

MEDICAID SUBSCRIBER CONTRACT



SECTION I INTRODUCTION

This Contract is between HealthPlus Partners, Inc., a nonprofit Michigan corporation, operating a state-licensed health maintenance organization and the Eligible Individual (and any Eligible Dependent, if applicable) who enrolls with HPP in order to receive Health Care Benefits. By enrolling with HPP, accepting this Contract, and using the HPP Identification Card, Eligible Individual (and any Eligible Dependent(s), if applicable) agree(s) 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 THE 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 HPP 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 notifications 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 a 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 an Eligible Individual.
- 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 HPP'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 HPP'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 HPP which 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 HPP 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 Dependent" means a dependent of an Eligible Individual who is determined to be eligible for membership in HPP by the Michigan Department of Community Health or its designee.
- 2.20 "Eligible Individual" means an individual who is determined to be eligible for membership in HPP by the Michigan Department of Community Health or its designee.
- 2.21 "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.
- 2.22 "Expedited Grievance" shall mean a Grievance for Urgent Care Claims.
- 2.23 "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 HPP.

- 2.24 "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.
- 2.25 "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; benefits or claims payment, handling or reimbursement for health care services;
 - C. the reduction, suspension, or termination of a previously authorized service;
 - D. the failure to provide services in a timely manner, as defined by the State;
 - E. the failure of HPP to act within the established timeframes for Grievance and appeal disposition;
 - F. for a resident of a rural area with only one Medicaid Health Plan, the denial of a Member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside HPP's network of Affiliated Providers;
 - G. matters pertaining to the contractual relationship between a Member and HPP;
 - H. the denial or limited authorization of a requested service, including the type or level of service; or
 - I. the denial in whole or in part, of a payment for a properly authorized and Covered Service.
- 2.26 "Grievance Appeal" means the second level of the Grievance process.
- 2.27 "Group" means the legal entity which has contracted with HPP for Health Care Benefits for Eligible Individuals and Eligible Dependents. Under this Contract, the legal entity is the State of Michigan, for and on behalf of the Michigan Department of Community Health.
- 2.28 "Health Care Benefits" mean the benefits provided by this Contract for health care services rendered to Members.
- 2.29 "Hearing Aid" means an electronic device of the type approved by HPP 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.
- 2.30 "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.
- 2.31 "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.

- 2.32 "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.
- 2.33 "HPP" means HealthPlus Partners, Inc., a nonprofit Michigan corporation with its principal office located at 2050 South Linden Road, Flint, Michigan 48532.
- 2.34 "HPP Medicaid Formulary" means a list of selected or preferred drug products and supplies available to a Member pursuant to relevant HPP organizational policies and procedures.
- 2.35 "Identification Card" means the card issued to an Eligible Individual by HPP.
- 2.36 "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.
- 2.37 "IRO" means Independent Review Organization.
- 2.38 "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.
- 2.39 "Medicaid Program" means the program administered by the Michigan Department of Community Health to provide for medical assistance established by Section 105 of Act No. 280 of the Public Acts of 1939, as amended, and Title XIX of the Social Security Act, as amended.
- 2.40 "Medicare" means Title XVIII of the Social Security Act and all amendments thereto.
- 2.41 "Member" means the Eligible Individual and his/her Eligible Dependents covered under this Contract.
- 2.42 "Michigan Department of Community Health" means the state agency responsible for administering the Medicaid Program.
- 2.43 "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.
- 2.44 "OFIR" means Office of Financial and Insurance Regulation.
- 2.45 "Orthotic Appliance" means an apparatus of the type approved by HPP which is used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.
- 2.46 "Outpatient Mental Health" means therapeutic services which last less than four (4) consecutive hours.
- 2.47 "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.

- 2.48 "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.
- 2.49 "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 or osteopathic medicine and surgery.
- 2.50 "Plan Physician" means any Physician who has entered into a written contract to provide services to Members.
- 2.51 "Podiatrist" 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 podiatric medicine.
- 2.52 "Preferred Mental Health Provider" means an Affiliated Provider specializing in the treatment of mental illness who is both selected by a Member for his/her care and is designated by HPP as a Preferred Mental Health Provider.
- 2.53 "Prescription Drug" means any medicinal substance listed in the HPP Medicaid Formulary that is approved by HPP 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.
- 2.54 "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.
- 2.55 "Post-Service Claim" shall mean any Claim that is not a Pre-Service Claim.
- 2.56 "Practitioner" means a licensed professional who provides health care services.
- 2.57 "Prevalent Language" means a non-English language spoken by a significant number or percentage of Members or potential Members in the state.
- 2.58 "Primary Care Physician" means a Plan Physician who is both selected by a Member or assigned by the Plan to provide his/her care and is designated and recorded by HPP as providing primary care services.
- 2.59 "Prosthetic Device" means a device of the type approved by HPP 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.
- 2.60 "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.
- 2.61 "Reasonable Charge" means the lesser of the treating Provider's charge or the amount determined to be a fair charge by HPP in comparison to charges of other Providers in the same geographic region.
- 2.62 "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.
- 2.63 "Reside" means the physical presence of a Member at a particular address.
- 2.64 "Semi-Private Room" means a room containing two (2) or more patient beds in an inpatient facility.
- 2.65 "Service Area" means the geographic area in which HPP is authorized by regulating agencies to provide Health Care Benefits to Members.

- 2.66 "Short-Term" means service for a condition which HPP determines can be expected to significantly improve within a period of sixty (60) days.
- 2.67 "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.
- 2.68 "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.
- 2.69 "Specialist Physician" means a Plan or Non-Plan Physician to whom a Member is Appropriately Referred.
- 2.70 "Urgent Care Claim" shall mean a Claim that, due to the medical status of the Member, resolution within HPP'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.
- 2.71 "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. Eligible Individuals. To be eligible to enroll as an Eligible Individual, a person must:
 - 1. be an Eligible Individual according to the eligibility requirements for the Medicaid 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 HPP or the Michigan Department of Community Health or its designee.
- B. Eligible Dependents. To be covered as an Eligible Dependent a person must be determined to be eligible for membership in HPP by the Michigan Department of Community Health or its designee.

3.2 INELIGIBILITY

- A. If a Member covered under this Contract loses his/her eligibility under the Medicaid 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 and Eligible Dependents may enroll by completing the enrollment process at the times specified by the Michigan Department of Community Health or its designee.
- B. Newborn children are automatically covered for the month of their birth as long as the mother is Medicaid eligible at the time of the birth, covered by HPP, and does not enroll the children in Children's Special Health Care Services ("CSHCS").
- C. All eligible, enrolled Members will be covered under this Contract on the date agreed upon between the Michigan Department of Community Health and HPP, which date shall be referred to as the Effective Date of Coverage.
- D. A Member will be notified in writing by HPP of the Effective Date of Coverage.
- E. A Member is not eligible for services under this Contract until the Effective Date of Coverage.

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, HPP 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 HPP under any of the following circumstances, HPP 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 HPP:

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

Member consents to HPP bringing suit against any third party to protect HPP's subrogation rights. HPP'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 HPP 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. HPP 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 HPP, 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 HPP.

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 Member shall have the right, on a yearly basis, to vote for the election of members to the HPP Board of Directors.

In addition, at least one-third (1/3) of the members of HPP'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, HPP's affairs.

- B. Each Member shall receive periodic HPP newsletters providing information concerning voting rights, current benefits and policies, maintaining and improving health, and other items of general interest.
- C. An adult Member may change his/her selection of Primary Care Physician upon notice to HPP. Changes for an enrolled child can only be made by the parent or guardian as identified by MDCH, unless otherwise permitted by order of court. 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 HPP's Customer Service Department to access these services or information.
- E. 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.

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

If Members are not happy with any aspect of HPP'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. HPP has thirty (30) calendar days to complete these two (2) steps, but can extend the time by up to ten (10) business days if a Member (or his or her Authorized Representative) allows. Here is how to use each of the steps:

a. Step One: Grievance

Members (or their Authorized Representative) can initiate this process by contacting HPP 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. HPP will respond in writing to Members' Grievances within fifteen (15) calendar days of receiving it. At that time, Members will be informed of HPP'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.

If an Authorized Representative files a Grievance on behalf of a Member, the Grievance is not considered to be received by HPP until any necessary written authorization form has been received by HPP.

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. HPP 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 HPP'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 (or their Authorized Representative) have exhausted their rights under the HPP Member Satisfaction Plan, or if they have not received a response from HPP 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, Appeals Section, OFIR, Health Plans Division, 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 HPP and the Member's health care Providers to disclose their Personal Health Information, including medical records, that are relevant to the review process.

If the final decision of HPP 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 HPP's final adverse 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 review the case and may refer the case to an IRO, made up of independent clinical reviewers, to review the case. Both HPP 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 HPP's determination. The Commissioner has seven (7) business 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.

F. Expedited Grievance

1. HPP Review

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

HPP will determine whether an Expedited Grievance is warranted based on the particular facts and circumstances of each request. In making such a determination, HPP will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, HPP 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.

HPP 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) calendar days following the oral notification.

Members (or their Authorized Representative) may request up to a ten (10) calendar day extension of an Expedited Grievance. However, an extension of an Expedited Grievance will move the Grievance from the expedited process to the routine process. HPP will notify the Member (or his or her Authorized Representative) of this change in timing and, if the Member (or his or her Authorized Representative) still requests the extension, the Expedited Grievance will be moved to the routine process. If the Member (or his or her Authorized Representative) withdraws the request for an extension, the determination will be made within seventy-two (72) hours after HPP receives the Member's (or his or her Authorized Representative's) original request for an Expedited Grievance.

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 following receipt of an Adverse Determination on an Expedited Grievance from HPP (or Outside Review Entity). The Member may write or call them at the following address and telephone number: Appeals Section, OFIR, Health Plans Division, 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 HPP and the Member's health care Providers to disclose their Personal Health Information, including medical records, that are relevant to the review process.

If a Physician believes that due to the Member's medical condition, resolution of the Expedited Grievance within HPP'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 HPP, 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 HPP 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 HPP's determination. The Commissioner has twenty-four (24) hours to make a decision.

G. Initial Claim Decisions

1. Time Frame for Decisions

- a. For Urgent Care Claims, HPP 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, HPP 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, HPP 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, HPP will notify Members

within eleven (11) working days of making the decision. HPP's decision to reduce or terminate the course of treatment is treated as an Adverse Determination subject to review, and HPP 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, HPP 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, HPP 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 HPP determines that, for reasons beyond the control of HPP, an extension is necessary to reach an initial Claim decision, a single fifteen (15) day extension is permitted. To use the extension, HPP 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 HPP expects to reach a decision. If the extension is necessary because the Member fails to provide information that HPP requires to reach a decision, the notice will specifically describe the missing information and HPP 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. HPP 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. HPP 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, HPP 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. HPP will allow the Member at least forty-eight (48) hours to provide the information described in the notice. HPP 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. HPP 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 HPP 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 HPP'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 file a State fair hearing request.
 - j. 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.

H. 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 HPP, 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 HPP (i.e., a Non-Affiliated Provider), the Primary Care Physician will initiate the out-of-plan referral process. Only services approved by HPP 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) business days from the time the referral is received by HPP. If the referral to the Non-Affiliated Provider is not approved, HPP will explain the reason for the denial.
 3. Primary Care Physicians know that certain procedures or items require prior authorization by HPP. If a Member has further questions regarding this issue, the Member should talk with his/her Primary Care Physician or call HPP Customer Service.
- I. 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 HPP's final determination. Such notification shall be in plain English (or translated as necessary). 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 HPP 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 HPP 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 HPP 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 (or his or her Authorized Representative) may request HPP to delay the processing of their Claim or Grievance for up to ten (10) business days. The Member may request the 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 delay processing a Member's Grievance for up to ten (10) business days if HPP can show that there is a need for additional information and the delay is in the Member's interest. If HPP extends the time period, it will give the Member (or his or her Authorized Representative) written notice of the reason for the delay.
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 or requests a fair hearing 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 or State fair hearing decision is adverse to the Member, HPP may recover the cost of the related 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. HPP will continue benefits pending resolution of a Grievance filed with HPP or a State fair hearing decision if the following five (5) conditions are met:
 - a. the Member, or his/her Authorized Representative, filed the Grievance or State fair hearing request timely (within ten (10) calendar days of HPP mailing the notice of the Adverse Determination);
 - b. the Grievance or State fair hearing request 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) calendar days pass after HPP mails the notice, providing resolution of the appeal against the Member, unless the Member, within the ten (10) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached;
 - c. a State fair hearing office issues a hearing decision adverse to the Member; or
 - d. the time period or service limits of a previously authorized service have been met.

J. State Medicaid Fair Hearing Process. Members or their Authorized Representative, may file a complaint directly with the State. Members do not have to contact HPP Customer Service staff or file a Grievance under the Member Satisfaction Plan before contacting the State. Listed below are the steps for the State Medicaid fair hearing process.

1. Call 1-800-642-3195 to have a hearing request (complaint) form sent to you. You may also call to ask questions about the hearing process.
2. Fill out the request (complaint form) and return it to the address listed on the form.
3. You will be sent a letter telling you when and where your hearing will be held, ten (10) days prior to the hearing.
4. The results will be mailed to you within ten (10) days after the hearing is held. If your complaint is taken care of before your hearing date, you must call to ask for a hearing request withdrawal form. You can call 1-800-642-3195 to request this form.

K. 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 may 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.

5.2 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 HPP or immediately upon discharge of his/her previous Primary Care Physician. If a Member does not select a Primary Care Physician within thirty (30) calendar days of enrollment, the plan will assign a provider and the Member will be notified. A Member always retains the right to change the Primary Care Physician at any time.
- B. A Member shall notify HPP within twenty-four (24) hours of any emergency admission or admission to a Non-Affiliated Hospital.
- C. A Member shall notify HPP and the Department of Human Services 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 HPP, 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 HPP 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, unless a Member is hospitalized at the time of termination. HPP shall be entitled to recover from Providers all claims payments made by HPP for services rendered to the Eligible Individual and/or Eligible Dependent 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 HPP or its designee to gain access to the Member's medical records, including mental health and substance abuse records.
- J. A Member shall enroll in Part B of Medicare upon their first date of eligibility under Title XVIII of the Social Security Act, and shall notify HPP of the date their Medicare coverage begins.

SECTION VI RECORDS

6.1 MEMBERSHIP RECORDS

HPP 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 HPP 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 HPP during regular business hours. An appointment for this purpose shall be required.

6.3 ACCURACY OF INFORMATION

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

6.4 CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

Members should refer to HPP'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 Medicaid Program in accordance with the terms of this Contract or the contract between HPP 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, or expiration of the benefit, whichever comes first.

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 HPP 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, or expiration of the benefit, whichever comes first.

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

7.3 DISENROLLMENT FROM HPP

- A. HPP may disenroll a Member on the date specified by HPP, after receiving consent from the Michigan Department of Community Health, for the following reasons:

1. if the Member fails to meet any eligibility requirement for participation in HPP or the Medicaid Program according to the Michigan Department of Community Health or its designee.
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 HPP 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 HPP 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 the Member has a medical condition of such magnitude (unknown by HPP at the time of enrollment) that interruption of an established regimen could be detrimental to the person's health.
7. if a Member obtains or attempts to obtain Health Care Benefits fraudulently.
8. if the Member no longer Resides in the Service Area.
9. if the Member breaches any term or condition of the Contract.
10. if the Member enters into active military duty, except for temporary duty of thirty (30) days or less.

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 HPP'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 HPP in accordance with all HPP policies and procedures. Only services that are Medically Necessary according to generally accepted standards of practice as determined by an HPP Medical Director are 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 Visits for treatment of illness or injury.
 - 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. Pediatric and adult immunizations in accordance with accepted medical practice.
- E. Maternity care, delivery, postpartum, miscarriage, and other related obstetrical services, including midwives. Self-referral to an in-plan obstetrician/gynecologist for an annual well-woman exam and routine obstetrical services.
- F. Professional services by Specialist Physicians.
- G. Hospital Visits as part of continued supervision of covered care.
- H. Allergy services, including allergy survey, allergy testing, allergy serum, and injections of allergy serum.
- I. Services by a Podiatrist.

COPAYMENT FOR PHYSICIAN OFFICE VISITS:

COPAYMENT:

A Copayment will apply to Physician office Visits except for Visits to an outpatient Hospital clinic or emergency room, or Physician office Visits for maternity care, delivery, postpartum, miscarriage, and other related obstetrical services.

\$2 per Visit

There will not be a Copayment for those Members under the age of twenty-one (21).

COPAYMENT FOR PODIATRIST OFFICE VISITS:

COPAYMENT:

A Copayment will apply to Podiatrist office Visits.

\$2 per Visit

There will not be a Copayment for those Members under the age of twenty-one (21).

8.2 HOSPITAL SERVICES (excluding Mental Health Services and Substance Abuse Services) when provided by a Hospital, when authorized by HPP 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, including:
 - 1. Semi-private room and board, including general duty nursing care.
 - 2. Private room and board accommodations for medical reasons when authorized by a Plan Physician.
 - 3. Therapeutic and support care, services, supplies, and appliances.
 - 4. Care in specialized units.
 - 5. Use of operating, delivery, recovery, and treatment rooms and equipment.
 - 6. Laboratory tests, X-rays, EKGs, EEGs, and other diagnostic tests performed in conjunction with, or following, admission to the Hospital.

7. Anesthetics, oxygen, drugs, and other biologicals.
 8. Dressings, casts, and special equipment when supplied by the Hospital for use in the Hospital.
 9. Special diets.
 10. Radiation, inhalation, and physical, occupational, and speech therapies.
 11. Medical rehabilitation, including Short-Term rehabilitation services and Short-Term physical, occupational, and speech therapies.
 12. Administration of whole blood and blood derivatives.
 13. Phase I cardiac rehabilitation services.
 14. Dialysis for End Stage Renal Disease.
- B. Outpatient services, including:
1. Use of operating, delivery, recovery, and treatment rooms and equipment.
 2. Laboratory tests, X-rays, EKGs, EEGs, and other diagnostic tests.
 3. Anesthetics, oxygen, Prescription Drugs, and other biologicals.
 4. Dressings, casts, and special equipment.
 5. Therapeutic and support care, services, supplies, and appliances.
 6. Radiation, inhalation, and physical, occupational, and speech therapies.
 7. Medical rehabilitation, including Short-Term rehabilitation services and Short-Term physical, occupational, and speech therapies.
 8. Administration of whole blood and blood derivatives.
 9. Phase II cardiac rehabilitation services, limited to twenty-four (24) sessions in twelve (12) weeks.
 10. Dialysis for End Stage Renal Disease.

COPAYMENT FOR INPATIENT HOSPITAL SERVICES:

A Copayment will apply to the first day of an inpatient Hospital stay except for the following:

- transfers between Hospitals
- transfers from Hospitals to rehabilitation facilities
- readmissions to Hospital within fifteen (15) days for the same medical diagnosis

There will not be a Copayment for those Members under the age of twenty-one (21), or for inpatient Hospital services that are pregnancy-related.

COPAYMENT:

\$50 per first day

COPAYMENT FOR OUTPATIENT HOSPITAL SERVICES:

COPAYMENT:

A Copayment will apply to outpatient Hospital clinic Visits. These include outpatient Hospital: clinics, chronic pain centers, urgent care clinics, and family practice clinics.

\$1 per Visit

There will not be a Copayment for those Members under the age of twenty-one (21), or for outpatient Hospital services that are pregnancy-related.

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.

HPP 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.

COPAYMENT FOR HOSPITAL EMERGENCY ROOM VISITS:

COPAYMENT:

A Copayment will apply to Hospital emergency room visits for non-Emergency Health Services except for Physician services when billed separately from Hospital facility charges.

\$3 per Visit

There will not be a Copayment for those Members under the age of twenty-one (21).

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 blood lead testing, hearing and vision screening as a preventive and early detection mechanism and early and periodic screening, diagnosis and treatment (EPSDT) services for Members under twenty-one (21) years of age.
- B. Pediatric and adult immunizations in accordance with accepted medical practice.
- C. Prenatal care and counseling.
- D. Health education and health counseling services.
- E. Tobacco cessation services.

- 8.5 **MENTAL HEALTH SERVICES** when authorized in advance by HPP or its designee, and when under the direction or care of an HPP Preferred Mental Health Provider or a Mental Health Provider to whom HPP or its designee has given prior authorization for services, including:
- A. Outpatient Mental Health Services.
 - B. Coordination of care with local Community Mental Health Boards.
- 8.6 **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 HPP, and when said services are in support of other Health Care Benefits set forth in this Contract.
- 8.7 **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 HPP 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.
- 8.8 **SHORT-TERM MEDICAL REHABILITATION SERVICES** in accordance with Medicaid guidelines when provided on an outpatient basis by Affiliated Providers, and when authorized in advance by the Member's Primary Care Physician and/or HPP, including Short-Term rehabilitation and Short-Term physical, occupational, and speech therapies.
- 8.9 **HOME HEALTH SERVICES** in accordance with Medicaid guidelines 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 HPP for a Skilled level of Care, including:
- A. Intermittent Skilled Nursing Care
 - B. Short-Term physical therapy
 - C. Part-time health aid services
- 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 HPP.

8.11 **DURABLE MEDICAL EQUIPMENT, ORTHOTIC APPLIANCES, AND PROSTHETIC DEVICES** when obtained from Affiliated Providers or suppliers, when determined by HPP to be an eligible item 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 HPP.

8.12 **HEARING AIDS**
Benefits for 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.

8.13 **DRUGS AND MEDICAL SUPPLIES**
Benefits for Prescription Drugs and certain over-the-counter drugs and medical supplies listed in the HPP Medicaid formulary, except for carved-out behavioral health medications (which are covered by MDCH), 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.

COPAYMENT FOR DRUGS AND MEDICAL SUPPLIES:

COPAYMENT:

A Copayment will apply to all prescriptions except the following:

\$1/Generic
\$3/Brand

- Birth control (family planning)
- Pregnancy related products
- Insulin
- Insulin syringes
- Over-the-counter drugs covered by HPP

There will not be a Copayment for those Members under the age of twenty-one (21).

Coverage under this Section 8.13 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.

HPP will cover Federal Food and Drug Administration-approved drugs used in antineoplastic therapy in accordance with Section 3406e of the Insurance Code.

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

- A. Medically indicated genetic testing and counseling in accordance with generally accepted medical practice.
- B. Except as provided in Section 9.2 S, services for diagnosis of infertility when Medically Necessary in accordance with generally accepted medical practice and/when authorized in advance by the Member's Primary Care Physician and HPP.
- C. 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. These services may be obtained from any provider of choice without authorization from the Member's Primary Care Physician, including but not limited to Planned Parenthood, the local health department, or an adolescent health center.
- D. Adult sterilization procedures for Members over twenty-one (21) years of age.
- E. Termination of pregnancy is covered only when it is determined medically necessary to save the life of the mother or as otherwise required in accordance with the Medicaid Program.

- 8.15 **ORAL SURGERY AND RELATED SERVICES** only when provided by Affiliated Providers and authorized in advance by HPP and the Member's Primary Care Physician for the following conditions:
- A. Prompt repair and treatment of jaw fractures and dislocation of the jaw immediately following an accident or traumatic injury.
 - B. Prompt repair of injury to the jaw, tongue, cheeks, lips and roof/floor of the mouth immediately following an accident or traumatic injury (repair/restoration of the teeth is not a Covered Service).
 - C. Orthognathic surgery prior to age twenty-one (21) for congenital defects directly affecting the growth, development, and function of the jaw.
 - D. Treatment of tumors, cysts, and lesions on or in the mouth except when in connection with an extraction.
 - E. Hospitalization charges for multiple extractions which must be performed in a Hospital due to a concurrent hazardous medical condition.
- 8.16 **ORGAN AND TISSUE TRANSPLANTS** only when provided by a Provider approved in advance by HPP to perform such services, and only when authorized in advance by HPP 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. Medically Necessary hospital, surgical, laboratory, and radiology expenses incurred by a non-Member donor for an authorized transplant to a Member will also be covered after it is determined that the non-Member's insurance is not sufficient to cover the total cost of such expenses.
- 8.17 **ROUTINE VISION SERVICES** when authorized in advance by HPP and obtained from Affiliated Providers, Suppliers, or Specialist Physicians, including:
- A. Complete eye examination and refraction.
 - B. Corrective lenses (single vision, multi-focal, or cataract lenses).
 - C. Eyeglass frames (or contact lenses, but only if required to be provided by the Medicaid Program).
 - D. Repair or replacement of frames/lenses due to body growth, loss, or breakage when prior authorized.

COPAYMENT FOR VISION SERVICES:

A Copayment will apply to office Visits for eye trauma and eye diseases for Members twenty-one (21) years of age or older.

There will not be a Copayment for those Members under the age of twenty-one (21).

COPAYMENT:

\$2 per Visit

8.18 HOSPICE SERVICES provided by an Affiliated Hospice, when ordered by the Member's Primary Care Physician and authorized, in advance, by HPP, including:

- A. Room and board charges
- B. Medical supplies, drugs, and medicines
- C. Medical-social services

8.19 SHORT-TERM RESTORATIVE OR REHABILITATIVE NURSING CARE services up to 45 days (within a rolling 12 month period from initial admission) of intermittent or short-term restorative or rehabilitative services in accordance with Medicaid guidelines provided by Affiliated Providers in or out of a facility (e.g. a Skilled Nursing Facility) when authorized in advance by the Member's Primary Care Physician, Specialist Physician to whom the Member is Appropriately Referred, and/or HPP. The 45-day maximum does not apply to restorative health services provided in places of service other than a nursing facility.

8.20 CHIROPRACTOR OFFICE VISITS when provided by Affiliated Chiropractors, and when authorized in advance by the Member's Primary Care Physician and/or HPP.

8.21 MISCELLANEOUS

- A. HPP 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 HPP.
- B. HPP will cover Covered Services rendered at a child and adolescent health center.
- C. HPP will cover certain Covered Services rendered at public health departments, rural health centers or federally qualified health centers as defined by state Medicaid guidelines.
- D. HPP 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 syringes.
 - 4. insulin pumps and medical supplies required for the use of an insulin pump.
 - 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.
- E. HPP will cover non-Emergency transportation to and from any medical Covered Service when authorized in advance by HPP (see Member Handbook or Provider Directory for transportation policy).
- F. HPP will cover Medically Necessary weight reduction services for severely obese Members with high-risk co-morbidities.
- G. HPP will cover Medically Necessary out-of-state services if authorized by HPP.
- H. During pregnancy, your body goes through various changes you may be unaware of. Childbirth education classes will help you understand these changes and help prepare you for delivery and taking care of your baby after the delivery. HPP covers these classes provided by qualified educators at most hospitals or through certified Maternal Infant Health Programs. Please see your doctor for a referral.

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 Medicaid Program and in the following ways:

- A. **Outpatient Mental Health Services.** The maximum number of Outpatient Visits provided for mental health evaluation and therapeutic services shall be twenty (20) Visits per Member per calendar year.
- B. **Major Disasters.** In the event of any major disaster, epidemic, or other circumstances beyond its control, HPP 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 HPP's control. Such circumstances include complete or partial disruption of facilities, war, riot, civil insurrection, disability of a significant part of a Affiliated Provider or plan personnel or similar causes.
- C. **Emergency Health Services.** 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 HPP. 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.

- D. **Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices.** Coverage shall be provided only for non-deluxe items, appropriate for use at home, as determined by HPP to be eligible for reimbursement. HPP shall determine whether the equipment, appliance, or device shall be purchased or rented. Covered Services include repair to a serviceable condition, or replacement when the equipment, appliance or device is irreparable or the condition or size of the patient requires replacement, whichever is determined by HPP or its designee to be appropriate. Orthotic Appliances are covered only when they are used to support, align, prevent, correct or improve a defect of body form or function. Prosthetic Devices are covered only when they replace a limb or other part of the body after accidental or surgical removal and/or when the Member's body growth necessitates a replacement. Comfort and convenience equipment, exercise and hygiene equipment, dental appliances, experimental or research equipment, and self-help devices not medical in nature are not a Covered Service. Any equipment, appliance, or device ordered before the Effective Date of Coverage will not be covered, even if delivered after the Effective Date of Coverage. Coverage of equipment, appliances, or devices for Members under age twenty-one (21) may be limited or excluded in accordance with the provisions of the Medicaid Program.
- E. **Prescription Drugs.** Benefits for Prescription Drugs in the HPP Medicaid 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 HPP determines the need for brand name medication. HPP reserves the right to determine generic equivalency of products available to HPP Members. HPP 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 HPP Members. Prior authorization, quantity or dose limits may apply for certain medications.
- F. **Inappropriate and Unnecessary Services.** Benefits shall be limited to providing coverage for necessary treatment as determined by reviewing the intensity of service, severity of illness, appropriateness of services rendered, and appropriateness of placement in special units and selected clinical support facilities. Services may be reviewed prospective, concurrent, or retrospective to the time of service. Such review shall impact only the level of Coverage provided by 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.
- G. **Chiropractic Services.** Benefits are limited to one set of x-rays of the spine per calendar year. A set of x-rays is defined as a maximum of two (2) x-rays.
- H. **Vision Services.** Benefits for Vision Services shall be limited to one (1) complete eye examination and refraction per Member every two (2) calendar years, unless deemed Medically Necessary more frequently, and one (1) complete pair of eyeglasses (frames and/or lenses) per Member every two (2) calendar years when new lenses are Medically Necessary. When a Member's frames and/or lenses are lost, stolen, or broken beyond repair, replacement eyeglasses are covered up to two (2) pairs of identical substitute eyeglasses per Member per calendar year for Members under the age of twenty-one (21) and one (1) pair of identical substitute glasses per Member per calendar year for Members age 21 and over provided the number of replacements have not exceeded Medicaid limits as listed. One year is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered. Coverage shall be provided only for Medically Necessary, non-deluxe frames and/or lenses determined by HPP to be eligible for reimbursement.

Replacement of Lenses Only - Replacement of a corrective lens(es), without frames, for one that is damaged or broken is a benefit if that lens(es) is covered by Medicaid and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or broken lens. For periods greater than 24 months from the date of the previous prescription when ordering subsequent lenses or complete eyeglasses, see Medicaid diopter guidelines.

Replacement of Frames Only - Replacement of a complete frame (front and temples) is a Medicaid benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement. If an identical frame is not listed as a Medicaid benefit, the beneficiary must select a frame that is a covered benefit. The contractor bills Medicaid for the complete frame. The vision provider inserts the lenses into the frame and bills Medicaid for the dispensing service.

- I. **Phase II Cardiac Rehabilitation Services.** Benefits are limited to twenty-four (24) sessions in twelve (12) weeks.

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, or as otherwise stated in this Contract.
- 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 Medicaid 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 8.15.
- 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 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 HPP 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. Mental health services and supplies which are:
 - 1. Rendered in connection with mental illness not classified in the International Classification of Diseases of the World Health Organization, as modified by the U.S. Center for Health Statistics;
 - 2. Extended beyond the period necessary for the evaluation and diagnosis of mental retardation; or
 - 3. For mental diseases or illness which, according to generally accepted professional standards, are not usually amenable to favorable modification.
- N. Inpatient mental health services, inpatient and outpatient substance abuse services, and intensive outpatient program.
- O. Vocational rehabilitation services.
- P. Personal comfort or convenience items such as television and telephone services.
- Q. 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.
- R. Sex transformation surgery and all expenses in connection with such surgery.
- S. Infertility treatment, including but not limited to: reversal of a voluntary sterilization, artificial insemination, all forms of in vitro fertilization, gamete intrafallopian transfer, and zygote intrafallopian transfer; transsexual surgery; all services related to surrogate parenting

arrangements; and all associated services and preparatory treatment related to any of the above. Drugs used specifically for the purpose of treating infertility are not a benefit.

Infertility services are not covered if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal or post-menopausal.

- T. Surgery and any other services or supplies for the purpose of weight reduction or control except when specifically approved by HPP for severely obese Members with high-risk co-morbidities.
- U. Wigs, prosthetic hair, hair transplants or other procedures or supplies to enhance hair growth.
- V. Court ordered tests, reports, or treatment, unless otherwise covered by this Contract.
- W. Care rendered while in police custody, unless authorized by the Member's Primary Care Physician.
- X. Services or products provided by Convalescent Homes, Homes for the Aged or Adult Foster Care Facilities.
- Y. Drugs, dietary and other supplements, articles, and supplies provided on an outpatient basis which are not specifically listed in the HPP Medicaid formulary. HPP may elect to cover and include certain over-the-counter drugs on the HPP Medicaid formulary based on recommendations made by our Pharmacy and Therapeutics Committee.
- Z. Ancillary Services provided as an adjunct to services for which Health Care Benefits are not provided under this Contract.
- AA. Skilled Care provided on a twenty-four (24) hour basis in the home.
- BB. Skilled Nursing Facility services that are considered long term care under the Medicaid Program.
- CC. Hearing Aids ordered prior to the Effective Date of Coverage under this Contract and the additional cost of an eyeglass type Hearing Aid or other Hearing Aid with special features that are not Medically Necessary over the conventional type of Hearing Aid.
- DD. Private duty nursing services.
- EE. Routine foot care including, but not limited to, hygienic care, treatment of corns, calluses or toenails.
- FF. Charges associated with hypnosis, or acupuncture services.
- GG. Services, products, or supplies which are illegal.
- HH. Charges for the completion of claim forms, interest on late payments, or charges for failure to keep scheduled appointments.
- II. 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.

- JJ. 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.
- KK. Premarital exams or classes.
- LL. Contact lenses, other than those required to be provided by the Medicaid Program.
- MM. 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.
- NN. Maternal Infant Health Program ("MIHP") services.
- OO. Behavioral health Prescription Drugs carved out from Medicaid Health Plans and covered by MDCH.

**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 HPP.

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 HPP Identification Card shall be deemed to be his/her acceptance of this Contract.

10.4 ENTIRE CONTRACT

This Contract constitutes the entire understanding between HPP 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 HPP, or other authorized Committee, has authority to waive any condition or restrictions of this Contract, or to bind HPP 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 HPP.

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

HPP 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 Eligible Individual, 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 HPP, which shall become the Effective Date of Coverage for all subsequent purposes hereof.

10.8 **IDENTIFICATION CARDS**

Identification Cards issued by HPP to Members 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**

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

10.10 **ASSIGNMENT**

All rights of a Member to receive Health Care Benefits are personal and may not be assigned. HPP may assign this Contract to its parent corporation, HealthPlus of Michigan, Inc., subject to any necessary regulatory approvals.

10.11 **PROVIDER DISCLAIMER**

HPP 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**

HPP's 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**

HPP shall be entitled to recover payments from the Eligible Individual and/or Eligible Dependent respecting any and all claims payments made by HPP for services rendered to the Eligible Individual and/or Dependent after the Effective Date of Termination.