HEALTHPLUS OF MICHIGAN
POS
MEMBER HANDBOOK

WELCOME TO HEALTHPLUS—GENERAL INFORMATION

IN THIS SECTION:

Welcome to HealthPlus

Welcome to HealthPlus of Michigan, Inc. (HealthPlus). We are pleased to have you as a member of our managed health care system. HealthPlus provides you and your family with comprehensive health care benefits and a team of friendly professionals to provide you with prompt customer service.

HealthPlus was incorporated as a Michigan non-profit, membership-based corporation in 1977. We operate as a non-profit state licensed and federally qualified health maintenance organization.

Customer Service

The HealthPlus Customer Service Department is available to answer your calls Monday through Friday 9 a.m. to 6 p.m. Language assistance is available for non-English speakers free of charge through the Customer Service Department. Just call 1-800-332-9161.

The telephone number for the deaf is 1-800-992-5070

We've enhanced our website to help you make the most of your health care program. You now can e-mail the Customer Service Department, 24 hours a day, seven days a week ... when it's convenient for you. By accessing the Member Service Center from our website (www.healthplus.org), you may:

- Change or select a Primary Care Physician
- Review eligibility information
- Print a temporary identification card or order a replacement identification card
- Check the status of referrals
- Search for a pharmacy by address or zip code
- Find drug information and your costs for a medication (if you have a prescription drug benefit)
- Change your address and much more!

If you would like to write or visit one of our business offices, the addresses are as follows:

HealthPlus of Michigan
2050 S. Linden Rd.
Flint, MI 48532

HealthPlus of Michigan
5454 Hampton Place
Saginaw, MI 48604

Eligibility

Some employer groups have unique eligibility requirements concerning who may enroll on your HealthPlus contract. Please call your personnel office or human resource department with questions concerning eligibility.

Enrolling New Dependents

To enroll new dependents you must apply within 31 days of the qualifying event. Enrollment is done through your personnel or human resource department by completing an enrollment application. Failure to follow this procedure may result in non-payment for services.

Your HealthPlus Identification Card

The front of your identification card lists you and family members covered under your contract. If any information on the card is incorrect, please contact the HealthPlus Customer Service Department at 1-800-332-9161 or visit us at www.healthplus.org with the correct information as soon as possible. The front of your card also provides the following information:

The **front** of your card provides the following information:

1. ***OV and ER/UC Copays:*** Indicates the Copays for Office Visit (Primary Care Physician and Specialist), and Emergency Room and Urgent Care Center.
2. ***ID Number*****:** Indicates the HealthPlus specific number assigned to the contract holder.
3. ***Group:*** Number assigned by HealthPlus that indicates group or individual coverage.
4. ***Name:*** Indicates the name of the contract holder.
5. List of members of your family that are covered under your contract. A two-digit relationship code precedes each covered member (i.e.,"01 JOHN"). You will need to have both the subscriber number and the relationship code available when you call or visit HealthPlus.

The **back** of your identification card also includes important information:

1. The customer service telephone number to call for authorizations, benefit information, billing information and any other questions or concerns.
2. The telephone number to call for to pre-certify mental health or substance abuse services.
3. The HealthPlus telephone number for the deaf and HealthPlus website address.
4. The address all providers should use to submit claims to HealthPlus.
5. Telephone numbers to call for emergency or urgent care when traveling outside the HealthPlus service area. Operators will direct you to the nearest provider within one of our travel networks.
6. Logos for the available provider networks when traveling outside the HealthPlus Service area.

Always show your identification card when you or a covered family member receive care. Do not allow anyone else to use your identification card. Improper use of your card can result in the cancellation of your health care coverage with HealthPlus. If you lose your identification card, or require additional cards, please contact the Customer Service Department or visit us on the web at www.healthplus.org.

Your identification card also is important in the event that you are hospitalized. HealthPlus must be notified in the event that a hospitalization occurs. The back of your card has the telephone number to call. Always have your card handy when you call or visit HealthPlus. This helps us serve you quickly and efficiently.

If You Have Other Health Care Coverage

You or other family members may be covered under another health care plan, such as a plan sponsored by your spouse's employer. If so, please tell HealthPlus the name of the other plan under which you are covered. We can then work together with the other plan to coordinate your benefits and make certain that maximum payments are made by each carrier for all allowable expenses. HealthPlus also coordinates benefits with auto insurance carriers and workers' compensation. We reserve the right to recover any or all costs of services to treat conditions covered by any other insurer.

If you did not indicate any other coverage on your enrollment form and are covered under another health plan or automobile carrier, please take a moment to call the HealthPlus Customer Service Department at 1-800-332-9161 or visit www.healthplus.org. Also contact us if your coverage should change. It will only take a few minutes and could help maximize your benefits.

The HealthPlus Managed Care Program—A Helpful Overview

The primary objective of the HealthPlus managed health care program is to promote timely preventive services and quality medical care in the appropriate setting.

Participating providers strive to provide quality health care consistent with recognized medical standards, HealthPlus policy and your benefits.

The Point of Service (POS) program has been designed to offer you additional choices for your health care needs, while continuing to provide you with the advantages of a managed care program. With the POS program, you have the option of obtaining services under the direction of a participating Primary Care Physician, or you may choose to self-refer to either a HealthPlus affiliated provider or a non-affiliated provider when you are seeking a particular

service. In other words, you decide which Level of benefits best meets your needs each time you seek healthcare services.

Under the Level 1 benefit option, all your health care services must be obtained through or under the direction of your HealthPlus Primary Care Physician. He or she will coordinate your health care services and when medically necessary, refer you to a specialist or other health care provider. Your role is to always work with your Primary Care Physician to address your health care needs. The selection of your primary Care Physician is the key to obtaining the highest Level of benefits available to you. The Level 1 benefit option provides you with maximum coverage with the least amount of out-of-pocket costs.

Your POS plan gives you the flexibility to receive certain covered services from affiliated and non-affiliated health care providers without a referral from your Primary Care Physician. When you elect to self-refer, covered health care services will be paid under your Level 2 or Level 3 benefit option, depending on your benefit Rider. Under the self-referral option, you will be required to pay more out-of-pocket costs then you would with Level 1 benefits because of higher Copayments. In addition, you will be responsible for charges from non-affiliated providers that are over and above the HealthPlus schedule of reasonable fees. Some services, including some preventive care services, may not be covered under this option.

We ask that you carefully review your subscriber contract and applicable benefit rider for a complete description of covered benefits and cost sharing requirements.

HealthPlus Provider Directory

The HealthPlus provider directory is now available online. Just go to our website at www.healthplus.org, choose the "Find a Doctor/Hospital" button, click on HMO/POS and follow the directions. You can search for providers by location or by name. The online directory also provides the following information about our physicians:

- Primary hospital or health system affiliation
- Member satisfaction and clinical quality scores
- Gender
- Medical school attended
- Languages spoken
- Patient accepting status
- Office hours and phone number
- Address and directions

If you would like additional information on the professional qualifications of HealthPlus practitioners beyond what is provided on our website, please call the HealthPlus Customer Service Department at 1-800-332-9161.

THE PRIMARY CARE PHYSICIAN

IN THIS SECTION:

The Role of the Primary Care Physician

At HealthPlus, we know the importance of a good physician-patient relationship. In fact, your relationship with your physician is the key to making the most of your HealthPlus benefits. When utilizing your Level 1 benefit option, your primary care physician will provide your basic health care needs and will coordinate and direct additional health care services you may need by referring you to other physician(s) for treatment when medically necessary. Your primary care physician will coordinate your emergency and follow-up care, refer you for any medically necessary hospital stay, answer your questions and advise you about healthy lifestyle changes.

When choosing a primary care physician, keep in mind that he or she will have your complete medical profile and will appropriately coordinate your care among the various specialists who may treat you. Your primary care physician selection will determine the specialists you see and which hospital you will use. It is important to develop a relationship with your primary care physician so he or she is familiar with your entire medical history.

Choosing the Right Primary Care Physician

When choosing a primary care physician take into consideration your individual needs and preferences. Family Practice Physicians, Internal Medicine Physicians and Pediatric Physicians all provide primary care, but in different capacities.

Family Practice Physicians treat a broad range of patients and conditions. They provide comprehensive care for male and female patients of all ages and health conditions. Family practitioners complete a residency-training program that includes training in all medical disciplines, including pediatrics, internal medicine, obstetrics, gynecology and surgery.

Internal Medicine Physicians specialize in internal medicine, focusing on the care of adults and elders with both common and complex medical problems. They complete a residency program that includes training in the diagnosis and treatment of conditions in all the medical specialties (cardiology, gastroenterology, neurology, etc.) and wellness and prevention.

Pediatric Physicians specialize in caring for children and adolescents. Their residency training includes experience in managing simple and complex childhood illnesses, preventive health and health education and chronic illness. They are knowledgeable in the developmental and health needs of children from newborns to young adults.

Selecting Your Primary Care Physician

Before utilizing the Level 1 benefit option, each family member who is covered by a HealthPlus must choose a Primary Care Physician from among hundreds who belong to our network (parents are expected to select for their children). The online provider directory includes doctors who specialize in Family Practice, Internal Medicine or Pediatrics. The listing for each Primary Care Physician also shows a "primary hospital." This is the hospital where your Primary Care Physician will direct you for hospital services in most instances. When you select a Primary Care Physician you are also agreeing to use the hospital listed.

A Primary Care Physician who knows and understands your needs can be your most valuable health partner. A host of specialists who work on separate health problems may not see your entire health picture or get a good understanding of what's important to you. Here are four things you should consider when choosing a Primary Care Physician:

- Professional Education
- Experience
- Availability
- Will the doctor work in partnership with me?

Professional Education and Experience

For most people, a good choice for a family doctor is a board-certified physician who specializes in Family Practice, Internal Medicine or Pediatrics. A doctor becomes board-certified by completing training in a particular specialty area and passing an examination to demonstrate that he or she has the skills and experience needed to practice that medical specialty. Most board-certified physicians have a broad knowledge about many common medical problems.

Availability

Because health problems rarely develop when it's convenient, it helps to have a doctor who can be contacted whenever he or she is needed. Before you select a doctor, call or visit his or her office. Tell the receptionist that you are looking for a new doctor. Ask these questions:

- Is the doctor accepting new patients?
- What are the office hours?
- If I called right now for a routine visit, how soon could I be seen?
- Does the doctor work with nurse practitioners or physician assistants?
  (These health professionals have special training in managing minor and routine health problems.)
- Who fills in for the doctor when he or she is not available?
- What hospital does the doctor use?

Partner Potential
During your first visit tell your doctor that you would like to share in making treatment decisions. Pay attention to how you feel during the visit.

- Does the doctor listen well?
- Does the doctor speak to you in terms you can understand?
- Does the doctor spend enough time with you?
- Do you think you could build a good working relationship with the doctor?

HealthPlus strives to keep the online (and paper) provider directory as up-to-date as possible. However, information may change. Providers may move out of the service area, leave the network or change their accepting status. If the physician you select is no longer accepting patients, please select another. You must provide HealthPlus with the name of the primary care physician chosen for each family member. After locating a primary care physician who is accepting new patients, call the HealthPlus Customer Service Department at 1-800-332-916 with your selection or visit our *Member Service Center* at www.healthplus.org.

Choosing a Hospital

Remember, when you choose a Primary Care Physician from the HealthPlus provider directory, you are also agreeing to use the hospital listed next to his or her name for inpatient and outpatient hospital care. Contact your Primary Care Physician before seeking any hospital services, except in a life-threatening emergency.

Changing Your Primary Care Physician

The HealthPlus provider directory will also help you if you decide to change your Primary Care Physician. Select a Primary Care Physician from those listed as accepting new patients, then call the HealthPlus Customer Service Department at 1-800-332-9161 or visit us on the web at www.healthplus.org with your selection. You must notify HealthPlus before receiving covered services from the new Primary Care Physician you have selected. The change will become effective on the first day of the month following notification to HealthPlus, and you may begin receiving covered services from him or her immediately after the change becomes effective.

Referrals to a Specialist Physician--Level 1 (PCP directed)

Your Primary Care Physician may decide that you require additional care by a specialist. When your Primary Care Physician decides that such care is necessary, he or she will initiate the appropriate HealthPlus referral process.

You will receive either written notification from HealthPlus, or a referral form from your Primary Care Physician, which will specify the number of visits and the length of time covered by this referral. If your referral expires and you need additional visits, contact your Primary Care Physician. If you change Primary Care Physicians, or your Primary Care Physician leaves the HealthPlus network, your current referral becomes invalid and a new referral must be issued by your new Primary Care Physician.

If the specialist to whom your Primary Care Physician is referring you does not participate with HealthPlus, your Primary Care Physician will initiate the out-of-plan referral process. Only services approved by HealthPlus prior to visiting an out-of-plan practitioner will be covered. You will receive a decision in writing, usually within five to seven working days from the time the referral is received by HealthPlus. If the referral to the out-of-plan specialist is not approved, HealthPlus will explain the reason for the denial.

Level 2 or Level 3 (Self-referral to a Specialist)
At times you may elect to self-refer for covered specialist services. The POS benefit plan allows you to obtain services from an affiliated or non-affiliated specialist without a referral from your Primary Care Physician. If you see a non-affiliated specialist for covered services, you may be required to pay the total cost for these services at the time the care is provided. If you pay for services when they are provided or receive a bill requesting payment, please forward the statement(s) to HealthPlus. Information on how to submit a bill for reimbursement can be found in the “Member Cost Sharing” section of this handbook. Please note that the difference between a non-affiliated specialist’s charges and the fee HealthPlus considers reasonable will be your responsibility.

Note: POS members may self-refer to non-affiliated providers including hospitals. Covered services will be paid at Level 2 or Level 3 with proper authorization from HealthPlus. There may be a Copayment “penalty” if proper authorization is not obtained. Please review your benefit rider for details about “penalty” payments.

Women's Health

At HealthPlus, we are committed to helping our members stay well by providing coverage for regular check-ups, and routine care for women is no exception. HealthPlus also recognizes the value of each member choosing a Primary Care Physician to coordinate that member's total health care needs. Your Primary Care Physician is appropriately trained and should be able to provide you with an annual well-woman exam. However, we also recognize your right to go to an in-plan obstetrician-gynecologist for an annual well-woman exam and routine obstetrical services without a referral.

HealthPlus strongly encourages those female members who wish to self-refer to an in-plan obstetrician-gynecologist to first talk with their Primary Care Physician. Most Primary Care Physicians work with a preferred group of in-plan obstetrician-gynecologists. If this is the case with your Primary Care Physician, we strongly encourage you to select from among this preferred group to obtain an annual well-woman exam and routine obstetrical services. Working together with your Primary Care Physician and obstetrician-gynecologist will promote the overall coordination of your health care needs.

Covered Services for women who self-refer to an in-plan obstetrician-gynecologist for an annual well-woman exam and/or routine obstetrical services will be paid as Level 1 benefits. Self-referral for covered services to a non-affiliated specialist will be paid according to your POS benefit rider at the applicable benefit Level 2 or Level 3.

INFORMATION ABOUT SPECIFIC SERVICES

IN THIS SECTION:

Please see your Benefit Rider for a complete description of Covered Services

Emergency Care

No matter where you are, you're covered for emergency care by HealthPlus. Your emergency services benefit may require a Copay for each emergency visit. This Copay is waived if you are admitted to the hospital.

Coverage Inside the HealthPlus Service Area

You are covered for emergency health services rendered by participating providers located within the HealthPlus service area. Services are also covered when rendered by a non-affiliated provider if a true emergency prevents you from accessing a participating provider.

If you think you have a medical emergency, call your Primary Care Physician first. He or she will help you determine if the problem requires immediate attention, help coordinate admission into an emergency facility and direct your treatment. If your Primary Care Physician's office is closed and you have a question or concern, or need care, an answering service can be reached by calling the doctor's office number. They will refer you to either your Primary Care Physician or to the doctor on call.

If you have a serious medical emergency that you feel is life threatening, go immediately to the nearest emergency room or call 911. You must then contact your Primary Care Physician within 24 hours, or as soon as possible after admission to an emergency facility. Please do not use emergency facilities for an illness that could be treated at an appointment during regular office hours with your Primary Care Physician.

Emergency Care Coverage Outside the HealthPlus Service Area

HealthPlus also provides emergency care coverage when you are out of the HealthPlus service area. If you need emergency or urgent care while traveling outside the HealthPlus service area, you may call one of the telephone numbers shown on the back of your HealthPlus identification card for assistance. As always, if you have a serious medical emergency that you feel is life threatening, go immediately to the nearest emergency room or call 911.

Routine or non-urgent care received outside of the service area without a referral from your Primary Care Physician is not a covered benefit. If you seek care for non-emergency, non-urgent conditions while you are out of the service area, you may have to pay for the services.

Emergency Hospital Admissions (Inside or Outside the Service Area)

Emergency hospital admissions require notification of HealthPlus within 24 hours, or as soon thereafter as possible. You may call HealthPlus 24 hours a day at the 800 number for authorizations shown on the back of your HealthPlus identification card. Please call promptly after an emergency hospital admission in order to confirm coverage, ensure proper follow-up care and assure payment for covered services you receive.

Benefits may be reduced if HealthPlus is not notified of an emergency hospitalization at a non-affiliated provider within 24 hours after admission. Please see your benefit rider for "penalty" payment details.

Urgent Care within the HealthPlus Service Area

Not all illnesses or injuries occur during your Primary Care Physician's regular office hours. For this reason, HealthPlus contracts with many local after hours facilities to provide care when your Primary Care Physician's office is closed and you cannot wait until the next day for treatment. Even though your Primary Care Physician's office is closed, call the office telephone number to reach the answering service or physician on call for specific directions regarding urgent care after hours. You may also check the online HealthPlus Provider Directory for a list (by zip code) of after hours facilities within the HealthPlus service area that can help you with your urgent care needs.

College Students

Dependent children at college outside the HealthPlus service area and included on your subscriber contract are covered for urgent and emergency services. To utilize Level 1 benefits, covered dependent college students must choose a primary care physician within the HealthPlus service area for all routine services, such as annual exams, immunizations and other non-urgent care.

Laboratory and X-Ray Services

HealthPlus covers lab work, x-rays and other diagnostic and therapeutic services when such services are in support of other covered health care benefits.

Lab work, x-rays and other diagnostic tests performed at facilities affiliated with HealthPlus will be covered under Level 1 of our POS plan. Remind your Primary Care Physician, or the treating provider, that you have HealthPlus coverage so that he or she can direct you to a participating facility.

Eligible lab work, x-rays and other diagnostic tests provided by a non-affiliated provider are covered according to your POS benefit rider at the applicable benefit Level 2 or Level 3. You may be required to pay for the entire cost of these services at the time they are provided. If you pay for services when they are provided or receive a bill requesting payment, please forward the statement(s) to HealthPlus for appropriate reimbursement.

Durable Medical Equipment

Items such as wheelchairs, hospital beds and oxygen equipment are considered Durable Medical Equipment, or DME. If your benefit plan includes DME coverage, to utilize Level 1 benefits services or equipment must be order or authorized by your primary care physician or specialist to whom you have been appropriately referred. Your physician will give you a written order for the necessary items and will direct you to a DME provider that is included in the HealthPlus network. You can also find a list of DME providers by using the only provider directory.

DiabeticTesting, Incontinence, and Urological Supplies

HealthPlus has partnered with J&B Medical Supply to provide members with diabetic testing, incontinence and urological supplies. If you need any of these supplies, please contact J&B at 1-800-737-0045 extension 115. The J&B customer service staff will help you set up your supply account. Please have your HealthPlus HMO ID card with you when you call. If you get your diabetic testing, incontinence and/or urological supplies from a health system DME supplier, you may continue to do so.

Behavioral Health

HealthPlus has affiliated Mental Health/Substance Abuse providers throughout the HealthPlus service area. You can find a list of these providers by zip code in the online provider directory; just go to www.healthplus.org choose the "Find a Doctor/Hospital" button, click on HMO/POS and follow the directions. Providers include psychiatrists,

psychologists, social workers, counselors and substance abuse providers. You may receive Level 1 benefits for Mental Health/Substance Abuse services from a provider listed in the directory without a referral from your Primary Care Physician. Covered services from Mental Health/Substance Abuse providers not listed in the HealthPlus provider directory (non-affiliated providers) will be paid under the Level 2 or Level 3 benefit options. Please see your benefit rider for more specific information concerning your Mental Health/Substance Abuse benefits and Copayments.

If you need assistance choosing a Behavioral Health provider or have questions, please call the HealthPlus Behavioral Health Department at 1-800-555-5025.

PRESCRIPTION DRUGS

IN THIS SECTION:

Prescription Drugs—Overview

If your benefit includes prescription drugs, you must use a participating HealthPlus pharmacy. A list of participating pharmacies may be found in your Provider Directory, or you may do a search by zip code on the website at www.healthplus.org. Prescriptions for covered drugs must be written by your PCP or by a specialist to whom you have been appropriately referred.

When you go to a participating pharmacy, show your HealthPlus identification card to the pharmacist. Your card reflects your benefit level, which lets the pharmacist know if a Copay should be applied. Copays vary based on your benefit plan.

The prescription drug benefit provides coverage for up to a 30-day supply of most medications, when prescribed by a HealthPlus Primary Care Physician or specialist with an appropriate referral. You may also be eligible for the HealthPlus 90-day medication programs, which are described in more detail below.

Drug Formulary

The HealthPlus Drug Formulary is a list of medications recommended for use under the HealthPlus prescription drug benefit. A drug formulary is a "preferred" list of drugs that contains generic and brand drugs. The drugs on the formulary are considered the best choices based on safety, effectiveness, uniqueness and reasonable cost. As new drugs become available, the selection of drugs on the formulary may change in order to assist physicians in having the drugs required to meet drug treatment needs. The drug formulary is developed with practicing physicians and pharmacists to help make sure that the list contains high quality and cost-effective medications.

HealthPlus covers most FDA-approved medications. Medications that are not listed on the formulary may still be a covered benefit, subject to the applicable benefit limitations and exclusions of your coverage and other HealthPlus programs, such as Prior Authorization and Step Therapy. Based on your benefit, you may be responsible for a higher Copay for brand drugs that are not on the formulary.

For the most up-to-date listing of the formulary, go to the website at www.healthplus.org, select the "Member" tab and go to the Pharmacy Center. Select "Drug Formularies" to view the formulary and find the formulary status or generic availability of a drug. Go to "My Pharmacy Tools" to find a pharmacy, search for drug information or find the cost of a drug based on your specific benefit. You may also contact HealthPlus Customer Service at 1-800-332-9161 for a printed copy of the formulary.

Generic Medications

A generic drug is a drug that contains the same active ingredients in the same amounts as a brand drug. After the patent expires on a brand drug, other companies can make the same drug in a generic version for a much lower cost. Just like brand drugs, generic drugs must be approved by the Food and Drug Administration (FDA), and are as safe and effective as the brand drug.

When your physician prescribes a medication that is available as a generic, HealthPlus covers the generic medication. You may still obtain the brand name drug if you request it at the pharmacy. However, based on your benefit, you may be responsible for additional costs or a higher Copay. If, in the judgment of your physician, a brand name drug is medically necessary (instead of the equivalent generic drug), your physician may submit a request for prior authorization for the brand drug. HealthPlus will review the request, along with documentation of medical necessity submitted by your physician, for determination of coverage.

Note: HealthPlus does not require generic substitution for certain "narrow therapeutic index" drugs.

Prior Authorization

HealthPlus requires prior authorization for certain medications, based on clinical, safety or cost issues. Prior authorization means that you have to meet certain criteria in order for the drug to be covered. This helps to make sure that you are getting an effective and cost-effective drug. In addition, as mentioned above, brand name drugs that have a generic equivalent may require prior authorization, or the quantity of a medication may be limited with prior authorization required for greater quantities.

If your doctor wants to prescribe a medication that requires prior authorization, your doctor must submit the request for prior authorization to HealthPlus by contacting the HealthPlus Pharmacy Department.

Step Therapy

HealthPlus uses step therapy for certain medications, which means that you must try certain "first step" drugs before other "second step" drugs are covered. Generic drugs are usually in the "first step" so that treatment starts with safe, effective and affordable drugs. Second step medications are generally more expensive brand drugs that are used to treat the same condition.

To obtain a copy of the HealthPlus Drug Formulary and prescription drug policies, please contact HealthPlus Customer Service at 1-800-332-9161, or visit us on the web at www.healthplus.org.

90-Day Medication Programs

Based on your benefit, you may be eligible for the HealthPlus **Ask for 90 Rx** 90-day medication programs. With the **Ask for 90 Rx** program, there are two options for obtaining a 90-day supply of medications:

1. LOCAL PHARMACIES-You may receive up to a 90-day supply of medications from participating local retail pharmacies, with Copay savings (if applicable based on your benefit). For more information, go to www.healthplus.org for a Frequently Asked Questions flyer and a list of retail pharmacies that participate in the Ask for 90 Rx program. Or, you may contact the HealthPlus Customer Service Department.

2. MAIL SERVICE PROGRAM-If you are eligible for the HealthPlus mail service program through Express Scripts, you may receive up to a 90-day supply of medications, save money on Copays (if applicable based on your benefit), and have your prescriptions delivered to your home with no shipping costs. For more information about mail service, go to www.healthplus.org, or contact the HealthPlus Customer Service Department.

Note: If you have prescription drug coverage with HealthPlus, the Ask for 90 Rx Frequently Asked Questions flier and an Express Scripts insert are included at the end of this "Handbook" section.

Copay savings from both of these programs are the same (if applicable). Based on your benefit, you pay the same Copay for a 90-day supply at an Ask for 90 Rx retail pharmacy as you do at Express Scripts.

Most maintenance medications are covered through the 90-day programs. Compounded medications and injectable medications (with the exception of injectable medications for diabetes, Epi-Pen and Imitrex) are NOT covered through the 90-day programs.

Note: Based on your benefit, you may be enrolled in the Mandatory 90-Day Medication Program. You are required to receive a 90-day supply each time your fill your prescription for most chronic medications (medication you take every day).

Specialty Pharmacy Program

HealthPlus has a specialty pharmacy program to help manage and deliver injectable medications to you and your doctor. This program includes medications that are injected in the doctor's office and medications that are self-injected. For more information about the specialty pharmacy program, please contact HealthPlus Customer Service at 1-800-332-9161, or visit us on the web at www.healthplus.org.

Note: Based on your benefit, you may be enrolled in the Mandatory Specialty Program. You are required to receive specific self-injected medications from a HealthPlus-contracted specialty pharmacy. The specialty pharmacy will mail the medications to your home. This program applies to self-injected medications for Rheumatoid Arthritis, Hepatitis C, Multiple Sclerosis and Infertility.

Prescriptions from Dentists

HealthPlus provides limited coverage for prescriptions written by dentists. The list of covered medications, called the Dental Formulary, includes several antibiotics and pain medications, but is not intended to include all medications that may be prescribed by a dentist. If your dentist prescribes a medication that is not on the Dental Formulary, it is not covered.

Summary of Program Limitations and Exclusions

- Drugs used for cosmetic purposes are not covered.
- Drugs used for in-vitro fertilization are not covered.
- Non-prescription drugs, dietary supplements or medical foods are not covered. However, HealthPlus may choose to include coverage for specific over-the-counter medications when written by a physician, only as specified by HealthPlus.
- Prescription medications for weight loss require prior authorization initiated through the Pharmacy Department.
- Drugs used for impotency are covered for men age 35 and older, when prescribed by a HealthPlus-affiliated Primary Care Physician or urologist, and are limited to six units/tablets total (for all products combined) every 30 days. Coverage for male members aged 34 or under is based on a member-specific review and established criteria through the Prior Authorization Program, with the same quantity limitations if approved.
- Coverage for specific migraine medications is limited to 9 tablets/units per month, unless a member-specific review determines that the member is also currently taking medication for the prophylaxis of migraine and still requires more than 9 tablets per month.
- Quantity or dose limits apply for certain antipsychotic medications, certain sleeping medications, certain anticonvulsant medications and acetaminophen-containing analgesic medications.
- Testosterone products are covered for male members only, unless a member-specific review for a female member determines medical necessity, or if the medication is being used for an FDA-approved indication.
- Estrogen products are covered for female members only.
- Coverage for medications included in the Dose Optimization Program is limited to once daily dosing, unless a member-specific review determines medical necessity for more than once daily administration.
- Prescription nicotine patches are not covered (generic over-the-counter nicotine patches are covered with a written prescription).

OTHER PROGRAMS AND SERVICES

IN THIS SECTION:

Benefit Interpretation & New Technology Evaluation

Medical technology is constantly advancing and improving. In keeping with our commitment to you, we strive to stay abreast of changes that affect and benefit your health care. HealthPlus has developed a process for evaluating new medical and behavioral procedures, medications and devices, along with new uses of existing technology. Our process begins with HealthPlus' review of information from several sources, including government regulatory agencies and published scientific findings. Appropriate health professionals are involved in the process. They decide whether to include new technologies or new uses of existing technologies in the benefits that HealthPlus

offers its members. Should we make changes to our benefits, we will notify HealthPlus members and Plan providers, as appropriate.

Utilization Case Management Program

Utilization case management is a process designed to evaluate the appropriateness of health care services. The goal of the utilization case management program at HealthPlus is to ensure that members receive access to timely and appropriate, high quality health care services.

HealthPlus utilization case managers work closely with you, your Primary Care Physician and any specialists to whom you have been referred, to assure that you receive medically necessary services and to facilitate communication among the health care professionals involved with your care. For example, utilization case management staff monitor the care you receive during a hospital stay and make arrangements for continuing or home care, if needed.

Most decisions about your care are made by you and your Primary Care Physician or the specialists to whom you have been referred by your Primary Care Physician. In some situations, HealthPlus utilization case management staff review proposed care or treatment, ongoing care or previously provided care with your physician to determine whether the recommended care is (or was) appropriate and medically necessary.

If one of the HealthPlus Medical Directors determines that a service is not medically necessary and is not eligible for coverage, you will receive a letter describing the reason for the denial, the criteria or guideline upon which the decision is based and your right to appeal this decision should you disagree.

To promote fair and consistent utilization management decision-making, we use nationally recognized guidelines and criteria, tailored to meet individual patient needs. The guidelines and criteria are reviewed at least annually by a committee of local physicians. The physicians and nurses involved in the utilization case management process make decisions based only on appropriateness of care and service. They are not rewarded for issuing denials and are not compensated or rewarded in any manner that would motivate them to make inappropriate coverage decisions or encourage under-utilization of services.

If you have any questions about the utilization case management process or specific utilization issues, call Customer Service at 1-800-332-9161. Utilization case management staff are available to receive and respond to your calls during normal business hours (9 a.m. to 6 p.m.) and to receive your questions after business hours. Calls received after business hours will be returned as soon as possible the next business day.

Disease Management

HealthPlus provides disease management programs for members with the following chronic conditions:

- Asthma
- Cardiovascular Conditions
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Heart Failure

For members who participate in the HealthPlus disease management programs, support from HealthPlus may include:

- Welcome Calls
- Introductory Packet
- Health Risk Appraisal
- Care Reminder Calls and Letters
- Educational Materials
- General Health and Condition Specific Assessments
- Newsletters
- Quality of Life Survey
- Screening for Depression
- Member Satisfaction Survey

Health and Lifestyle Management

With HealthPlus, you can take advantage of our year-round program that offers a variety of wellness activities to help you feel great, boost energy and learn more about your health. Whether you are in good health or need a plan to get started, our wellness tools and programs can help you reduce your risks and improve your quality of life.

To get started, complete the **HealthPlus Wellness Assessment**. This confidential wellness questionnaire will help you identify your individual health risks, and understand what they mean.Your personalized wellness report also helps you identify activities, programs and resources that help you begin to better manage your health:

- **Healthy Living Programs**:
  These six-week online programs will help you reach your health goals at your own pace.
- **Online Monthly Seminars**:
  Every month, we will feature a new interactive online seminar designed to help you learn about a variety of health topics to help improve specific health risks. These seminars are approximately 10 to 15 minutes long and can be viewed at any time in the comfort of your home.
- **Quarterly Wellness Challenges**:
  We provide structured, fun, wellness challenges to help you improve your health with a chance to win prizes!
- **Personal Health Record**:
  Record and manage your health history in this personal health record that's completely confidential, secure and easy to access and share with your physician.
- **Health Coaching:**
  HealthPlus offers health coaching if you need a little extra support to improve your health. After completing the wellness assessment, you may receive an invitation to join the health coaching program. This six-month voluntary program offers phone, email and online chat support with a professional health coach. The health coach is available to answer your questions, discuss goal setting, barriers and provide ongoing encouragement to improve your health.

To learn more about HealthPlus' health & wellness programs, visit www.healthplus.org**, *Health & Wellness*.**

HealthPlus Perks

HealthPlus is always looking for innovative ways to show you that we appreciate you choosing us. HealthPlus Perks provides valuable discounts. For example:

- Weight Watchers
- Anytime Fitness
- Door to Door Organics

For more information and the most up to date HealthPlus Perks, go to our website at www.healthplus.org, *Health & Wellness*.

MEMBER COST SHARING

IN THIS SECTION:

Copays and Out-of-Pocket Maximums

Some covered benefits have a fixed dollar amount or percentage of charges for which you will be responsible. This amount is called a Copay, and must be paid at the time services are received. The Copay amount is, in part, determined by the choices you make when obtaining health care services. Copays are minimized when covered services are obtained from or arranged through you designated Primary Care Physician (Level 1 benefits on your POS plan).

Benefit Level 2 and/or 3 Copayments per member and per contract will be limited each benefit year to the amount specified in your benefit rider(s). Your benefit rider(s) will also explain which out of pocket costs associated with Level 2 and/or 3 services will not count toward reaching the out-of-pocket maximums. You will continue to be responsible for these Copayments after you have reached your out-of-pocket maximums.

Your benefit rider(s) will identify which services require Copays from you, and the specific amounts. Complete benefit descriptions, exclusions, limitations and other rights and responsibilities are explained in the Subscriber Contract and applicable Rider(s).

Submitting Claims

If you receive a bill or are requesting reimbursement for covered services, please complete a Request for Reimbursement form. Send the completed form, along with your original prescription or medical receipt, to HealthPlus within one year of the date of service.

Address the envelope to:
HealthPlus of Michigan
Attn: Customer Service Department
P.O. Box 1700
Flint, MI 48501-1700

To obtain a Request for Reimbursement form, please call the HealthPlus Customer Service Department at 1-800-332-9161, or you can print a form from the HealthPlus website at www.healthplus.org.

Explanation of Benefits (EOB)

An Explanation of Benefits (EOB) document is created when claims are paid for plans that have a member deductible and/or percent Copay or coinsurance. The EOB document will detail the charges billed, the allowable amount for the services rendered, any deductible, Copay or coinsurance applied to the allowed amount and any amount that would be the financial responsibility of the member. The EOB will also keep track of charges applied to the member and/or family deductibles and out-of-pocket maximums for the current benefit year. You should keep all EOBs for your records.

Remember — the EOB document is not a bill. The treating physician or facility will bill directly for charges that are your responsibility.

WHEN YOUR COVERAGE TERMINATES

IN THIS SECTION:

Why Coverage Terminates

Your HealthPlus coverage will be terminated if:

1. You enter active military service, except for temporary duty of 30 days or less.
2. You are no longer eligible according to the Subscriber Contract.
3. The monthly subscription charge for benefits is not paid on time, subject to a 30-day grace period. The coverage will terminate effective on the last coverage date for which payment was received.
4. You fail to pay required Copays. The coverage will end 30 days after written notice is provided to the member by HealthPlus.
5. You knowingly give HealthPlus false information at the time of enrollment, or breach any term or condition of your Subscriber Contract.
6. You attempt to obtain services fraudulently.

Please note: HealthPlus also has the right to terminate coverage if plan physicians are unable to establish a satisfactory physician/patient relationship with you. Before coverage terminates, HealthPlus will notify you in writing 30 days in advance of termination. You may appeal this decision as explained in the "Member Satisfaction Plan" section of this handbook.

Option to Continue Group Coverage

You may have the right to continue your group coverage, even after it would otherwise end. This applies to your spouse and any children covered under the plan. This option is provided under Federal Law, specifically the Consolidated Omnibus Budget Reconciliation Act (COBRA).

For full details, please consult your personnel office or Human Resource Department.

Converting to an Individual Plan

If your group coverage ends, you may be eligible for an individual plan with HealthPlus. Application and payment for individual coverage must be made within 30 days of notice of termination from HealthPlus.

Your individual plan will become effective the date your coverage ends under your group plan. If you choose this option, you will receive the individual benefit plan that is standard for HealthPlus at that time. See your Subscriber Contract for eligibility provisions.

PATIENT SAFETY

IN THIS SECTION:

Patient safety is a top priority at HealthPlus. We encourage our members to actively participate in their personal health care and that of their families. Following is information about the Leapfrog Group and what they are doing to improve patient safety. Visit their website at *www.leafproggroup.org* for more information about his very important issue.

The Leapfrog Group—Overview

The Leapfrog Group is composed of more than 160 public and private organizations that provide health care benefits to approximately 34 million consumers in all 50 states. The Leapfrog Group works with medical experts throughout the U.S. to identify problems and propose solutions that it believes will improve hospital systems and reduce medical errors that harm patients.

The Leapfrog Group's mission is to trigger giant "leaps" forward in safety, quality and affordability of health care by supporting informed health care decisions by those who use and pay for health care, and to promote high-value health care through incentives and rewards for those who provide health care.

The Leapfrog Group identified, and has since refined, several hospital quality and safety practices that are the focus of its health care provider performance comparisons and hospital recognition and rewards program. Based on independent scientific evidence, the quality practices are:

- **Computer Physician Order Entry (CPOE):** With CPOE systems, hospital staff enter medication orders via computers linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50%.
- **Evidence-Based Hospital Referral:** Consumers and health care purchasers should choose hospitals with extensive experience and the best results with certain high-risk surgeries and conditions. By referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria—such as the number of times a hospital performs these procedures each year or other process or outcomes data—research indicates that a patient's risk of dying could be reduced by 40 percent.
- **ICU Physician Staffing.** Staffing ICUs with doctors who have special training in critical care medicine, called "intensivists," has been shown to reduce the risk of patients dying in the ICU by 40 percent
- **Leapfrog Quality Index:** The 30 Safe Practices endorsed by the National Quality Forum covers a range of practices that, if utilized, would reduce the risk of harm in certain processes, systems or environments of care. Included in the 30 practices are the original three Leapfrog leaps (shown above). This new leap assesses hospitals' progress on the remaining 27 safe practices.
- **Adherence to "Never" Events Policy:** In this recently added category, Leapfrog encourages hospitals to follow certain practices each time certain events and mistakes happen. These include: apologizing to the patient and family; reporting the event to state and accreditation agencies; performing an analysis of root cause of the event; and waving costs related to the "never" event.

This list is based on four primary criteria: (1) There is overwhelming scientific evidence that these quality and safety leaps will significantly reduce preventable medical mistakes. (2) Their implementation by the health industry is feasible in the near term. (3) Consumers can readily appreciate their value. (4) Health plans, purchasers or consumers can easily ascertain their presence or absence in selecting among health care providers. These leaps are a practical first step in using purchasing power to improve hospital safety and quality.

For more information on the Leapfrog Group, visit www.leapfroggroup.org or www.healthplus.org.

MEMBER RIGHTS AND RESPONSIBILITIES

IN THIS SECTION:

Patient Bill of Rights Notification

As a member of HealthPlus, you have certain rights as specified by a Michigan law called the Patient Bill of Rights. This notice is provided to you in order to explain those rights. The following are intended to assist you in understanding your health coverage provided by HealthPlus:

1. HealthPlus Service Area

As a state-licensed health maintenance organization (HMO), HealthPlus is licensed to enroll individuals within the HealthPlus "Service Area" as defined by the Office of Financial and Insurance Services.

2. HealthPlus Subscriber Contract

In order to provide a clear description of your new health care benefits, you are also provided a copy of the applicable HealthPlus Subscriber Contract and Rider(s). These documents contain a clear, complete and accurate description of the following:

a. Covered benefits, including prescription drug coverage, if applicable, with specifications regarding requirements for the use of generic drugs;
b. Description of emergency health coverage and benefits;
c. Out-of-area coverage and benefits;
d. An explanation of your financial responsibility, if any, for Copays, deductibles, and any other out-of-pocket expenses;
e. An explanation of how to file a grievance.

3. Continuity of Treatment

If an affiliated provider's participation terminates during a member's course of treatment by that provider, HealthPlus shall, depending upon the circumstances, do either of the following:

a. Arrange for the continuation of treatment by that provider; or
b. Assist the member in selecting a new provider to continue with treatment.

4. Intractable Pain

Intractable pain is a pain state where the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of medicine, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. If you believe that you may be experiencing intractable pain, we encourage you to talk with your Primary Care Physician about your condition. Your Primary Care Physician will evaluate and treat you or refer you to a specialist if he or she decides that is necessary. Physician and other services are covered in accordance with the terms of your applicable HealthPlus Subscriber Contract and Rider(s).

5. Additional Information

As a member of HealthPlus, you have the right to request and receive additional information about HealthPlus. This includes:

a. Provider Information

You are entitled to receive a copy of the HealthPlus Provider Directory, which provides you information concerning physicians and other providers who contract to provide services to HealthPlus members. It contains:

1) Names, location, hospital affiliation and specialty (type of practice) of affiliated physicians;
2) Explanation of the referral process;
3) Designation of which physicians are accepting new patients;
4) Process for changing physicians; and
5) Listing of other contracting providers.

b. Physician Credentials
You are entitled to receive information concerning the professional credentials of participating physicians, including:

1) Degrees received;
2) Certification date, if applicable; and
3) Identification of the affiliated facilities where the physician has privileges for any treatment, illness or procedure you identify.

c. Physician Status/Discipline
We can provide you with information on how to contact the Michigan Department of Consumer and Industry Services. This state agency maintains records concerning licensed physicians.

d. Specific Benefits
You are entitled to information concerning any requirements, limitations, restrictions or exclusions including, but not limited to, information concerning the HealthPlus drug formulary, as may be applicable by type of service, benefit or provider or, if applicable, by specific service, benefit or type of drug.

e. Financial Arrangement with Providers
You are entitled to summary information concerning the financial relationship between HealthPlus and any provider, including:

1) Whether a "fee-for-service" arrangement exists;
2) Whether a "capitation" arrangement exists; and
3) Whether the HealthPlus payment to providers is based upon cost, quality or patient satisfaction.

6. Who to Contact
To receive information concerning any of the above topics, call the HealthPlus Customer Service Department at 1-800-332-9161. Our Customer Service Department can help you understand how to file a grievance, as well as assist you with any other question you may have about your HealthPlus coverage.

HealthPlus Privacy Notice* (Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Information We Have. We receive enrollment information about you, which includes your date of birth, sex, identification number, and other personal information including social security numbers. We also receive bills, physician reports and other information about your medical care. For some health insurance programs, HealthPlus may have credit card and/or bank account information which is supplied by you for payment of premiums.

Our Privacy Policy. We care about your privacy and we guard your information carefully. We are required to maintain the privacy of your information and to provide you with this notice of our legal duties and our privacy practices. Internally, we protect your oral, written and electronic information by requiring employees and others with access to such information to follow specific confidentiality and technology use procedures. We maintain physical safeguards such as shredding documents and securing buildings; electronic safeguards, such as encryption and monitoring; and procedural safeguards, such as customer authentication procedures, to guard your information against unauthorized access or use. We will not sell any information about you. Only people who have both the need and the legal right may see your information. Unless you give us a written authorization, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so. We will notify you of any breach of unsecured protected health information about you as required by federal and state law.

Treatment. We may disclose medical information about you for the purpose of coordinating your health care. For example, we may notify your personal doctor about treatment you receive in an emergency room.

Payment. We may use and disclose medical information about you so that the medical services you receive can be properly billed and paid. For example, we may ask a hospital emergency department for details about your treatment before we pay the bill for your care.

Business Operations. We may need to use and disclose medical information about you in connection with our business operations with affiliated entities. For example, we may use medical information about you to review the quality of services you receive and to investigate fraud and abuse.

Underwriting. We may use and disclose information for underwriting purposes. Genetic information shall not be used or disclosed for underwriting purposes.

Health-Related Benefits and Services. We, or our agents, may contact you about other health-related benefits and services that may be of interest to you.

As Required By Law. We will release information about you when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, public health services, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

Employer Plans. We will share only enrollment information or summary health information (or other information if required by law) with an employer or plan sponsor. However, we may share your personal and medical information with the employer or plan sponsor if you are a participant or dependent in a self-funded employer health plan and the employer has provided us with written assurances that the information will be kept confidential and will not be used for an improper purpose.

Authorizations. According to federal and state law, we may use and disclose your personal and protected health information for certain circumstances only with your written authorization to do so. These include, but are not limited to, psychotherapy notes, marketing activities, sale of PHI, or for research. If you give us a written authorization, you have the right to change your mind and revoke that authorization.

Copies of this Notice. You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

Changes to this Notice. We reserve the right to revise the Privacy Notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website and in our member newsletter.

Other Laws and Regulations. HealthPlus must comply with all federal and state laws and regulations. Michigan law and other federal law may provide additional protection for your personal health information (e.g., social security numbers, HIV/AIDS, behavioral health, and minors).

Your Right to Inspect and Copy. Upon written request, you have the right to inspect the information we have about you and to get copies of that information.

Your Right to Amend. If you feel that the information about you, which we have, is incorrect or incomplete, you can make a written request to us to amend that information. We can deny your request for certain limited reasons, but we must give you a written reason for our denial.

Your Right to a List of Disclosures. Upon written request, you have the right to receive a list of our disclosures of your information, except when you have authorized those disclosures or if the disclosures are made for treatment, payment, or health care operations. We are not required to give you a list of disclosures made before April 14, 2003.

Your Right to Request Restrictions on Our Use or Disclosure of Information. If you do so in writing, you have the right to request restrictions on the information we may use or disclose about you. We are not required to agree to such requests.

Your Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we contact you only at home or only at a certain address or only by mail.

How to Use Your Rights Under This Notice. If you want to use your rights under this notice, you may call us or write to us. If your request to us must be in writing, we will help you prepare your written request, if you wish.

Complaints and Communications to Us. If you want to exercise your right under this Notice or if you wish to communicate with us about privacy issues or if you wish to file a complaint, you can write to: Compliance & Privacy/Security Official at 2050 S. Linden Road, Flint, Michigan, 48532 or call the Compliance Hotline at 1-800-345-9956. You will not be penalized for filing a complaint.

Complaints to the Federal Government. If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to: Office of the Secretary, Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint with the federal government.

* When we refer to HealthPlus, we, or our, we mean HealthPlus of Michigan, Inc. and its affiliated entities, HealthPlus Partners, Inc., HealthPlus Options, Inc., and HealthPlus Insurance Company. We are affiliated entities as defined under the Health Insurance Portability and Accountability Act and related regulations ("HIPAA") and we share information among ourselves as appropriate. When we refer to you, we mean a member of a HealthPlus of Michigan, Inc. and its affiliated entities, HealthPlus Partners, Inc., HealthPlus Options, Inc., and HealthPlus Insurance Company. (updated 8/21/13)

Janet's Law

The "Women's' Health & Cancer Rights Act of 1998" is a Federal law also known as "Janet's Law." Your HealthPlus Benefit Rider explains the medical and surgical benefits in connection with a mastectomy as provided by this Act. If you have had a mastectomy and wish to elect breast reconstruction in connection with the mastectomy, please note that the following coverage is available to you:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses, if prosthetic devices are listed as a covered service in your Benefit Rider; and
4. Care for physical complications from all stages of the mastectomy, including lymphedemas.

The above described coverage must be provided in a manner determined in consultation with you and your attending physician. Finally, please note that the above described coverage is subject to any applicable annual deductibles, coinsurance provisions, and Copays as provided in your Subscriber Contract and Benefit Rider(s).

If you have any questions, please call the HealthPlus Customer Service Department at 1-800-332-9161.

Your Right to Make Medical Treatment Decisions

Many people today are worried about the medical care they would be given should they become terminally ill and unable to communicate. You may now state your health care preferences in writing, while you are still healthy and able to make such decisions. We are giving you this material to tell you about your right to make your own decisions about your medical treatment. As a competent adult, you have the right to accept or refuse any medical treatment. "Competent" means you have the ability to understand your medical condition and the medical treatments for it, to weigh the possible benefits and risks of each such treatment, and then to decide whether you want to accept treatment or not.

Who decides what treatment I will get?

As long as you are competent, you are the only person who can decide what medical treatment you want to accept or reject. You will be given information and advice about the pros and cons of different kinds of treatment and you can ask questions about your options. But only you can say "yes" or "no" to any treatment offered. You can say "no" even if the treatment you refuse might keep you alive longer and even if others want you to have it.

What if I'm in no condition to decide?

If you become unable to make your own decisions about medical care, decisions will have to be made for you. If you haven't given prior instructions, no one will know what you would want. There may be difficult questions. For instance, would you refuse treatment if you were going to die soon, no matter what? Would you want to receive any treatment your caregivers recommend? When your wishes are not known, your family or the courts may have to decide what to do.

What can I do now to see that my wishes are honored in the future?

While you are competent, you can name someone to make medical treatment decisions for you should you ever be unable to make them for yourself. To be certain that the person you name has the legal right to make those decisions, you must fill out a form called either a Durable Power of Attorney for health care or a Patient Advocate Designation. The person named in the form to make or carry out your decisions about treatment is called a Patient

Advocate. You have the right to give your written or spoken instructions about what medical treatment you want and don't want to receive.

Who can be my Patient Advocate?
You can choose anyone to be your Patient Advocate as long as the person is at least 18 years old. You can pick a family member or a friend or any other person you trust, but you should make sure that person is willing to serve by signing an acceptance form. It's a good idea to name a backup choice, too, just in case the first person is unwilling or unable to act when the time comes.

Where can I get a Patient Advocate Designation form?
Many Michigan hospitals, nursing homes, homes for the aged, hospices and home health care agencies make forms available to people free of charge. Many senior citizens' groups and church and civic groups do, too. You can also get a free form from various members of the Michigan legislature. Many lawyers also prepare Patient Advocate Designations for their clients. The forms aren't all alike. You should pick the one which best suits your situation.

How do I sign a Patient Advocate Designation form so that it's valid?
All you have to do is fill in the name of the advocate and sign the form in front of two witnesses. But that's not as simple as it sounds, because under this law, some people cannot be your witness. Your spouse, parents, grandchildren, children, and brothers or sisters, for example, cannot witness your signature. Neither can anyone else who could be your heir or who is named to receive something in your will, or who is an employee of a company that insures your life or health. Finally, the law disqualifies the person you name as your Patient Advocate, your doctors and all employees of the facility or agency providing health care to you, from being a witness to your signature. It is easier to make a Patient Advocate Designation before you become a patient or resident of a health care facility or agency. Friends or co-workers are often good people to ask to be witnesses, since they see you often and can, if necessary, swear that you acted voluntarily and were of sound mind when you made out the form.

What do I do with my forms after I fill them out?
You should give copies of the completed forms to your doctor and/or health care facility so that it can be placed in your medical records. You should also tell your family and friends that you have chosen a Patient Advocate, and consider giving them a copy of the form as well.

Do I have to give my Patient Advocate instructions?
No. A Patient Advocate Designation can be used just to name your Patient Advocate, the person you want to make decisions for you. But written instructions are generally helpful to everybody involved. And, if you want your Patient Advocate to be able to refuse treatment and let you die, you have to say so specifically in the Patient Advocate Designation document itself. Any other instructions you have you can either write down or just tell your Patient Advocate. Either way, the Patient Advocate's job is to follow your instructions.

Can I just give instructions and not name a Patient Advocate?
Yes, you can simply tell somebody, for example, your caregiver or your family and close friends, what your wishes are. Better yet, you can write what is called a "Living Will," which is a written statement of your choices about medical treatment. Even though there is not yet a state Living Will law, courts and health care providers still find Living Wills valuable. Those taking care of you will pay more attention to what you have written about your treatment choices, whether in a Patient Advocate Designation or a Living Will, because they can be more confident they know what you would have wanted. Most doctors, hospitals and other health care providers will also pay attention to what you've said to others, especially your family, about medical treatment. But again, it's better for everyone involved if you write down your wishes.

Do I have to make a decision now about my future medical treatment?
No. You don't have to fill out a Patient Advocate Designation or a Living Will and you don't have to tell anybody your wishes about medical treatment. You will still get the medical treatment you choose now, while you are competent. If you become unable to make decisions, but you've made sure that your family and friends know what you would want, they will be able to follow your wishes. Without instructions from you, your family or friends and caregivers may still be able to agree how to proceed. If they don't, however, a court may have to name a guardian to make decisions for you.

If I make decisions now, can I change my mind later?
Yes, you can give new instructions in writing or orally. You can also change your mind about naming a Patient Advocate at all and cancel a Patient Advocate Designation at any time. You should review your Patient Advocate

Designation or Living Will at least once a year to make sure it still accurately states how you want to be treated and/or names the person you want to make decisions for you.

What else should I think about?
Treatment decisions are difficult. We encourage you to think about them in advance and discuss them with your family, friends, advisors and caregivers. You can and should ask your facility or agency about their treatment policies and procedures to be sure you understand them and how they work.

If you want more information about a Patient Advocate Designation or Living Wills, or sample forms, please ask your caregiver for assistance. Many facilities and agencies have staff available who can answer your questions. Additional materials may be available from your state representative or senator.

Members Rights and Responsibilities

HealthPlus is committed to treating its members in a manner that respects their rights and addresses their responsibility for cooperating with HealthPlus staff and affiliated providers. HealthPlus recognizes the following rights of its members:

- To be treated with respect and to have their dignity and personal privacy recognized.
- To receive advice or assistance in a prompt, courteous and responsible manner.
- To receive information about HealthPlus, their rights and responsibilities as a member, their health care benefits, and the participating physicians and other affiliated health care providers from whom they receive care.
- To express a complaint and/or grievance about HealthPlus or about care they have received, and to receive a response to the complaint and/or grievance within a reasonable period of time.
- To participate in decisions involving their health care.
- To participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To refuse treatment and to be informed of the probable consequences of their actions.
- To be assured of confidential health records except when disclosure is required by law or permitted in writing by them. With adequate notice, they have the right to review their medical records with their physician.
- To make recommendations regarding the members' rights and responsibilities policy.

HealthPlus recognizes the following responsibilities of its members:

- To treat all HealthPlus and affiliated provider personnel and other members respectfully and courteously.
- To keep scheduled appointments or give adequate notice of delay or cancellation.
- To provide information that HealthPlus, participating physicians and other affiliated health care providers need in order to provide health care benefits and to care for them.
- To be honest and complete when providing information to the treatment staff, including a complete and accurate medical history and any complications that may arise in the course of treatment.
- To follow the recommendations and advice they agreed to with the treatment staff concerning their care and to consider the potential consequences if they refuse to comply.
- To participate in understanding their health problems and developing mutually agreed-upon treatment goals.
- To express their opinions, concerns or complaints in a constructive manner to the appropriate people within HealthPlus or the affiliated provider network.

This statement of members' rights and responsibilities in no way modifies the benefit coverage and limitations provided by the applicable HealthPlus Subscriber Contract and applicable Rider(s).

Member Satisfaction Plan Summary

Because your satisfaction is one of the main goals at HealthPlus of Michigan, Inc. ("HPM"), we have established a Member Satisfaction Plan. The Member Satisfaction Plan has two main purposes. The first purpose is to see that you receive the answers to any questions you have about HPM. The second is to provide ways of reaching fair solutions to any problems you may have with HPM.

When you have a question or problem, please call the Customer Service Department. They can be reached by calling 1-800-332-9161. Customer Service staff will document and date the source of all member contacts. Most inquiries can be resolved within two (2) working days.

If you are not happy with any aspect of HPM's operations or benefits, and you cannot resolve your concerns with the Customer Service Department, you or a person you have authorized to represent you can use the Member Satisfaction Plan. You must file your grievance within two (2) years of the event giving rise to the grievance or within two (2) years of discovering the facts giving rise to the grievance.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your grievance. You may submit written comments, documents, records, and other information relating to the grievance.

Routine Grievance
The Member Satisfaction Plan has two internal steps for routine grievances: Grievance and Grievance Appeal. We have thirty (30) calendar days to complete these two steps, but we can extend the time by any amount of time that you allow us to. Here's how to use each of the steps:

Step One: Grievance
Whenever your concerns regarding HPM cannot be handled by the Customer Service Department, you can file a grievance. You can initiate this process by contacting HPM by phone (1-800-332-9161), mail (2050 S. Linden Road, P.O. Box 1700, Flint, Michigan, 48501-1700), fax (1-810-733-1947), or a personal meeting. HPM will respond in writing to your grievance within fifteen (15) calendar days of receiving it. At that time, you will be informed of HPM's investigation into your grievance, any action taken, and advised of your rights to further review if your grievance has not been resolved in your favor.

Step Two: Grievance Appeal
If you are not satisfied with the outcome of your grievance, you can appeal it within a reasonable amount of time following notification of the decision. HPM will schedule a meeting of the Grievance Appeal Committee within thirteen (13) calendar days of receipt of your request to file a Grievance Appeal.

You have the opportunity to appear and speak before the Grievance Appeal Committee with or without representation. If you cannot appear in person, you also have the option of speaking by telephone or other appropriate technology.

You will receive notification of the Grievance Appeal Committee's decision within two (2) calendar days of the meeting. This will be HPM's final decision on your grievance. You will be advised of your right to further appeal to the State of Michigan, Office of Financial and Insurance Services.

External Review
If you have exhausted your rights under the HPM Member Satisfaction Plan, or if you have not received a response from us at the end of fifteen (15) calendar days from filing your appeal under Step Two: Grievance Appeal, you can appeal to the Office of Financial and Insurance Services at no cost to you by writing or calling:

State of Michigan, Office of Financial and Insurance Services, Appeals Section, 611 W. Ottawa Street, P.O. Box 30220 Lansing, Michigan 48909-7720 or call: 1-517-373-0220 or 1-877-999-6442 (toll free).

By submitting a request for external review, you are authorizing HPM and your health care providers to disclose your health information, including medical records that are relevant to the review process.

If the final decision of HPM was an adverse determination, you must file your request for external review with the Office of Financial and Insurance Services within sixty (60) calendar days following receipt of HPM's final decision.

An 'adverse determination' is a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced or terminated. You need to complete a Request for External Review form for the Office of Financial and Insurance Services to be able to process your request. You can obtain the form from HPM's Customer Service Department.

If your request for external review of an adverse determination is found to be appropriate for external review, the Commissioner of the Office of Financial and Insurance Services will either review the case or assign an Independent Review Organization, made up of independent clinical reviewers, to review your case. Both HPM and you will have an opportunity to provide this Independent Review Organization with supporting documentation. Within fourteen (14) calendar days, the Independent Review Organization will recommend to the Commissioner to uphold or reverse HPM's determination. The Commissioner has seven (7) working days to make a decision.

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

If you would like more information about your right to an external review, you may contact the Office of Financial and Insurance Services at the address or telephone numbers listed above.

Expedited Grievance
If you (or another person, including a physician, who is authorized in writing to act on your behalf) believes that due to your medical status resolution of your grievance within HPM's normal times frames would seriously jeopardize your life or health or ability to regain maximum function or subject you to severe pain that cannot be managed adequately, the expedited grievance process may be utilized. You may only request an expedited grievance when we have denied your request for benefits prior to your having received a service.

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

HPM will make a determination concerning your expedited grievance and communicate that to you and your physician as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after receipt. You and your physician will be provided with written confirmation of this determination within two (2) working days or three (3) calendar days, whichever is less, following the oral determination.

External Review
A request for an expedited external review may be forwarded to the Office of Financial and Insurance Services at no cost to you within ten (10) calendar days following receipt of HPM's determination. You may write or call them at the following address and telephone numbers: Office of Financial and Insurance Services, Appeals Section, 611 W. Ottawa Street, P.O. Box 30220, Lansing, Michigan 48909-7720, or call: 1-517-373-0220 or 1- 877-999-6442 (toll free).

By submitting a request for external review, you are authorizing HPM and your health care providers to disclose your health information, including medical records, which are relevant to the review process. You need to complete a Request for External Review form for the Office of Financial and Insurance Services to be able to process your request. You can obtain the form from HPM's Customer Service Department.

If a physician believes that due to your medical condition, resolution of your expedited grievance within HPM's time frames for an expedited grievance would seriously jeopardize your life or health or ability to regain maximum function or subject you to severe pain that cannot be managed adequately, and you have filed a request for an expedited grievance with HPM, you may request an expedited external review from the Office of Financial and Insurance Services.

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

If you would like more information about your right to an external review, you may contact the Office of Financial and Insurance Services at the address or telephone numbers listed above.

Fraud and Abuse

HealthPlus is licensed to do business as a Health Maintenance Organization. Laws regulate the health care services provided by HealthPlus. HealthPlus members, employees and providers must follow these laws.

Fraud can mean lying to get a benefit that is not in your contract. Abuse can mean doing something that leads to extra costs for HealthPlus. It also means paying doctors for services that:

- Are not medically necessary
- Do not meet the standard of care

To report fraud or abuse, call the confidential Compliance Hotline at 1-888-706-1504. You also can write to:
Theresa M. Schurman, Esq.
Compliance Official
2050 S. Linden Rd
Flint, MI 48532

Or go to our website at www.healthplus.org. You do not need to give your name.

Examples of fraud and abuse by a member include the following:

- Changing a prescription
- Changing medical records
- Letting someone else use your HealthPlus insurance card to get medical services
- Falsifying information on a HealthPlus application for benefits

Examples of fraud and abuse by a provider include the following:

- Lying about credentials such as a college degree
- Billing for services that weren't done
- Billing a balance that isn't allowed
- Double billing, upcoding and unbundling
- Collusion among providers – providers agreeing on minimum fees they will charge and accept
- Underutilization – not ordering services that are medically necessary

Examples of fraud and abuse by an employee of HealthPlus include the following:

- Lying about a provider's credentials or provider network
- Forging a signature on a contract
- Intentionally submitting false claims
- Rigging bids – collusion between state employees and PPO employees
- Self-dealing – awarding a contract based solely on friendship or family relationships
- Embezzlement or theft
- Excessive salaries and fees to close associates of HealthPlus

HealthPlus Board of Directors

At least one-third of the individuals who sit on the HealthPlus Board of Directors are elected from the HealthPlus member population. The remaining board members are providers and members of the business community. HealthPlus subscribers elect the entire Board of Directors. This allows subscribers a voice in deciding how HealthPlus provides health care benefits to its members.

If you are interested in serving on the HealthPlus Board, please contact the HealthPlus Legal Department at (810) 230-2168.

When to Contact HealthPlus: We want to help you make the most of your HealthPlus coverage. To do this, we need your assistance. If any of the following should occur, please contact the Customer Service Department Monday through Friday, 9 a.m. to 6 p.m. at 1-800-332-9161 or visit our website, www.healthplus.org.

- Address changes
- Physician changes
- Changes in family status
- Changes regarding other health care coverage
- Lost or stolen identification cards
- Special health care needs
- Quality of care concerns

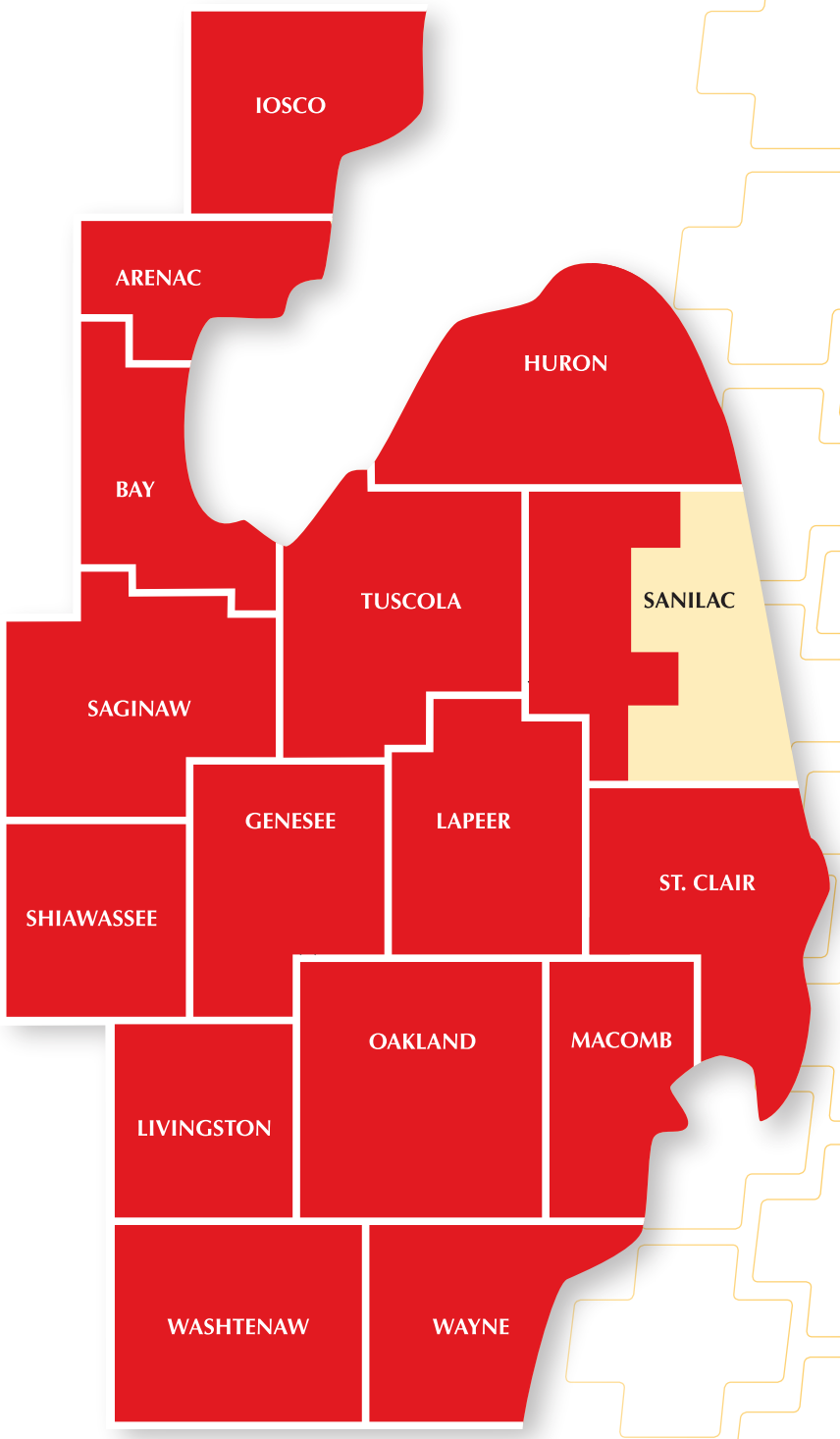
We look forward to serving as your partners in managed care.

HealthPlus Core Service Area

All HealthPlus members are covered worldwide for urgent and emergency care.

HealthPlus PPO members have expanded access outside this service area using the PHCS or MultiPlan networks.

Visit multiplan.com to find an in-network provider.



Core Service Area
Effective January 1, 2014

800-332-9161 • healthplus.org

FLINT 2050 S. Linden Road, Flint, MI 48532
SAGINAW 5454 Hampton Place, Saginaw, MI 48604
TROY 101 W.Big Beaver Road, Suite 1400, Troy,MI 48084

HealthPlus®
The Right Plan for a Healthier You®