

# **MICHILD SUBSCRIBER CONTRACT**



## **SECTION I INTRODUCTION**

This Contract is between HealthPlus of Michigan, Inc. a nonprofit Michigan corporation operating a state-licensed and federally-qualified health maintenance organization and the Subscriber who enrolls with HPM in order to receive Health Care Benefits. By enrolling with HPM, accepting this Contract, and using the HPM Identification Card, Subscriber agrees to be bound by the terms and conditions of this Contract. Under this Contract, Covered Services must be provided by Affiliated Providers unless otherwise indicated.

## **SECTION II DEFINITIONS THE FOLLOWING DEFINITIONS SHALL APPLY TO THIS CONTRACT**

- 2.1 "Act" means Public Act 368 of 1978, Michigan Public Health Code, as amended.
- 2.2 "Acute Care Service" means the provision of highly concentrated care to patients requiring comprehensive observation, continuous monitoring, and treatment with immediate Physician intervention when necessary due to the seriousness or unstable nature of the illness or injury.
- 2.3 "Adverse Determination" shall mean an HPM determination that an admission, availability of care, continued stay, or other health care service (including the type or level of 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 notification that may be required by state or federal law.
- 2.4 "Affiliated" means, as it relates to a Hospital, Physician, or other Provider, any such Provider who has agreed in writing to provide services to Members.
- 2.5 "Application" means those documents each person must complete in order to become eligible to become a Subscriber.
- 2.6 "Appropriately Referred" means that situation when a referral is issued on behalf of a Member from that Member's Primary Care Physician to another Provider, or from a Physician to whom a Member is referred to another Provider, if such referrals are consistent with HPM's referral policy.
- 2.7 "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.
- 2.8 "Basic Care" means the provision of care to persons who may have need of assistance with the activities of daily living, visual observation of patient individual needs, maintenance of a hazard free environment, and the provision of dietary, social and emergency services.

- 2.9 "Chiropractor" 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 chiropractic medicine.
- 2.10 "Claim" shall mean any request for benefits made by a Member, or his or her Authorized Representative, that complies with HPM's procedures for making benefit claims. Claims include Pre-Service Claims, Post-Service Claims, and Urgent Care Claims.
- 2.11 "Concurrent Care Decisions" shall mean decisions affecting an ongoing course of treatment taking place over a period of time or a number of treatments.
- 2.12 "Contract" means the Application, the Identification Card, this document and any other document issued by Group or HPM that is necessary for the administration of benefits.
- 2.13 "Copayment" means the amount each Member must pay per Visit to a treating Provider or Pharmacy in connection with Health Care Benefits.
- 2.14 "Cosmetic" means to improve appearance or self-perception.
- 2.15 "Covered Services" mean a service(s) for which Health Care Benefits are available under this Contract.
- 2.16 "Dental Care" means services or procedures which concern maintenance or repair of the teeth and/or gums or are performed to prepare the mouth for dentures.
- 2.17 "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.
- 2.18 "Durable Medical Equipment" means equipment of the type approved by HPM which 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.
- 2.19 "Eligible Individual" means an individual who is determined to be eligible for membership in HPM by the Michigan Department of Community Health or its designee.
- 2.20 "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.
- 2.21 "Expedited Grievance" shall mean a Grievance for Urgent Care Claims.
- 2.22 "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 HPM.
- 2.23 "Freestanding Emergency Center" means a facility which 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.
- 2.24 "Grievance" shall mean 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. the reduction, suspension, or termination of a previously authorized service;
  - D. payment (including denial, in whole or in part, of payment of a properly authorized and Covered Service), handling or reimbursement for health care services;
  - E. the failure to provide services in a timely manner;
  - F. the failure of HPM to act within the established timeframes for Grievance disposition;
  - G. matters pertaining to the contractual relationship between a Member and HPM; or
  - H. an expression of dissatisfaction about any matter.
- 2.25 "Group" means the legal entity which has contracted with HPM for Health Care Benefits for Subscribers and Dependents. Under this Contract, the legal entity is the State of Michigan, for and on behalf of the Michigan Department of Community Health.
- 2.26 "Health Care Benefits" mean the benefits provided by this Contract for health care services rendered to Members.
- 2.27 "Hearing Aid" means an electronic device of the type approved by HPM 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.
- 2.28 "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 is approved to provide home health services.
- 2.29 "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.
- 2.30 "Hospital" means a facility offering inpatient, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily direction or supervision of a Physician. Hospital does not include a mental health hospital licensed or operated by the Department of Community Health or a hospital operated by the Department of Corrections.
- 2.31 "HPM" means HealthPlus of Michigan, Inc., a nonprofit Michigan corporation with its principal office located at 2050 South Linden Road, Flint, Michigan 48532.
- 2.32 "HPM Formulary" means a list of selected or preferred drug products and supplies available to a Member pursuant to relevant HPM organizational policies and procedures.
- 2.33 "Identification Card" means the card issued to a Subscriber.
- 2.34 "Insurance Code" means Public Act 218 of 1956, as amended.
- 2.35 "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.
- 2.36 "IRO" means Independent Review Organization.
- 2.37 "Medically Necessary" means services or supplies provided to Members that are medically required and appropriate to diagnose and 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 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 a Member on an outpatient basis.

- 2.38 "Medicare" means Title XVIII of the Social Security Act and all amendments thereto.
- 2.39 "Member" means the Subscriber covered under this Contract.
- 2.40 "Michigan Department of Community Health" means the state agency responsible for administering the MICHild Program.
- 2.41 "MICHild" means a health and dental insurance program using funds authorized under Title XXI of the Social Security Act to furnish health and dental coverage to low income children.
- 2.42 "Non-Affiliated" or "Non-Plan" means, as it relates to a Hospital, Physician, or other Provider, any such Provider who has not agreed in writing to provide services to Members.
- 2.43 "OFIR" means Office of Financial and Insurance Regulation.
- 2.44 "Orthotic Appliance" means an apparatus of the type approved by HPM which is used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.
- 2.45 "Personal Health Information" includes medical information (i.e., claims, referrals, health assessments, etc.) and other administrative data (i.e., names, addresses, social security numbers, etc.) that are personally identifiable.
- 2.46 "Pharmacy" means a business licensed under the Act or similar licensing statute or law of its governing state or governmental unit to engage in the practice of pharmacy.
- 2.47 "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.
- 2.48 "Plan Physician" means any Physician who has entered into a written contract to provide services to Members.
- 2.49 "Post-Service Claim" shall mean any Claim that is not a Pre-Service Claim.
- 2.50 "Practitioner" means a licensed professional who provides health care services.
- 2.51 "Pre-Service Claim" shall mean any Claim that, under the terms of the Member's Subscriber Contract, must be approved (either in whole or in part) before medical care is obtained.
- 2.52 "Prescription Drug" means any medicinal substance that is approved by HPM and the original packaging of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription," or which is designated by the State Board of Pharmacy as one which may only be dispensed pursuant to a prescription for the Member's personal use.
- 2.53 "Prevalent Language" means a non-English language spoken by a significant number or percentage of Members or potential Members in the state.
- 2.54 "Primary Care Physician" means a Plan Physician who is both selected by a Member to provide his/her care and is designated and recorded by HPM as providing primary care services.
- 2.55 "Prosthetic Device" means a device of the type approved by HPM that replaces all or a 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.

- 2.56 "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.
- 2.57 "Reasonable Charge" means the lesser of the treating Provider's charge or the amount determined to be a fair charge by HPM in comparison to charges of other Providers in the same geographic region.
- 2.58 "Reconstructive" means to effect a substantial improvement or restoration of bodily function or to correct deformities resulting from disease, injury, or congenital or developmental abnormalities.
- 2.59 "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 at least nine (9) months and shall be evidenced by notice of voter registration, driver's license address, or other such verification.
- 2.60 "Semi-Private Room" means a room containing two (2) or more patient beds in an inpatient facility.
- 2.61 "Service Area" means the geographic area in which HPM is authorized by regulating agencies to provide Health Care Benefits to Members.
- 2.62 "Short-Term" means service for a condition that HPM determines can be expected to significantly improve within a period of sixty (60) days.
- 2.63 "Skilled 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.
- 2.64 "Skilled Nursing Facility" means a facility licensed to provide Skilled Care in accordance with the Act or other similar licensing statute of its governing state or governmental unit.
- 2.65 "Specialist Physician" means a Plan or Non-Plan Physician to whom a member is Appropriately Referred.
- 2.66 "Subscriber" means the Eligible Individual so designated in the Application.
- 2.67 "Urgent Care Claim" shall mean a Claim that, due to the medical status of the Member, resolution within HPM'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.
- 2.68 "Visit" means a meeting between a Member and Provider for the purpose of rendering Covered Services, without regard to the frequency of meetings if each such meeting is separated by any period of time.

**SECTION III  
ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE**

**3.1 ELIGIBILITY**

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

1. be an Eligible Individual according to the eligibility requirements for the MICHild Program as set forth by the Michigan Department of Community Health or its designee;
2. reside in the Service Area;
3. complete the enrollment process as defined by the Michigan Department of Community Health or its designee; and

4. meet any other specific eligibility criteria specified by HPM or the Michigan Department of Community Health or its designee, including payment of MICHild premiums.

### 3.2 **INELIGIBILITY**

- A. If a Member covered under this Contract loses his/her eligibility under the MICHild Program, he/she is no longer eligible for Health Care Benefits under this Contract.
- B. In all cases, final determination of eligibility will be determined by the Michigan Department of Community Health or its designee.

### 3.3 **ENROLLMENT AND EFFECTIVE DATE OF COVERAGE**

- A. Eligible Individuals may enroll by completing the enrollment process at the times specified by the Michigan Department of Community Health or its designee.
- B. All eligible, enrolled Members will be covered under this Contract on the date agreed upon between the Michigan Department of Community Health and HPM, which date shall be referred to as the Effective Date of Coverage.
- C. A Member will be notified in writing by HPM of the Effective Date of Coverage.
- D. A Member is not eligible for services under this Contract until the Effective Date of Coverage.
- E. A Member shall have the first ninety (90) calendar days from the Effective Date of Coverage to enroll with another health care organization.

## **SECTION IV COORDINATION OF BENEFITS AND SUBROGATION**

### 4.1 **COORDINATION OF BENEFITS**

- A. If a Member entitled to Health Care Benefits under this Contract is also entitled to benefits under any other private or public health benefit plan or insurance policy, including automobile insurance, benefits shall not be available under this Contract, whether a claim is made for same, until the benefits of the other health benefit plan or insurance policy are exhausted. However, HPM 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 and controlling law.
- B. In no event shall any Member through coordination of two (2) or more health plans or insurance policies recover more than the actual or reasonable expenses for all services provided to that Member.

### 4.2 **SUBROGATION**

If a Member receives benefits from HPM under any of the following circumstances, HPM will hold a lien against and be otherwise subrogated to the rights of the Member (or legal representative) to the extent of benefits paid by HPM:

- A. Services for which benefits are available under any other public or private health plan or insurance (including but not limited to automobile, home-owners, or business insurance) for which HPM 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.

#### 4.3 **MEMBER CONSENT**

Accepting Health Care Benefits from HPM automatically assigns to it any rights a Member has to recover payment from a third party. Member consents to the release to and from HPM or its designee of all claims and other information necessary to exercise HPM's coordination and subrogation rights and agrees to execute all documents necessary for HPM to exercise said rights. Member agrees to take no action legal or otherwise which would lessen or diminish HPM's coordination and subrogation rights.

Member consents to HPM bringing suit against any third party to protect HPM's subrogation rights. HPM'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 HPM be fully reimbursed for Health Care Benefits it has paid on the Member's behalf whether or not the amount he or she recovers compensates him or her in full for the entire amount of his or her claimed loss. HPM 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 HPM, prior to 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 HPM.

### **SECTION V MEMBERS RIGHTS AND RESPONSIBILITIES**

#### 5.1 **RIGHTS**

In addition to the rights and benefits conferred by the other terms of this Contract, Members shall have the following specific rights:

- A. Each adult Subscriber shall have the right, on a yearly basis, to vote for the election of members to the HPM Board of Directors.

In addition, at least one-third (1/3) of the members of HPM's Board of Directors must be adult Members who are not compensated officers or employees, or others responsible for the conduct of, or financially interested in, HPM's affairs.

- B. Each Subscriber shall receive periodic HPM newsletters providing information concerning voting rights, current benefits and policies, maintaining and improving health, and other items of general interest.
- C. A Member may change his/her selection of Primary Care Physician upon notice to HPM. Changes will be effective on the first day of the month following notice.
- D. Members and potential Members have the right to oral interpretation services for any language and written information for Prevalent Languages. Information may also be available in alternate formats. Members should contact HPM's Customer Service Department to access these services or information.
- E. Members have a right to file a Grievance (See Section 5.3).

#### 5.2 **RESPONSIBILITIES**

In addition to the Member responsibilities which exist under the other terms of this Contract, Members shall have the following duties:

- A. A Member must select a Primary Care Physician upon enrolling with HPM or immediately upon discharge of his/her previous Primary Care Physician. A Member always retains the right to change the Primary Care Physician at any time.

- B. A Member shall notify HPM within twenty-four (24) hours of any emergency admission or admission to a Non-Affiliated Hospital.
- C. A Member shall notify HPM and the Michigan Department of Community Health or its designee of any change in name, address, marital status, dependency status, or any other criteria of eligibility within thirty (30) days of the change.
- D. A Member shall immediately notify HPM, in writing, of any loss or theft of his/her Identification Card.
- E. 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 HPM Member.
- F. 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, Health Care Benefits shall not be extended by this Contract for the condition under treatment.
- G. A Member shall be responsible for all services rendered prior to his/her Effective Date of Coverage and following the Effective Date of Termination. HPM shall be entitled to recover from the Subscriber all claims payments made by HPM for services rendered to the Subscriber after the Effective Date of Termination.
- H. A Member shall be responsible for payment of all services which are not Covered Services.
- I. A Member shall execute any and all releases necessary in order for HPM or its designee to gain access to the Member's medical records.

### 5.3 MEMBER SATISFACTION PLAN

- A. When Members have questions or problems, they can call the Customer Service Department at 1-800-332-9161 (TDD: 1-800-992-5070). Customer Service staff will document and date the source of all Member contacts. Most inquiries can be resolved within two (2) working days.

HPM will provide Members reasonable assistance in completing forms and taking other procedural steps.

If Members are not happy with any aspect of HPM's operations or benefits, and cannot resolve their concerns with the Customer Service Department, Members or their Authorized Representative can use the Member Satisfaction Plan.

#### 1. Routine Grievance

The Member Satisfaction Plan has two internal steps for routine grievances: Grievance and Grievance Appeal. HPM has thirty (30) calendar days to complete these two (2) steps, but can extend the time by up to ten (10) working days if a Member allows. Here is how to use each of the steps:

##### a. Step One: Grievance

Members can initiate this process by contacting HPM by phone (1-800-332-9161), mail (2050 S. Linden Road, P.O. Box 1700, Flint, Michigan, 48501-1700), fax (1-810-733-1947), or arranging a personal meeting. HPM will use its best efforts to respond in writing to Members' Grievances within fifteen (15) calendar days of receiving it. At that time, Members will be informed of HPM's investigation into the Grievance, any action taken, and information

regarding the Member Satisfaction Plan, including the Member's rights to further review if the Grievance was not resolved in their favor.

b. Step Two: Grievance Appeal

A Member dissatisfied with the outcome of a Grievance may appeal it within five (5) calendar days following notification of the decision. HPM staff will schedule a meeting of the Grievance Appeal Committee within thirteen (13) calendar days of receipt of a Member's request to appeal a Grievance.

Members have the opportunity to appear and speak before the Grievance Appeal Committee with or without representation. If a Member cannot appear in person, he or she may also have the option of speaking by telephone or other appropriate technology.

Members will receive notification of the Grievance Appeal Committee's decision within two (2) calendar days of the meeting. This will be HPM's final decision on the Grievance. Members will be advised of their right to further appeal to the State of Michigan, OFIR.

c. External Review

If Members have exhausted their rights under the HPM Member Satisfaction Plan, or if they have not received a response from HPM at the end of fifteen (15) calendar days from filing their appeal under Step Two: Grievance Appeal, they can appeal to OFIR at no cost to the Member by writing or calling:

State of Michigan, OFIR, Health Plans Division, Appeals Section, 611 W. Ottawa, P.O. Box 30220, Lansing, Michigan 48909-7720 or call 1-517-373-0220 or 1-877-999-6442 (toll free).

By submitting a request for external review, Members are authorizing HPM and the Member's health care Providers to disclose their Personal Health Information, including medical records which are relevant to the review process.

If the final decision of HPM was an Adverse Determination, a Member must file his or her request for external review with OFIR within sixty (60) calendar days following receipt of HPM's final decision.

If a Member's request for external review of an Adverse Determination is found to be appropriate for external review, the Commissioner of OFIR will either review the case or assign the case to an IRO, made up of independent clinical reviewers, to review the case. Both HPM and the Member will have an opportunity to provide the IRO with supporting documentation. Within fourteen (14) calendar days, a recommendation will be made to the Commissioner to uphold or reverse HPM's determination. The Commissioner has seven (7) working days to make a decision.

If a Member's request for external review does not involve an Adverse Determination, but is found to be appropriate for external review, the Commissioner will assign his or her staff to review the case. Within fourteen (14) calendar days, the Commissioner will make a decision.

## B. Expedited Grievance

### 1. HPM Review

An Expedited Grievance process may be utilized for Urgent Care Claims. Members may only request an Expedited Grievance when HPM has denied the request for benefits prior to the Member having received a service.

HPM will determine whether an Expedited Grievance is warranted based on the particular facts and circumstances of each request. In making such a determination, HPM will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, HPM will consult with 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. If an Expedited Grievance is not warranted, the routine Grievance process will be followed.

HPM will make a determination concerning the Expedited Grievance and communicate that to the Member and his/her Physician as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after receipt. The Member and his/her Physician will be provided with written confirmation of this determination within two (2) working days or three (3) calendar days, whichever is less, following the oral notification.

### 2. External Review

A request for a further expedited review may be forwarded to OFIR at no cost to the Member within ten (10) calendar days of the Member filing an Expedited Grievance with HPM.

The Member may write or call OFIR at the following address and telephone number: State of Michigan, OFIR, Health Plans Division, Appeals Section, 611 W. Ottawa, P.O. Box 30220, Lansing, Michigan 48909-7720 or call 1-517-373-0220 or 1-877-999-6442 (toll free).

By submitting a request for external review, Members are authorizing HPM and the Member's health care Providers to disclose their Personal Health Information, including medical records which are relevant to the review process.

If a Physician believes that due to the Member's medical condition, resolution of the Expedited Grievance within HPM's time frames for an Expedited Grievance would seriously jeopardize the Member's life, health or ability to regain maximum function or subject a Member to severe pain that cannot be managed adequately, and the Member has filed a request for an Expedited Grievance with HPM, the Member may request an expedited external review from OFIR.

Upon receipt of a Member's request, the Commissioner will immediately decide if it is appropriate for external review and, if so, assign it to an IRO. If the IRO decides that a Member does not have to first complete the HPM Expedited Grievance process, it will review the Member's case and make a recommendation to the Commissioner within thirty-six (36) hours to uphold or reverse HPM's determination. The Commissioner has twenty-four (24) hours to make a decision.

## C. Initial Claim Decisions

### 1. Time Frame for Decisions

a. For Urgent Care Claims, HPM will notify the Member of its initial decision on the Claim as soon as possible, but no later than one (1) calendar day after

making the decision. If the Member seeks review of an Urgent Care Claim decision, the Member will be instructed to file an Expedited Grievance using the Member Satisfaction Plan.

- b. For Pre-Service Claims, HPM will notify the Member of its initial Claim decision within a reasonable time appropriate to medical circumstances but not later than fourteen (14) calendar days after receiving the Claim. If a Member seeks review of a Pre-Service Claim decision, the Member will be instructed to file a Grievance using the Member Satisfaction Plan.
- c. For Post-Service Claims, HPM will provide notice of its initial decision within a reasonable time, but not later than thirty (30) calendar days after receiving the Claim. (This time frame requirement concerns the decision of the Claims only and not the time frame for payment.)
- d. Concurrent Care Decisions may be subject to special time frames. Concurrent Care Decisions are those affecting an ongoing course of treatment that will take place over a period of time or a number of treatments. For Concurrent Care Decisions regarding inpatient, intensive outpatient behavioral health and residential behavioral health, HPM will make the decision within one (1) calendar day. HPM will notify Members within two (2) working days of making the decision. For Concurrent Care Decisions regarding ongoing ambulatory care, HPM will notify Members within eleven (11) working days of making the decision. HPM's decision to reduce or terminate the course of treatment is treated as an Adverse Determination subject to review, and HPM must give notice of the decision early enough to allow the Member receiving the treatment to request a review and receive a review decision before the reduction or termination occurs.

A Member's request to extend a course of treatment may involve an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim (depending on the type of treatment and other circumstances). If the request involves an Urgent Care Claim, HPM will notify the recipient of its Concurrent Care Decision within twenty-four (24) hours, provided that the request is made at least twenty-four (24) hours before the course of treatment expires. If the request involves a Pre-Service or Post-Service Claim, it is subject to the time frame for other Claims of the same type.

- e. For termination, suspension or reduction of a previously authorized Covered Service, HPM will provide notice of its decision generally within ten (10) days before the action is taken. Exceptions to this ten (10) day advance notice requirement include:
  - (1) Factual information confirming the death of the Member;
  - (2) The Member's whereabouts are unknown and the mail directed to him/her is returned with no forwarding address; or
  - (3) A change in the level of medical care has been prescribed by the Member's Physician.

## 2. Extensions

- a. For Pre-Service Claims and Post-Service Claims, if HPM determines that, for reasons beyond the control of HPM, an extension is necessary to reach an initial Claim decision, a single fifteen (15) day extension is permitted. To use the extension, HPM will notify the Member (by the date in which notice of the initial decision would normally be due) of the circumstances that require the extension and the date by which HPM expects to reach a decision. If the

extension is necessary because the Member fails to provide information that HPM requires to reach a decision, the notice will specifically describe the missing information and HPM will allow the Member at least forty-five (45) days to provide the information. The time frames begin to run from receipt of the Claim, even if the Claim is incomplete. The time period for notice of the initial decision is tolled, however, from the time the notice of the extension is sent to the Member until the Member responds to the request for additional information. HPM may not further extend the time for making its decision unless the Member agrees to a further extension.

- b. Extensions are not permitted for decisions on Urgent Care Claims.
3. Notice of Incomplete Claims or Improper Filing
- a. HPM will notify a Member who has failed to submit an Urgent Care or Pre-Service Claim properly. The notice will describe the failure and the proper procedures to be followed. It will be provided as soon as possible but not later than five (5) calendar days after the failure occurs (twenty-four (24) hours in the case of an Urgent Care Claim).
  - b. For an Urgent Care Claim, HPM will also notify the Member if the Claim is incomplete. This notice will be provided as soon as possible but not later than twenty-four (24) hours after receiving the Claim. The notice will identify the specific information necessary to complete the Claim. HPM will allow the Member at least forty-eight (48) hours to provide the information described in the notice. HPM will also notify the Member of its decision within forty-eight (48) hours of the time that the Member provides the information or the period for doing so expires, whichever comes first.
  - c. HPM is not required to notify Members who have submitted Post-Service Claims improperly.
4. Manner and Content of Notification of Adverse Determination. Members will be provided with written or electronic notification of any initial Adverse Determination. The notification will set forth, in a manner calculated to be understood by the Member, all of the following:
- a. the action HPM has taken or intends to take.
  - b. the specific reason or reasons for the Adverse Determination.
  - c. reference to the specific plan provisions on which the determination is based.
  - d. a description of any additional material or information necessary for the Member to perfect the Claim and any explanation of why such material or information is necessary.
  - e. a description of HPM's Member Satisfaction Plan for filing a Grievance and the time limits applicable to such procedures.
  - f. a copy or a statement that a rule, guideline or protocol was relied upon and is available upon request and free of charge (if an internal rule, guideline or protocol was relied upon in reaching an Adverse Determination).
  - g. an explanation of the scientific or clinical judgment behind the determination, or a statement that the explanation is available upon request (if the adverse decision is based on a determination of medical necessity, Experimental treatment or similar exclusion or limitation).

- h. a description of the expedited review process (contained in the Member Satisfaction Plan) applicable to the Claim (for Urgent Care Claims).
- i. the Member's right to have benefits continue pending resolution of the Grievance, how to request that benefits be continued, and the circumstances under which the Member may be required to pay for costs of these services.

D. Obtaining Appropriate Referral and/or Prior Authorization

- 1. If the Member's Primary Care Physician determines that the Member requires additional care, the Primary Care Physician will initiate the appropriate referral process. The Member will receive either written notification from HPM, or a referral from the Primary Care Physician, which will specify the number of visits and the length of time covered by the referral. If the referral expires and the Member needs additional visits, the Member should contact his/her Primary Care Physician.
- 2. If the Provider to whom the Primary Care Physician is referring the Member does not participate with HPM (i.e., a Non-Affiliated Provider), the Primary Care Physician will initiate the out-of-plan referral process. Only services approved by HPM prior to visiting a Non-Affiliated Provider will be covered. The Member will receive a decision in writing, usually within five (5) to seven (7) working days from the time the referral is received by HPM. If the referral to the Non-Affiliated Provider is not approved, HPM will explain the reason for the denial.
- 3. Primary Care Physicians know that certain procedures or items require prior authorization by HPM. If a Member has further questions regarding this issue, the Member should talk with his/her Primary Care Physician or call HPM Customer Service.

E. Other Procedural Information Regarding Review of Claim Decisions and the Member Satisfaction Plan.

- 1. The Grievance process does not apply to a Provider's complaint concerning Claims payment, handling or reimbursement for health care services.
- 2. The Grievance must be filed within ninety (90) calendar days following the date of receipt of the notice of Adverse Determination.
- 3. The Member will be provided with the written or electronic notification of HPM's final determination. In the case of a final Adverse Determination, the notification must set forth, in a manner calculated to be understood by the Member, all of the following:
  - a. the specific reason or reasons for the Adverse Determination.
  - b. reference to the specific plan provisions on which the determination is based.
  - c. a statement that the Member 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 Claim for benefits.
  - d. a copy or a statement that a rule, guideline or protocol was relied upon and is available upon request and free of charge (if an internal rule, guideline or protocol was relied upon in reaching an Adverse Determination).
  - e. 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).

4. Members may submit written comments, documents, records, and other information relating to the Claim or Grievance.
5. Review of the Claim or Grievance will take into account all comments, documents, records, and other information submitted by the Member relating to the Claim or Grievance, without regard to whether such information was submitted or considered in the initial Adverse Determination.
6. The original Physician or Practitioner who made the denial 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.
7. Review of the Grievance will not afford deference to the initial Adverse Determination and will be conducted by an appropriate named employee of HPM who is neither the individual who made the Adverse Determination that is the subject of the appeal nor the subordinate of such individual.
8. In deciding an appeal 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, the appropriate named HPM employee will consult with 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.
9. Identification of the title and qualifications of individuals whose advice was obtained on behalf of HPM in connection with a Member's Adverse Determination will be provided to the Member upon request, 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.
10. At any point in time the Member may request HPM to delay the processing of their Claim or Grievance for up to ten (10) working days. The Member may request a delay if more time is needed to obtain medical records or other information pertinent to resolving the Claim or Grievance, or if personal issues make the timing not convenient for the Member. Likewise, at any point in time, Member Satisfaction staff may request the Member to consent to a delay in processing their Grievance for up to ten (10) working days if HPM can show that there is a need for additional information and the delay is in the Member's interest. Irrespective of who requests a delay, the Member and Member Satisfaction staff 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 refuses to consent to a delay that is requested by Member Satisfaction staff 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.
11. Claims determinations and the Member Satisfaction Plan will not be administered in any way that duly inhibits or hampers the initiation or processing of a Claim or filing a Grievance (e.g., a requirement that a fee be paid as a condition to making a Grievance or appealing an Adverse Determination). Claims determinations and the Member Satisfaction Plan will be applied consistently with respect to similarly situated Members.
12. If the Member requests, Health Care Benefits will continue if the Member files an appeal within the required timeframes. However, the Member may be required to pay the cost of services furnished while the appeal is pending if the final decision is not in the Member's favor.

13. If the final resolution of the Grievance is adverse to the Member, HPM may recover the cost of the services furnished to the Member while the appeal is pending, to the extent that they were furnished solely because of state or federal requirements.
14. HPM will continue benefits pending resolution of a Grievance filed with HPM if the following five (5) conditions are met:
  - a. the Member, or his/her Authorized Representative, filed the Grievance timely (within ten (10) days of HPM mailing the notice of the Adverse Determination);
  - b. the Grievance involves termination, suspension or reduction of a previously authorized course of treatment;
  - c. the services were ordered by an Plan Provider;
  - d. the original period covered by the original Appropriate Referral has not expired; and
  - e. the Member requests the extension of benefits.
15. The benefits will continue under paragraph 14 above until one of the following occurs:
  - a. the Member withdraws the appeal;
  - b. ten (10) days pass after HPM mails the notice, providing resolution of the appeal against the Member; or
  - c. the time period or service limits of a previously authorized service have been met.

F. **Statement of Rights Under the Newborns' and Mothers' Health Protection Act.**

Under federal law, group health plans and health insurance issuers (including health maintenance organizations) 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 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., your Physician), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 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 plan or issuer may not require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

**5.4 TERMINATION OF A PROVIDER'S PARTICIPATION**

A Plan Provider (or the Provider's network) may choose to terminate his/her (its) contract or arrangement with HPM. Therefore, HPM cannot guarantee that a given Plan Provider will be available to treat a Member during the entire time the Member is covered by HPM. If a Plan Provider informs a Member that the Provider will no longer be contracting with HPM, the Member should contact HPM's Customer Service Department (at 1-800-332-9161) as soon as possible. If a Plan Provider terminates his/her contract or arrangement with HPM, a Member receiving services from the terminating Provider will be

required to select a different Plan Provider. However, a Member who is undergoing an ongoing course of treatment with the terminating Plan Provider may be eligible to continue to be treated by this Provider if:

- A. The Provider is not leaving HPM's network because of failing to meet HPM'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 HPM;
- D. The Provider agrees to continue to meet HPM's quality standards and comply with HPM's policies and procedures; and
- E. The Provider agrees to accept, as payment in full, reimbursement from HPM 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 HPM's 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.

## **SECTION VI RECORDS**

### **6.1 MEMBERSHIP RECORDS**

HPM shall keep records concerning eligibility and claims paid on behalf of Members for a reasonable period of time. Members and/or Group shall forward information periodically as required by HPM in connection with the administration of this Contract.

### **6.2 INSPECTION OF RECORDS BY MEMBER**

Any Member may review his/her own records at the offices of HPM during regular business hours. An appointment for this purpose shall be required.

### **6.3 ACCURACY OF INFORMATION**

HPM shall not be liable for the inaccuracy of any retained information furnished by the Member or Group. Incorrect information furnished to HPM may be corrected by a Member if HPM has not acted to its prejudice by relying on it.

### **6.4 CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION**

Members should refer to HPM's Privacy Notice (mailed to Members upon enrollment and annually thereafter) for a description of how personal and medical information about Members may be used and disclosed and how Members can get access to this information.

## **SECTION VII TERMINATION OF COVERAGE**

### **7.1 TERMINATION**

- A. Coverage under this Contract ends immediately when a Member is no longer eligible for services under the MICHild Program in accordance with the terms of this Contract or the contract between HPM and the Michigan Department of Community Health or as otherwise determined by the Michigan Department of Community Health or its designee.

If a Member is receiving inpatient Hospital services on the Effective Date of Termination, Hospital benefits shall continue for the condition under treatment until the date of discharge from the Hospital.

### **7.2 DISENROLLMENT**

- A. If a Member wishes to disenroll, he/she must follow the procedures set forth by the Michigan Department of Community Health or its designee. Disenrollment information is available upon request from the HPM Customer Service Department and the Michigan Department of Community Health or its designee.

- B. All rights to Health Care Benefits cease as of the effective date of disenrollment without prejudice to any current claims. The disenrollment date will be determined by the Michigan Department of Community Health or its designee. The Member will be notified of said date in writing.

If a Member is receiving inpatient Hospital services on the Effective Date of Termination, Hospital benefits shall continue for the condition under treatment until the date of discharge from the Hospital.

- C. If the contract between HPM and the Michigan Department of Community Health pursuant to which this Contract is issued is terminated, Members will be assisted in applying for another comparable program, if available.

### **7.3 DISENROLLMENT FOR CAUSE**

- A. HPM may disenroll a Member on the date specified by HPM, with the consent of the Michigan Department of Community Health, for the following reasons:

1. if the Member fails to meet any eligibility requirement for participation in HPM or the MICHild Program according to the Michigan Department of Community Health or its designee, including non-payment of MICHild premiums.
2. for willingly and knowingly providing false or misleading information or withholding material information on the Application.
3. for permitting the use or misuse of the HPM Identification Card by any other person, or if the Member uses another person's Identification Card.
4. if the Member's behavior is disruptive, unruly, abusive, or uncooperative to HPM personnel, Affiliated Providers, other providers, or other Members.
5. if after reasonable effort, the Member and the Primary Care Physician are unable to establish and/or maintain a satisfactory provider/patient relationship.
6. if a Member obtains or attempts to obtain Health Care Benefits fraudulently.

7. if the Member no longer Resides in the Service Area.
8. if the Member breaches any term or condition of the Contract.

#### 7.4 **EFFECTIVE DATE OF TERMINATION**

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

### **SECTION VIII COVERED SERVICES**

The services and benefits described in this Section VIII are offered in accordance with HPM's policies and procedures for benefit administration. Except for Emergency Health Services and except as otherwise provided below, coverage under this Contract is only available for those services and benefits authorized in advance by the Member's Primary Care Physician and/or HPM in accordance with all HPM policies and procedures. Only services that are Medically Necessary according to generally accepted standards of practice as determined by an HPM Medical Director (but, as always, subject to the Member Satisfaction Plan as provided in Section 5.3) are Covered Services under this Contract. There are no fees, Copayments, or deductibles for Covered Services under this Contract.

Subject to the Limitations and Exclusions of Section IX, Covered Services include:

#### 8.1 **PHYSICIAN SERVICES** (other than Mental Health Services) provided by, or under the direction of, the Member's Primary Care Physician, or provided by a Specialist Physician to whom the Member is Appropriately Referred, including:

- A. Office, nursing home, and clinic visits and consultations for diagnosis and treatment of an injury, illness or disease.
- B. Periodic routine physical examinations or health assessments by the Member's Primary Care Physician.
- C. Pediatric care, including well-child care, and diagnosis and treatment of illness and injury.
- D. Home Visits.
- E. Pediatric and adult immunizations in accordance with accepted medical practice.
- F. Professional services by Specialist Physicians.
- G. Routine maternity care, delivery, postpartum, miscarriage, and other related routine obstetrical services (when provided by a Physician, or a Certified Nurse Midwife who has an interdependent and formal relationship established for the supervision, consultation, collaboration and referral to an obstetrician/gynecologist in the event that further and/or immediate medical attention is required).
- H. Routine Papanicolaou (PAP) test once every twelve (12) consecutive months.
- I. Dermatology services.
- J. Hospital and Skilled Nursing Facility Visits as part of continued supervision of covered care.
- K. Allergy services, including allergy survey, allergy testing, allergy serum, and injections of allergy serum.
- L. Second surgical opinion consultations.
- M. Cataract surgery and first lens implant(s).

- N. Technical surgical assistance when an intern, resident, or house officer is not available or qualified.
- O. Communicable disease services.
- P. Peritoneal Dialysis services.
- Q. Midwife services.

8.2 **HOSPITAL SERVICES** (excluding Mental Health Services and Substance Abuse Services) when provided by an Affiliated Hospital, when authorized by HPM and when under the direction of the Member's Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred, including:

- A. Inpatient services (up to 365 days per benefit year), including:
  - 1. Semi-Private Room and board accommodations.
  - 2. General nursing services.
  - 3. Therapeutic and support care, services, supplies, and appliances.
  - 4. Delivery rooms and birthing center services.
  - 5. Care in specialized units.
  - 6. Use of operating, recovery, and treatment rooms and equipment.
  - 7. Laboratory tests, pathology exams, X-rays, EKGs, CAT, MRI, MRA, PET scans, and other diagnostic tests performed in conjunction with, or following, admission to the Hospital.
  - 8. Anesthetics, drugs, solutions, and other biologicals.
  - 9. Oxygen and other gas therapies.
  - 10. Dressings, casts, and special equipment when supplied by the Hospital for use in the Hospital.
  - 11. Special diets and meals.
  - 12. Chemotherapy for malignant and non-malignant disease.
  - 13. Radiation, inhalation, and physical therapies.
  - 14. Medical rehabilitation, including Short-Term rehabilitation services and Short-Term physical, occupational, and speech therapies.
  - 15. Routine nursery care of the newborn when the mother is eligible for maternity care.
  - 16. Administration of whole blood and blood derivatives.
- B. Outpatient services, including:
  - 1. Surgery.
  - 2. Use of operating, delivery, recovery, and treatment rooms and equipment.

3. Laboratory tests, X-rays, EKGs, CAT, MRI, MRA, PET scans, and other diagnostic tests.
4. Anesthetics, oxygen, drugs, and other biologicals.
5. Dressings, casts, and special equipment.
6. Therapeutic and support care, services, supplies, and appliances.
7. Chemotherapy.
8. Hemodialysis, including peritoneal services.
9. Radiation, inhalation, and physical therapies.
10. Medical rehabilitation, including Short-Term rehabilitation services and Short-Term physical, occupational, and speech therapies.
11. Special hospital programs including home hemophilia and hemodialysis.
12. Administration of whole blood and blood derivatives.

8.3 **EMERGENCY HEALTH SERVICES**, including:

- A. Hospital Emergency Room (in or out of the Service Area).
- B. Freestanding Emergency Center (in or out of the Service Area).
- C. Physician services when billed separately from facility charges.

If a Member needs Emergency Health Services and is unable to get to an Affiliated Hospital or freestanding emergency center, he or she should proceed to the nearest emergency facility. HPM will pay for such services, except HPM 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.

8.4 **PREVENTIVE HEALTH SERVICES** provided to a Member by, or under the direction of, the Member's Primary Care Physician or provided by a Specialist Physician to whom the Member is Appropriately Referred, including:

- A. Periodic routine physical examinations or health assessments by the Member's Primary Care Physician, including hearing and vision screening as a preventive and early detection mechanism.
- B. Pediatric and adult immunizations in accordance with accepted medical practice.
- C. Prenatal care, post partum care, and counseling.
- D. Health education and health counseling services.
- E. Blood lead screening.

8.5 **DIAGNOSTIC LABORATORY SERVICES** (other than provided in a Hospital) when provided by Affiliated laboratories, when ordered and/or authorized in advance by the Member's Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred and/or HPM, and when said services are in support of other Health Care Benefits set forth in this Contract.

- 8.6 **DIAGNOSTIC AND THERAPEUTIC RADIOLOGICAL SERVICES** (other than provided in a Hospital) when provided by Affiliated Providers, when ordered and/or authorized in advance by the Member's Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred and/or HPM or its designee, and when said services are in support of other Health Care Benefits set forth in this Contract, including:
- A. Electrocardiograms.
  - B. Electroencephalograms.
  - C. Diagnostic X-rays.
  - D. Radiation therapy.
  - E. Breast cancer screening mammograms in accordance with Section 3406d of the Insurance Code.
  - F. Other medically acceptable diagnostic or therapeutic procedures.
- 8.7 **SKILLED NURSING FACILITY SERVICES** are covered up to one hundred twenty (120) days per admission in an Affiliated Skilled Nursing Facility while convalescing from general conditions and pulmonary tuberculosis. After all benefit days have been exhausted, they are renewed when there has been a lapse of at least ninety (90) days.
- 8.8 **SHORT-TERM MEDICAL REHABILITATION SERVICES** are covered for a combined maximum of sixty (60) visits per calendar year when provided on an outpatient basis by Affiliated Providers, and when authorized in advance by the Member's Primary Care Physician and/or HPM, including Short-Term rehabilitation and Short-Term physical, occupational, and speech therapies.
- 8.9 **HOME HEALTH SERVICES** when provided in the Member's home by Affiliated Providers, when the Member is confined to home, and when authorized in advance by the Member's Primary Care Physician and/or HPM for a Skilled level of Care for one hundred twenty (120) days per calendar year, including:
- A. Intermittent Skilled Nursing Care.
  - B. Short-Term physical, speech and occupational therapy.
  - C. Part-time health aide services.
  - D. Medical and surgical supplies.
  - E. Oxygen, laboratory services and drugs.
  - F. Nutritional guidance and social service.
- 8.10 **AMBULANCE SERVICES**
- Authorized emergency vehicle and personnel which provide Emergency Health Services and transportation to a Provider where Emergency Health Services and treatment can be rendered. Any other use of ambulance services requires authorization in advance by the Member's Primary Care Physician and/or HPM. Any other use of ambulance services, including trips to or from the hospital, Skilled Nursing Facility or Member's home, requires authorization in advance by the Member's Primary Care Physician and/or HPM.
- 8.11 **DURABLE MEDICAL EQUIPMENT** when obtained from Affiliated Providers or suppliers, when determined by HPM to be an eligible item (but, as always, subject to the Member Satisfaction Plan as provided in Section 5.3) and when ordered and/or authorized in advance by the Member's Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred and/or HPM.

8.12 **PROSTHETIC DEVICES AND ORTHOTIC APPLIANCES** (including orthopedic shoe inserts), when obtained from Affiliated Providers or suppliers, when determined by HPM to be an eligible item (but, as always, subject to the Member Satisfaction Plan as provided in Section 5.3) and when ordered and/or authorized in advance by the Member's Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred and/or HPM.

8.13 **HEARING AIDS**

A Hearing Aid(s) and hearing tests for fitting and post performance evaluation of a Hearing Aid(s) when authorized, in advance, by the Member's Primary Care Physician and obtained from an Affiliated Provider are covered once every thirty-six (36) consecutive months. Coverage includes:

- A. Audiometric examination to measure hearing ability, including tests for air conduction, bone conduction, speech reception, and speech discrimination.
- B. Hearing Aid evaluation tests to determine what type of Hearing Aid(s) should be prescribed to compensate for loss of hearing.
- C. Hearing Aids including in-the-ear, behind-the-ear, and on-the-body designs, and binaural aids purchased together.
- D. Dispensing fees for the normal services required in the fitting of a Hearing Aid.
- E. Hearing Aid conformity tests to evaluate the performance of a Hearing Aid and its conformity to the original prescription after the aid has been fitted.

8.14 **PRESCRIPTION DRUGS**

Benefits for Prescription Drugs and certain over-the-counter nonprescription drugs in the HPM Formulary, when prescribed by a Plan Physician, Dentist, or a Non-Plan Provider to whom a Member was Appropriately Referred and when furnished by an Affiliated Pharmacy Provider.

Coverage under this section 8.14 will include Federal Food and Drug Administration approved drugs used for off-label purposes and the reasonable cost of supplies Medically Necessary to administer the drug in accordance with section 3406q of the Insurance Code.

8.15 **FAMILY PLANNING SERVICES** when obtained from Affiliated Providers, including:

- A. Contraceptive drugs, devices, supplies, and other appropriate family planning services for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases.
- B. Termination of pregnancy is covered only when it is determined Medically Necessary to save the life of the mother, or in cases of rape and/or incest, or as otherwise required in accordance with the MChild Program. Treatment for medical complications occurring as a result of an elective abortion is covered. Treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies are covered.

8.16 **ORAL SURGERY AND RELATED SERVICES** only when provided by Affiliated Providers and authorized in advance by HPM and the Member's Primary Care Physician for the following conditions:

- A. Treatment of jaw fractures, dislocation or wound of the jaw.
- B. Treatment of tumors, cysts, and other disease tissues.
- C. Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction.

- D. Alteration of the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement (example – TMJ procedures).
  - E. Charges for Office Visits related to the above procedures.
- 8.17 **ORGAN AND TISSUE TRANSPLANTS** only when provided by a Provider approved in advance by HPM to perform such services, and only when authorized in advance by HPM and the Member's Primary Care Physician. Benefits are limited to human organ or tissue transplant procedures that are Medically Necessary and not considered to be Experimental.
- 8.18 **VISION SERVICES** when authorized in advance by HPM and obtained from Affiliated Providers, suppliers, or Specialist Physicians, including:
- A. Complete annual eye examination, refraction and glaucoma testing.
  - B. Corrective lenses (single vision, multi-focal, or cataract lenses) and eyeglass frames once every twenty-four (24) months or once every twelve (12) months with a prescription change.
  - C. Contact lenses when Medically Necessary or therapeutic, to correct a visual impairment when glasses are insufficient to correct a visual impairment.
- 8.19 **HOSPICE SERVICES** provided by a certified Affiliated Hospice program, when ordered by the Member's Primary Care Physician and authorized, in advance, by HPM, for up to two hundred ten (210) days -- two (2) periods of ninety (90) days each, and one period of thirty (30) days -- during a Member's lifetime, including:
- A. Short-Term inpatient care.
  - B. Nursing care by a registered nurse or under the supervision of a registered nurse.
  - C. Home health aid and homemaker services.
  - D. Medical supplies, drugs, and medicines.
  - E. Physical, speech, and occupational therapy.
  - F. Medical-social services.
  - G. Bereavement counseling for the family for up to thirty (30) days following the Member's death.
  - H. Members under twenty-one (21) years of age may receive Hospice care concurrently with curative treatment of the Member's terminal illness. This allows the Member or Member's representative to elect the Hospice benefit without foregoing any curative service to which the Member is entitled under MICHild for treatment of the terminal condition. The need for Hospice care must be certified by a Primary Care Physician and the Affiliated Hospice program's medical director. HPM will reimburse for the curative care separately from the Hospice services. HPM will not reimburse for these types of treatments when they are used palliatively. As such they are the responsibility of the Hospice and must be included in the per diem cost.
- 8.20 **ACUPUNCTURE THERAPY** treatments up to a maximum of twenty (20) in a calendar year when performed by (not just under the direction of) the Member's Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred for the treatment of any one of the following illnesses: sciatica, neuritis, post herpetic neuralgia, tic douloureux, chronic headaches (e.g. migraine), osteoarthritis, rheumatoid arthritis, myofascial complaints (e.g., neck and lower back pain).
- 8.21 **CHIROPRACTIC SERVICES** up to a maximum of twenty-four (24) Visits per calendar year, when provided by Affiliated Chiropractors and when authorized in advance by the Member's Primary Care Physician, including:

- A. Initial office exam.
- B. First aid treatment of musculoskeletal injury.
- C. X-rays relating to back and spine.
- D. Spinal manipulations.

8.22 **TOBACCO CESSATION** including diagnostic, therapy and counseling services and pharmacotherapy (including coverage of prescription and non-prescription tobacco cessation agents approved by the Federal Drug Administration (FDA)).

8.23 **MISCELLANEOUS**

- A. HPM will cover Federal Food and Drug Administration-approved drugs used in antineoplastic therapy in accordance with Section 3406e of the Insurance Code.
- B. HPM will cover Medically Necessary Reconstructive surgery, including breast Reconstructive surgery following a mastectomy, when authorized in advance by the Member's Primary Care Physician, a Specialist Physician to whom the Member is Appropriately Referred, and/or HPM.
- C. HPM will cover Cosmetic surgery or Reconstructive surgery only for the correction of birth defects, conditions resulting from accidental injuries and deformities resulting from certain surgeries, when authorized in advance by the Member's Primary Care Physician, a Specialist Physician to whom the Member is Appropriately Referred, and/or HPM.
- D. HPM will cover Covered Services rendered at Child and Adolescent Health Centers (CAHCs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Tribal Health Centers (THCs), as required by the MICHild Program. A referral is required for services received at a Non-Affiliated FQHC.
- E. HPM 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 Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred:
  - 1. blood glucose monitors and blood glucose monitors for the legally blind.
  - 2. test strips for glucose monitors, visual reading and urine testing 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.

With regard to coverage for diabetes self-management training, the following conditions apply:

- a. it is limited to completion of a certified diabetes education program should either of the following occur:
  - (1) if considered Medically Necessary upon the diagnosis of diabetes by the Member's Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred 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.

(2) if the Member's Primary Care Physician or a Specialist Physician to whom the Member is Appropriately Referred 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.

b. 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 practicable.

F. HPM will cover weight loss counseling for morbid obesity when prescribed by a Member's Primary Care Physician.

G. HPM will cover chelation therapy for certain diagnoses.

H. HPM will cover pain management services when ordered by the Member's Primary Care Physician.

I. HPM will cover oral screening and referral and fluoride varnish treatments four (4) times in a period of twelve (12) consecutive months for Members aged zero to three (0-3) years.

## **SECTION IX BENEFIT LIMITATIONS AND EXCLUSIONS**

### **9.1 LIMITATIONS**

The Covered Services set forth in Section VIII of this Contract shall be limited in accordance with the provisions of the MICChild Program and in the following ways:

A. Major Disasters. In the event of any major disaster, epidemic, or other circumstances beyond its control, HPM shall render or attempt to arrange Covered Services insofar as practical, according to its best judgment, within the limitations of facilities and personnel then available. However, no liability or obligations are incurred 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 HPM's control. Such circumstances include complete or partial disruption of facilities, war, riot, civil insurrection, disability of a significant part of an Affiliated Provider or plan personnel or similar causes.

B. Emergency Health Services. HPM 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. Members hospitalized at Non-Affiliated Hospitals may be transferred to an Affiliated Hospital upon request by the Member's Primary Care Physician as soon as it is medically appropriate in the opinion of the attending physician. Should a Member, or his or her designee, refuse a transfer to an Affiliated Hospital, continued care provided to that Member at a Non-Affiliated Hospital shall not constitute Covered Services and shall no longer be the financial responsibility of HPM. Coverage for Emergency Health Services provided by a Non-Affiliated Provider shall be limited to a Reasonable Charge for said services. Any necessary follow-up care after emergency treatment must be provided, arranged, or authorized by the Member's Primary Care Physician.

C. Durable Medical Equipment. Coverage shall be provided only for non-deluxe items, appropriate for use at home, as determined by HPM to be eligible for reimbursement (but, as always, subject to the Member Satisfaction Plan as provided in Section 5.3). HPM shall determine whether the equipment shall be purchased or rented. Covered Services include repair to a serviceable condition due to normal wear and tear, or replacement when the

equipment is lost, irreparable or the condition or size of the patient requires replacement, whichever is determined by HPM or its designee to be appropriate. 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 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.

- D. Prosthetic Devices and Orthotic Appliances. Coverage shall be provided only for non-deluxe items as determined by HPM to be eligible for reimbursement (but, as always, subject to the Member Satisfaction Plan as provided in Section 5.3). Coverage includes Prosthetic Devices and Orthotic Appliances that are pre-fabricated or custom-fitted; the repair, fitting, and/or adjustment of a covered Prosthetic Device or Orthotic Appliance; and the replacement of appliances when they are damaged beyond repair or worn out, or because of a change in a child's condition or size. Prosthetic Devices are artificial and/or mechanical appliances (such as arms, legs, eyes, etc.) that replace all or part of the functions of a permanently inoperative or real functioning body organ. Orthotic Appliances are appliances that support or straighten a deformed body part. Experimental, research and self-help appliances or devices not medical in nature are not a Covered Service. Any appliance, or device ordered before the Effective Date of Coverage will not be covered, even if delivered after the Effective Date of Coverage. Appliances or devices ordered while a Member, but delivered after the Effective Date of Termination, will not be covered.
- E. Hospice Services. Coverage is provided when all of the following conditions are met: the Member's Primary Care Physician, or a Specialist Physician to whom the Member has been Appropriately Referred, and/or HPM certify that the Member is terminally ill (the person has been diagnosed as having six (6) months or less to live), the Member/Member's representative chooses to receive care from a Hospice instead of standard benefits for the terminal illness, and care is provided by a certified Hospice program.
- F. Prescription Drugs. Benefits for Prescription Drugs in the HPM Formulary will be limited to the reasonable cost of generically available products, unless no generically equivalent product exists or a Member specific review for medical necessity by HPM determines the need for brand name medication. HPM reserves the right to determine generic equivalency of products available to HPM Members. HPM reserves the right to review Prescription Drug products and procedures for medical necessity, efficacy of use, and quality to determine if they should be available to HPM Members. Prior authorization, quantity or dose limits may apply for certain medications. Prescription Drugs for the diagnosis and treatment of Attention Deficit Hyperactivity Disorder and Attention Deficit Disorder are covered, but only when prescribed by Affiliated Providers.
- G. 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 HPM and shall not serve, or be construed as, any limitation or infringement on any Member's right to select and pay for any level of care desired in any location.
- H. Chiropractic Services. When a Member is referred to a Chiropractor by his/her Primary Care Physician, benefits are limited to one set of X-rays of the spine per calendar year and up to twenty-four (24) Visits for spinal manipulation per calendar year. A set of X-rays is defined as a maximum of two (2) X-rays.
- I. Vision Services. Benefits for Vision Services shall be limited to one (1) complete eye examination, glaucoma testing and refraction per Member every calendar year and one (1) complete pair of eyeglasses (frames and lenses) per Member every twenty-four (24) months or once every twelve (12) months with a prescription change. Coverage shall be provided only for Medically Necessary, non-deluxe frames and/or lenses determined by HPM to be

eligible for reimbursement (but, as always, subject to the Member Satisfaction Plan as provided in Section 5.3). Contact lenses are covered when Medically Necessary or therapeutic to correct visual impairment when glasses are insufficient to correct visual impairment.

- J. Short-Term Medical Rehabilitation Services. Benefits for Short-Term medical rehabilitation services, including those listed under Home Health Services, shall be limited to sixty (60) combined visits per Member per calendar year. Coverage is provided at home or outside the home if necessary medical equipment cannot be brought into the home to restore or improve a functional loss caused by injury, illness, disease or congenital anomaly when authorized in advance by the Member's Primary Care Physician, a Specialist Physician to whom the Member has been Appropriately Referred, and/or HPM.
- K. Hearing Care. Benefits are not payable for the replacement of lost or broken Hearing Aids unless the thirty-six (36) month coverage limitation does not apply.

## 9.2 EXCLUSIONS

Coverage for services and products not specifically identified by this Contract are not Covered Services, including, but not limited to:

- A. Services and supplies not provided by, or under the direction of, the Member's Primary Care Physician, except Emergency Health Services and/or services rendered by a Non-Affiliated Provider after being Appropriately Referred.
- B. Services and supplies to the extent not Medically Necessary for the diagnosis and treatment of injury, illness, or pregnancy.
- C. Services and supplies not required to be provided in accordance with the provisions of the MICHild Program.
- D. Charges that are in excess of Reasonable Charges.
- E. Dental Care and associated supplies, services, and tests, except as specifically provided in Section 8.16.
- F. Cosmetic surgery and other services and products for Cosmetic purposes, such as procedures to correct baldness or wrinkling. However this exclusion would not apply to Medically Necessary Reconstructive surgery.
- G. Custodial or domiciliary care, Basic Care or housekeeping provided on an inpatient, outpatient, or in-home basis.
- H. 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.
- I. Services for any injury or illness to the extent any benefits, settlements, awards or damages are available under Worker's 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.
- J. Services for which the Member is eligible under any other 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.

- K. 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 or program.
- L. Medical, surgical, or psychiatric procedures, treatment or devices, pharmacological regimens (except for antineoplastic drugs required to be covered in accordance with Section 3406e of the Insurance Code) and associated health care services, which are considered Experimental in nature under accepted standards of practice. Something may be considered by HPM to be Experimental if one of the following circumstances applies:
  1. FDA approval 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.
  5. It is being provided pursuant to experimental or research protocol testing for factors such as safety, efficacy, or toxicity.
  6. Published literature indicates that further research is needed to define factors such as safety, efficacy, or toxicity.
- M. Vocational rehabilitation services.
- N. Personal comfort or convenience items such as television and telephone services.
- O. Any type of shoe supply for flexible flat feet or toe-in, toe-out problems, except where there is a specific rigid deformity of the foot, or torsional problems of the extremities, except when shoes are attached to a brace, or are prescribed by a Physician.
- P. Sex transformation surgery and all expenses in connection with such surgery.
- Q. Reversal of a voluntary sterilization; all services for the diagnosis, counseling or treatment of infertility including but not limited to: embryo transfer procedures, artificial insemination, all forms of in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, transsexual surgery; and all services related to surrogate parenting arrangements of any kind. Drugs used specifically for the purpose of treating infertility are not a benefit.
- R. Surgery and any other services and supplies for the purpose of weight reduction or control, except when specifically approved by HPM for severely obese Members with high-risk comorbidities.
- S. Wigs, prosthetic hair, hair transplants or other procedures or supplies to enhance hair growth.
- T. Court ordered tests, reports, or treatment, unless otherwise covered by this Contract.
- U. Care rendered while in police custody, unless authorized by the Member's Primary Care Physician.
- V. Nonprescription drugs (or their Prescription Drug equivalents), dietary and other supplements, articles, and supplies provided on an outpatient basis, and not specifically identified as Health Care Benefits under this Contract. HPM may elect to cover and include certain over-the-counter nonprescription drugs on the HPM Formulary based on recommendations made by our Pharmacy and Therapeutics Committee.

- W. Services or products provided by Convalescent Homes, Homes for the Aged or Adult Foster Care Facilities.
- X. Ancillary Services provided as an adjunct to services for which Health Care Benefits are not provided under this Contract.
- Y. Skilled Care provided on a twenty-four (24) hour basis in the home.
- Z. Hearing Aids ordered prior to the Effective Date of Coverage under this Contract; replacement of parts (including batteries or ear molds) and/or repair of Hearing Aids because of loss or misuse; and the additional cost of an eye-glass type Hearing Aid or other Hearing Aid with special features that are not Medically Necessary over the conventional type of Hearing Aid.
- AA. Private duty nursing services provided by a person who ordinarily resides in the Member's home or by a person who is part of the Member's family or the family of the Member's spouse.
- BB. Routine foot care including, but not limited to, hygienic care, treatment of corns, calluses or toenails.
- CC. Charges associated with hypnosis, massage therapy, light therapy, or other alternative non-standard treatments.
- DD. Services, products, or supplies which are illegal.
- EE. Charges for the completion of claim forms, interest on late payments, or charges for failure to keep scheduled appointments.
- FF. 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 these services. Transplants of artificial organs are not covered.
- GG. Services which are provided by individuals who are not licensed/certified under the Michigan Public Health Code (or other similar code/statute of any other state or governmental unit) or services which are beyond the treating individual's licensing.
- HH. Premarital exams or classes.
- II. Contact lenses, other than those required to be provided by the MICHild Program.
- JJ. Charges for transportation and/or lodging which may be required to receive Covered Services.
- KK. Mental health and substance abuse services including: substance abuse assessment, detoxification, intensive outpatient counseling and other outpatient services, methadone treatment and Prescription Drugs prescribed specifically for the purpose of treating substance abuse disorders. (These services are provided by Community Mental Health and local coordinating agencies; this includes any Prescription Drugs prescribed by Community Mental Health or local coordinating agency providers).
- LL. 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.
- MM. Services or supplies furnished or ordered by a Provider included in the U.S. Department of Health and Human Services, Office of Inspector General's List of Excluded Individuals/Entities.
- NN. Services provided by a school district and billed through an Intermediate School District.

**SECTION X  
GENERAL CONDITIONS**

**10.1 NOTICE**

Any notice required or permitted to be given by this Contract 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 the principal office of HPM.

**10.2 GOVERNING LAW**

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

**10.3 ACCEPTANCE OF CONTRACT**

It is acknowledged and agreed that the Member's execution of the Application form and/or use of the HPM Identification Card shall be deemed to be his/her acceptance of this Contract.

**10.4 ENTIRE CONTRACT**

This Contract constitutes the entire understanding between HPM and Members, and, as of the Effective Date of Coverage, supersedes all other like agreements.

**10.5 WAIVER BY AGENTS**

No agent or other person, except an officer of HPM, or other authorized Committee, has authority to waive any condition or restrictions of this Contract, or to bind HPM by making promise or representation or by giving or receiving any information. No change in this Contract shall be valid unless evidenced by an endorsement or Rider formally issued by HPM.

**10.6 AMENDMENTS**

This Contract shall be subject to amendment, modification or termination in accordance with its provisions or as required by law.

**10.7 REINSTATEMENTS**

HPM may reinstate this Contract 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 Group. No such payment shall create any rights to service for periods prior to the reinstatement date determined by HPM, which shall become the Effective Date of Coverage for all subsequent purposes hereof.

**10.8 IDENTIFICATION CARDS**

Identification Cards issued by HPM to Subscribers are for identification only. Possession of an Identification Card confers no rights to Health Care Benefits not otherwise available under this Contract.

**10.9 POLICIES AND PROCEDURES**

HPM may unilaterally adopt and change reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Contract. HPM reserves the right to review services, supplies, products and procedures for efficacy of use and quality to determine if they should be available to HPM Members.

**10.10 ASSIGNMENT**

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

**10.11 PROVIDER DISCLAIMER**

HPM assumes no responsibility for Physicians or other Providers treating the Member, their competency, or their acts or omissions.

**10.12 TREATMENT BY NON-AFFILIATED PROVIDERS**

This Contract shall not be interpreted to restrict a Member's decision to be treated by any Provider chosen by the Member; provided, however, Health Care Benefits may be limited or excluded if the provisions of this Contract are not followed by the Member.

**10.13 HEADINGS**

The headings and titles of this Contract are for ease of reference only, and shall not be interpreted to expand the Health Care Benefits afforded.

**10.14 SEVERABILITY**

In the event that any section or portion thereof, of this Contract, 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.

**10.15 WAIVER**

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

**10.16 RECOVERY OF PAYMENTS**

HPM shall be entitled to recover payments from the Subscriber respecting any and all claims payments made by HPM for services rendered to the Subscriber after the Effective Date of Termination.

**10.17 LEGAL ACTIONS**

No action at law or in equity shall be brought to recover on this Contract prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Contract. 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.