HEALTHPLUS
INSURANCE COMPANY

SIGNATURE ONE
INDIVIDUAL
CERTIFICATE OF COVERAGE

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

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

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HEALTHPLUS INSURANCE COMPANY
SIGNATURE ONE INDIVIDUAL
CERTIFICATE OF COVERAGE

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

SECTION I – INTRODUCTION

1.1 This Certificate of Coverage ("Certificate") is between HealthPlus Insurance Company ("HPI"), a Michigan for-profit corporation authorized to operate a health insurance company, and each Member. The Certificate includes: this document, the Schedule of Benefits, the Member's HPI Identification Card, the Application, the Acceptance Notice, all forms, questionnaires and other documents completed by the Member and any amendments, Riders, or endorsements to this Certificate.

1.2 By enrolling with HPI, accepting this Certificate, and using the HPI Identification Card, Member agrees to be bound by the terms and conditions of this Certificate.

1.3 This Certificate provides the terms and conditions for enrollment, membership, payment, and Coverage related to Covered Services for Members. Covered Services a Member may be entitled to are included in Section VII of this document, the Schedule of Benefits, and the Rider(s) (if any). Covered Services are subject to certain limitations and exclusions, as provided in Section VIII of this document, and the Schedule of Benefits, and any applicable Rider(s).

SECTION II- DEFINITIONS

2.1 "Acceptance Notice" means the written or electronic communication a Member receives from HPI notifying the Member that his or her Application for Coverage has been approved by HPI. This Acceptance Notice is incorporated into this Certificate.

2.2 "Act" means Public Act 368 of 1978, Michigan Public Health Code, as amended by Act 354 of 1982, as amended.

2.3 "Adverse Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. An Adverse Determination shall also include any rescission of coverage and any decision to deny coverage in an initial eligibility determination. 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 "Allowed Amount" means the maximum amount HPI will pay for a Covered Service furnished by a Preferred or Non-Preferred Provider. For a Non-Preferred Provider, the Allowed Amount is what HPI reasonably determines is usual and customary for the services provided.

2.5 "Ambulance" means a licensed motor vehicle or rotary aircraft operated by licensed and certified personnel and used to provide transportation and life support services.

2.6 "Application" means those documents each person must complete in order to become eligible to become a Member.

2.7 "Authorized Representative" means 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 "Certificate" means the description of Covered Services including the Member's Application, Acceptance Notice, HPI Identification Card, this document, the attached Schedule of Benefits, and Riders, and any other document issued by HPI that is necessary for the administration of benefits.

2.9 "Claim" means any request for benefits made by a Provider, a Member, or his or her Authorized Representative, that complies with HPI's procedures for making benefit claims. Claims include Pre-Service Claims, Post-Service Claims, and Urgent Care Claims.

2.10 "Clinical Trial" means an organized study conducted in people with a specific disease to answer specific questions about vaccines, a new treatment, or new ways of using known treatments. Clinical trials (also called medical research and research studies) are used to determine whether new drugs or treatments are both safe and effective.

2.11 "Closed Formulary" means that a Member's Prescription Drug benefit, if a Member purchases a Prescription Drug Rider, is limited to products that are listed on the HPI Closed Formulary only. Prescription Drugs that are not listed on the HPI Closed Formulary are not covered. Additionally, if a Member chooses not to purchase a Prescription Drug Rider, he/she will automatically receive a Prescription Drug Discount Rider. Under the Discount Rider, a Member receives HPI's discounted rate for products listed on the HPI Closed Formulary only (no discount for products that are not on the HPI Closed Formulary).

2.12 "Coinsurance" means the percentage of the fee or cost of a Covered Service that a Member must pay. A Member's Coinsurance is listed in the Schedule of Benefits.

2.13 "Concurrent Care Decisions" means decisions affecting an ongoing course of treatment taking place over a period of time or a number of treatments.

2.14 "Copayment" means the amount each Member must pay per Visit to a treating Provider for certain Covered Services. A Member's Copayments are listed in the Schedule of Benefits and any applicable Riders.

2.15 "Cosmetic" means to improve appearance or self-perception.

2.16 "Coverage" means payment for the Health Care Benefits identified by this Certificate.

2.17 "Covered Services" means a service(s) for which Health Care Benefits are available under this Certificate, and the Schedule of Benefits, and any applicable Rider(s).

2.18 "Day Treatment Mental Health/Substance Abuse Program" means a program providing generally accepted therapeutic services and/or ancillary services which last four (4) or more consecutive hours.

2.19 "Deductible" means the annual amount a Member must pay in advance for Covered Services before HPI Coverage for health care services begins. A Member's Deductible is included in the Schedule of Benefits and any applicable Rider(s).

2.20 "Dental Care" means services or procedures that concern maintenance or repair of the teeth and/or gums or are performed to prepare the mouth for dentures or implants.

2.21 "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.

2.22 "DIFS" means Department of Insurance and Financial Services of the State of Michigan.

2.23 "Durable Medical Equipment" means equipment of the type approved by HPI that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury.

2.24 "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.

2.25 "Excess Charges" means charges for Covered Services beyond the Allowed Amount.

2.26 "Expedited Grievance" means a Grievance for Urgent Care Claims.

2.27 "Experimental" means that a service is of doubtful medical usefulness or effectiveness to the Member, as assessed by local medical community standards. The final determination of experimental procedures shall be made by HPI.

2.28 "Freestanding Emergency Center" means a facility that is licensed, certified, or otherwise authorized pursuant to the Act or any similar licensing statute or law of its governing state or governmental unit to provide services in emergencies or after hours.

2.29 "Grace Period" means a period of either: ten (10) days for Members who pay their Premium on a monthly basis, or thirty-one (31) days for Members who pay their Premium on an annual basis, beyond the date on which Premiums are due and during which the Member may make payments to HPI without a lapse of Coverage under this Certificate.

2.30 "Grievance" means a dispute on behalf of a Member, presented (orally or in writing) by the Member or his/her Authorized Representative, including a Practitioner, regarding:

A. The availability, delivery, or quality of health care services (including an Adverse Determination concerning utilization review);

B. Pre-Service Claims or Post-Service Claims;

C. Payment, handling or reimbursement for health care services; or

D. Matters pertaining to the contractual relationship between a Member and HPI.

2.31 "Health Care Benefits" mean the benefits provided by this Certificate for health care services rendered to Members.

2.32 "Hearing Aid" means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if Medically Necessary.

2.33 "Home Health Agency" means a facility or program which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit and approved to provide home health services.

2.34 "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.

2.35 "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.

2.36 "HPI" means HealthPlus Insurance Company, a Michigan corporation and wholly-owned subsidiary of HealthPlus of Michigan, Inc., with its principal office located at 2050 South Linden Road, Flint, Michigan 48532.

2.37 "Identification Card" means the card issued to a Member upon approval of an Application by HPI.

2.38 "Inpatient Mental Health Hospitalization" means hospitalization in a setting providing psychiatric services and twenty-four (24) hour medical care and nursing in a structured environment.

2.39 "In Network Benefit" means any Covered Services furnished by a Preferred Provider.

2.40 "Intermediate Care" means, as it applies to mental health and substance abuse services, the use of a full or partial residential therapy setting (also known as Day Treatment or partial hospitalization programs), or intensive outpatient programs and shall include generally accepted therapeutic techniques and other therapeutic and ancillary services.

2.41 "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.

2.42 "Medically Necessary" (or "Medical Necessity") means services or supplies provided to Members that are medically required and appropriate to diagnose or treat a Member's physical or mental condition. Also, such services or supplies must: (1) meet widely accepted criteria and professionally recognized standards of health care; (2) not be used primarily for the comfort or convenience of the Member, the Member's family or caregiver, or the Member's treating Physician; (3) not be excessive in cost as compared to alternative services or supplies effective for the diagnosis or treatment of the Member's physical or mental condition; and (4) not be provided to the Member as an inpatient when the services or supplies could be safely and appropriately provided to the Member on an outpatient basis.

2.43 "Medicare" means the federal program of medical care benefits, generally for those over age sixty five (65) comprised of Medicare Part A (hospital services, extended care facilities, hospices) and Medicare Part B (physician and other types of care not covered under Part A).

2.44 "Member" means the Member covered under this Certificate.

2.45 "Non-Covered Services" means those health care services that are not covered or excluded from Coverage by HPI under this Certificate, any Excess Charges, or services that were rendered at a time when the Member was not eligible for Coverage under this Certificate.

2.46 "Non-Preferred Provider" means a Provider who has not entered into a written agreement with HPI, or otherwise agreed, to provide services to Members.

2.47 "Orthotic Appliance" means an apparatus of the type approved by HPI which is used to support, align, prevent, or correct deformities, or to improve the function of moveable parts of the body.

2.48 "Out of Network Benefit" means any Covered Services furnished by a Non-Preferred Provider.

2.49 "Out of Pocket Costs" means all costs that a Member must pay based on this Certificate as described in the Schedule of Benefits and any applicable Riders, including: Copayments, Coinsurance, Deductibles, and any Excess Charges or penalties for failing to obtain Prior Authorization when required.

2.50 "Out of Pocket Maximum" means the total amount of Out of Pocket Costs a Member must pay for Covered Services during each calendar year. Out of Pocket Costs that do and do not count towards meeting a Member's Out of Pocket Maximum are described in the Schedule of Benefits.

2.51 "Physician" means an individual licensed under the Act or other similar licensing statute or law of the applicable governing state or governmental unit to engage in the practice of allopathic medicine, osteopathic medicine, chiropractic, or podiatric medicine and surgery.

2.52 "Post-Service Claim" means any Claim that is not a Pre-Service Claim.

2.53 "Practitioner" means a licensed professional who provides health care services.

2.54 "Pre-Service Claim" means any Claim that, under the terms of the Member's Certificate of Coverage, requires Prior Authorization (either in whole or in part) before medical care is obtained.

2.55 "Preferred Provider" means a Provider who has entered into a written agreement with HPI, or otherwise agreed, to provide services to Members.

2.56 "Preferred Provider Organization" (or "PPO") means HPI's preferred provider organization product. Participating providers are afforded "preferred status" within PPO plans. Generally, if a Member in a PPO plan utilizes a Preferred Provider, the Member is responsible for lower Copayments, Coinsurance and/or Deductibles than if the Member had obtained health services from a Non-Preferred Provider.

2.57 "Prescription Drug" means any medicinal substance and/or 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 an individual's personal use.

2.58 "Premium" means the monthly or annual prepayment rate charged by HPI for the Health Care Benefits provided in this Certificate.

2.59 "Preventive Services" means those services aimed at prevention, early detection, and early treatment of health conditions. This includes, but is not limited to, routine physical examinations, routine gynecological services, immunizations, preventive diagnostic screenings, and well person care.

2.60 "Prior Authorization" means the process of obtaining any necessary prior approval from HPI or its designee. Services that require prior approval are subject to the clinical review criteria of HPI or its designee to ensure quality and efficacy in health care services.

2.61 "Prosthetic Device" means a device that replaces all or part of an internal body organ or external body member, or that replaces all or a part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.

2.62 "Protected Health Information" includes medical information (i.e., claims, health assessments, etc.) and other administrative data (i.e., names, addresses, social security numbers, etc.) that are personally identifiable.

2.63 "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.

2.64 "Reconstructive" means to affect a substantial improvement or restoration of bodily function or to correct deformities resulting from disease, injury, or congenital, or developmental abnormalities.

2.65 "Reside" means the physical presence of a Member at a particular address with the intention to permanently remain at that address. For purposes of this definition, "permanently remain" at an address shall refer to a period of time longer than nine (9) months and shall be evidenced by notice of forwarding address, voter registration, driver's license address, or other such verification.

2.66 "Residential Mental Health Treatment" means non-Medically Necessary, primarily custodial treatment provided in a facility that provides services twenty-four (24) hours a day.

2.67 "Residential Substance Abuse Treatment" means treatment in a medically supervised residential setting where patients spend the night and are involved in a structured treatment program at least eight (8) hours per day, five (5) days per week.

2.68 "Rider" means an addition to this Certificate that provides for additional, different, or reduced Coverage for Covered Services and Members' responsibility for Out of Pocket Costs.

2.69 "Schedule of Benefits" means the document issued with this Certificate containing a brief summary of benefits, and the Copayment, Coinsurance, and Out of Pocket Costs (including Out of Pocket Maximum Costs) a Member is responsible for paying related to Covered Services. Although a benefit is listed in the Schedule of Benefits, it may require Prior Authorization or may not be a Covered Service. Benefits are subject to any exclusions and/or limitations contained in this Certificate or in any Rider.

2.70 "Semi-Private Room" means a room containing two (2) or more patient beds in an inpatient facility.

2.71 "Short-Term" means service for a condition that HPI determines can be expected to significantly improve within a period of sixty (60) days.

2.72 "Skilled Nursing Care" means concentrated observation, monitoring, evaluation, and intervention by licensed and trained personnel under the direction of a Physician and usually does not require daily intervention for conditions that are stable or stabilizing.

2.73 "Skilled Nursing Facility" means a facility licensed to provide Skilled Nursing Care in accordance with the Act or other similar licensing statute or its governing state or governmental unit.

2.74 "Specialist Physician" means a Physician who specializes in an area of medicine, other than family practice, internal medicine, or pediatrics.

2.75 "Sponsor" means the person who assumes financial responsibility for remitting Premium payments to HPI on behalf of the Member.

2.76 "Terminal Illness" means a medical or surgical condition for which an individual has a medical prognosis that his/her life expectancy is six (6) months or less if the illness runs its normal course.

2.77 "Urgent Care Center" means a facility that provides Urgent Care Services.

2.78 "Urgent Care Claim" means a Claim for which resolution within HPI's normal time frames, due to the medical status of the Member, would seriously jeopardize the life or health of a Member or his/her ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately. Only Pre-Service Claims, and not Post-Service Claims, can be Urgent Care Claims.

2.79 "Urgent Care Services" means Medically Necessary services furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition.

2.80 "Visit" means a meeting between a Member and Provider for the purpose of rendering Covered Services, without regard to the frequency of meetings if such meeting is separated by any period of time.

SECTION III – ELIGIBILITY FOR BENEFITS; ENROLLMENT

3.1 Members

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

A. Reside in the State of Michigan;

B. Complete and submit an Application for enrollment and the first Premium payment for himself/herself;

C. Be between the ages of nineteen (19) and thirty (30) on the date of enrollment or the date of renewal;

D. Not be covered for similar benefits and to a similar extent by another expense-incurred hospital, medical, surgical, or sick-care insurance policy or certificate, hospital or medical service contract, medical practice or other prepayment plan, or other expense-incurred plan or program;

E. Not be covered by Medicare, Medicaid, or Children's Special Healthcare Services (CSHS); and

F. Meet any other specific eligibility criteria specified by HPI.

3.2 Newly born or adopted children

A Member must notify HPI within thirty-one (31) days after the birth of a child or the date of adoption or placement for adoption of a child. Such children are not eligible for Coverage under this Certificate, however, a Member who wishes to provide coverage for the child may change to a HealthPlus Signature Select, Signature Savings, or Signature Network plan for himself/herself and the child.

3.3 Ineligibility

No person shall be entitled to enroll as a Member if he/she has had a prior HPI Certificate of Coverage terminated based on his/her violation of the terms of the Certificate.

3.4 Notification of Changes that Affect Coverage

A Member, his/her Authorized Representative or Sponsor must notify HPI in writing, within thirty-one (31) days, of any of the following events that may affect Coverage under this Certificate:

A. Change in address or phone number;

B. Eligibility of Member for Medicare, Medicaid, or CSHS;

C. Death of Member; or

D. Health care coverage by any other insurance or health plan.

The Member (or his/her Authorized Representative or Sponsor) is responsible for notifying HPI of any such changes. Failure to timely notify HPI of any of these changes may affect Coverage or result in the Member losing HPI Coverage. HPI is not responsible for any lapse in Coverage because of failure to notify HPI of any change in status.

SECTION IV – EFFECTIVE DATE OF COVERAGE

4.1 Effective Date

Except as provided in Paragraph 4.2 below, the Effective Date of Coverage shall mean the first (1st) of the month provided all of the following have taken place:

A. The completed Application for the Member has been received and approved by HPI; (evidence of approval by HPI will be based on the issuance of an Identification Card and policy certificate);

B. The appropriate advance Premium has been received by HPI for Member; and

C. The Member is eligible for Health Care Benefits as determined by HPI.

4.2 Inpatient on Effective Date

In the case of a Member who is an inpatient on the Effective Date of Coverage specified in Paragraph 4.1, above, HPI will coordinate inpatient benefits if an eligible individual has coverage provided or available through any other carrier, program or insurance. If the eligible individual has no other coverage provided or available on a continuing or extended basis through any other carrier, program, or insurance, HPI will provide Coverage for inpatient benefits beginning on the Effective Date of Coverage.

SECTION V – ACCESSING COVERED SERVICES

5.1 PPO Plans and Members' Responsibilities

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

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

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

5.2 Provider of Choice

A. Members may receive Health Care Benefits from any Provider the Member chooses. However, if a Member receives Health Care Benefits from a Non-Preferred Provider, the Member will be responsible for paying higher Copayments, Coinsurance, and Deductibles. Members should refer to the Schedule of Benefits and any applicable Riders for further information.

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

5.3 Termination of a Provider's Participation

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

A. The Provider is not leaving HPI's PPO network because of failing to meet HPI's quality standards or based on fraudulent conduct;

B. The Provider is still available to continue treating Members;

C. The continuation period is approved by HPI;

D. The Provider agrees to continue to meet HPI's quality standards and comply with HPI's policies and procedures; and

E. The Provider agrees to accept, as payment in full, reimbursement from HPI at the rates applicable prior to the Provider's termination.

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

A. For up to ninety (90) days after the Member receives notice that the Provider is leaving HPI's PPO network; or

B. In the case of a Member with a Terminal Illness, through the remainder of the Member's life for treatment related to the Terminal Illness.

5.4 Member Identification Cards

A. A Member is required to present his/her Member Identification Card to a Provider before receiving Covered Services. Merely possessing an Identification Card does not entitle the holder to Health Care Benefits under this Certificate unless all required Premiums have been paid.

B. A Member shall not allow any other person to use his/her Identification Card. A Member who allows another person to use his/her Identification Card may have his/her Identification Card confiscated and be immediately terminated by HPI, at HPI's direction. Additionally, any person who receives Health Care Benefits through the unauthorized use of an Identification Card will be required to repay the costs of such Health Care Benefits at prevailing rates. A Member shall immediately notify HPI, in writing, of any loss or theft of his/her Identification Card.

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

5.5 Forms and Applications

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

SECTION VI – PRIOR AUTHORIZATION FOR BENEFITS

6.1 Obtaining Prior Authorization

A. Medical Prior Authorization

Members may be required to obtain Prior Authorization from HPI or its designee for certain services and/or supplies. If required, Prior Authorization must be obtained from HPI (or its designee) at least five (5) days before a Member receives the service requiring such Prior Authorization. If a Member does not obtain Prior Authorization, the Member will be responsible for the entire cost of the service if HPI or its designee, determines that the service was not Medically Necessary. If HPI determines that the service for which Prior Authorization was required but not obtained was Medically Necessary, the Member will be charged a penalty of the lesser of the cost of the service or the amount specified in the Member's Schedule of Benefits. However, for certain services, if the Member has not obtained Prior Authorization if required, there will be no HPI Coverage for the service even if the service is Medically Necessary (see Section 7.4C). Neither the costs a Member pays for non-Medically Necessary Services obtained without required Prior Authorization nor the "lesser of the cost" or the penalty amount for obtaining Medically Necessary Services without required Prior Authorization will be applied to the Member's Deductible or Out of Pocket Maximum, as described in the Schedule of Benefits.

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

6.2 Review of HPI's Prior Authorization Decisions

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

6.3 Time for Making Prior Authorization Decisions

For most non-urgent Prior Authorization decisions, HPI or its designee will make its decision within fifteen (15) calendar days after receiving the request. For Prior Authorization decisions involving Urgent Care Claims, HPI or its designee will make its decision within twenty-four (24) hours of receiving the request.

6.4 Services Requiring Prior Authorization

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

A. Consultations and procedures for:

1. Plastic, cosmetic or reconstructive surgery, including but not limited to, surgery of the skin, Botox injections, removal of skin tags, eye or eyebrow lifts, or removal of excess skin due to weight loss.

2. Heat, cold or chemical treatment of acne.

3. Surgery of the jaw or gums and jaw reconstruction.

4. Breast enlargement, reduction, and/or adjustment (to make breasts of equal size).

5. Removal of breast implants.

6. Weight loss (Bariatric) surgery.

7. Surgical treatments for sleep apnea.

8. Transplant and evaluations for transplant.

9. Autologous chondrocyte knee transplantation.

10. Bone-anchored Hearing Aid.

11. Services of an anesthesiologist for outpatient dental procedures.

12. Covered infertility Services.

13. Varicose vein treatments.

14. Robotic Image Guided Linear Accelerator (e.g., CyberKnife, Novalis Tx, Acesse).

15. Clinical Trials and associated routine medical care.

B. Inpatient Care

1. Elective (non-emergent) admissions; inpatient skilled nursing; and sub acute, long-term acute and rehabilitation care.

2. Mental health and substance abuse admissions, including detoxification, residential day treatment (partial hospitalization) and intensive outpatient/Intermediate Care.

3. Inpatient Hospice care.

4. Clinical trials and associated routine care.

C. Outpatient Services

1. Specialty injectable medications, for example growth hormones or injectable drugs for rheumatoid arthritis or multiple sclerosis, at a physician’s office or outpatient facility.

2. Outpatient pulmonary rehabilitation.

3. Psychological testing for Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), and Oppositional Defiant Disorder (ODD).

4. All Prosthetic Devices and Orthotic Appliances.

5. Home health services beyond thirty (30) Visits per benefit year.

6. Residential Hospice or home Hospice care beyond one hundred eighty (180) days.

7. Non-emergency ambulance transportation between health care facilities.

8. Clinical trials and associated routine medical care.

D. Durable Medical Equipment

1. The Durable Medical Equipment (DME) listed below *always* require Prior Authorization:

- Bone growth (Osteogenic) stimulators, electric or ultrasonic.
- CPAP (Continuous Positive Airway Pressure) or BiPAP (Bi-level Positive Airway Pressure) machine for sleep apnea. A Member must also re-certify every three (3) months.
- Custom made compression stockings.
- Insulin pumps.

2. Any DME costing over three thousand dollars ($3,000) *always* requires Prior Authorization. Common examples include, but are not limited to:

- Chair-lift mechanisms
- Chest compression vest
- Life vests (wearable automatic cardiac defibrillators)
- Power wheelchairs
- Power operated vehicles
- Speech generating machines
- Ventilators

E. Imaging Services, Diagnostic, and/or Therapeutic Services

1. Imaging services such as Nuclear Cardiac Studies, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Magnetic Resonance Angiography (MRA), and Positron Emission Tomography (PET scan) are covered only if a Member or a Physician acting on a Member's behalf obtains Prior Authorization from HPI or its designee.

2. Virtual studies, such as virtual colonoscopy and capsule endoscopy studies.

This list may be updated from time to time. Members should carefully review this Certificate of Coverage, the Schedule of Benefits, and any applicable Rider. A Member may obtain a list of services and supplies requiring Prior Authorization by visiting HPI's website, www.healthplus.org, or by contacting HPI's Customer Service department. If a Member has specific questions regarding whether Prior Authorization

is required for a particular service or supply, the Member should contact HPI's Customer Service department at 1-888-212-1512.

SECTION VII – SCHEDULE OF COVERED SERVICES

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

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

7.1 Immunizations and Preventive Services

Preventive Services are routine health care services aimed at prevention, early detection and early treatment, including screenings, immunizations and examinations that are provided based on a Member's age and sex. Certain services are not considered Preventive Services based on the place at which they are provided. For example, services provided in an inpatient Hospital setting, Hospital emergency department, Freestanding Emergency Center, or Urgent Care Center are not Preventive Services and Members are responsible for paying any applicable Out-of-Pocket Costs. Preventive Services are not subject to Deductibles or Coinsurance, but may be subject to office visit Copayments (Members should refer to the Schedule of Benefits for details).

Generally, the following Preventive Services are covered:

A. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, as the same may be amended from time to time.

B. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010 with respect to the individual involved, as the same may be amended from time to time.

C. Immunizations for routine use in adults that have in effect a recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, as the same may be amended from time to time. A recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

Immunizations that are Covered Services may include:

A. Meningitis vaccine – once between ages nineteen (19) and twenty (20)

B. Influenza vaccine – every year

C. Pneumonia vaccine if Medically Necessary

D. Tetanus/diphtheria – booster at age twenty-five (25), and then if injured

E. HPV vaccine

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

Travel-related immunizations are not covered.

Preventive Services that are Covered Services may include:

A. Routine health maintenance examination and assessment for adults: one (1) per calendar year.

B. "Well Woman" services:

- Gynecological examination – one (1) per calendar year.
- Cervical cancer screening Pap smear (laboratory and pathology services) - one (1) per calendar year beginning at age nineteen (19).
- Chlamydia screening – one (1) per calendar year for women ages nineteen (19) through twenty-five (25).

C. Cholesterol screening: once per calendar year beginning at age twenty (20).

Members should note that preventive diagnostic screenings furnished more than once a calendar year and/or done before the age indicated are not deemed to be Preventive Services and the Member will be responsible for paying any applicable Copayment and Deductible for such services. No Coverage for Preventative Services obtained from a Non-Preferred Provider.

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

7.2 Physician and Professional Services

A. Inpatient and outpatient consultations provided by a Physician or Specialist Physician.

B. Surgical and anesthesiology services provided by a Physician or Specialist Physician.

C. Other Physician services provided for the diagnosis and/or treatment of an illness or injury including those services associated with Emergency Health Services.

D. Other professional Practitioner services provided for the diagnosis and/or treatment of an illness or injury including those services associated with Emergency Health Services.

7.3 Emergency Health Services

A. Hospital emergency department Visits.

B. Physician and Practitioner services in a Hospital emergency department for Emergency Health Services.

C. Ambulance services (air or ground), not including Ambulance services from a Hospital to a Member's home, when Medically Necessary. No Coverage if a Member receives treatment by Ambulance personnel but is not transported to a Hospital. Prior

Authorization is required for Ambulance transfers between facilities. All other non-emergency Ambulance transportation is not covered.

D. Freestanding Emergency Center or Urgent Care Center Visits.

Emergency Health Services do not require Prior Authorization and Members are subject to the same Deductible, Coinsurance and Copayment amounts whether the services are provided In-Network by Preferred Providers or Out-of-Network by non-Preferred Providers.

7.4 Outpatient Laboratory and Diagnostic Services

A. Clinical laboratory and pathology tests ordered by a Physician.

B. Diagnostic and therapeutic radiological services such as:

- Electrocardiogram.
- Electroencephalogram.
- Diagnostic x-rays.
- Therapeutic procedures.
- Physician services when required to read and/or administer certain radiological tests.

C. Imaging services, including but not limited to: MRI, CAT scan, CT, CTA, MRA, PET scan, and nuclear cardiac studies and virtual studies are covered only if Member, or his/her Physician acting on Member's behalf, obtains Prior Authorization from HPI or its designee.

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

7.5 Hospital Care
(other than mental health and substance abuse services (see Sections 7.8 and 7.9 below))

A. Inpatient care including:

- Room and board in Semi-Private Room or in a private room for medical reasons (when authorized by a Physician).
- Inpatient Physician services.
- General nursing care.
- Hospital services and supplies.
- Therapeutic and support care.
- Care in specialized units as Medically Necessary.
- Fees for use of operating, delivery, recovery, and treatment rooms and equipment.
- Special diets.
- Short-Term inpatient rehabilitation services.
- Medical detoxification.

B. Hospital services and supplies for procedures performed on an outpatient basis.

C. Surgical services including appropriate professional services, anesthesia, and all related surgical services and supplies.

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

See Sections 6.1 through 6.4 for Prior Authorization requirements including lists of services that require Prior Authorization and Member financial responsibility if the Prior Authorization process is not followed.

7.6 Alternatives to Hospital Care

A. HOSPICE

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

1. inpatient care for pain and/or symptom control that cannot be done safely in another location, and/or up to five (5) days of respite care in a thirty (30) day period. Prior Authorization from HPI or its designee is required.

2. residential care in a freestanding Hospice facility. No Prior Authorization is required for the first one hundred eighty (180) days. Prior Authorization from HPI or its designee is required for up to an additional one hundred and eighty (180) days thereafter.

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

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

B. HOME HEALTH CARE

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

1. Intermittent Skilled Nursing Care;

2. Short-Term physical therapy;

3. Short-Term speech therapy in conjunction with Skilled Nursing Care;

4. medical-social services in conjunction with Skilled Nursing Care; and

5. Short-Term occupational therapy in conjunction with Skilled Nursing Care

Limited to one hundred (100) Visits per calendar year.

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

7.7 Organ and Tissue Transplants

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

A. Human organ transplants: liver, heart, lung, pancreas, heart/lung, small bowel/liver, and kidney.

B. Bone marrow transplants.

C. Cornea and skin transplants.

D. Organ/tissue donor expenses

The following donor expenses are covered:

1. typing or screening of a potential donor only if the proposed transplant recipient is a Member and the potential donor is a parent, child or sibling of the Member proposed to receive the transplant.

2. computer organ bank searches and any subsequent testing necessary after a potential donor is identified, unless covered by other insurance.

3. donor's medical expenses if the person receiving the transplant is a Member and the donor's expenses are not covered by other insurance.

The following donor expenses are not covered:

1. community wide searches for a donor.

2. all donor expenses, even those for donors who are Members, for transplant recipients who are not Members.

Anti-rejection drugs received after a transplant on an outpatient basis may be covered by a Prescription Drug Rider.

7.8 Mental Health Services

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

A. Inpatient Mental Health Hospitalization.

B. Intermediate Care, including Day Treatment Mental Health Programs/partial hospitalization Programs and intensive outpatient Programs.

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

C. Outpatient mental health Visits.

D. Attention deficit and disruptive disorders and other behavioral disorders—only the initial Visit and periodic medication management Visits are covered for these disorders. Prior Authorization from HPI or its designee is required for all psychological testing. Additional outpatient Visits for these diagnoses do not meet Medical Necessity under the mental health benefit..

E. Mental retardation disorders, learning disorders, motor skills disorders, communication disorders and pervasive developmental disorders—only the initial Visit and periodic medication management Visits are covered for these disorders. Prior Authorization from HPI or its designee is required for all neuropsychological testing. Additional outpatient Visits for these diagnoses do not meet Medical Necessity under the mental health benefit.

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

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

7.9 Substance Abuse Treatment

Coverage for treatment of substance abuse as listed below.

A. Inpatient detoxification.

B. Residential Substance Abuse Treatment.

C. Intermediate Care, including Day Treatment Substance Abuse Programs/partial hospitalization Programs and intensive outpatient Programs.

Prior Authorization from HPI or its designee is required for all substance abuse admissions, including: inpatient detoxification, Residential Substance Abuse Treatment and Intermediate Care.

D. Outpatient substance abuse Visits. Must meet Medical Necessity criteria.

7.10 Autism

HPI will cover the diagnosis and treatment of autism spectrum disorders as defined by the diagnostic and statistical manual published by the American Psychiatric Association, including:

A. Autistic disorder.

B. Asperger's disorder.

C. Pervasive developmental disorder.

HPI may as a condition of providing autism spectrum disorder Coverage:

A. Request a review of the treatment consistent with current protocols and require a treatment plan,

B. Request the results of the autism diagnostic observation schedule,

C. Request that the autism diagnostic observation schedule be performed not more frequently than once every 3 years, and

D. Request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to HPI.

Coverage for the treatment of autism spectrum disorders includes:

A. Applied Behavior Analysis and other evidence-based counseling and treatment programs defined as established treatments in the National Standards Report published by the National Autism Center. A Prior Authorization is required from HPI and will require documentation of progress in the treatment plan for consideration of continuing care. If the clinical interventions do not result in measurable progress over a 6 month intervention period, Coverage for further treatment may be denied.

B. Physical therapy, speech therapy, occupational therapy provided as part of the treatment of autism spectrum disorders. A Prior Authorization is required from HPI. If these therapies do not result in measurable progress over a 6 month intervention period, Coverage for further treatment may be denied. Physical, occupational and speech therapy services used as part of the autism benefit will not count toward the number of medical visits that may be limited for these therapies.

Coverage for the diagnosis and treatment of the above autism spectrum disorders will be provided to a Member through 18 years of age. The following maximum annual Allowed Amount applies to Applied Behavior Analysis provided as part of the treatment of autism spectrum disorders:

A. For a Member through 6 years of age, $50,000.00.

B. For a Member from 7 years of age through 12 years of age, $40,000.00.

C. For a Member from 13 years of age through 18 years of age, $30,000.00.

HPI will prorate the maximum annual Allowed Amount in years when a Member changes from one age band to another.

No Coverage for autism beyond the stated limitation even if the services remain Medically Necessary. Prescription Drugs and related services are not covered unless Member has Prescription Drug Coverage through HPI. Coverage will be subject to all general exclusions and limitations as set forth under this Certificate, including, but not limited to, coordination of benefits; Preferred Provider requirements; restrictions on services provided by family or household members; services provided at school as part of any Individualized Educational Program, federal or state mandated provision or Early On; experimental services; review of Health Care Benefits including review of Medical Necessity; and other applicable provisions under this Certificate.

7.11 Short-Term Outpatient Rehabilitative Therapy

Coverage for Short-Term outpatient therapy including:

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

Coverage is limited to twenty (20) Visits total consisting of physical therapy, speech therapy, and/or occupational therapy per calendar year for treatment of an illness, injury or congenital birth defect if the Member has surgery to correct such defect.

Coverage is limited to twenty (20) Visits per calendar year, even if the services remain Medically Necessary after twenty (20) Visits. No Coverage for developmental delays or

learning disabilities; or for treatment of congenital birth defects, unless the Member has had surgery to correct such a condition. No Prior Authorization is required.

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

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

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

7.12 Durable Medical Equipment ("DME")

Coverage for Medically Necessary equipment obtained from Preferred Providers including urological and ostomy supplies, and diabetic management supplies.

Members should contact HPI's Customer Service department for more information regarding specific Coverage questions. Prior Authorization from HPI or its designee is required for individual DME items costing three thousand dollars ($3,000.00) or more, and those DME items listed in Section 6.4(D)(1). No Coverage for DME obtained from a Non-Preferred Provider.

7.13 Prosthetic Devices and Orthotic Appliances ("P&O")

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

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

7.14 Therapeutic Services

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

7.15 Diabetic Services

A. HPI will cover the following equipment, supplies and educational training related to the treatment of diabetes if determined to be Medically Necessary and prescribed by the Member's treating Physician:

1. blood glucose monitors and blood glucose monitors for the legally blind.

2. test strips for glucose monitors, visual reading and urine treating strips, lancets, and spring-powered lancet devices.

3. insulin pumps and medical supplies required for the use of an insulin pump.*

4. insulin syringes.

5. diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management and treatment of their condition.

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

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

1. it is limited to completion of a certified diabetes education program only if:

- considered Medically Necessary upon the diagnosis of diabetes by the Member's treating Physician who is managing the Member's diabetic condition and if the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or

- the Member's treating Physician diagnoses a significant change with long-term implications in the Member's symptoms or conditions that requires changes in the Member's self-management or a significant change in medical protocol or treatment modality.

2. it shall be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Department of Community Health. This training shall be conducted in group settings whenever available.

7.16 Obtaining services from retail clinics and university clinics

A Member may receive Covered Services from a retail clinic or a university clinic. A Member receiving Covered Services at these locations must pay for the services himself/herself and then request reimbursement from HPI by following the procedures provided in Section 9.4 of this Certificate. The Member's in network Deductible and Coinsurance will apply.

7.17 Coverage when traveling outside of the United States

When a Member is traveling outside of the United States, HPI provides Coverage for Emergency Health Services and Urgent Care Services only, provided that such services are not reimbursed by another entity, including but not limited to the health service of a foreign government.

A Member receiving treatment for an Emergency Health or Urgent Care Service while outside of the United States must pay for services himself/herself and then request reimbursement from HPI by following the procedure provided in Section 9.4 of this Certificate. The Member's in network Deductible and Coinsurance will apply.

If a Member's treatment for an Emergency Health or Urgent Care Service requires hospitalization, the Member or his/her representative must contact HPI as soon as reasonably possible for authorization.

7.18 Other Services

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

B. Prosthetic Devices and reconstructive therapy after mastectomy:

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

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

1. the drug is ordered by a Physician for the treatment of a specific type of neoplasm;

2. the drug is approved by the federal Food and Drug Administration ("FDA") for use in antineoplastic therapy;

3. the drug is used as part of an antineoplastic drug regimen;

4. current medical literature substantiates the drug's efficacy and recognized oncology organizations generally accept the treatment; and

5. the Physician has obtained informed consent from the Member for the treatment regimen that includes FDA-approved drugs for off-label indications.

D. Vision care Coverage for: (1) medical conditions and diagnoses related to vision loss, (2) one (1) pair of glasses post-cataract surgery (limited to a maximum of two hundred and fifty dollars ($250.00)), and (3) one (1) retinal eye exam per calendar year for diabetics.

E. Pain management services including Coverage for the evaluation and treatment of intractable pain.

F. Oral surgery and related services when Medically Necessary for the following conditions:

1. prompt repair and treatment of fractures and dislocation of the jaw immediately following an accident or traumatic injury.

2. prompt repair of injury to the jaw, tongue, cheeks, lips, and roof/floor of the mouth immediately following an accident or traumatic injury (implants and repair/restoration of the teeth are <u>not</u> a Covered Service).

3. orthognathic surgery prior to age twenty-one (21) for congenital defects directly affecting the growth, development, and ability to chew or maintain nourishment.

4. treatment of tumors, cysts, and lesions on or in the mouth except when in connection with an extraction.

5. hospitalization for: (a) multiple extractions which must be performed in a Hospital due to a concurrent hazardous medical condition, or (b) when general anesthesia is required due to: (i) Member's physical or mental condition, (ii) significant trauma in the facial area, (iii) the nature of a special procedure requires general anesthesia, or (iv) the Member's age along with other contributing factors necessitates the use of general anesthesia in a hospital setting. <u>Members are required to obtain Prior Authorization from HPI or its designee for dental hospitalizations</u>.

Routine Dental Care is <u>not</u> a Covered Service.

G. Medically Necessary Reconstructive surgery to correct congenital birth defects or the effects of illness/injury. <u>Prior Authorization from HPI or its designee is required</u>.

Treatment must begin within two (2) years following the occurrence necessitating treatment.

H. Medically Necessary neuropsychological testing/assessment, limited to no more than two (2) per calendar year.

I. Specialty injectable medications. Prior Authorization from HPI or its designee is required

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

J. Dietician services/nutritional counseling with a Registered Dietician, up to a maximum of six (6) Visits per calendar year.

K. A Member's participation in either treatment or palliative Clinical Trials only if all of the following conditions are met:

1. there is no clearly superior, non-investigational treatment alternative relative to established therapies;

2. the available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative;

3. the Member, the Member's treating Physician and an HPI Medical Director conclude that the Member's participation in the Clinical Trial is Medically Necessary and appropriate pursuant to procedures established by HPI or its designee; and

4. the Member's treating Physician is involved in the coordination of care.

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

SECTION VIII – LIMITATIONS AND EXCLUSIONS

8.1 Coverage Limitations

A. Services covered by another party

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

1. covered under a workers' compensation policy, no fault or other auto policy, Medicare, CHAMPUS, or any other state or federal program, other insurance plan, or by any other third party payor.

2. for educational or sports-related purposes.

3. pursuant to a court order to determine competency or as a condition of parole or probation (including mental health or substance abuse evaluation and/or treatment).

B. Major disasters

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

C. Emergency Health Services

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

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

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

E. Inappropriate and unnecessary services

Benefits shall be limited to providing Coverage for necessary treatment as determined by reviewing the intensity of service, severity of illness, appropriateness of services rendered, and appropriateness of placement in special units and selected clinical support facilities. Services may be reviewed prospective, concurrent, or retrospective to the time of service. Such review shall impact only the level of Coverage provided by HPI and shall not serve, or be construed as, any limitation or infringement of any Member's right to select and pay for any level of care desired in any location.

8.2 Additional Services

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

8.3 Exclusions from Coverage

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

A. Services determined not to be Medically Necessary for which Prior Authorization was required but not obtained.

B. Services and supplies to the extent not Medically Necessary for the diagnosis and treatment of injury, illness, or pregnancy

C. Excess Charges.

D. Services performed before the Effective Date of Coverage or after the Effective Date of Termination.

E. Charges incurred by a Member that HPI is not legally required to pay.

F. Dental Care (including orthodontic care) and associated supplies, services, and tests, except as specifically provided in Section 7.17(F).

G. Cosmetic surgery and other services and products for Cosmetic purposes, such as procedures to correct baldness or wrinkling, facial peels, chin lifts, and repair of skin color defects. However, this exclusion does not apply to Medically Necessary Reconstructive surgery.

H. Custodial or domiciliary, basic care, or housekeeping provided on an inpatient, outpatient, or in-home basis.

I. Vision care including: (a) visual therapy (except vision therapy for amblyopia, acquired esotropia, strabismus, intermittent exotropia, heterotropia, convergence insufficiency and accommodative deficiencies), (b) treatment of dyslexia, (c) vision correction surgery, and (d) eyeglasses or contact lenses (except for the initial pair of eyeglasses prescribed following cataract surgery), or other artificial aids, or the examination for, fitting or maintenance thereof.

J. Examinations, reports or any other services related to requirements or documentation of health status for employment, licenses, insurance, travel, or for educational or sports/recreational purposes.

K. Services for any injury or illness to the extent any benefits, settlements, awards or damages are available under workers' compensation, any insurance plan or other third party payor, state or federal legislation or any school or other public program supported in whole or in part by governmental funds. Services for any injury or illness related to an accident involving an automobile or other motor vehicle when the Member has an uncoordinated auto insurance policy.

L. Services for which the Member is eligible under any governmental program, or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member.

M. Services for any injury or illness resulting from war, or an act of war or service in the armed forces of any country, to the extent coverage of such injury or illness is available through any governmental plan.

N. Non-Emergency Health Services furnished by a Provider outside of the United States.

O. Emergency Health Services outside the United States covered by a foreign governmental public health program.

P. Medical, surgical, or psychiatric procedures, treatment or devices, pharmacological regimens (except antineoplastic drugs as provided in Section 7.17C above), and associated health care services, which are considered Experimental in nature under accepted standards of practice. Something may be considered by HPI to be Experimental if one of the following circumstances applies:

1. FDA approval, if applicable, has not been granted at the time of its use or proposed use;

2. it is the subject of an investigational new drug or device application on file with the FDA;

3. it is being provided as part of a Phase I, II, or III clinical trial;

4. it is being provided under the supervision of an Institutional Review Board formally designated by an institution to review, approve, and conduct biomedical research involving human subjects as required and defined by applicable federal regulations; or

5. it is being provided pursuant to experimental or research protocol testing for factors such as safety, efficacy, or toxicity; or published authoritative literature concerning the particular procedure, treatment, device, or regimen indicates that further research is needed to define factors such as safety, efficacy, or toxicity.

Q. Mental health services and supplies which are:

1. rendered in connection with mental illness not classified in the International Classification of Diseases of the World Health Organization, as modified by the U.S. Center for Health Statistics;

2. extended beyond the period necessary for the evaluation and diagnosis of mental retardation; or

3. for mental diseases or illness that, according to generally accepted professional standards, are not usually amenable to favorable modification, such as autism or pervasive developmental disorders (except as provided in Section 7.8E above).

R. Long-term psychotherapy and extended behavior modification.

S. Treatment of: personality disorders (such as Antisocial Personality Disorder), insomnia/sleep disorders, nicotine/caffeine abuse or addiction, sexual/gender identity issues, adoption adjustment issues, methadone maintenance, and phototherapy.

T. Vocational rehabilitation services, such as work hardening, work training and other work-related or return to work programs.

U. Long-term rehabilitation treatment and services.

V. Personal comfort or convenience items such as television and phone services, environmental control, and self help products and services (including but not limited to: feeding, dressing, and bathroom aids, and communication devices).

W. Cognitive services (such as skills and memory training, stress reduction, or relaxation therapy).

X. Orthopedic or other corrective footwear, unless attached to a prescribed hip, knee, and/or ankle-foot orthopedic brace, and outflow shoes for children age three (3) and under.

Y. Sex transformation surgery and all expenses in connection with such surgery.

Z. Parentage testing.

AA. Genetic testing.

BB. Surgery and any other services or supplies for the purpose of weight reduction or control, except when specifically approved by HPI for severely obese Members with high-risk co-morbidities.

CC. Wigs, prosthetic hair, hair transplants, or other procedures or supplies to enhance hair growth.

DD. Court ordered tests, reports, or treatment, including involuntary psychiatric treatment or substance abuse treatment, unless otherwise covered by this Certificate or a Rider.

EE. Care rendered while in police custody.

FF. Services or products provided by Convalescent Homes, Homes for the Aged, or Adult Foster Care facilities.

GG. Nonprescription drugs (or their Prescription Drug equivalents), dietary and other supplements (such as vitamins, minerals, protein or caloric boosting supplements, food supplements, medical foods and infant formula), and articles and supplies provided on an outpatient basis, and not specifically identified as Health Care Benefits by this Certificate or a Rider.

HH. Ancillary services provided as an adjunct to services for which Health Care Benefits are not provided under this Certificate.

II. Skilled nursing services provided on a twenty-four (24) hour basis in the Home.

JJ. Durable Medical Equipment that is available without a Physician’s prescription (over the counter) except diabetic supplies, and portable, battery operated nebulizers.

KK. Replacement or repair of a Covered Durable Medical Equipment item due to misuse or loss by a Member.

LL. Private duty nursing services.

MM. Routine foot care including, but not limited to, hygienic care, treatment of corns, calluses, toenails, or fungus.

NN. Charges associated with alternative or non-standard therapies, including, but not limited to: hypnosis/hypnotherapy, biofeedback (except for certain circumstances involving urinary incontinence), acupuncture services, light therapy, massage therapy, exercise programs, herbal therapies, aromatherapy, holistic or homeopathic treatment, and Reiki or Rolf therapy.

OO. Coverage for treatment that is necessary because of the Member’s commission of, or attempt to commit, a felony, or because the Member was engaged in an illegal occupation.

PP. Services, products, or supplies that are illegal.

QQ. Charges for the completion or copying of claims forms or medical records, interest on late payments, or charges for failure to keep scheduled appointments.

RR. Medical expenses incurred by a Member who donates an organ or tissue to a non-Member. Medical Expenses incurred by a non-Member who donates an organ or tissue to a Member will only be covered if the non-Member does not have coverage for those services.

SS. Services that are provided by individuals who are not licensed/certified under the Act (or other similar code/statute of any other state or governmental unit) or services which are beyond the treating individual's licensing.

TT. Charges for transportation and/or lodging that may be required to receive Covered Services.

UU. Premarital exams or classes.

VV. 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.

WW. Speech therapy to treat or correct a foreign accent, lisping or stuttering; or as part of a cognitive rehabilitation program, or for Members with developmental or learning disabilities.

XX. Educational services, therapy, and testing.

YY. Autopsies.

ZZ. Chemotherapy sensitivity and resistance testing.

AAA. Continuous blood glucose monitoring systems.

BBB. Earplugs.

CCC. Services or supplies furnished or ordered by a Provider included on the U.S. Department of Health and Human Services, Office of Inspector General's "List of Excluded Individuals/Entities" ("LEIE"). The LEIE lists individuals and entities that have been excluded from participation in federal health care programs and can be accessed electronically at: oig.hhs.gov/fraud/exclusion.html.

DDD. Academic education while receiving treatment at Day Treatment Mental Health/Substance Abuse program.

EEE. Consultation with a mental health professional for adjudication of marital disputes/divorce proceedings, and child support and custody cases.

FFF. Marriage counseling except when rendered in connection with a mental disorder classified in the International Classification of Diseases of the World Health Organization, as modified by the U.S. Center for Health Statistics.

GGG. Treatment for personal or professional, growth, development, training, or professional certification.

HHH. Treatment or consultations provided via telephone.

III. Cytotoxicity testing (Bryan's Test), urine autoinjection, and provocative and neutralization testing for allergies.

JJJ. Sensory integration therapy (except as provided in Section 7.8D).

KKK. Outpatient rehabilitative therapy for:

1. maintenance of a physical or chronic condition (such as Cerebral Palsy), or developmental status (including developmental delays);

2. apraxius and cognitive disorders; or

3. an impairment that is not based on an illness, injury or a congenital birth defect (which the Member has had a surgery to correct).

LLL. Outpatient rehabilitative therapy provided by massage therapists or non-health professionals.

MMM. Sleep and relational therapy and testing.

NNN. Craniosacral therapy.

OOO. Residential Mental Health Treatment.

PPP. Chiropractic services.

QQQ. Hearing testing, Hearing Aids, and Hearing Aid batteries.

RRR. Prescription Drugs.

SSS. Skilled Nursing Facility services.

TTT. Maternity services (including but not limited to: pre-natal and post-natal care, delivery and post-partum care, miscarriage, and obstetrical services).

UUU. Family planning and infertility services, including but not limited to: genetic testing and counseling; sterilization; insertion and removal of contraceptive devices; contraceptive injections; termination of pregnancy; and diagnosis, counseling, or treatment of infertility.

VVV. Physician office Visits, except for preventive services.

SECTION IX – PAYMENT AND CLAIMS PROVISIONS

9.1 Payment of Premium

All Premiums are payable on the fifteenth (15th) of the month by the Member (or Sponsor) for the next month's Coverage. A Member's first payment will be charged against a credit or debit card upon acceptance of Coverage under this Certificate. For those Members who elect to have subsequent payments made from a bank account, credit card, or debit card, payments will be processed against such account on the fifteenth (15th) of the month for the next month's Coverage. For those Members who choose to receive a paper bill, such bill will be sent on or about the first (1st) of the month with payment due on the fifteenth (15th) of the month for next month's Coverage.

9.2 Changes in Prepayment Rates

HPI reserves the right to change the Premium for Health Care Benefits provided under this Certificate on the yearly renewal date.

9.3 Coverage; Grace Period

For a Member to be entitled to Coverage under this Certificate, the Member must be current in Premium payments. If a Premium is not paid when due, Coverage will be terminated by HPI. However, a Grace Period of ten (10) days for Members who pay their Premium on a monthly basis, or thirty-one (31) days for Members who pay their Premium on an annual basis will be granted for the payment of each Premium falling due after the first Premium, during which Grace Period the policy shall continue in force. HPI reserves the right to pend any and all Claims submitted during this Grace Period.

9.4 Payment for Services by Member

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

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

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

Failure to furnish such proof within the required time shall not invalidate or reduce any Claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

B. Claim forms

HPI, upon receipt of a notice of Claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the Member gives such notice, the Member shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting, within ninety (90) calendar days from the date of loss, written proof covering the occurrence, the character and the extent of loss for which the Claim is made.

C. Legal actions

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

D. Payment of Claims.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Member. Any other accrued indemnities unpaid at the Member's death may, at the option of HPI, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Member. Subject to any written direction of the Member in the application or otherwise all or a portion of any indemnities provided by this Certificate on account of hospital, nursing, medical, or surgical services may, at HPI's option and unless the Member requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services. Any payment made by HPI in good faith pursuant to this provision shall fully discharge HPI to the extent of such payment.

9.5 Physical Examination and Autopsy

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

SECTION X – COORDINATION OF BENEFITS AND SUBROGATION

10.1 Coordination of Benefits

A. At the time of enrollment and if requested by HPI thereafter, Members are required to disclose to HPI whether they have health insurance coverage through any other private or public health plan (including government programs such as Medicare or Medicaid) or any other third party payor. Members must also immediately notify HPI if there are any changes in such coverage. If a Member fails to provide such information when requested, or to notify HPI upon any changes to the Member’s other health insurance coverage, HPI may deny payment for individual Claims.

B. If a Member entitled to Health Care Benefits under this Certificate is also entitled to benefits under any other private or public health plan or insurance policy, including but not limited to automobile insurance and workers’ compensation, benefits shall not be available under this Certificate, whether a claim is made for same, until the benefits of the other health benefit plan or insurance policy are exhausted. However, HPI will coordinate benefits with other health benefit plans or insurance in accordance with the Michigan Coordination of Benefits Act (Public Act No. 64 of 1984, as amended) or any other applicable or controlling law. When coordinating benefits, the plan that is “primary” must pay its benefits first (without considering coverage by any other plan). The plan that is “secondary” may take into consideration the benefits of the primary plan and pays for covered services that are not covered by the primary plan.

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

1. the other plan has primary responsibility if it has no coordination of benefits provision.

2. the benefits of a plan that covers a member other than as a dependent are primary.

3. if none of the above establishes the order of payment, the plan that has provided coverage the longest is primary.

C. In no event shall any Member through coordination of two (2) or more health plans or insurance policies recover more than the actual or Allowed Amount for all services provided to that Member.

D. If a Member also has coverage under a non-group plan issued as a hospital indemnity, surgical indemnity, specific disease or other non-group disability insurance policy (as such policies are defined by Michigan law), such coverage shall have no effect on the Member's Coverage under this Certificate.

10.2 Subrogation

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

A. Services for which benefits are available under any public or private health plan or insurance (including but not limited to, automobile, homeowners, workers' compensation or business insurance) and for which HPI is not the primary carrier under applicable law; or

B. Damages or injuries caused by or attributed to the willful or negligent act or omission of any third party for which the Member receives (or could receive) payment.

10.3 Member Consent

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

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

SECTION XI – MEMBER RIGHTS AND RESPONSIBILITIES

11.1 Member Rights – Grievance Process

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

11.2 Other Members Rights

A. A Member has the right to receive medical care in a prompt manner for his/her illness or injury.

B. A Member has the right to be treated with dignity and respect and to participate in health care decisions.

C. A Member has a right to privacy and confidentiality of his/her medical records and other personal information.

D. A Member has a right to receive information about appropriate treatment options.

E. A Member has a right to request and receive information about his/her Health Care Benefits and Coverage.

F. A Member has a right to review his/her medical records during normal business hours.

11.3 Member Responsibilities

A. A Member shall review and comply with this Certificate, the attached Schedule of Benefits, and any Riders, and shall contact HPI if he/she has any questions.

B. A Member shall notify HPI within twenty-four (24) hours or as soon as reasonably possible of an emergency admission.

C. A Member shall notify HPI of any change in name, address, or any other criteria for eligibility within thirty-one (31) days of the change.

D. A Member shall comply with any HPI Prior Authorization requirements.

E. A Member shall pay all applicable Copayments, Deductibles, and Coinsurance, as well as any penalty for not obtaining Prior Authorization when required and Out of Pocket Costs for Non-Covered Services or Covered Services furnished by a Non-Preferred Provider.

F. A Member shall notify HPI if the Member has any other health insurance coverage.

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

H. A Member shall not allow any other person to use his/her Identification Card or otherwise allow others to erroneously represent his/her identity as an HPI Member.

I. A Member may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by his/her treating Physician. If a Member refuses appropriate care recommended by his/her treating Physician and no alternative care

exists in the opinion of the Member's treating Physician, Coverage shall not be extended by this Certificate for the condition under treatment.

J. A Member shall be responsible for all services rendered prior to his/her Effective Date of Coverage and following the Effective Date of Termination. HPI shall be entitled to recover from the Member all Claims paid by HPI for services rendered to the Member after the Effective Date of Termination.

K. A Member shall execute any and all releases necessary in order for HPI to gain access to the Member's medical records, including mental health and substance abuse records.

L. A Member shall provide complete and truthful information, to the best of the Member's knowledge on all forms and correspondence submitted to HPI.

M. A Member shall not make an intentional misrepresentation of material fact.

N. A Member shall not perform an act, practice or omission that constitutes fraud.

SECTION XII – RECORDS

12.1 Membership Records

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

12.2 Inspection of Records by Member

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

12.3 Accuracy of Information

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

12.4 Confidentiality of Members' Protected Health Information

HPI may share a Member's Protected Health Information with other entities, such as health care Providers, payors, and HPI affiliates and contractors, when necessary to coordinate and oversee a Member's treatment, for payment purposes related to a Member's receipt of Covered Services under this Certificate, and for HPI's operation activities, such as those activities that enable HPI to monitor the quality of care a Member is receiving.

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

SECTION XIII – TERM AND TERMINATION

13.1 Term

Regardless of when the Effective Date of Coverage is, this Certificate shall terminate on November 30, 2014.

13.2 Termination

A. Member's loss of eligibility

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

B. Termination based on failure to pay Premium

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

1. at the end of the Grace Period if any Premium remains unpaid at the expiration of the Grace Period; or

2. on the date during any Grace Period that HPI receives written notice of termination from the Member.

C. Termination

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

D. Rescission of Coverage
HPI shall not rescind Coverage back to the Effective Date of this Certificate as it applies to a Member except under the following conditions:

1. The Member or person seeking Coverage on their behalf performs an act, practice or omission that constitutes fraud; or

2. The Member makes an intentional misrepresentation of material fact.

HPI shall provide at least thirty (30) days advance written notice to each Member who would be affected before Coverage may be rescinded under this Section.

E. Other reasons for termination by HPI

This Certificate shall terminate:

1. on the date the Member no longer Resides in Michigan;

2. on the date specified by HPI, after a Member obtains or attempts to obtain Health Care Benefits fraudulently or misrepresents or fails to disclose any material information to HPI;

3. on the date specified by HPI, if a Member becomes disruptive, unruly, abusive, threatening, or uncooperative and it seriously impairs HPI's ability to arrange for Covered Services for that Member or other Members enrolled in HPI, then the

rights of such Member under this Certificate may be terminated following not less than thirty (30) days written notice, but subject to the Member's rights under HPI's Member Satisfaction Plan;

4. on the date specified by HPI, if a Member does not notify HPI of his/her coverage under any health insurance or other insurance policy under which Member may be entitled to Health Care Benefits;

5. on the date specified by HPI, if a Member fails to provide requested information to HPI for its coordination or oversight of Member's care or Coverage under this Certificate;

6. on the date specified by HPI, if a Member allows someone else to use his/her Identification Card or uses another HPI Member's Identification Card;

7. on the date of a Member's entry into active military duty, except for temporary duty of thirty (30) days or less; or

8. if HPI terminates its operations as a disability insurer providing health insurance.

F. Nonpayment of Member Copayments or Coinsurance

HPI may terminate this Certificate if Member fails to pay Copayments, Coinsurance, Deductibles, or penalties for failure to obtain Prior Authorization when required following ninety (90) days written notice to the Member. The termination shall be effective on the date specified by HPI. HPI shall give reasonable notice of such termination.

G. Termination by Member

A Member may terminate his/her Coverage under this Certificate by providing prior written notice to HPI.

H. Effect of Termination

If this Certificate is terminated by HPI or a Member as described above, as of the Effective Date of Termination, the Member will no longer have Health Benefit Coverage under this Certificate. If a Member disagrees with HPI's decision to terminate the Member's Coverage, the Member may follow the procedures provided in HPI's Member Satisfaction Plan. Terminated Members will have Coverage under this Certificate until the Effective Date of Termination as provided below.

I. Effective Date of Termination

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

J. Time limit on certain defenses

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

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

SECTION XIV – GENERAL TERMS AND CONDITIONS

14.1 Interpretation and Construction

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

14.2 Entire Agreement

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

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

14.3 Amendments

This Certificate is subject to amendment, modification or termination in accordance with its provisions upon at least thirty (30) days written notice to Member. If Member continues to pay the Premium after such notice of amendment or modification by HPI, then such amendment or modification is deemed as accepted.

14.4 Notices

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

14.5 Governing Law

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

14.6 Reinstatements

If any renewal Premium be not paid within the time granted the Member for payment, a subsequent acceptance of Premium by HPI or by any agent duly authorized by HPI to accept such Premium, without requiring in connection therewith an Application for reinstatement, shall reinstate the policy. Provided, however, that if HPI or such agent requires an Application for reinstatement and issues a conditional approval receipt for the Premium tendered, the policy will be reinstated upon approval of such Application by HPI or, lacking such approval, upon the forty-fifth (45^{th}) day following the date of such conditional receipt unless HPI has previously notified the Member in writing of disapproval of such Application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects,

the Member and HPI shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

14.7 Identification Cards

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

14.8 Policies and Procedures

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

14.9 Adjustments and Refunds

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

14.10 Assignment

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

14.11 Independent Contractors

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

14.12 Provider Disclaimer

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

14.13 Headings

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

14.14 Severability

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

14.15 Waiver

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

14.16 Recovery of Payments

HPI shall be entitled to recover payments from the Member for any and all Claims payments made by HPI for services rendered to the Member after the Effective Date of Termination.

14.17 Time Of Payment Of Claims

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

HEALTHPLUS INSURANCE COMPANY
INDIVIDUAL MEMBER SATISFACTION PLAN

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

I. HPI ROUTINE (NON-EXPEDITED) GRIEVANCE PROCESS

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

Whenever Member concerns cannot be handled by the Customer Service Department or other appropriate staff, the Member (or his or her Authorized Representative) is afforded the opportunity to initiate the Grievance process. The Grievance process will be initiated at the request of a Member (or his or her Authorized Representative) by contacting HPI's Customer Service Department at 1-888-212-1512, mail (2050 S. Linden Road, P.O. Box 1700, Flint, Michigan, 48501-1700), fax (1-810-733-1947), or arranging a personal meeting.

Grievance

A. The Grievance will be forwarded to Member Satisfaction staff or outside review entity, along with any accompanying information or documents pertaining to the Grievance, in a timely manner to accommodate the clinical urgency of the situation.

B. Member Satisfaction staff or outside review entity will acknowledge receipt of the Grievance in writing to the Member (or his or her Authorized Representative) within five (5) business days and notify Members of his/her right to request a managerial level conference. The managerial level conference shall be an informal meeting with an appropriate manager, or higher level employee, of HPI during which the Member and/or his/her Authorized Representative may discuss the basis for his/her Grievance and present any information or documents the Member deems appropriate. This conference may be in person or conducted telephonically for the convenience of the Member.

C. Member Satisfaction staff or outside review entity, acting as investigator, will thoroughly research the Grievance, including all aspects of clinical care, by contacting all relevant parties and recording their responses, including their recommendations for resolution. The Member may review the HPI file for the Grievance. Before issuing or providing notice of a final Adverse Determination that is based upon a new or additional rationale and/or evidence, HPI will provide such rationale and/or evidence to the Member, at no cost, and sufficiently in advance of the date the notice of final Adverse Determination is to be provided to permit the Member a reasonable opportunity to respond prior to that date.

D. In Grievances involving clinical issues, a medical director or an actively practicing health care practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment will be consulted to review the Grievance and provide a written opinion. This actively practicing health care practitioner will not have been previously involved in the initial determination. However, the original physician or practitioner who made the initial denial determination will be consulted first to see whether he/she upholds the denial. If the denial is upheld, a non-

involved physician or practitioner will be consulted and will render a decision. In Grievances involving non-clinical issues, an individual who was not previously involved in the initial determination will be consulted and will render a decision. For Grievances involving clinical or non-clinical issues, a subordinate of the individual previously involved in the determination will not be consulted.

E. Member Satisfaction staff or outside review entity will make a determination regarding the Grievance and communicate the decision to the Member (or his or her Authorized Representative) in writing. This notification will take place within thirty (30) calendar days of receipt of the Grievance. This period may be extended by up to ten (10) business days if HPI has not received requested information from the provider. Notification will include the basis for the decision, the denial code (including its meaning) and, the right to request an external review within sixty (60) calendar days. A discussion of the decision and an explanation of the standard applied, if any, will be included. HPI will, upon receipt of a request from the Member (or his or her Authorized Representative), provide the Member with all the diagnosis codes (including their meanings), and the treatment codes (including their meanings) applicable to the Grievance. Member's (or his or her Authorized Representative's) request for such diagnosis and treatment information will not be considered a request for an internal appeal or external review.

II. DIFS ROUTINE EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

If Members (or their Authorized Representative) have exhausted their rights under the HPI Member Satisfaction Plan, or if they have not received a response from HPI at the end of thirty (30) calendar days from filing their Grievance, they can appeal to DIFS by writing or calling:

Department of Insurance and Financial Services
Office of General Counsel / PRIRA
P.O. Box 30220
Lansing, Michigan 48909-7720
or call 1-517-373-0220 or 1-877-999-6442 (toll free).

If the Grievance involved an Adverse Determination, the Member (or his or her Authorized Representative) has sixty (60) calendar days from receipt of HPI's final decision to request external review through DIFS. If the request is accepted for external review, DIFS will either review the case or assign the case to an independent review organization (IRO) and notify both the Member (or his or her Authorized Representative) and HPI. The external review may only be terminated if HPI reconsiders its Adverse Determination, reverses its decision and notifies the Member (or his or her Authorized Representative), the IRO and DIFS. Upon receipt of a notice from DIFS reversing the Adverse Determination, HPI will immediately approve the coverage for the Member. The Member (or his or her Authorized Representative) will not be charged any fees for the external review process.

If DIFS reviews the case, it will issue a decision within fourteen (14) calendar days after the request is accepted for review. If the case is assigned to an IRO, the IRO will provide DIFS with its recommendation within fourteen (14) calendar days after it is assigned the review, and DIFS will issue its decision within seven (7) business days after it receives the recommendation from the IRO.

III. HPI EXPEDITED GRIEVANCE PROCESS

An Expedited Grievance may be requested (orally or in writing) for Urgent Care Claims. HPI or outside review entity will make a determination whether an Expedited Grievance is warranted based on the particular facts and circumstances surrounding each request. In making such a determination, HPI or outside review entity will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If a determination is made that an

Expedited Grievance is not warranted, the routine Grievance process will be followed. Whenever a physician substantiates (orally or in writing) that due to the medical status of the Member resolution of his or her Grievance within HPI's normal time frames would seriously jeopardize the Member's life or health or ability to regain maximum function, the Expedited Grievance process will be followed.

A. At the same time as the Member (or his or her Authorized Representative) files an Expedited Grievance request with HPI, the Member (or his or her Authorized Representative) may file a request for an expedited external review with DIFS as set forth in Section IV below.

B. HPI or outside review entity will make and communicate to the Member (or his or her Authorized Representative) and his/her physician a determination concerning an Expedited Grievance as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after receipt. The determination may be communicated orally. Outside review entity will make the determination on the Expedited Grievance based on medical necessity guidelines consistent with the Member's diagnosis. The Member may review the HPI file for the Expedited Grievance and may present evidence if time permits. Before issuing or providing notice of a final Adverse Determination that is based upon a new or additional rationale and/or evidence, HPI will provide such rationale and/or evidence to the Member, at no cost, and, if time permits, sufficiently in advance of the date the notice of final Adverse Determination is to be provided to permit the Member a reasonable opportunity to respond prior to that date.

C. If time permits so as not to jeopardize the medical status of a Member, in Expedited Grievances involving clinical issues, an actively practicing health care practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment will be consulted to review the Expedited Grievance and provide a written opinion. This actively practicing health care practitioner will not have been previously involved in the initial determination nor be a subordinate of the individual(s) previously involved. The practitioner will not give deference to the initial decision when reviewing the Expedited Grievance. HPI or outside review entity will review and consider the written opinion of the actively practicing health care practitioner in making its decision.

D. Member Satisfaction staff or outside review entity will ensure that all necessary information, including the benefit determination on review, will be transmitted to the Member (or his or her Authorized Representative) by telephone, facsimile, or other available similarly expeditious method. Notification will include the basis for the decision, the denial code (including its meaning), information identifying the claim, date of service, the health care provider, the claim amount (if applicable), a discussion of the decision and an explanation of the standard applied, if any, and the right to request external review of the decision through DIFS, and a Health Care Request for External Review form, (DIFS FIS Form 0018). HPI will, upon receipt of a request from the Member (or his or her Authorized Representative), provide the Member with all the diagnosis codes (including their meanings), and the treatment codes (including their meanings) applicable to the Grievance. Member's (or his or her Authorized Representative's) request for such diagnosis and treatment information will not be considered a request for an internal appeal or external review.

E. Member Satisfaction staff or outside review entity will provide written or electronic confirmation of the determination to the Member (or his or her Authorized Representative) and the Member's physician within two (2) business days or three (3) calendar days, whichever is less, following the oral notification.

F. Within ten (10) calendar days after receiving HPI's or outside review entity's determination on the Expedited Grievance, the Member (or his or her Authorized Representative) may request an expedited external review of the decision through DIFS.

IV. DIFS EXPEDITED EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

A. A Member (or his or her Authorized Representative) may request an expedited external review through DIFS by writing or calling them at the following address and telephone number: Department of Insurance and Financial Services, Office of General Counsel / PRIRA, P.O. Box 30220, Lansing, Michigan 48909-7720 or call 1-517-373-0220 or 1-877-999-6442 (toll free). The request for an expedited external review may be made either at the same time the Member (or his or her Authorized Representative) files a request for Expedited Grievance with HPI, or within ten (10) calendar days of receiving an Adverse Determination when the health care service has not yet been provided or concurrent with the health care service being provided if both of the following are met:

1. The Adverse Determination involves a medical condition of the Member for which the time frame for completion of an internal Expedited Grievance by HPI or outside review entity would seriously jeopardize his or her life or health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately as substantiated by a physician either orally or in writing.

2. The Member (or his or her Authorized Representative) has filed a request for an internal Expedited Grievance with HPI or outside review entity.

B. If the request is accepted for expedited external review, DIFS will assign the case to an IRO and notify both the Member (or his or her Authorized Representative) and HPI. If the internal Expedited Grievance process has not been completed, the IRO immediately will determine whether the Member (or his or her Authorized Representative) will be required to complete the internal Expedited Grievance process prior to any expedited external review.

C. The expedited external review will be completed within seventy-two (72) hours after the request has been accepted.

D. Upon receipt of a notice from DIFS reversing the Adverse Determination, HPI immediately will approve the coverage for the Member. The Member (or his or her Authorized Representative) will not be charged any fees for the expedited external review process.

V. INITIAL CLAIM DECISIONS

A. Time Frame for Decisions

1. For Urgent Care Claims, HPI will notify the Member of its initial decision on the Claim as soon as possible, but no later than seventy-two (72) hours after receipt of the Claim. 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.

2. For Pre-Service Claims, HPI will notify the Member of its initial Claim decision within a reasonable time appropriate to medical circumstances but not later than fifteen (15) 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.

3. For Post-Service Claims, HPI 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.)

4. 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, HPI will make the decision within one (1) calendar day. HPI will notify Members within two (2) working days of making the decision. For Concurrent Care Decisions regarding ongoing ambulatory care, HPI will notify Members within eleven (11) working days of making the decision. HPI's decision to reduce or terminate the course of treatment is treated as an Adverse Determination subject to review, and HPI 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, HPI will notify the recipient of its Concurrent Care Decision within twenty-four (24) hours. 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.

5. Extensions

   a. For Pre-Service Claims and Post-Service Claims, if HPI determines that, for reasons beyond the control of HPI, an extension is necessary to reach an initial Claim decision, a single fifteen (15) day extension is permitted. To use the extension, HPI 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 HPI expects to reach a decision. If the extension is necessary because the Member fails to provide information that HPI requires to reach a decision, the notice will specifically describe the missing information and HPI will allow the Member at least forty-five (45) days from receipt of HPI's request 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. HPI 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.

6. Notice of Incomplete Claims or Improper Filing

   a. HPI 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, HPI 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. HPI will allow the Member at least forty-eight (48) hours to provide the information described in the notice. HPI 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. HPI is not required to notify Members who have submitted Post-Service Claims improperly.

7. 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. information identifying the Claim, date of service, health care provider, Claim amount, the specific reason or reasons for the Adverse Determination, including the denial code (and its meaning). The diagnosis code (and its meaning), and the treatment code (and its meaning) is available upon Member's request.

b. reference to the specific plan provisions on which the determination is based.

c. 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.

d. a description of HPI's Member Satisfaction Plan for filing a Grievance and the time limits applicable to such procedures.

e. 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).

f. 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).

g. a description of the expedited review process (contained in the Member Satisfaction Plan) applicable to the Claim (for Urgent Care Claims).

VI. MISCELLANEOUS

A. The Grievance process does not apply to a provider's complaint concerning Claims payment, handling or reimbursement for health care services.

B. The Grievance must be filed within three hundred and sixty-five (365) calendar days following receipt of the event giving rise to the Grievance or within three hundred and sixty-five (365) calendar days of discovering the facts giving rise to the Grievance.

C. Member Satisfaction staff or outside review entity will assure that the routine Grievance process takes no longer than thirty (30) calendar days for Pre-Service and Post-Service Claims . These periods may be tolled, however, for any reasonable period of time the

Member (or his or her Authorized Representative) may take under the Grievance process, or for a period of time that will not exceed ten (10) business days if HPI has not received requested information from a health care facility or provider.

D. The Member (or his or her Authorized Representative) will be provided with the written or electronic notification of HPI's or outside review entity's Grievance or Expedited Grievance determination. In the case of an Adverse Determination, the notification must set forth, in a manner calculated to be understood by the Member (or his or her Authorized Representative), all of the following:

1. the specific reason or reasons for the Adverse Determination.

2. reference to the specific plan provisions on which the determination is based.

3. a statement that the Member (or his or her Authorized Representative) is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the Member's Grievance. A document, records, or other information is "relevant" to a Grievance if:

   a. it was relied upon in making the determination.

   b. it was submitted, considered or generated in the course of reaching that determination (even if not relied upon).

   c. it demonstrates compliance with the administrative processes and safeguards required by HPI.

   d. it constitutes a statement of HPI's or outside review entity's policy or guidance with respect to the plan concerning the denied treatment option or benefit, regardless of whether such information was relied on in making the determination.

4. a copy or a statement that a rule, guideline or protocol was relied upon and is available upon request and free of charge.

5. 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).

6. identification of the title, qualifications and specialties (if applicable) of individuals whose advice was obtained on behalf of HPI without regard to whether the advice was relied upon in making the benefit determination. The individual(s) engaged for purposes of a consultation will be an individual who was not consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.

E. Members (or their Authorized Representative) may submit written comments, documents, records, and other information relating to the Grievance.

F. Review of the Grievance will take into account all comments, documents, records, and other information submitted by the Member (or his or her Authorized Representative) relating to the Grievance, without regard to whether such information was submitted or considered in the initial Adverse Determination.

G. Review of the Grievance will not afford deference to the initial Adverse Determination and will be conducted by an appropriate individual from HPI or outside review entity who is neither the individual who made the Adverse Determination that is the subject of the appeal nor the subordinate of such individual.

H. In deciding any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, an actively practicing practitioner from the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment in question will be consulted.

I. At any point in time the Member (or his or her Authorized Representative) may request HPI or outside review entity to delay the processing of their Grievance for a reasonable period of time. The Member (or his or her Authorized Representative) may request a delay if more time is needed to obtain medical records or other information pertinent to resolving the Grievance, or if personal issues make the timing not convenient. Likewise, at any point in time, Member Satisfaction staff or outside review entity may request the Member (or his or her Authorized Representative) to consent to a delay in processing their Grievance for a reasonable period of time. Irrespective of who requests a delay, the Member (or his or her Authorized Representative) and Member Satisfaction staff or outside review entity shall discuss and document why a delay was requested, whether a delay was mutually agreed to or not, and how long of a delay was mutually agreed to (which will depend on the circumstances of each case). If a Member (or his or her Authorized Representative) refuses to consent to a delay that is requested by Member Satisfaction staff or outside review entity in order to obtain medical records or other information pertinent to resolving the Grievance, the Grievance will be decided based on all information available at the time.

J. 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 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.

K. Health Care Benefits will continue if the Member files a Grievance, an appeal or requests an external review 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.

L. By submitting a request for external review or expedited external review, the Member (or his or her Authorized Representative) is authorizing HPI and the Member's health care providers to disclose their personal health information, including medical records that are relevant to DIFS' review process.

VII. HOW TO CONTACT DIFS' HEALTH INSURANCE CONSUMER ASSISTANCE PROGRAM

You may contact DIFS' Health Insurance Consumer Assistance Program for assistance at any time at the following:

Michigan Department of Insurance and Financial Services
Michigan Health Insurance Consumer Assistance Program (HICAP)
P.O. Box 30220
Lansing, MI 48909
Telephone: (877) 999-6442
Website: http://michigan.gov/difs
E-mail: difs-hicap@michigan.gov