date of Coverage or after the Termination Date of Coverage.
- E. Charges incurred by a Member that HPI is not legally required to pay.
- F. Dental Care (including orthodontic care) and associated supplies, services, and tests, except as specifically provided in Section VIII, Paragraph 8.17(F).
- G. Cosmetic surgery and other services and products for Cosmetic purposes, such as procedures to correct baldness or wrinkling, facial peels, chin lifts, and repair of skin color defects. However, this exclusion does not apply to Medically Necessary Reconstructive surgery.
- H. Custodial or domiciliary, basic care, or housekeeping provided on an inpatient, outpatient, or in-home basis.
- I. Vision care including: (a) visual therapy, (b) treatment of dyslexia, (c) vision correction surgery, and (d) eyeglasses or contact lenses (except for the initial pair of eyeglasses prescribed following cataract surgery), or other artificial aids, or the examination for, fitting or maintenance thereof.
- J. Examinations, reports or any other services related to requirements or documentation of health status for employment, licenses, insurance, travel, or for educational or sports/recreational purposes.
- K. Services for any injury or illness to the extent any benefits, settlements, awards or damages are available under workers' compensation, any insurance plan or other third party payor, state or federal legislation or any school or other public program supported in whole or in part by governmental funds. Services for any injury or illness related to an accident involving an automobile or other motor vehicle when the Member has an uncoordinated auto insurance policy.

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- L. Services for which the Member is eligible under any governmental program, or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member.
- M. Services for any injury or illness resulting from war, or an act of war or service in the armed forces of any country, to the extent coverage of such injury or illness is available through any governmental plan.
- N. Non-Emergency Health Services furnished by a Provider outside of the United States.
- O. Emergency Health Services outside the United States covered by a foreign governmental public health program.
- P. Medical, surgical, or psychiatric procedures, treatment or devices, pharmacological regimens (except antineoplastic drugs as provided in Section 8.17C above), and associated health care services, which are considered Experimental in nature under accepted standards of practice. Something may be considered by HPI to be Experimental if one of the following circumstances applies:
1. FDA approval, if applicable, has not been granted at the time of its use or proposed use;
 2. it is the subject of an investigational new drug or device application on file with the FDA;
 3. it is being provided as part of a Phase I, II, or III clinical trial;
 4. it is being provided under the supervision of an Institutional Review Board formally designated by an institution to review, approve, and conduct biomedical research involving human subjects as required and defined by applicable federal regulations; or
 5. it is being provided pursuant to experimental or research protocol testing for factors such as safety, efficacy, or toxicity; or published authoritative literature concerning the particular procedure, treatment, device, or regimen indicates that further research is needed to define factors such as safety, efficacy, or toxicity.
- Q. Mental health services and supplies which are:
1. rendered in connection with mental illness not classified in the International Classification of Diseases of the World Health Organization, as modified by the U.S. Center for Health Statistics;
 2. extended beyond the period necessary for the evaluation and diagnosis of mental retardation; or
 3. for mental diseases or illness that, according to generally accepted professional standards, are not usually amenable to favorable modification, such as autism or pervasive developmental disorders (except as provided in Section 8.9E above).
- R. Long-term psychotherapy and extended behavior modification.
- S. Treatment of: personality disorders (such as Antisocial Personality Disorder), insomnia/sleep disorders, nicotine/caffeine abuse or addiction, sexual/gender identity issues, adoption adjustment issues, methadone maintenance, and phototherapy.

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- T. Vocational rehabilitation services, such as work hardening, work training and other work-related or return to work programs.
 - U. Long-term rehabilitation treatment and services.
 - V. Personal comfort or convenience items such as television and phone services, environmental control, and self help products and services (including but not limited to: feeding, dressing, and bathroom aids; and communication devices).
 - W. Cognitive services (such as skills and memory training, stress reduction, or relaxation therapy).
 - X. Orthopedic or other corrective footwear, unless attached to a prescribed hip, knee, and/or ankle-foot orthopedic brace, and outflow shoes for children age three (3) and under.
 - Y. Sex transformation surgery and all expenses in connection with such surgery.
 - Z. Reversal of sterilization and the following infertility services are specifically excluded: In Vitro Fertilization and associated services; Gamete Intro Fallopian Transfer and associated services; Zygote Intro Fallopian Transfer and associated services; sperm bank services; pre-embryo cryo-preservation techniques and associated services; infertility services if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal; and all services related to surrogate parenting arrangements of any kind.
 - AA. Parentage testing.
 - BB. Non-medically indicated genetic testing for a Member.
 - CC. Medically indicated genetic testing of a non-Member.
 - DD. Surgery and any other services or supplies for the purpose of weight reduction or control, except when specifically approved by HPI for severely obese Members with high-risk comorbidities.
 - EE. Wigs, prosthetic hair, hair transplants, or other procedures or supplies to enhance hair growth.
 - FF. Court ordered tests, reports, or treatment, including involuntary psychiatric treatment or substance abuse treatment, unless otherwise covered by this Certificate or a Rider.
 - GG. Care rendered while in police custody.
 - HH. Services or products provided by Convalescent Homes, Homes for the Aged, or Adult Foster Care facilities.
 - II. Nonprescription drugs (or their Prescription Drug equivalents), dietary and other supplements (such as vitamins, minerals, protein or caloric boosting supplements, food supplements, medical foods and infant formula), and articles and supplies provided on an outpatient basis, and not specifically identified as Health Care Benefits by this Certificate or a Rider.
 - JJ. Ancillary services provided as an adjunct to services for which Health Care Benefits are not provided under this Certificate.

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- KK. Skilled nursing services provided on a twenty-four (24) hour basis in the Home.
- LL. Durable Medical Equipment that is available without a Physician's prescription (over the counter) except diabetic supplies, and portable, battery operated nebulizers.
- MM. Replacement or repair of a Covered Durable Medical Equipment item due to misuse or loss by a Member.
- NN. Private duty nursing services.
- OO. Routine foot care including, but not limited to, hygienic care, treatment of corns, calluses, toenails, or fungus.
- PP. Charges associated with alternative or non-standard therapies, including, but not limited to: hypnosis/hypnotherapy, biofeedback (except for certain circumstances involving urinary incontinence), acupuncture services, light therapy, massage therapy, exercise programs, herbal therapies, aromatherapy, holistic or homeopathic treatment, and Reiki or Rolf therapy.
- QQ. Coverage for treatment that is necessary because of the Member's commission of, or attempt to commit, a felony, or because the Member was engaged in an illegal occupation.
- RR. Services, products, or supplies that are illegal.
- SS. Charges for the completion or copying of claims forms or medical records, interest on late payments, or charges for failure to keep scheduled appointments.
- TT. Medical expenses incurred by a Member who donates an organ or tissue to a non-Member. Medical Expenses incurred by a non-Member who donates an organ or tissue to a Member will only be covered if the non-Member does not have coverage for those services.
- UU. Services that are provided by individuals who are not licensed/certified under the Act (or other similar code/statute of any other state or governmental unit) or services which are beyond the treating individual's licensing.
- VV. Charges for transportation and/or lodging that may be required to receive Covered Services.
- WW. Premarital exams or classes.
- XX. Services provided to the Member by: the Member, immediate family members of the Member, or individuals that have the same legal residence as the Member.
- YY. Speech therapy to treat or correct a foreign accent, lisp or stuttering; or as part of a cognitive rehabilitation program, or for Members with developmental or learning disabilities.
- ZZ. Educational services, therapy, and testing.
- AAA. Autopsies.
- BBB. Chemotherapy sensitivity and resistance testing.

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- CCC. Continuous glucose monitors.
- DDD. Earplugs.
- EEE. Services or supplies furnished or ordered by a Provider included on the U.S. Department of Health and Human Services, Office of Inspector General's "List of Excluded Individuals/Entities" ("LEIE"). The LEIE lists individuals and entities that have been excluded from participation in federal health care programs and can be accessed electronically at: oig.hhs.gov/fraud/exclusion.html.
- FFF. Academic education while receiving treatment at Day Treatment Mental Health/Substance Abuse program.
- GGG. Consultation with a mental health professional for adjudication of marital disputes/divorce proceedings, and child support and custody cases.
- HHH. Marriage counseling except when rendered in connection with a mental disorder classified in the International Classification of Diseases of the World Health Organization, as modified by the U.S. Center for Health Statistics.
- III. Treatment for personal or professional, growth, development, training, or professional certification.
- JJJ. Treatment or consultations provided via telephone.
- KKK. Cytotoxicity testing (Bryan's Test), urine autoinjection, and provocative and neutralization testing for allergies.
- LLL. Sensory integration therapy (except as provided in Section 8.9D).
- MMM. Outpatient rehabilitative therapy for:
1. maintenance of a physical or chronic condition (such as Cerebral Palsy), or developmental status (including developmental delays);
 2. apraxius and cognitive disorders; or
 3. an impairment that is not based on an illness, injury or a congenital birth defect (which the Member has had a surgery to correct).
- NNN. Outpatient rehabilitative therapy provided by massage therapists or non-health professionals.
- OOO. Sleep and relational therapy and testing.
- PPP. Craniosacral therapy.
- QQQ. Residential Mental Health/Substance Abuse Treatment.
- RRR. Chiropractic services.
- SSS. Hearing testing, Hearing Aids, and Hearing Aid batteries.
- TTT. Prescription Drugs.

SECTION X – PAYMENT AND CLAIMS PROVISIONS

10.1 PREPAYMENT OF PREMIUM

All Premiums are payable in advance by the Subscriber's Group, or the designated Remitting Agent, to HPI at its offices in Flint, Michigan. The first prepayments are due and payable on or before the Effective Date of Coverage. Subsequent prepayments are due and payable prior to the first day of each month thereafter or any other period designated by HPI's agreement with the Subscriber's Group.

10.2 CHANGES IN PREPAYMENT RATES

HPI reserves the right to change the Premium for Health Care Benefits provided under this Certificate on the monthly renewal date unless otherwise provided in HPI's agreement with the Subscriber's Group.

10.3 COVERAGE; GRACE PERIOD

For a Subscriber (and Dependent(s), if applicable) to be entitled to Coverage under this Certificate, the Subscriber's Group must be current in Premium payments. If a Premium is not paid when due, Coverage may be terminated by HPI. However, a Grace Period of thirty (30) 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. HPI reserves the right to pend any and all Claims submitted during this Grace Period.

10.4 TERMINATION BASED ON LATE PAYMENT

If a Group does not pay a required Premium, HPI may terminate the agreement between HPI and the Group to provide benefits under this Certificate. If HPI terminates a Group based on non-payment, HPI may refuse to accept payment of the Premium from the Group after the date of termination. However, the Group's Subscribers may be eligible to convert their Coverage to an individual conversion policy as described in Section XV below.

10.5 PAYMENT FOR SERVICES BY MEMBER

- A. Written notice of a Claim for which a Member has paid for Covered Services, including satisfactory proof of loss, must be submitted to HPI within ninety (90) days after the occurrence or commencement of any loss covered by this Certificate, or as soon thereafter as reasonably possible.

Satisfactory proof of loss shall mean the submission of an HPI approved Claim form that is both legible and complete and contains the following information:

1. Patient name.
2. Member number.
3. Amount billed.
4. Amount paid.
5. Description of the service and procedure codes.
6. Diagnosis and diagnosis codes.

7. Location of service.
8. Date of service.

Failure to furnish such proof within the required time shall not invalidate or 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.

B. Claim forms

HPI, 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 fifteen (15) days after the Member gives such notice, the Member shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting, within ninety (90) calendar days from the date of loss, written proof covering the occurrence, the character and the extent of loss for which the Claim is made.

C. Legal actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

10.6 PHYSICAL EXAMINATION AND AUTOPSY

HPI, at its own expense, has the right and opportunity to examine the person of a Member when and as often as it may reasonably require during the pendency of a Claim under this Certificate and to make an autopsy in the case of death where it is not forbidden by law.

SECTION XI – COORDINATION OF BENEFITS AND SUBROGATION

11.1 COORDINATION OF BENEFITS

- A. At the time of enrollment and if requested by HPI thereafter, Members are required to disclose to HPI whether they have health insurance coverage through any other private or public health plan (including government programs such as Medicare or Medicaid) or any other third party payor. Members must also immediately notify HPI if there are any changes in such coverage. If a Member fails to provide such information when requested, or to notify HPI upon any changes to the Member's other health insurance coverage, HPI may deny payment for individual Claims.
- B. If a Member entitled to Health Care Benefits under this Certificate is also entitled to benefits under any other private or public health plan or insurance policy, including but not limited to automobile insurance and workers' compensation, benefits shall not be available under this Certificate, whether a claim is made for same, until the benefits of the other health benefit plan or insurance policy are exhausted. However, HPI will coordinate benefits with other health benefit plans or insurance in accordance with the Michigan Coordination of Benefits Act (Public Act No. 64 of 1984, as amended) or any other applicable or controlling law. When coordinating benefits, the plan that is "primary" must pay its benefits first (without considering coverage by any other plan). The plan that is "secondary" may take into consideration the benefits of the primary plan and pays for covered services that are not covered by the primary plan.

The following rules will be used by HPI to establish the order of benefit determination:

1. the other plan has primary responsibility if it has no coordination of benefits provision.
 2. the benefits of a plan that covers a member other than as a dependent are primary. However, if a member is also covered by Medicare, and Medicare is primary to the plan that covers the member other than as a dependent, and secondary to the plan that covers the member as a dependent, then the order is reversed (the plan that covers the member as a dependent is primary and the plan that covers the member as other than a dependent is secondary).
 3. if two plans cover a child as a dependent, the plan of the parent whose birthday (month and day, not year) falls first during the year is primary. If the birthday of the parents is the same date, the plan that has covered the dependent longer is primary, except as otherwise provided in this subsection (3). This is known as the "birthday rule." In the case of a plan which lawfully does not adopt the "birthday rule" and as a result each plan determines its benefits after the other, the coordination of benefits procedure set forth in the plan which does not have the coordination of benefits procedure based on the "birthday rule" will determine the order of benefits.
 - a. if the parents are divorced and a divorce decree or Qualified Medical Child Support Order requires one parent to pay the health care expenses of the child, the plan of the parent with financial responsibility is primary.
 - b. if the preceding does not apply, and the parents are legally separated or divorced, the following is the order of payment: the plan of (i) the parent with physical custody of the child, (ii) the stepparent with physical custody of the child, (iii) the parent without physical custody, or (iv) the stepparent without physical custody. If the parents have joint custody, the "birthday rule" applies.
 - c. if a member is covered under a COBRA (or other) continuation plan and a non-continuation plan, the non-continuation plan is primary.
 4. if none of the above establishes the order of payment, the plan that has provided coverage the longest is primary, except that:
 - a. a plan covering a member as an employee (but not a laid-off employee, retired employee or dependent of such a person) is primary to a plan that covers the member as a laid-off employee, retired employee or dependent of such person; and
 - b. if either plan does not have a provision regarding laid-off or retired employees, and as a result, each plan pays benefits after the other, the provisions of subsection 4(a) will not apply.
- C. In no event shall any Member through coordination of two (2) or more health plans or insurance policies recover more than the actual or Allowed Amount for all services provided to that Member.
- D. If a Member also has coverage under a non-group plan issued as a hospital indemnity, surgical indemnity, specific disease or other non-group disability insurance policy (as such policies are defined by Michigan law), such coverage shall have no effect on the Member's Coverage under this Certificate.

- E. HPI will coordinate benefits with Medicare based on the following:
1. if an individual covered by Medicare is also eligible for Coverage under this Certificate and declines such Coverage, Medicare is primary and HPI will not provide any Coverage.
 2. if a Member is sixty-five (65) years of age or older and has Coverage under this Certificate based on current employment status (or based on current employment status of a spouse of any age), the order of benefits is: (a) if the Member's (or Member's spouse's) employer has twenty (20) or more employees – this Plan is the primary payer and Medicare is secondary, or (b) if the Member's (or Member's spouse's) employer has less than twenty (20) employees – Medicare is the primary payer and this Plan is secondary. If a Member is sixty-five (65) years of age or older and has Coverage under this Certificate not based on the Member's (or the Member's spouse's) current employment status, then Medicare is the primary payer and this Plan is secondary.
 3. if a Member is entitled to Medicare coverage based on disability (and is less than sixty-five (65) years of age) and has Coverage under this Certificate based on the Member's (or the Member's spouse's) current employment status, the order of benefits is: (a) if the Member's (or the Member's spouse's) employer has one hundred (100) or more employees – this Plan is the primary payer and Medicare is secondary, or (b) if the Member's (or Member's spouse's) employer has less than one-hundred (100) employees – Medicare is the primary payer and this Plan is secondary. If a Member is disabled and has Coverage under this Certificate not based on the Member's (or the Member's spouse's) current employment status, then Medicare is the primary payer and this Plan is secondary.
 4. if a Member is eligible for or entitled to Medicare coverage based on End-Stage Renal Disease (“ESRD”) and has Coverage under this Certificate: (a) for the first thirty (30) months the Member is eligible for or entitled to Medicare, this Plan is the primary payer and Medicare is secondary, and (b) after the first thirty (30) months of Medicare eligibility or entitlement, Medicare is the primary payer and this Plan is secondary.

Members who are eligible for Medicare Part A and/or Part B services must enroll in these programs to obtain the highest level of benefits. HPI will consider a Member who is eligible for Medicare as covered under Medicare, even if the Member has not in fact enrolled in Medicare, when determining the order of benefits between HPI and Medicare. Thus, if a Member is eligible for Medicare, and Medicare is the primary payer for health care services, HPI will not provide Coverage for Medicare-covered services, even if the Member has not enrolled in Medicare.

Should any federal law or regulations regarding the coordination of benefits between Medicare and group health plans change, or a new law or regulation is enacted regarding the same, HPI shall be secondary to Medicare as permitted by the revised or new federal law or regulation despite any provision in this Certificate to the contrary.

11.2 SUBROGATION

If a Member receives payment for Covered Services from HPI under any of the following circumstances, HPI will hold a lien against and be otherwise subrogated to the rights of the Member or the Member's legal representative (that is, HPI will be able to stand in the Member's shoes to sue a third party) to the extent that benefits were paid by HPI for:

- A. Services for which benefits are available under any public or private health plan or insurance (including but not limited to, automobile, homeowners, workers' compensation or business insurance) and for which HPI is not the primary carrier under applicable law; or
- B. Damages or injuries caused by or attributed to the willful or negligent act or omission of any third party for which the Member receives (or could receive) payment.

11.3 MEMBER CONSENT

Accepting Health Care Benefits from HPI automatically assigns to HPI any rights a Member has to recover payment from a third party. A Member consents to and authorizes HPI (or its designee) to release, claim, or obtain any information from any source (such as a Provider of services or another health or insurance plan) as necessary for HPI to exercise its coordination and subrogation rights and agrees to execute all documents necessary for HPI to exercise said rights. A Member agrees to take no legal action or otherwise which would lessen or diminish HPI's coordination and subrogation rights.

A Member consents to HPI bringing suit against any third party to protect HPI's subrogation rights. HPI's subrogation rights and rights of recovery are asserted against any money collected by a Member by operation of any legal suit, settlement, or otherwise and requires that HPI be fully reimbursed for Health Care Benefits it has paid on the Member's behalf whether or not the amount he/she recovers compensates him/her in full for the entire amount of his/her claimed loss. HPI may assert its lien against the total amount recovered, and is entitled to repayment in full, to the extent of Health Care Benefits paid by HPI, prior to the release of recovered funds to any other party, without any offset or reduction for attorneys' fees and costs. However, when reasonable legal expenses are incurred in the recovery of monies, an equitable division of expenses may be made at the direction of HPI.

SECTION XII – MEMBER RIGHTS AND RESPONSIBILITIES

12.1 MEMBER RIGHTS – GRIEVANCE PROCESS

Members should refer to the HPI Member Satisfaction Plan at the end of this Certificate of Coverage for details regarding the Member Grievance process.

12.2 OTHER MEMBERS RIGHTS

- A. A Member has the right to receive medical care in a prompt manner for his/her illness or injury.
- B. A Member has the right to be treated with dignity and respect and to participate in health care decisions.
- C. A Member has a right to privacy and confidentiality of his/her medical records and other personal information.
- D. A Member has a right to receive information about appropriate treatment options.
- E. A Member has a right to request and receive information about his/her Health Care Benefits and Coverage.
- F. A Member has a right to review his/her medical records during normal business hours.

12.3 STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering health coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the health plan or issuer may pay for a shorter stay if the attending Provider (e.g., the Member's Physician), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, health plans and issuers may not set the level of benefits or out of pocket costs so that any later portion of the forty-eight (48)-hour (or ninety-six (96)-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, under federal law, a health plan or issuer may not require that a Physician or other health care Provider must obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (for a vaginal delivery) or ninety-six (96) hours (for a cesarean section).

12.4 MEMBER RESPONSIBILITIES

- A. A Member shall review and comply with this Certificate, the attached Schedule of Benefits, and any Riders, and shall contact HPI if he/she has any questions.
- B. A Member shall notify HPI within twenty-four (24) hours or as soon as reasonably possible of an emergency admission.
- C. A Member shall notify HPI of any change in name, address, marital status, dependency status, or any other criteria for eligibility within thirty-one (31) days of the change.
- D. A Member shall comply with any HPI Prior Authorization requirements.
- E. A Member shall pay all applicable Copayments, Deductibles, and Coinsurance, as well as any penalty for not obtaining Prior Authorization when required and Out of Pocket Costs for Non-Covered Services or Covered Services furnished by a Non-Preferred Provider.
- F. A Member shall notify HPI if the Member has any other health insurance coverage.
- G. A Member shall immediately notify HPI, in writing, of any loss or theft of his/her Identification Card.
- H. A Member shall not allow any other person to use his/her Identification Card or otherwise allow others to erroneously represent his/her identity as an HPI Member.
- I. A Member may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by his/her treating Physician. If a Member refuses appropriate care recommended by his/her treating Physician and no alternative care exists in the opinion of the Member's treating Physician, Coverage shall not be extended by this Certificate for the condition under treatment.
- J. A Member shall be responsible for all services rendered prior to his/her Effective Date of Coverage and following the Effective Date of Termination. HPI shall be entitled to recover from the Subscriber and/or Dependent(s) all Claims paid by HPI for services rendered to the Subscriber and/or Dependent(s) after the Effective Date of Termination.

- K. A Member shall execute any and all releases necessary in order for HPI to gain access to the Member's medical records, including mental health and substance abuse records.
- L. A Member shall provide complete and truthful information, to the best of the Member's knowledge on all forms and correspondence submitted to HPI.

SECTION XIII – RECORDS

13.1 MEMBERSHIP RECORDS

HPI shall keep records concerning eligibility and Claims paid on behalf of Members for a reasonable period of time. Individual Members and/or Groups shall forward information periodically as required by HPI in connection with the administration of this Certificate.

13.2 INSPECTION OF RECORDS BY MEMBER

A Member may review his/her own records at HPI's offices during regular business hours. An appointment for this purpose is required.

13.3 ACCURACY OF INFORMATION

HPI shall not be liable for the inaccuracy of any retained information furnished by the Member, Remitting Agent, or Group. A Member may correct information he/she has incorrectly furnished to HPI if HPI has not acted to its prejudice by relying on such incorrect information.

13.4 CONFIDENTIALITY OF MEMBERS' PERSONAL HEALTH INFORMATION

HPI may share a Member's Personal Health Information with other entities, such as health care Providers, payors (including health plans or employers who sponsor self-funded health benefit plans), HPI affiliates and contractors, when necessary to coordinate and oversee a Member's treatment, for payment purposes related to a Member's receipt of Covered Services under this Certificate, and for HPI's operation activities, such as those activities that enable HPI to monitor the quality of care a Member is receiving.

Members should refer to HPI's Notice of Privacy Practices (included in the HPI Member Handbook, on HPI's website, www.healthplus.org, and also mailed to Members annually) for a detailed description of how and when a Member's Personal Health Information may be used and disclosed and how Members may obtain access to their Personal Health Information.

SECTION XIV – TERM AND TERMINATION

14.1 TERM

This Certificate shall have a term of one (1) month beginning on the Effective Date of Coverage, and shall automatically renew, from month to month, by payment of Premiums, unless terminated pursuant to this section.

14.2 TERMINATION

- A. Member's loss of eligibility

HPI will terminate a Member's Coverage under this Certificate if a Member no longer meets the eligibility requirements provided in Section III of this Certificate.

- B. Termination based on failure to pay Premium

HPI shall retroactively terminate this Certificate to the last date for which Premium payments, if any, have been made under any of the following conditions:

1. at the end of the Grace Period if any Premium remains unpaid at the expiration of the Grace Period; or
2. on the date during any Grace Period that HPI receives written notice of termination from the Subscriber's Group.

C. Termination

Termination of this Certificate shall be without prejudice to any claim originating prior to the Effective Date of Termination. Upon termination of this Certificate, all Premiums which are accrued and unpaid at the time of termination shall be due to HPI.

D. Ineligible enrollment

HPI may cancel this Certificate from the Effective Date of Coverage as it applies to a Subscriber or a Subscriber's claimed Dependent(s), or both, when HPI has extended Coverage based on erroneous information supplied by a Group, a Subscriber, or a Dependent concerning eligibility. In exchange for the return of Premiums paid, HPI shall be entitled to reimbursement for Health Care Benefits provided from the Group, the Subscriber, or the claimed Dependent.

E. Other reasons for termination by HPI

This Certificate (or Dependent eligibility hereunder, as applicable) shall terminate:

1. on the date specified by HPI, after a Member has refused to pay a required Copayment, Coinsurance, Deductible or penalty for failure to obtain Prior Authorization when required following thirty (30) days written notice to the Member;
2. on the date specified by HPI, after a Subscriber has knowingly given false material information at the time of enrollment;
3. on the date the Member no longer Resides in one of the fifty (50) United States;
4. on the date of a Member's entry into active military duty, except for temporary duty of thirty (30) days or less;
5. on the date specified by HPI, after a Member obtains or attempts to obtain Health Care Benefits fraudulently or misrepresents any material information to HPI;
6. on the date specified by HPI, if a Member becomes disruptive, unruly, abusive, threatening, or uncooperative and it seriously impairs HPI's ability to arrange for Covered Services for that Member or other Members enrolled in HPI, then the rights of such Member under this Certificate may be terminated following not less than thirty (30) days written notice, but subject to the Member's rights under HPI's Member Satisfaction Plan;
7. on the date specified by HPI, if a Member does not notify HPI of his/her coverage under any health insurance or other insurance policy under which Member may be entitled to Health Care Benefits;

8. on the date specified by HPI, if a Member fails to provide requested information to HPI for its coordination or oversight of Member's care or Coverage under this Certificate;
9. on the date specified by HPI, if a Member allows someone else to use his/her Identification Card or uses another HPI Member's Identification Card;
10. on the date specified by HPI, if the Group Enrollment and Coverage Agreement between HPI and the Subscriber's Group is terminated; or
11. if HPI terminates its operations as a disability insurer providing health insurance.

F. Termination by Subscriber

A Subscriber may terminate his/her and/or any eligible Dependent's Coverage under this Certificate by providing prior written notice to both the Subscriber's Group and HPI.

G. Effect of Termination

If this Certificate is terminated by HPI or a Subscriber as described above, as of the Effective Date of Termination, the Subscriber and the Subscriber's eligible Dependents will no longer have Health Benefit Coverage under this Certificate. If a Member disagrees with HPI's decision to terminate the Member's Coverage, the Member may follow the procedures provided in HPI's Member Satisfaction Plan. Terminated Members will have Coverage under this Certificate until the Effective Date of Termination as provided below. Additionally, a terminated Member may be eligible to convert his/her Coverage to an individual policy as described in Section XV.

H. Effective Date of Termination

The Effective Date of Termination is the earliest date this Certificate may be considered terminated under this Section XIV.

I. Time limit on certain defenses

After three (3) years from the date of issue of this Certificate, no misstatements, except fraudulent misstatements made by an applicant in his/her Application for Health Care Benefits under this Certificate, shall be used to void this Certificate or to deny a Claim for loss incurred or disability commencing after the expiration of such three (3) year period.

This provision, however, shall not be construed to affect any legal requirement for avoidance of a policy or denial of a Claim during the initial three (3) year period.

SECTION XV – CONVERSION AND CONTINUATION

15.1 CONVERSION OPTION

- A. A Member who loses eligibility for Coverage as a Group Member under this Certificate because: (1) the Subscriber terminates his/her employment with the Group, (2) the Subscriber dies or a Member and the Subscriber divorce, or (3) a Member loses eligibility based on his/her age or no longer having Dependent status, may be entitled to convert this Certificate to an individual policy/Certificate.
- B. A Member may be eligible to convert to individual Coverage if:

1. the Member's termination from Coverage under this Certificate is not based on a violation of this Certificate, including but not limited to, failing to pay any required contribution towards a Premium or committing fraud related to Coverage under this Certificate;
2. the Member's terminated Group Coverage under this Certificate was not replaced by other group coverage or Medicare; and
3. the Member has been continuously covered by this Certificate for at least three (3) months immediately prior to termination.

Members should contact HPI's Customer Service department (at 1-888-212-1512) regarding questions related to eligibility for individual coverage under a conversion policy.

- C. For an eligible Member electing to convert this Certificate to individual Coverage, HPI has an arrangement with Celtic Insurance Company ("Celtic"), whereby Celtic provides individual conversion coverage to HPI Members eligible for such coverage residing in any of the fifty (50) states, including Michigan. Members who are interested in Celtic's individual coverage should contact Celtic by phone at 800-365-2365 or may complete Celtic's "Your Rights Your Options" form (available on Celtic's website at: www.celtic-net.com/major_medical_insurance.aspx) and mail to Celtic at P.O. Box 06469, Chicago, IL 60606, within thirty-one (31) days of the Member's termination of his or her Group Coverage.

15.2 CONTINUATION OF GROUP COVERAGE OPTION

A. COBRA

A Member may be entitled under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue his/her Coverage under this Certificate by making periodic payments directly to his/her Group. Subject to its terms and conditions, and timely payment, this Certificate shall be continued for such Members until the continuation of Coverage is no longer available through the Member's Group.

B. Military service

A Subscriber and his/her Dependents whose Coverage ends based on an absence from employment for greater than thirty (30) days for military service may be eligible to purchase continuation coverage under COBRA and/or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Such continuation coverage under COBRA may be available for between eighteen (18) and thirty-six (36) months, depending on the circumstances. Under USERRA, continuation coverage is available for up to twenty-four (24) months from the first date of absence.

SECTION XVI – GENERAL TERMS AND CONDITIONS

16.1 INTERPRETATION AND CONSTRUCTION

HPI alone shall make determinations under this Certificate, including decisions regarding the Medical Necessity of Covered Services, and shall interpret and construe this Certificate as necessary in its administration of the terms of this Certificate consistent with applicable HPI policies and procedures and requirements of law. All such decisions, constructions, and interpretations made by HPI shall be binding on Members, subject to any applicable rights under the Member Grievance process.

16.2 ENTIRE AGREEMENT

This Certificate, including this document, the Schedule of Benefits, the Group Enrollment and Coverage Agreement, and any amendments, Riders, or endorsements, constitutes the entire contract of insurance between HPI and Members. No agent or other person, except an officer of HPI, or other authorized committee, has authority to waive any condition or restrictions of this Certificate, to extend the time for making payment, or to bind HPI by making promise or representations or by giving or receiving any information. No change in this Certificate shall be valid unless evidenced by an endorsement or Rider formally issued by HPI.

All statements made by Group, or any officer or trustee of Group, or by individual Members, shall, in the absence of fraud, be deemed representations and not warranties, and such statements will not be used in defense of a Claim under this Certificate, unless contained in a written Application.

16.3 AMENDMENTS

This Certificate is subject to amendment, modification or termination in accordance with its provisions upon at least thirty (30) days written notice to Subscriber. If Subscriber, or Group, acting on behalf of Subscriber continues to pay the Premium after such notice of amendment or modification by HPI, then such amendment or modification is deemed as accepted. HPI may also amend, modify, or terminate this Certificate in accordance with its provisions by mutual agreement between HPI and Group.

16.4 NOTICES

Any notice required or permitted to be given under this Certificate shall be appropriately given if in writing and either personally delivered, or deposited in the United States mail with postage prepaid and addressed to the Member at the address of record on file at HPI's principal office. Subscriber is responsible for promptly notifying HPI of any change in address. Notice may also be provided electronically if agreed to by Group or Member and permitted by law.

16.5 GOVERNING LAW

This Certificate is made and shall be interpreted under the laws of the State of Michigan.

16.6 REINSTATEMENTS

HPI may reinstate this Certificate after the Effective Date of Termination without the execution of a new Application or the issuance of a new Identification Card or any notice to the Subscriber, other than the unqualified acceptance of an additional payment from the Subscriber, the Group, or Remitting Agent. No such payment shall create any rights or service for periods prior to the reinstatement date determined by HPI, which shall become the Effective Date of Termination of Coverage for all subsequent purposes hereof.

16.7 IDENTIFICATION CARDS

Identification Cards issued by HPI to Subscribers/Members are for identification only. Possession of an Identification Card confers no rights to Health Care Benefits that are not otherwise available under this Certificate.

16.8 POLICIES AND PROCEDURES

HPI may unilaterally adopt and change reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Certificate. HPI reserves the right to

review services, supplies, products, and procedures for efficacy of use and quality to determine if they should be available to HPI Members.

16.9 ADJUSTMENTS AND REFUNDS

All requests for adjustments and refunds must be filed on forms approved by HPI. Adjustments shall be made in accordance with HPI policy. When making adjustments, HPI shall not charge or refund any amount arising from events, which transpired more than one (1) year prior to the filing of the request.

16.10 ASSIGNMENT

All rights of a Member to receive Health Care Benefits are personal and may not be assigned.

16.11 INDEPENDENT CONTRACTORS

Providers who have contracted with HPI to provide services under this Certificate are independent contractors, and not employees or agents of HPI.

16.12 PROVIDER DISCLAIMER

Since each Member selects his/her treating Physician and other Providers, HPI assumes no responsibility for Physicians and other Providers treating the Member, their competency, or their acts.

16.13 HEADINGS

The headings and titles of this Certificate are for ease of reference only, and shall not be interpreted to expand the Coverage afforded.

16.14 SEVERABILITY

In the event that any section, or portion hereof, of this Certificate is held unenforceable or invalid by any competent adjudication, the validity and enforceability of the remaining sections, or portions thereof, shall not be affected thereby.

16.15 WAIVER

HPI's waiver or failure to enforce any section, or portion thereof, of this Certificate on any one occasion shall not constitute a release of that section, or portion thereof, or waiver of its terms on any future occasion.

16.16 RECOVERY OF PAYMENTS

HPI shall be entitled to recover payments from the Subscriber and/or Dependent(s) for any and all Claims payments made by HPI for services rendered to the Subscriber and/or Dependent(s) after the Effective Date of Termination.

16.17 ERISA

For those Plans covered by the Employee Retirement Income Security Act, as amended ("ERISA"), HPI serves only to process and pay claims and handle claims appeals, not as the Plan administrator. The Plan's Group (or its designee) serves as the ERISA required Plan administrator and is responsible for: advising individuals covered under the Plan regarding their rights and benefits under the Plan (including COBRA rights), and for determining when a Plan

Member's Coverage shall be terminated. HPI is the named claims administrator for ERISA Plans but otherwise is not a named fiduciary for any purpose under ERISA.

HEALTHPLUS INSURANCE COMPANY MEMBER SATISFACTION PLAN

HealthPlus Insurance Company (HPI) is committed to providing the best possible service to our members. The Member Satisfaction Plan has been established to provide our members an avenue to follow in situations where they are dissatisfied with a contracted practitioner, provider, policy, procedure, or benefit of HPI. Both a routine and expedited process are specified to assure that an appropriate problem resolution process is utilized that accommodates the clinical urgency of the situation. HPI provides our members with an opportunity to express their concerns through the Member Satisfaction Plan in part to improve and strengthen our programs. In keeping with this philosophy, Member Satisfaction staff are committed to continuous quality improvement by way of education for our members, providers and other HealthPlus staff.

In order to assure central coordination and administration of the plan, the Director of Customer Service administers the Grievance System and dedicated Member Satisfaction staff oversee adherence to the policies and procedures that govern Grievances, maintain centralized record keeping functions and prepare quarterly summaries for the HPI Board of Directors. Member Satisfaction staff will also prepare and file any information and summary data as may be required by state or federal law. Grievance files will be available at the principal office of HPI for inspection by the Office of Financial and Insurance Regulation (OFIR) for at least two (2) years following the year the Grievance was filed, as required by MCL 500.2213.

For operational tracking purposes, Grievances are categorized by specific codes. These codes were developed to facilitate HPI's commitment to continuous quality improvement and to assist HPI in providing feedback to contracted providers, members and staff. The types, codes and definitions of member Grievances are maintained by Member Satisfaction staff.

SECTION I -- HPI ROUTINE (NON-EXPEDITED) GRIEVANCE PROCESS

When members have questions or problems, they can call or otherwise contact the Customer Service Department at 1-888-212-1512 (or TDD: 1-800-922-5070).

Whenever member concerns cannot be handled by customer service or other appropriate staff, the member (or his or her Authorized Representative) is afforded the opportunity to initiate the Grievance process.

The Grievance process will be initiated at the request of a member (or his or her Authorized Representative) in the following circumstances:

- Problems or situations which cannot be resolved to the member's satisfaction by customer service or other appropriate staff;
- Dissatisfaction with an Adverse Determination regarding Pre-Service, Post-Service and concurrent care decisions;
- An alleged instance of inadequate access to care, poor quality of care, poor service or inappropriate care provided to an HPI member; and
- Reports of an inaccurate and/or inappropriate provider communication to members.

Stage I: Grievance

- A. The substance of the Grievance and all actions taken will be fully documented by HealthPlus staff, outside review entity, the member, or the member's Authorized

Representative.

- B. The Grievance will be forwarded to Member Satisfaction staff or outside review entity, along with any accompanying information or documents pertaining to the Grievance, in a timely manner to accommodate the clinical urgency of the situation.
- C. Upon receipt, Member Satisfaction staff or outside review entity will:
 - 1. Act as investigator;
 - 2. Assign a number and code to the Grievance;
 - 3. Forward a copy of any Grievance regarding a provider quality issue to the HealthPlus Quality Management and regional Provider Network Management Departments for their information and input; and
 - 4. Log the Grievance into the call tracking system and the Grievance reporting system and assign an expected completion date.
- D. Member Satisfaction staff or outside review entity will acknowledge receipt of the Grievance in writing to the member (or his or her Authorized Representative) within five (5) working days.
- E. Member Satisfaction staff or outside review entity, acting as investigator, will thoroughly research the Grievance, including all aspects of clinical care, by contacting all relevant parties and recording their responses, including their recommendations for resolution. Member Satisfaction staff should attempt to resolve the Grievance based on existing HPI policies, procedures or administrative directives (e.g., at this level no existing HPI policy should be revised, modified or ignored by Member Satisfaction staff in order to resolve a Grievance). Outside review entity should attempt to resolve the Grievance based on medical necessity guidelines consistent with the member's diagnosis.
- D. Whenever resolution of the Grievance involves extraordinary circumstances, or interpretation of policy is necessary, Member Satisfaction staff will seek assistance from the applicable Director and/or Vice President. Existing policies or procedures should be followed; however, upon determination by the applicable Director and/or Vice President, they may be waived on a case-by-case basis. The applicable Director and/or Vice President will authorize any such waiver or refer the matter to an appropriate committee or staff member for guidance or resolution.
- G. A medical director or other physician or practitioner who was not previously involved in the initial determination will be consulted in all matters involving the clinical aspects of care and service and will render a decision. However, the original physician or practitioner who made the initial denial determination will be consulted first to see whether he/she upholds the denial. If the denial is upheld, a non-involved physician or practitioner will be consulted and will render a decision. In Grievances involving non-clinical issues, an individual who was not previously involved in the initial determination will be consulted and will render a decision. For Grievances involving clinical or non-clinical issues, a subordinate of the individual previously involved in the determination will not be consulted.
- H. Member Satisfaction staff or outside review entity will make a determination regarding the Grievance, fully document all actions taken, record the decision on the Grievance form, log it into the call tracking and Grievance reporting systems, and communicate the decision to the member (or his or her Authorized Representative) in writing. This

notification will take place within fifteen (15) calendar days of receipt of the Grievance. Notification will include the basis for the decision and the right to request, within a reasonable amount of time, further review of the decision by the Grievance Appeal Committee. This communication will include information regarding the entire member satisfaction process.

- I. Once a Grievance regarding a provider is resolved, a summary of the Grievance will be forwarded to the HealthPlus Quality Management and regional Provider Network Management Departments where an internal process is implemented for tracking provider issues.

Stage II: Grievance Appeal

This stage may be initiated by any HPI member (or his or her Authorized Representative) who remains dissatisfied with the solution proposed to them during the Stage I process.

The Grievance Appeal Committee is composed of three (3) voting members, including two (2) members of the HealthPlus of Michigan (HPM) Board of Directors, who were not previously involved, nor subordinates of the individual(s) previously involved, in the initial determination or a prior stage of the Grievance process. HealthPlus staff will schedule a meeting of the Grievance Appeal Committee within thirteen (13) calendar days of receipt of any request for continued review of a Grievance.

A. The procedure is as follows:

1. The request for continued review is dated, reviewed, assigned a unique identifying number, and entered into the Grievance log and the call tracking reporting system.
2. Receipt of the request for continued review is acknowledged in writing to the member (or his or her Authorized Representative) within five (5) working days.
3. All pertinent information regarding the Grievance, including all aspects of clinical care, is collected, summarized and prepared for presentation to the Grievance Appeal Committee. A medical director or other physician or practitioner who was not previously involved in the initial determination or a prior stage of the Grievance process will be consulted in all matters involving the clinical aspects of care and service.
4. In Grievances involving clinical issues, an actively practicing health care practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment will be consulted to review the Grievance and provide a written opinion. This actively practicing health care practitioner must not have been previously involved in the initial determination or a prior stage of the Grievance process nor be a subordinate of the individual(s) previously involved.
5. A meeting of the Grievance Appeal Committee is scheduled, participants to include:
 - a. The HPI President and Chief Executive Officer, or his/her designee;
 - b. An enrollee member of the HPM Board of Directors;
 - c. A physician member of the HPM Board of Directors; and

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- d. HealthPlus legal counsel (who acts as the non-voting chairperson of the Grievance Appeal Committee).
6. Prior to the scheduled Grievance Appeal Committee meeting, case summary packets are distributed to all Committee members. The case summary will document all pertinent information regarding the Grievance, including all aspects of clinical care.
 7. Member Satisfaction staff will notify the member (or his or her Authorized Representative) of the scheduled meeting date of the Grievance Appeal Committee. Such notification will advise the member (or his or her Authorized Representative) of the opportunity to meet with the Committee, should the member (or his or her Authorized Representative) choose to do so. The member may also choose to be represented at the Grievance Appeal Committee meeting. If the member and/or their representative is unable to appear in person, they are advised that they can communicate by telephone conference or other appropriate technology.
- B. The Grievance Appeal Committee will meet and review all information on file regarding the Grievance. In Grievances involving clinical issues, the Grievance Appeal Committee will review and consider the written opinion from the actively practicing health care practitioner in the same or similar specialty who was consulted.
 - C. If the member and/or their representative is present, they are allowed to present their case. Members of the Committee may question the member and/or their representative, and the member and/or their representative may also question the Committee members. After excusing the member and/or their representative, if present, the Committee discusses the case and makes a decision regarding the Grievance by majority rule. This decision will constitute HPI's final determination on any routine non-Expedited Grievance.
 - D. Member Satisfaction staff are responsible for notifying the member (or his or her Authorized Representative) in writing of the decision of the Grievance Appeal Committee within two (2) calendar days of the meeting. This information will be logged into the call tracking system and the Grievance reporting system. Notification will include the basis for the decision and the right to request external review of the decision through the OFIR, as required under the Patient's Right to Independent Review Act, MCL 500.1901, *et seq.* ("PRIRA"). Grievances that do not involve an Adverse Determination are handled through the OFIR's regular complaint process as provided under PRIRA.

SECTION II -- OFIR ROUTINE EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

If members (or their Authorized Representative) have exhausted their rights under the HPI Member Satisfaction Plan, or if they have not received a response from HPI at the end of fifteen (15) calendar days from filing their appeal under Stage II: Grievance Appeal, they can appeal to OFIR, as provided under PRIRA. If the Grievance involved an Adverse Determination, the member (or his or her Authorized Representative) has sixty (60) calendar days from receipt of HPI's final decision to request external review through OFIR, as required under PRIRA. If the request is accepted for external review, OFIR will either review the case or assign the case to an independent review organization (IRO) and notify both the member (or his or her Authorized Representative) and HPI, as provided under PRIRA. Not later than seven (7) working days after receipt of the notice from OFIR, HPI will provide to the IRO all information used in making and upholding the Adverse Determination. If HPI fails to provide such information within seven (7) working days, OFIR may reverse the Adverse Determination and notify the IRO, the member (or his or her Authorized Representative) and HPI, as required under PRIRA. The external review may only be terminated if HPI reconsiders its Adverse Determination, reverses its decision and notifies the member (or his or her Authorized Representative), the IRO and OFIR, as provided by PRIRA. Upon receipt of a notice from OFIR reversing the Adverse Determination, HPI immediately shall approve the

coverage for the member, as required under PRIRA. HPI may not charge the member (or his or her Authorized Representative) any fees for the external review process.

SECTION III -- HPI EXPEDITED GRIEVANCE PROCESS

An Expedited Grievance may be requested for Urgent Care Claims. HPI or outside review entity will make a determination whether an Expedited Grievance is warranted based on the particular facts and circumstances surrounding each request. In making such a determination, HPI or outside review entity must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If a determination is made that an Expedited Grievance is not warranted, the routine Grievance process will be followed. Whenever a physician substantiates (orally or in writing) that due to the medical status of the member resolution of his or her Grievance within HPI's normal time frames would seriously jeopardize the member's life or health or ability to regain maximum function, the Expedited Grievance process shall be followed.

- A. HPI or outside review entity shall make and communicate to the member (or his or her Authorized Representative) and his/her physician a determination concerning an Expedited Grievance as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after receipt. This determination may be communicated orally. The Grievance Appeal Committee shall make the determination on the Expedited Grievance with the advice of the HealthPlus Legal Department. Outside review entity shall make the determination on the Expedited Grievance based on medical necessity guidelines consistent with the member's diagnosis. Member Satisfaction staff or outside review entity shall be responsible for documenting and maintaining the file associated with the Expedited Grievance.
- B. If time permits so as not to jeopardize the medical status of a member, in Expedited Grievances involving clinical issues, an actively practicing health care practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment will be consulted to review the Expedited Grievance and provide a written opinion. This actively practicing health care practitioner must not have been previously involved in the initial determination nor be a subordinate of the individual(s) previously involved. The practitioner will not give deference to the initial decision when reviewing the Expedited Grievance. The Grievance Appeal Committee or outside review entity will review and consider the written opinion of the actively practicing health care practitioner in making its decision.
- C. Member Satisfaction staff or outside review entity will ensure that all necessary information, including the benefit determination on review, will be transmitted to the member (or his or her Authorized Representative) by telephone, facsimile, or other available similarly expeditious method.
- D. Member Satisfaction staff or outside review entity shall provide written confirmation of the determination to the member (or his or her Authorized Representative) and the member's physician within two (2) working days or three (3) calendar days, whichever is less, following the oral notification.
- E. Within ten (10) calendar days after receiving HPI's or outside review entity's determination on the Expedited Grievance, the member (or his or her Authorized Representative) may request an expedited external review of the decision through OFIR, as provided by PRIRA.

SECTION IV -- OFIR EXPEDITED EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

- A. As provided by PRIRA, a member (or his or her Authorized Representative) may request

an expedited external review through OFIR within ten (10) calendar days of receiving an Adverse Determination when the health care service has not yet been provided or concurrent with the health care service being provided if both of the following are met:

1. The Adverse Determination involves a medical condition of the member for which the time frame for completion of an internal Expedited Grievance by HPI or outside review entity would seriously jeopardize his or her life or health or ability to regain maximum function or subject the member to severe pain that cannot be managed adequately as substantiated by a physician either orally or in writing.
 2. The member (or his or her Authorized Representative) has filed a request for an internal Expedited Grievance with HPI or outside review entity.
- B. If the request is accepted for expedited external review, OFIR will assign the case to an IRO and notify both the member (or his or her Authorized Representative) and HPI, as provided by PRIRA. If the internal Expedited Grievance process has not been completed, the IRO immediately will determine whether the member (or his or her Authorized Representative) will be required to complete the internal Expedited Grievance process prior to any expedited external review.
- C. Not later than twelve (12) hours after receipt of the notice from OFIR that a case has been accepted for expedited external review, HPI or outside review entity will provide to the IRO in the most expeditious manner all information used in making and/or upholding the Adverse Determination, as required under PRIRA.
- E. Upon receipt of a notice from OFIR reversing the Adverse Determination, HPI immediately shall approve the coverage for the member. HPI may not charge the member (or his or her Authorized Representative) any fees for the expedited external review process

SECTION V -- MEMBER SATISFACTION REPORTS

- A. Member Satisfaction staff provides a biannual Report to the Marketing Committee, Medical Affairs Committee and the Board of Directors. The Report contains:
- Number of Grievances and Grievance Appeals received
 - Grievance resolution time
 - Overview of Grievances and Grievance Appeals and problem areas identified in the data
 - Initiatives to avoid problematic areas
 - Resolution of Grievances and Grievance appeals
- B. Member Satisfaction staff also provide summary data on the number and types of complaints and Grievances, Grievance Appeals and external appeals to OFIR filed for the previous year with, and on the form provided by, the Commissioner of the OFIR, as required by MCL 500.2213.
- C. Member Satisfaction staff, other appropriate staff and/or the Committees or Board may suggest steps to help correct a specific problem area. If the Board of Directors identifies an area of concern, the Board may direct Member Satisfaction staff to conduct further review and provide a detailed report back to the Board. The Board may also direct

Member Satisfaction staff to make any necessary changes based on such reports.

SECTION VI -- MISCELLANEOUS

- A. For purposes of the HPI Member Satisfaction Plan, the following definitions shall apply:
1. "Adverse Determination" shall mean a coverage determination that an admission, availability of care, continued stay, or other health care service or benefit has been reviewed and denied, reduced or terminated. Failure to respond in a timely manner to a request for a determination constitutes an Adverse Determination. Whenever an Adverse Determination is made, a written statement containing the reasons for the Adverse Determination will be provided to the member (or his or her Authorized Representative) along with any written notifications that may be required by state or federal law.
 2. "Authorized Representative" shall mean any of the following:
 - a. a person to whom a member has given express written consent, including a practitioner, to represent him/her in a Grievance or an external review;
 - b. a person authorized by law to provide substituted consent for a member; or
 - c. for Urgent Care Claims or if the member is unable to provide consent, a family member of the member or the member's treating health care professional.
 3. "Claim" shall mean any request for benefits made by a member (or his or her Authorized Representative) that complies with HPI's procedure for making benefit claims. Claims include Pre-Service Claims, Post-Service Claims, and Urgent Care Claims.
 4. "Expedited Grievance" shall mean a Grievance for Urgent Care Claims.
 5. "Grievance" shall mean a dispute on behalf of a member, presented (orally or in writing) by the member (or his or her Authorized Representative), regarding:
 - a. the availability, delivery or quality of health care services (including an Adverse Determination concerning utilization review);
 - b. Pre-Service Claims or Post-Service Claims;
 - c. payment, handling or reimbursement for health care services; or
 - d. matters pertaining to the contractual relationship between a member and HPI.
 6. "Pre-Service Claim" shall mean any Claim that, under the terms of the member's Certificate of Coverage or summary plan description, must be approved (either in whole or in part) before medical care is obtained.
 7. "Post-Service Claim" shall mean any Claim that is not a Pre-Service Claim.
 8. "Urgent Care Claim" shall mean a Claim that, due to the medical status of the

member, resolution within HPI's normal time frames would seriously jeopardize the life or health or ability to regain maximum function of a member or subject a member to severe pain that cannot be managed adequately. Only Pre-Service Claims, and not Post-Service Claims, can be Urgent Care Claims.

- B. The Grievance process does not apply to a provider's complaint concerning Claims payment, handling or reimbursement for health care services.
- C. The Grievance must be filed within two (2) years following receipt of the event giving rise to the Grievance or within two (2) years of discovering the facts giving rise to the Grievance.
- D. Member Satisfaction staff or outside review entity will assure that the routine Grievance process takes no longer than thirty (30) calendar days for Pre-Service and Post-Service Claims (no more than fifteen (15) calendar days for each stage of the Grievance). These periods may be tolled, however, for any reasonable period of time the member (or his or her Authorized Representative) may take under the Grievance process.
- E. The member (or his or her Authorized Representative) will be provided with the written or electronic notification of HPI's or outside review entity's Grievance determination on review. In the case of an Adverse Determination, the notification must set forth, in a manner calculated to be understood by the member (or his or her Authorized Representative), all of the following:
 - 1. the specific reason or reasons for the Adverse Determination.
 - 2. reference to the specific plan provisions on which the determination is based.
 - 3. a statement that the member (or his or her Authorized Representative) is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the member's Grievance. A document, records, or other information is "relevant" to a Grievance if:
 - a. it was relied upon in making the determination.
 - b. it was submitted, considered or generated in the course of reaching that determination (even if not relied upon).
 - c. it demonstrates compliance with the administrative processes and safeguards required by HPI.
 - d. it constitutes a statement of HPI's or outside review entity's policy or guidance with respect to the plan concerning the denied treatment option or benefit, regardless of whether such information was relied on in making the determination.
 - 4. a statement of the member's right to bring an action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).
 - 5. a copy or a statement that a rule, guideline or protocol was relied upon and is available upon request and free of charge.
 - 6. an explanation of the scientific or clinical judgment behind the determination, or a statement that the explanation is available upon request (if the Adverse

Determination is based on a determination of medical necessity, experimental treatment or similar exclusion or limitation).

7. identification of the title, qualifications and specialties (if applicable) of individuals whose advice was obtained on behalf of HPI without regard to whether the advice was relied upon in making the benefit determination. The individual(s) engaged for purposes of a consultation will be an individual who was not consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.
- F. Members (or their Authorized Representative) may submit written comments, documents, records, and other information relating to the Grievance.
- G. Review of the Grievance will take into account all comments, documents, records, and other information submitted by the member (or his or her Authorized Representative) relating to the Grievance, without regard to whether such information was submitted or considered in the initial Adverse Determination.
- H. Review of the Grievance will not afford deference to the initial Adverse Determination and will be conducted by an appropriate individual from HPI or outside review entity who is neither the individual who made the Adverse Determination that is the subject of the appeal nor the subordinate of such individual.
- I. In deciding a Grievance appeal (Stage II) of any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, an actively practicing practitioner from the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment in question will be consulted.
- J. At any point in time the member (or his or her Authorized Representative) may request HPI or outside review entity to delay the processing of their Grievance for a reasonable period of time. The member (or his or her Authorized Representative) may request a delay if more time is needed to obtain medical records or other information pertinent to resolving the Grievance, or if personal issues make the timing not convenient. Likewise, at any point in time, Member Satisfaction staff or outside review entity may request the member (or his or her Authorized Representative) to consent to a delay in processing their Grievance for a reasonable period of time. Irrespective of who requests a delay, the member (or his or her Authorized Representative) and Member Satisfaction staff or outside review entity shall discuss and document why a delay was requested, whether a delay was mutually agreed to or not, and how long of a delay was mutually agreed to (which will depend on the circumstances of each case). If a member (or his or her Authorized Representative) refuses to consent to a delay that is requested by Member Satisfaction staff or outside review entity in order to obtain medical records or other information pertinent to resolving the Grievance, the Grievance will be decided based on all information available at the time.
- K. The HPI Member Satisfaction Plan is available to all HPI members. The Member Satisfaction Plan will not be administered in any way that duly inhibits or hampers the initiation or processing of a Grievance (e.g., a requirement that a fee be paid as a condition to making a Grievance or appealing an Adverse Determination). The Member Satisfaction Plan will be applied consistently with respect to similarly situated members.