HMO
Health Maintenance Organization

Health Alliance Plan of Michigan

Group Subscriber Contract

Health Alliance Plan of Michigan (HAP) hereby certifies that individuals eligible for coverage are covered under the above Contract as determined by the provisions contained in Section 2 of this Contract. The Contract details the benefits and terms of coverage. You are entitled to the benefits described in the Contract in exchange for the Premium paid to HAP.

The benefits available under this Contract will be administered consistent with the requirements of state and federal law, including but not limited to the Affordable Care Act (ACA), as such provisions may be defined, implemented or amended over time. Groups that qualify as grandfathered as that term is defined in ACA may be eligible for different Riders than non-grandfathered groups. Groups shall self-identify as a grandfathered group, if such status applies.

Health Alliance Plan of Michigan
2850 W. Grand Blvd., Detroit, Michigan 48202
hap.org

HAP-HMO 2018

HEALTH ALLIANCE PLAN
HMO SUBSCRIBER CONTRACT

TABLE OF CONTENTS

OTHER DOCUMENTS

HEALTH ALLIANCE PLAN
HMO SUBSCRIBER CONTRACT

SECTION 1 - INTRODUCTION

1.1 Your Coverage

You and your eligible Dependents are entitled to receive the benefits described in this Contract pursuant to an agreement between Your Group and Us. This Contract may also include Riders. Riders explain the Cost-Sharing requirements of Covered Services and may change the benefits and Eligibility rules described in this Contract. You should keep this Contract, Riders and the Summary of Benefits and Coverage with Your other important papers so that they are available for Your future reference.

1.2 Definitions

Throughout this Contract, Health Alliance Plan is referred to as “We”, “Us”, “Our” or “HAP”. The words “You”, “Your”, “Yours” or “Member” refer to the Subscriber and any Dependents covered under this Contract. There are other words and phrases used in this Contract that have meanings unique to this Contract. These words and phrases are capitalized and generally defined in Section 11. Any words or phrases used in the Contract that are not defined in Section 11 will have the meaning defined by applicable state or federal law.

1.3 HMO Coverage

This Contract provides coverage through Health Alliance Plan (HAP), a nonprofit corporation licensed by the State of Michigan as a Health Maintenance Organization (HMO). This Contract describes Your health coverage under an HMO arrangement. It is important to read this Contract carefully before You need services.

Because HAP is an HMO, many services covered under this Contract must be provided, arranged or authorized in advance by Your Primary Care Physician (PCP). Your PCP is an Affiliated Provider that You choose who is primarily responsible for providing or arranging for health care services for You. In some cases, Your PCP will also need to have services authorized by Us.

You may choose an Affiliated family practitioner, general practitioner, or internist as Your PCP. A pediatrician may be chosen as the PCP for a Dependent child.

You may choose to see any Affiliated obstetrician or gynecologist Specialist without a Referral from Your PCP. These providers, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, procedures for making Referrals.

A Referral from Your PCP may be required to obtain Covered Services from any other type of Affiliated Specialist. Our directory of Affiliated Providers is updated on an ongoing basis and published on Our website, **hap.org**.

There are no benefits for services that are provided by Non-Affiliated Providers, except for treatment of an Emergency Medical Condition as defined in this Contract. Non-Affiliated Providers may require You to pay the balance between the Allowable Amount and the provider’s actual Charge for Covered Services. This is also referred to as Balance Billing.

Affiliated Providers agree to accept Our payment of the Allowable Amount for Covered Services as payment in full, other than applicable Cost-Sharing. Affiliated Providers may not Balance Bill You.

Because Your PCP is the key to receiving services under this Contract, make an appointment to see Your PCP soon.

1.4 Your Agreement and Consent

This Contract is an agreement between HAP and persons who have enrolled as Members. It contains important information about Your coverage. You should read this Contract carefully before You need services. By enrolling in and accepting this Contract, and/or by using Your Identification Card and receiving benefits under this Contract, You agree to abide by its terms. You recognize that We are responsible for arranging, paying or reimbursing for only those services that are Covered Services, subject to all exclusions and limitations described in this Contract and only for Covered Services provided while Your coverage under this Contract remains in effect.

SECTION 2 - ELIGIBILITY

2.1 Subscriber and Dependent Eligibility Criteria

a. General requirements: You are eligible for coverage as a Subscriber or Dependent under this Contract if You meet the following Eligibility requirements:

   1. You must meet the Group's eligibility requirements and meet the Eligibility requirements in this Section 2. If there is a conflict between the requirements described in this Section and the terms of Your Group's operating agreement with Us, the terms of the Group's operating agreement will control; and
   2. You live or work in Our Service Area.

b. Other requirements:

   1. Enrollment must be sought in an enrollment period recognized by the Group and Us; and
   2. You must meet any additional Eligibility requirements described in any Rider or amendment attached to this Contract.
   3. Subscribers and Dependents identified by the Federal government as terrorists or others similarly ineligible for coverage on the basis of federal or state law may be denied enrollment.

2.2 Dependents

The following persons are eligible for coverage under this Contract as the Subscriber's Dependents if they meet Our Eligibility requirements and the eligibility requirements of the Subscriber's Group:

a. The Subscriber's Spouse.

b. The Subscriber's children, by birth or legal adoption who are under the age of 26;

c. The children of the Subscriber's Spouse, by birth or legal adoption who are under the age of 26;

d. A Subscriber's child who is recognized under a Qualified Medical Child Support Order. A copy of the court order or divorce decree is required to enroll the child;

e. A child to whom the Subscriber or the Subscriber's Spouse is a legal guardian. A copy of the court appointment of the guardian is required to enroll the child; and

f. A Permanently Disabled child of the Subscriber or the Subscriber's Spouse who meets all of the following requirements:

   1. Is over the age of 26;
   2. Is not married;
   3. Was Permanently Disabled before reaching the age of 26; and
   4. Relies on the Subscriber or Subscriber's Spouse for more than half of their support, as determined under Section 152 of the Internal Revenue Code, as amended.

Proof of the Permanent Disability and financial dependence must be provided within 30 days of enrollment.

2.3 Eligibility When an Inpatient

Eligibility will not be denied under this Contract based upon the fact that You were an Inpatient on Your first day of coverage. However, We reserve the right to claim that Our coverage is secondary to that of another carrier who is obligated to provide coverage during Your Inpatient stay. You should notify Us of Your Inpatient status within 48 hours after the day Your coverage begins under this Contract.

2.4 Coverage Periods for Dependents

a. Coverage for the Subscriber's Spouse continues throughout the marriage. In the event of a divorce, coverage for the Subscriber's Spouse ends on the last day of the month in which the divorce occurs.

b. Coverage for a child who is Your Dependent ends on the last day of the Calendar Year in which the child reaches the age of 26, unless otherwise indicated below or in an attached Rider.

c. Coverage for a child who is Your Dependent continues without regard to age if the child is diagnosed as Permanently Disabled before the child reached the age of 26, and the child relies on You for all or most of their support. A Permanently Disabled Dependent is eligible for continued coverage if all of the following apply:

   1. The Dependent is the child of the Subscriber or the Subscriber's Spouse;
   2. The Dependent is not capable of engaging in self-sustaining employment because of a Permanent Disability. Certain diagnoses, including but not limited to attention deficit disorder or depression, by themselves, are not evidence of Permanent Disability. Learning disabilities, substance abuse, or the inability to "hold a job" alone is not evidence of Permanent Disability. Examples of diagnoses that may constitute a Permanent Disability include Down Syndrome and traumatic brain injury.
   3. The Permanent Disability started and was diagnosed before age 26; and
   4. The Dependent relies on the Subscriber or the Subscriber's Spouse for more than half of their support, as determined under Section 152 of the Internal Revenue Code, as amended.

   You must provide satisfactory proof to Us of Your Dependent's Permanent Disability and financial dependence no later than 30 days after the Dependent attains age 26. After the initial proof of Permanent Disability, You must give Us proof when We ask for it, from time to time, but not more often than once each year.

   Coverage for the Permanently Disabled Dependent will end if any of the following events occur:

   1. The Dependent is no longer a dependent of You or Your Spouse as determined under Section 152 of the Internal Revenue Code, as amended;
   2. The Dependent's Permanent Disability ends;
   3. We do not receive proof that the Dependent is Permanently Disabled within 30 days after requesting such information;

4. The Dependent no longer meets Eligibility requirements for any reason other than reaching 26 years of age; or
5. The Dependent is married after reaching 26 years of age.

If the Permanently Disabled Dependent is enrolled in Medicare, We must be notified of the Medicare coverage in order to coordinate benefits.

d. Coverage for a child under a Qualified Medical Child Support Order begins on the date of the court order, if We receive notice within 30 days of the court order. If We receive notice longer than 30 days after the court order is issued, coverage is effective on the date We receive the notice. If the Subscriber who is under the court order does not enroll the child, the other parent or the State child support enforcement agency may enroll the child. Coverage continues for as long as the court order is in effect or until the child no longer meets Our Eligibility requirements, whichever is earlier.

e. Coverage for a minor child to whom the Subscriber or the Subscriber's Spouse is a legal guardian, continues as long as the court appointment is in effect or until the minor child reaches the age of 18, whichever is earlier.

2.5 Effect of Medicare Eligibility

If You are eligible for Medicare, You may be eligible for coverage under this Contract only if You are an active Employee, an eligible retiree or an eligible Dependent as defined by Your Group and Your Group purchases the Complementary Medicare Rider / Medicare Wrap Rider. If you are a Group retiree eligible for Medicare Part A you must enroll in Part A. If you are a group retiree eligible for Medicare Part B you must enroll in Part B. Check with Your Group to find out if Your Group offers retiree health plan benefits.

2.6 Initial Enrollment and Open Enrollment Periods

During the initial enrollment period, You and Your Dependents must enroll for coverage within 30 days of becoming eligible. You may also enroll during the annual Open Enrollment period specified by your Group or Remitting Agent. If You do not enroll during one of these enrollment periods, You and/or Your Dependents will not be allowed to enroll until the next Open Enrollment period, unless You experience a life event that entitles You to a Special Enrollment Period.

2.7 Special Enrollment Periods

Outside of Your Group's Open Enrollment Period, You may encounter a life event which may make You and/or Your Dependents eligible for a Special Enrollment Period. This would not apply to Your Dependents if the Group does not offer coverage for Spouses or Dependents. We must receive notice of these events from Your Group or Remitting Agent within 30 days of the event in order to provide coverage and/or adjust Premiums. We will only cover new Dependents upon timely payment of any additional Premium due to Us. Qualifying life events include, but are not limited to the following:

- Loss of qualifying health coverage, such as COBRA coverage ending, job loss, reduction in the number of hours employed, divorce, death, aging off a parent's health plan.
- Change in household size, such as marriage, birth or adoption of a child, divorce, legal separation or death.

- Newly qualified employee.
- Other circumstances allowed under state or federal law.

2.8 Notifying Us of Important Changes

You must notify Your Group and Us as soon as possible, but no later than 30 days after any of the following changes for either You or Your Dependent(s):

a. A change in Your name, address or telephone number.

b. Retirement or other changes in Your employment status.

c. A change in Medicare eligibility or coverage such as entitlement to, enrollment in or disenrollment from Medicare Parts A and/or B.

d. The addition of, or a change in, any other health coverage to which You or Your Dependent may be entitled.

2.9 Failure to Notify Us of Changes

Failure to provide timely and complete notice of changes in Eligibility or other important changes as noted above may result in a lapse in coverage and a denial of claims. We are not responsible for a lapse in coverage when You, Your Group or Remitting Agent do not notify Us of these changes.

2.10 Documentation for Coverage

Upon request by Us, You must give Us information, including copies of documents, which help Us determine the Eligibility of You or Your Dependents for coverage under this Contract.

SECTION 3 - PAYMENT OF PREMIUMS AND COPAYMENTS

3.1 Payment of Premium

All Premiums are due and payable in advance. The first Premium must be paid before coverage becomes effective. Thereafter, We will continue coverage under this Contract for the entire period covered by the payment if We receive payment within 30 days of the date the payment was due.

3.2 Grace Period

A grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the Contract will continue in force, subject to our right to cancel in accordance with Section 8.3 of this Contract.

3.3 Agreement to Pay for Services if Premium is Not Paid

You are not entitled to Covered Services during any period for which a Premium was due but not paid by Your Group or Remitting Agent. If You receive Covered Services during such a period, You are responsible for paying the provider for those services or reimbursing Us in the event that We paid for such services.

3.4 Change in Premiums

We may change the Premiums as of any Premium Due Date by giving written notice to Your Group or Remitting Agent. Notice will be given at least 30 days prior to the effective date of such change, unless otherwise allowed or disallowed under applicable law.

3.5 Premium Refund

If a Member dies while this Contract is in force, We will refund the Premium paid from the date following the date of death to the end of the period for which Premium has been paid. The Premium refund will be issued to the Group that paid the Premium.

3.6 Copayment and Out-of-Pocket Expenses

You are responsible for paying any Copayment, Coinsurance, Deductible, Out-of-Pocket Limit and any other Cost-Sharing amounts for Covered Services established in all applicable Riders. You are also responsible for all costs associated with services that are not Covered Services as defined under this Contract.

SECTION 4 - SERVICES AND BENEFITS

The services and benefits described in this Section are Covered Services when provided in accordance with Our Benefit, Referral and Practice Policies by an Affiliated Provider, except in an Emergency, or as otherwise approved by Us or Our designee.

We will pay benefits only for Covered Services that were furnished while Your coverage under this Contract is in force. No benefits are payable for health care expenses incurred before the Effective Date or after Your coverage has terminated; even if the expenses were incurred as a result of an Injury or Illness which occurred, commenced or existed while Your coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

We assume no responsibility for the outcome of any Covered Services. We make no express or implied warranties concerning the outcome of any Covered Services. Coverage is limited to the most appropriate method and scope of treatment according to Our Benefit, Referral and Practice Policies, except in an Emergency.

No Charges in excess of Allowable Amounts will be reimbursed for Covered Services.

Covered Services are subject to Copayments, Coinsurance, Deductibles and Out-of-Pocket Limits established in all applicable Riders and the Summary of Benefits and Coverage. Covered Services may be limited by Maximum Benefits permissible under state and federal law as described in this Section or any attached Rider(s).

Affiliated Providers agree to accept Our payment of the Allowable Amount for Covered Services as payment in full, other than applicable Cost-Sharing. Affiliated Providers may not Balance Bill You.

Non-Affiliated Providers may require You to pay the balance between the Allowable Amount and the provider's actual Charge for Covered Services. This is also referred to as Balance Billing.

Only services that are listed as preventive services in Section 4.4 and services that are Medically Necessary and approved by Us or Our designee are Covered Services under this Contract. These services have limitations and exclusions that are outlined in this Section and in Section 5.

4.1 Inpatient Hospital and Long Term Acute Care

Inpatient hospital and long term acute care admissions must be Prior Authorized by Us. You or Your representative must notify Us prior to an elective admission and within 48 hours of and Emergency Hospital admission. Coverage for Inpatient Hospital services and long term acute care services includes but is not limited to:

a. Semi-private room and board, including meals and special diets;

b. Regular nursing services;

c. Special care units, such as intensive or coronary care units;

d. Operating, recovery and other treatment rooms;

e. Diagnostic laboratory tests, X-rays and pathology services;

f. Drugs and medications, including anti-cancer drugs described in section 4.20;

g. Administration of blood, blood plasma and other biologicals;

h. Medical supplies and equipment, including oxygen;

i. Anesthetics and anesthesia services;

j. Rehabilitation services (e.g., physical, occupational and/or speech therapy);

k. Radiation therapy; and

l. Inhalation therapy.

4.2 Outpatient Hospital and Ambulatory Surgical Center Care

Services and supplies provided in an outpatient section of a Hospital or a fully licensed free standing outpatient facility when You are confined for less than 24 hours. Coverage includes, but is not limited to:

a. Pre-surgical testing;

b. Dressings, casts, and sterile tray services;

c. Operating, recovery, and other treatment rooms;

d. Diagnostic laboratory tests, X-rays, high tech radiology exams and pathology services;

e. Outpatient Surgery;

f. Physician Charges related to outpatient services or ambulatory surgery;

g. Drugs provided as part of outpatient services that are not for the sole purpose of administering or infusing drugs;

h. Administration of blood, blood plasma and other biologicals;

i. Medical supplies and equipment, including oxygen;

j. Anesthetics and anesthesia services.

k. Radiation therapy; and

l. Observation for treatment and assessment by medical personnel pending a decision regarding the need for additional care up to the point You are released or admitted as an Inpatient.

4.3 Physicians Services

Professional services of a PCP or Specialist Physician as follows:

a. In the Physician's office, in the outpatient section of a Hospital or other outpatient clinic, medical center or ambulatory surgical center;

b. During an Inpatient Hospital stay; and

c. In a skilled nursing facility.

4.4 Preventive Services

Preventive services are evidence-informed preventive care and screenings described in comprehensive guidelines supported by the Health Resources and Services Administration and are defined by the Affordable Care Act (ACA). Additional preventive services are 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 (USPSTF) and immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These guidelines and recommendations may be amended from time to time. We follow these guidelines and recommendations.

As required by the ACA, preventive services are provided without Cost-Sharing. For a list of preventive services, refer to Our Preventive Services Guidelines at

https://www.hap.org/providers/docs/lists/preventive_brochure.pdf.

You may also request a copy by contacting Customer Service at the phone number on Your ID Card.

Preventive services are covered only when provided by an Affiliated Provider and include the following services:

a. Immunizations (doses and recommended ages/populations vary), including:
    1. Certain Vaccines for children from birth to age 18; and
    2. Certain Vaccines for all adults.
b. Certain drugs and supplements when prescribed in writing by a Physician, including:
    1. Aspirin for use by men and women of certain ages;
    2. Folic acid supplements for women who may become pregnant;
    3. Fluoride supplements for children who do not have fluoride in their water source;
    4. Iron supplements for children from 6 to 12 months of age who are at risk for anemia; and
    5. Tobacco cessation drugs for tobacco users according to Our Benefit, Referral and Practice Policies.

    A Prescription Drug Rider is required for coverage of these drugs and supplements. If You are not covered under any plan providing prescription drug benefits, these drugs and supplements are covered under Preventive Services.
c. Assessment, Screening and Counseling Services for Adults, including:
    1. Abdominal Aortic Aneurysm – one-time screening for men of specified ages who have ever smoked;
    2. Alcohol Misuse Screening and Counseling for all adults;
    3. Annual physical exam for all adults;
    4. Blood Pressure Screening for all adults;
    5. Cholesterol Screening for adults of certain ages or adults at higher risk;
    6. Colorectal Cancer Screening for adults over age 50;
    7. Depression Screening for all adults;
    8. Type 2 Diabetes Screening for adults of certain ages or adults at higher risk;
    9. Diet Counseling for adults at higher risk of chronic disease;
    10. HIV Screening for adults at higher risk;
    11. Obesity Screening and Counseling for all adults;
    12. Sexually Transmitted Infection (STI) Prevention Counseling for adults at higher risk;
    13. Tobacco Use Screening for all adults, including cessation interventions for tobacco users; and
    14. BRCA Counseling and Genetic Testing for all adults at higher risk.

d. Assessment, Screening and Counseling Services for Women Only (Including Pregnant Women), including:

1. Anemia Screening on a routine basis for pregnant women;
2. Bacteriuria (urinary tract or other infection) Screening for pregnant women;
3. Breast Cancer Mammography Screenings once during the five year period for women age 35 to 39 and every year for women age 40 and over;
4. Breast Cancer Chemoprevention Counseling for women at higher risk;
5. Breastfeeding which includes comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
6. Cervical Cancer Screening, including Human Papillomavirus (HPV);
7. Domestic and Interpersonal Violence Screening and Counseling for all women;
8. Gestational Diabetes Screening;
9. Hepatitis B Screening for pregnant women at their first prenatal visit;
10. Osteoporosis Screening for women over age 60 depending on risk factors;
11. Rh Incompatibility Screening for all pregnant women and follow-up testing for women at higher risk;
12. Tobacco Use Screening and expanded counseling for pregnant tobacco users;
13. Well-Women Visits; and
14. Women's Prescribed Contraception Methods including Food and Drug Administration approved contraceptive methods, sterilization procedures, and education and counseling. Coverage is subject to the following exclusions and limitations:

    a) No coverage is provided for Women's Prescribed Contraceptive Methods if this Contract is part of a benefit plan established or maintained by the following types of Employers that are either exempt or provided an accommodation from providing such coverage under the ACA:

        1. Religious Employers as defined in 45 CFR §147.131(a); or
        2. Eligible Organizations as defined in 45 CFR §147.131(b).

    b) A Prescription Drug Rider is required for coverage of contraceptive methods obtained at a pharmacy including, but not limited to, oral contraceptives, foams, gels and other methods as listed on Our Formulary.

    Your Physician must certify Medical Necessity in order to obtain coverage with no Cost-Sharing for contraceptives not listed on Our Formulary. Cost-Sharing may apply if this Contract is considered a grandfathered plan as defined in the ACA.

    c) If You are not covered under any plan providing prescription drug benefits, contraceptive methods are covered under Preventive Services.

    d) No coverage is provided for abortifacient drugs.

    e) Sterilization procedures are limited to tubal ligation only.

e. Prenatal care and counseling including breastfeeding counseling and the following prenatal laboratory services if ordered by a Physician:
    1. Asymptomatic Bacteriuria screening
    2. Chlamydia infection screening
    3. Hepatitis B virus infection screening
    4. Iron deficiency anemia screening
    5. RH (D) incompatibility screening
    6. Syphilis infection screening
    7. Gestational diabetes screening
    8. HIV screening
f. Assessments and Screenings for Children, including:
    1. Routine well child visits including physical and developmental screenings and assessments for all children at age appropriate intervals;
    2. Alcohol and Drug Use Assessments for adolescents;
    3. Cervical Dysplasia for sexually active females;
    4. Depression Screening for adolescents;
    5. Cholesterol Screening for children at higher risk for lipid disorders;
    6. HIV Screening for adolescents at higher risk;
    7. Sexually Transmitted Infection (STI) Prevention Counseling and Screening for adolescents at higher risk;
    8. Vision screening for Children; and
    9. Hearing screening for Children.

Eligible preventive services are based on governmental guidelines that may be updated to reflect new scientific and medical advances. For a complete list of recommended preventive services, please visit the U.S. Preventive Services Task Force website at http://www.uspreventiveservicestaskforce.org/BrowseRec/Index.

If the main purpose of an office visit is not to receive preventive services, You are responsible for any Cost-Sharing that applies to that office visit.

4.5 Diabetic Care

The following services for diabetic Members are covered when ordered, arranged and provided by an Affiliated Provider:

a. Blood glucose monitors, insulin infusion pumps and supplies. Quantity and other limits apply.
b. Diet and self-management sessions with a certified diabetes educator, registered nurse, or dietitian. The purpose of these sessions is to help a person with diabetes learn how to control their blood sugar and manage the disease.
c. Shoe inserts for a person with peripheral neuropathy, including diabetic neuropathy.
d. Specialty shoes prescribed for a person with diabetes.

4.6 Dietitian Services

Consultations with an Affiliated dietitian, upon Referral from Your PCP, for medically appropriate services are covered according to Our Benefit, Referral and Practice Policies.

4.7 Obstetrical, Gynecological and Maternity Care Services

a Routine obstetric and gynecological ("OB/GYN") care such as pelvic exams, pap smears and screening mammograms that are provided in addition to those services covered under the Preventive Services Section.

b. Prenatal care, inpatient Hospital delivery services and postnatal care including midwife services.

c. Inpatient Hospital services in connection with childbirth for the mother and newborn child for a length of stay of up to 48 hours after a vaginal delivery and up to 96 hours after a delivery by cesarean section. The mother's or newborn's attending Physician may, after consulting with the mother, discharge the mother or newborn earlier than 48 hours or 96 hours as applicable.

   If delivery occurs in a Hospital, the length of stay begins at the time of delivery. If the delivery occurs outside the Hospital, the length of stay begins at the time of admission to the Hospital. These inpatient Hospital stays do not require Prior Authorization.

d. Medically appropriate services to treat obstetrical and gynecological conditions or diseases according to Our Benefit, Referral and Practice Policies.

e. Childbirth preparation classes according to Our Benefit, Referral and Practice Policies.

4.8 Weight Loss Programs and Services

If the guidelines in Our Benefit, Referral and Practice Policies are met, the following weight loss services are covered when approved by Us or Our designee:

a. Weight loss programs conducted by an Affiliated Provider, according to Our Benefit, Referral and Practice Policies.

b. Bariatric surgery performed at a facility approved by Us with a $1,000 Copayment. Coverage is limited to one bariatric surgery per lifetime. Unless Medically Necessary, a second bariatric surgery is not covered, even if the initial surgery occurred prior to coverage under this Contract. All services must be Medically Necessary according to Our Benefit, Referral and Practice Policies.

4.9 Ambulance and Transportation Services

Ambulance services provided by Affiliated or Non-Affiliated Providers, without Prior Authorization, under the following situations:

a. When You receive services related to an Emergency Medical Condition.

b. When the Ambulance is ordered by an Employer, or a school, fire, or public safety official, and You are not in a position to refuse treatment.

c. Transfers between facilities by Ambulance, when approved by Us.

4.10 Emergency Services

Services, supplies and drugs provided by Affiliated or Non-Affiliated Providers, without Prior Authorization, to diagnose, treat and Stabilize an Emergency Medical Condition. Emergency services end when Your Emergency Medical Condition is Stabilized.

If You are admitted to the Hospital as an Inpatient for an Emergency Medical Condition, You or Your representative must notify Us within 48 hours of the Hospital admission. If notice is not given to Us within 48 hours, the Inpatient Hospital services will not be covered, unless Your medical condition prevented You from notifying Us or instructing Your representative to notify Us. If You are conscious and able to communicate with others, You are considered to be capable of notifying Us. In the case of a minor child, the legal guardian is responsible for notifying Us.

4.11 Services After an Emergency

a. You should contact Your PCP after an Emergency is Stabilized so that any necessary follow-up care may be provided or arranged. Follow-up care received from any provider is not covered unless provided or arranged by Your PCP and, if necessary, approved in advance by Us.

b. If, during or following an Emergency, You are admitted to a Hospital that is not an Affiliated Hospital, or to an Affiliated Hospital outside Your assigned Physician Network or Medical Group, We may transfer You to an Affiliated Hospital within Your assigned Physician Network or Medical Group. We may transfer You when the transfer can be safely provided and would not jeopardize Your medical condition, in the judgment of the attending Physician and Us or Our designee. Covered Services will be extended until a transfer can be safely provided or until discharge, whichever occurs first. In the event of a transfer, the cost of appropriate transportation is a Covered Service.

c. If You, or a representative on Your behalf, refuse a transfer that We and the attending Physician have deemed appropriate, We will not cover continued care and services provided at the Non-Affiliated Hospital. You will be solely responsible for the costs of any services provided at the Non-Affiliated Hospital after refusing the transfer.

4.12 Urgent Care Services

a. Services, supplies and drugs for the treatment of a medical condition requiring Urgent Care are covered without Prior Authorization. When possible, You should seek services from an Affiliated urgent care center. If this is not possible, services provided at a Non-Affiliated urgent care center are covered.

b. After receiving services at an urgent care center, You must contact your PCP to arrange or provide any necessary follow-up care. Follow-up care is not covered if it is not provided or arranged by Your PCP and, if necessary, approved in advance by Us.

4.13 Behavioral Health Services

Coverage for Mental Disorders is limited to the most appropriate method and scope of treatment as approved by Us or Our designee. You must contact the Coordinated Behavioral Health Management (CBHM) department directly at (800) 444-5755 to Prior Authorize Inpatient Hospital, partial hospitalizations and certain outpatient procedures

and services. Prior Authorization is not needed in an Emergency. You may also contact the CBHM department to coordinate care for all other behavioral health services.

Services must be provided by the following Affiliated Providers:

a. Licensed psychiatrist.

b. Licensed master of social work, fully/limited licensed psychologist, licensed professional counselor, or clinical nurse specialist working in an accredited mental health clinic.

c. Licensed residential treatment center.

d. A Hospital which provides mental health services.

The following services are Covered Services:

a. Inpatient (Acute) Mental Health Services

   This level of care provides high intensity medical and nursing services in a structured setting. This care provides 24-hour skilled nursing and medical care for an acute short term mental health condition or acute aggravation of an ongoing condition. Charges may include:
   1) Semi-private room and board.
   2) Hospital or facility based professional services.
   3) Attending Physician services.
   4) Medical services and supplies.

b. 23-Hour Observation

   A period of observation for up to 23 hours when services provided are less than acute level of care. These services are indicated for situations where full criteria for Inpatient hospitalization are not met. Observation allows additional time for information gathering or risk assessment.

c. Mental Health Partial Hospitalization Services

   This is a non-residential level of care. This level of care is provided in a structured setting similar to acute Inpatient mental health treatment. You are generally in treatment more than 4 hours but fewer than 8 hours daily.

d. Outpatient Mental Health Services

   Outpatient mental health services may include psychiatric consultations and diagnosis and the use of other psychotherapeutic services. These services must be identified in a treatment plan approved by Us or Our designee. These visits must be provided by a properly licensed behavioral health professional. This is the least intensive level of service. These services are normally provided in an office setting for individuals or groups with limited identified time limits from 20-50 minutes (for individuals) and to 90 minutes (for group therapies) per day. Charges may include:
   1) Evaluation and diagnostic services.
   2) Therapeutic services including psychiatric services.
   3) Brief intervention and counseling services.
   4) Treatment for a Dependent including family therapy.
   5) Group therapy sessions.
   6) Medication reviews.

e. Intensive Outpatient Mental Health Treatment Services

Multidisciplinary, structured services that are more intense and provided more often than routine outpatient treatment. These services generally last up to three hours per day, up to five days per week. Services include individual, family, group and drug therapies.

4.14 Chemical Dependency Services

Coverage for treatment of Chemical Dependency is limited to the most appropriate method and level of treatment necessary as approved by Us or Our designee. You must contact the Coordinated Behavioral Health Management (CBHM) department directly at (800) 444-5755 to Prior Authorize Inpatient Hospital, partial hospitalizations and certain outpatient procedures and services. Prior Authorization is not needed in an Emergency. You may also contact the CBHM department to coordinate care for all other Chemical Dependency services.

Chemical Dependency services are only available when treatment is received from one of the following Affiliated Providers:

a. Licensed psychiatrists/licensed physicians who are addictionologists.

b. Licensed master of social work, fully/limited licensed psychologist, or licensed professional counselor working in an accredited mental health clinic.

c. Licensed chemical dependency clinic.

d. Licensed residential treatment center.

e. Bachelor degree with certified addiction counselor credentials working in a licensed residential treatment center or hospital which provides Chemical Dependency services.

f. A hospital which provides Chemical Dependency services.

The following services are Covered Services:

a. Inpatient Chemical Dependency Detoxification Services

This level of care provides high intensity medical and nursing services in a structured setting. This care provides 24-hour skilled nursing and medical care for an acute short term Chemical Dependency condition.

b. Inpatient Chemical Dependency Rehabilitation Services

This level of care provides 24-hour per day supervised care for a substance abuse diagnosis not requiring full nursing and medical services.

c. Chemical Dependency Outpatient/Ambulatory Detoxification

Detoxification services provided in a structured outpatient or ambulatory program with medical and nursing supervision. These services must be part of a treatment plan that achieves the set goals of safe withdrawal.

d. Chemical Dependency Partial Hospitalization Services

This is a non-residential level of care. This level of care is provided in a structured setting similar to acute Inpatient Chemical Dependency treatment. You are generally in treatment more than 4 hours but fewer than 8 hours daily.

e. Outpatient Chemical Dependency Services

Outpatient Chemical Dependency services include Chemical Dependency consultations, and other services, such as medical testing, diagnostic evaluation and implementation of other Chemical Dependency services. These services must be identified in the treatment plan approved by Us or Our designee. These visits must be provided by a properly licensed behavioral health professional. This is the least intensive level of service. These services are normally provided in an office setting for individuals or groups and are limited to 20-50 minutes (for individuals) and 90 minutes (for group therapies) per day.

f. Chemical Dependency Intensive Outpatient Services

Multidisciplinary, structured services that are more intense and provided more often than routine outpatient treatment. These services generally last up to three hours per day, up to five days per week. Services include individual, family, group and medication therapies.

g. Outpatient treatment of Chemical Dependency may include:

1) Evaluation and diagnostic services.
2) Therapeutic services including psychiatric services.
3) Brief intervention and counseling services.
4) Treatment for a Dependent including family therapy.
5) Group therapy sessions.
6) Drug reviews.

h. Inpatient treatment of Chemical Dependency may include:

1) Semi-private room and board.
2) Hospital or facility based professional services.
3) Attending physician services.
4) Detoxification services.

4.15 Breast Cancer Screening, Diagnostic, Treatment, Rehabilitative and Mastectomy Services

Covered Services for breast cancer include the following:

a. Breast cancer screening (mammography) is covered under the Preventive Services as described in Section 4.4

b. Breast cancer diagnostic services including mammography, surgical breast biopsy, and pathological examination and interpretation.

c. Breast cancer treatment services including surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

d. Breast cancer rehabilitative services including reconstructive plastic surgery, physical therapy, and psychological and support services.

e. All stages of reconstruction of the affected breast.

f. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

g. Prostheses required after mastectomy.

h. Treatment of physical complications from all stages of mastectomy, including lymphedemas.

4.16 Home Health Care

Covered Services for Home Health Care include the following:

a. Skilled nurse care;

b. Medical supplies furnished as part of a Home Health Care visit;

c. Intermittent home health aide services for patient care managed under the guidance of a Nurse when:

   1. You are required to be homebound;

   2. The services are provided for the care and treatment of an Injury or Illness so severe that Confinement in a Hospital or other health care facility would be required without these services;

   3. The services are ordered by a Physician;

   4. The services are skill-levels of care according to Our Benefit, Referral and Practice Policies;

   5. The services are managed by a Home Health Care Agency; and

   6. The services follow a home care plan.

d. The number of visits for Home Health Care shall be approved according to Our Benefit, Referral and Practice Policies, and are limited to 60 consecutive calendar days per Illness or Injury beginning with the first visit.

e. Home Health Care is further limited to care needed on a part-time or intermittent basis, as defined under the guidelines of Our Benefit, Referral and Practice Policies.

f. Rehabilitative Services provided during a Home Health Care visit are considered part of Therapy Services as described in Section 4.17 of this Contract.

4.17 Therapy Services

a. Therapy for Rehabilitative services includes physical, nutritional, speech and occupational therapy, and cardiac and pulmonary rehabilitation. Therapy for Habilitative Services includes evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker for the treatment of Autism Spectrum Disorders (ASD). The condition needing therapy must meet all of the following criteria:

   1. Your condition must be so complex that the required services can be performed safely and effectively only by or under the direction of a qualified therapist;

   2. The requested Therapy Services must be related directly and specifically to a treatment plan as established by Your Affiliated Provider and the qualified therapist;

   3. The services must be reasonable and necessary for the treatment of the condition according to all of the following:

      a) The treatment must be effective and consistent with standards of medical practice for the condition; and

      b) The condition is expected to greatly improve in a reasonable (and usually predictable) period of time. Or the services are needed for a safe and effective maintenance program as related to a specific disease state.

4. There is a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy. This limit does not apply to Habilitative Services for the treatment of ASD.

b. Physical Therapy

Short-term physical Therapy Services are Covered Services when provided, either in the home or in an outpatient clinical setting, according to Our Benefit, Referral and Practice Policies.

The number of visits for physical therapy is limited to a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy. This limit does not apply to Habilitative Services for the treatment of ASD.

c. Speech Therapy

1. The therapy must be related to an organic medical condition (i.e., due to a physical cause). Or it must be used to restore speech right after surgery or during post-surgery recovery.
2. Short-term speech Therapy Services are Covered Services when provided, either in the home or in an outpatient clinical setting, according to Our Benefit, Referral and Practice Policies.

The number of visits for speech therapy is limited to a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy. This limit does not apply to Habilitative Services for the treatment of ASD.

d. Occupational Therapy

1. The therapy must be used to improve or restore Your ability to perform certain tasks You need to function on Your own that have been impaired or permanently lost due to Illness or Injury.
2. Short-term occupational Therapy Services are Covered Services when provided, either in the home or in an outpatient clinical setting, according to Our Benefit, Referral and Practice Policies.

The number of visits for Medically Necessary occupational therapy is limited to a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy. This limit does not apply to Habilitative Services for the treatment of ASD.

e. Cardiac Rehabilitation

Cardiac rehabilitation therapy is a Covered Service when the therapy is approved in advance according to Our Benefit, Referral and Practice Policies.

1. Phase I of the program must take place during an approved Inpatient hospitalization.
2. Phase II is a Physician supervised and monitored outpatient program that includes exercise and testing. This phase of the program is covered when it is approved in advance according to Our Benefit, Referral and Practice Policies.

f. Pulmonary Rehabilitation

Pulmonary rehabilitation is a Covered Service when the therapy is approved in advance according to Our Benefit, Referral and Practice Policies.

g. Other Medical Rehabilitation Services

Other rehabilitation services, except as specifically excluded in this Contract, may be Covered Services. These services must be ordered, arranged for, and provided according to Our Benefit, Referral and Practice Policies.

4.18 Reproductive Care and Family Planning Services

The following services are Covered Services, unless excluded by a Rider:

a. History, physical exams, lab tests, counseling, and Physician care related to family planning are covered according to Our Benefit, Referral and Practice Policies.

b. Genetic testing and counseling are covered according to Our Benefit, Referral and Practice Policies.

c. Services for diagnosis, counseling, and treatment of bodily disorders causing infertility are covered according to Our Benefit, Referral and Practice Policies. Following the initial diagnosis and treatment, additional treatment will be undertaken only when approved by Us or Our designee according to Our Benefit, Referral and Practice Policies.

d. Coverage for adult sterilization procedures is limited to vasectomy and tubal ligation procedures.

4.19 Oral and Maxillofacial Services

Oral and maxillofacial surgery and related X-rays are Covered Services with prior approval from Us or Our designee, according to Our Benefit, Referral and Practice Policies, for the following conditions:

a. Emergency treatment and prompt stabilization of fractures and facial dislocation of the jaw caused by a non-work related Injury.

b. Oral and maxillofacial surgery and related x-rays for Emergency treatment and prompt stabilization of a traumatic injury to sound natural teeth caused by a non-work related injury. Services provided after the Emergency are not covered.

c. Removal of teeth for treatment of lesions, tumors, and cysts on or in the mouth when approved by Us or Our designee according to Our Benefit, Referral and Practice Policies.

d. Hospital and related professional services will be covered when multiple extractions, concurrent with a hazardous medical condition, require the procedure to be performed in a Hospital. These services must be arranged and approved by Us or Our Designee according to Our Benefit, Referral and Practice Policies.

e. Temporomandibular Joint (TMJ) dysfunction therapy according to Our Benefit, Referral and Practice Policies is a covered benefit when the following conditions are met:

1) A consultative visit with an Affiliated Provider when it has been arranged for and approved in advance by Us or Our Designee. The visit must result in a proposed treatment plan.

2) Treatments consisting of non-invasive, reversible procedures. Invasive procedures and additional services, such as occlusal bite splints, are not Covered Services.

f. Medically Necessary Orthognathic Surgery when approved by Us or Our Designee according to Our Benefit, Referral and Practice Policies.

4.20 Anti-Cancer Drugs

Drugs approved by the federal Food and Drug Administration (FDA) that are used in antineoplastic therapy and their administration. Coverage will be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received FDA approval if all of the following are met:

a. The drug is ordered for the treatment of a specific type of neoplasm;

b. The drug is approved by the FDA for use in antineoplastic therapy;

c. The drug is used as part of an antineoplastic drug regimen;

d. Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and

e. Informed consent has been obtained from You for the treatment regimen that includes FDA approved drugs for off-label indications.

Anti-cancer drugs that can be self-administered or are self-injectable and provided by a retail, mail order or specialty pharmacy are only covered if a Prescription Drug Rider is included in this Contract. If this Contract does not include a Prescription Drug Rider and You have outpatient prescription drug coverage under another plan, self-administered or self-injectable drugs are covered under Your other outpatient prescription drug plan before coverage under this Contract applies. If You do not have outpatient prescription drug coverage under this plan or another plan, anti-cancer drugs are covered under this Contract. Anti-cancer drugs that are provided while You are hospitalized as an inpatient are covered under the inpatient hospital stay.

4.21 Organ and Tissue Transplantation

a. Organ and tissue transplants and related services are Covered Services when all of the following conditions are met:

   1. All services must be Prior Authorized and provided by an Affiliated Provider;

   2. The organ or tissue transplant is determined not to be Experimental and Investigative, as defined in this Contract;

   3. An Affiliated Provider submits the initial evaluation for Prior Authorization by Us or Our designee; and

   4. The transplant recipient is covered under this Contract.

b. When the transplant recipient is covered under this Contract, but the donor is not, benefits are provided for the recipient. Benefits are also provided for the donor to the extent they are not available under any other health care coverage. In this case the donor must have a notarized statement indicating that no other coverage is available.

c. Donor searches and related evaluation and testing of parents siblings, and children of the transplant recipient to establish compatibility and suitability of potential and actual donors.

d. Donor benefits are limited to expenses incurred for all pre- and post-testing, Physician services, laboratory procedures and hospitalizations needed to harvest the organ, until the donor's discharge from the Hospital immediately following the transplant. If the recipient is not covered under this Contract, no benefits will be provided for, or on behalf of, the donor even if the donor is covered under this Contract.

e. Expenses incurred in the evaluation and procurement of cadaver organs and tissue for Subscribers and Dependents who meet the above conditions.

f. Drugs related to pre- or post-transplantation are covered only if a Prescription Drug Rider is included in this Contract.

g. Benefits for organ transplants will end as soon as the Subscriber or Dependent is no longer covered under the Contract.

4.22 Hospice Care

Hospice care is covered when given as part of a Hospice Program. The following conditions must be met:

a. The choice of Hospice is made on or after the Effective Date of coverage; and

b. The Physician provides a written statement of Your terminal Illness. The written statement is provided to Us according to Our Benefit, Referral and Practice Policies.

c. The Hospice benefit is limited to a total benefit period not to exceed 210 days per lifetime.

4.23 Outpatient Prescription Drugs

a. Outpatient Medical Drugs

The following outpatient medical drugs are covered when prescribed by a Physician according to Our Benefit, Referral and Practice Policies. These drugs may be supplied by a Physician, outpatient facility or by an outpatient or specialty pharmacy.

1. Drugs that are injected or infused and normally require administration by a health care professional. The administration or infusion could take place in a Physician's office, at Your home or in an outpatient setting.
2. Drugs prescribed for use with Durable Medical Equipment such as nebulizers.
3. Blood clotting factors You give yourself if You have hemophilia.

b. Outpatient Prescription Drugs (Prescription Drug Rider Required) 

Drugs requiring a written prescription that are self-administered or self-injectable and provided by a retail, mail order or specialty pharmacy are only covered if a Prescription Drug Rider is included in this Contract. Coverage is only provided as specified in the Rider. No coverage is provided under this Contract, except for Urgent Care or Emergency services or as provided in Section 4.20.

c. Off-Label Use of Drugs

Off-Label use of a federal Food and Drug Administration (FDA) approved drug and the reasonable cost of supplies Medically Necessary to administer the drug are covered under items a. and b. above, if all of the following conditions are met:

1. The drug is approved by the FDA.
2. The drug is prescribed for the treatment of a condition that is Life-Threatening or a Chronic and Seriously Debilitating condition.
3. The drug must be Medically Necessary to treat that condition.
4. The drug must be on Our Formulary or accessible through Our Formulary procedures.
5. The drug has been recognized for treatment of the condition for which it is prescribed according to Our Benefit, Referral and Practice Policies.
6. Upon request the Physician must provide Us with documentation supporting compliance with the above conditions.

4.24 Eye Care and Vision Services

a. Routine eye exams once every calendar year, limited to the following services:
   1. Medical history;
   2. Testing the sharpness of vision;
   3. Ocular refraction;
   4. Internal and external examination of the eyes; and
   5. Testing for glaucoma.
b. Treatment of medical conditions and diseases of the eye.
c. Lens replacement due to Aphakia, including one pair of prescription lenses and one pair of frames according to Our Benefit, Referral and Practice policies.

4.25 Hearing Care Services

a. Routine hearing exams limited to the following services:
   1. Hearing tests or screening to evaluate hearing function; and
   2. Audiometric studies to evaluate hearing loss.
b. Treatment of medical conditions and diseases of the auditory system.
c. External bone anchored hearing aids (BAHA) when Medically Necessary and approved by Us according to Our Benefit, Referral and Practice Policies.

4.26 Routine Foot Care Services

Routine foot care necessary as a result of an Injury or systemic conditions which affect the foot. Routine foot care includes, but is not limited to, treatment of nails, corns, calluses, and bunions in accordance with Our Benefit, Referral and Practice Policies.

4.27 Educational Services

a. Education about managing a chronic disease state such as diabetes or asthma.
b. Maternity classes.

4.28 Approved Clinical Trial Services

Routine Patient Costs are covered for a Qualified Individual participating in an Approved Clinical Trial when the following conditions are met:

a. One or more Affiliated Providers is participating in the Approved Clinical Trial; and

b. The Approved Clinical Trial is conducted within the Service Area.

Definitions Applicable only to Approved Clinical Trial Services

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening Condition or disease and is one of the following:

a. The study or investigation is a federally funded trial that is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   1. The National Institutes of Health (NIH).
   2. The Centers for Disease Control and Prevention (CDC).
   3. The Agency for Health Care Research and Quality (AHRQ).
   4. The Centers for Medicare & Medicaid Services (CMS).
   5. A qualified non-governmental research entity identified in the NIH guidelines for center support grants.
   6. Department of Defense, Department of Veteran's Affairs or Department of Energy (if the trial has undergone an unbiased, scientific peer review by experts without a conflict and the Department of Health and Human Services Secretary deems the review to be comparable to the NIH peer review system).
   7. Cooperative group or center of any of the above agencies, other than the Department of Energy.

b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Life-threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual means an individual covered under this Contract who meets the following conditions:

a. The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another Life-Threatening Condition or disease; and

b. Either:

   1. The referring provider is an Affiliated Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item a; or
   2. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item a.

Routine Patient Costs include all items and services consistent with the coverage provided in this Contract that is typically covered for a Subscriber or Dependent who is not enrolled in an Approved Clinical Trial.

4.29 Pain Management

Evaluation and treatment of chronic and/or acute pain as specified in Our Benefit, Referral and Practice Policies.

4.30 Autism Spectrum Disorder (ASD) Services

a. Diagnosis of Autism Spectrum Disorders through a comprehensive multidisciplinary assessment ordered by an Affiliated or contracted clinician for a suspected ASD according to Our Benefit, Referral and Practice Policies. Services are covered only for a Subscriber or Dependent who is less than 19 years old.

b. Treatment of Autism Spectrum Disorders for a Subscriber or Dependent who is less than 19 years old. Treatment will be covered only if (and only to the extent that) the following criteria is met (or continues to be met, as applicable):

   1. You have been diagnosed with one of the ASD by an Affiliated or contracted clinician.
   2. A written treatment plan including objectives and goals of treatment has been submitted by an Affiliated Provider and approved by Us.
   3. You demonstrate progress toward the approved treatment goals and objectives.
   4. A new treatment plan is submitted and approved by Us every six (6) months for continued treatment.
   5. Treatment is prescribed or ordered by an Affiliated or contracted Physician or psychologist.
   6. Treatment is provided by a professional and/or facility within Our autism network, or is otherwise approved by Us.
   7. Treatment is provided by a health professional that meets all state licensing and certification requirements and is within the scope of their practice.

c. Pharmacy Care is covered only if a Prescription Drug Rider is included in this Contract.

We specifically reserve the right to adopt policies and procedures surrounding the provision of benefits for Autism Spectrum Disorders.

Definitions Applicable Only to Autism Spectrum Disorders Services

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorders (ASD) means any of the following pervasive developmental disorders as defined by the diagnostic and statistical manual:

1. Autistic disorder.
2. Asperger's disorder.

3. Pervasive developmental disorder not otherwise specified.

Behavioral Health Treatment means evidence-based counseling and treatment programs, including Applied Behavior Analysis that meets both of the following requirements:

1. Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
2. Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

Diagnosis of Autism Spectrum Disorder means assessments, evaluations, or tests, including the autism diagnostic observation schedule, performed by a licensed Physician or licensed psychologist to diagnose whether an individual has one of the Autism Spectrum Disorders.

Pharmacy Care means drugs prescribed by an Affiliated Physician and related services performed by an Affiliated pharmacist and any health-related services considered Medically Necessary to determine the need or effectiveness of the drugs.

Psychiatric Care means evidence-based direct or consultative services provided by a licensed Affiliated psychiatrist.

Psychological Care means evidence-based direct or consultative services provided by a licensed Affiliated psychologist.

Therapeutic Care means evidence-based services provided by an Affiliated and licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

Treatment of Autism Spectrum Disorders means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed Physician or a licensed psychologist who determines the care to be Medically Necessary:

1. Behavioral Health Treatment.
2. Pharmacy Care.
3. Psychiatric Care.
4. Psychological Care.
5. Therapeutic Care.

4.31 Reconstructive Surgery

a. Reconstructive surgery to correct Congenital Birth Defects including cleft palate and cleft lip repair are covered as specified in Our Benefit, Referral and Practice Policies.

b. Prior Authorization is required for reconstructive surgery to correct the effects of Illness or Injury and are covered according to Our Benefit, Referral and Practice Policies. Surgeries may include but are not limited to:

    1. Surgical treatment of chest wall deformities;

2. Breast reconstruction, repair or reduction;
3. Surgical treatment of gynecomastia (for males and female);
4. Eye lid surgery;
5. Surgery to remove extra fat and skin in the abdominal and stomach areas;
6. Surgery to reshape or resize the nose; and
7. Surgical procedures done on the nose and the wall within the nose that separates the left and right sides.

4.32 Coverage for Students Away at School

When a Dependent resides outside the Service Area for the sole purpose of attending school full time, the following services are Covered Services only when performed by Affiliated Providers located outside the Service Area. This restriction does not apply to Urgent Care or treatment of an Emergency Medical Condition.

a. Emergency care, Urgent Care or acute care;
b. Follow-up office visit related to acute Illness or Injury only with advance approval from Our Associate Medical Director;
c. Diagnostic imaging provided in the outpatient setting and related to the acute Illness or acute Injury;
d. Laboratory tests provided in the outpatient setting and related to the acute Illness or acute Injury;
e. Routine immunizations according to the recommendation from the Centers for Disease Control and Prevention (CDC);
f. Allergy injections;
g. Physical therapy for rehabilitation beyond the first and second follow-up appointments related to an acute Illness or acute Injury, but only with Our advance approval;
h. Durable Medical Equipment related to an acute Illness or acute Injury, when ordered or arranged through Us. We reserve the right to pay maximally only the usual, customary and reasonable (fee schedule) rates for such items. This only applies if this Contract includes a Rider that adds coverage for Durable Medical Equipment. Benefits are covered as specified in the Rider;
i. Drugs related to an acute Illness or acute Injury. This only applies if this Contract includes a Prescription Drug Rider. Benefits are covered as specified in the Rider;
j. Conditions identified as requiring immediate follow-up services;
k. In the event of an Inpatient Emergency admission, Our Admission Department must be notified within 48 hours. We reserve the right to transfer a Dependent to an alternative facility if deemed necessary for continued care;
l. Regular maintenance visits for chronic conditions with advance approval from Us; and
m. Office visits to begin or continue birth control.

For purposes of this Section the word “acute” means the sudden onset of an Illness or Injury while the student is away from Our Service Area attending school.

4.33 Gender Dysphoria and Gender Reassignment Services

If the guidelines in Our Benefit, Referral and Practice Policies are met, the following Medically Necessary services associated with Gender Dysphoria are covered when approved by Us or Our designee:

a. Behavioral health services as described in Section 3.17;

b. Hormone therapy; and

c. Gender reassignment surgery.

The following limitations apply to these Covered Services:

a. Services must be ordered and performed by an Affiliated Provider.

b. Gender reassignment surgery must to Prior Authorized by a HAP Medical Director or designee.

c. Gender reassignment surgery must be performed at an Affiliated facility with expertise in gender reassignment surgery.

4.34 Additional Covered Services

a. Medically Necessary treatment of any injury that is the result of an act of domestic violence, as defined by Michigan law.

b. Allergy testing, evaluations and injections, including serum costs, according to Our Benefit, Referral and Practice Policies.

SECTION 5 - EXCLUSIONS AND LIMITATIONS

The following are not covered under this Contract:

5.1 Non-Covered Services

a. Reproductive Care and Family Planning Services

1. Voluntary abortion.
2. Reversal of sterilization.
3. Infertility services to persons with a history of voluntary sterilization.
4. All fees related to parenting arrangements of any kind, not including coverage for maternity care and services.
5. Services related to the collection or storage of sperm or eggs, and donor fees.
6. Home pregnancy monitoring devices.
7. Services provided in connection with any Assisted Reproductive Technologies (ART) procedures.
8. No coverage is provided for tubal ligation procedures if this Contract is part of a benefit plan established or maintained by the following types of Employers that are either exempt or provided an accommodation from providing such coverage under the Affordable Care Act:
   a) Religious Employers as defined in 45 CFR §174.131(a); or
   b) Eligible Organizations as defined in 45 CFR §174.131(b).

b. Gender Dysphoria and Gender Reassignment Services

Non-covered services include, but are not limited to the following, according to Our Benefit, Referral and Practice Policies:

1. All fees related to parenting arrangements of any kind, not including maternity care and services;
2. Reversal of prior gender reassignment surgery;
3. Services related to a host uterus, the collection or storage of sperm or eggs, and donor fees;
4. Surgery that is considered cosmetic in nature and not Medically Necessary when performed as a component of a gender reassignment, according to Our Benefit, Referral and Practice Policies;
5. Services, treatment and surgeries that are considered Experimental and Investigative;
6. Voice therapy;
7. Treatment received at a Non-Affiliated facility; and
8. Services provided by a Non-Affiliated Provider.

c. Cosmetic Services

1. Cosmetic Surgery or any of the related services such as pre-surgical and post-surgical care.
2. Cosmetic complications of Cosmetic Surgery.

3. Follow-up care and reversal or revision of Cosmetic Surgery.
4. The correction of treatments or surgery to improve appearance or any complications of treatments or surgery to improve appearance if the original treatment or surgery was not a Covered Service under this Contract or would not have been a Covered Service if You had been insured.
5. Services, supplies or drugs for the treatment of hair loss or restoration, regardless of cause.

d. Weight Loss Programs and Services

1. Food or supplements used for weight loss or as part of any weight loss program.
2. Community based weight loss programs or classes.
3. Reversals or revisions of bariatric surgery that are not Medically Necessary according to Our Benefit, Referral and Practice Policies.
4. Weight loss procedures performed for Members who do not meet established criteria according to Our Benefit, Referral and Practice Policies.

e. Experimental and Investigative Services

1. Any drug, treatment, device, procedure, or service that is Experimental and Investigative as defined in the Definitions Section of this Contract.
2. Complications resulting from drugs, treatments, devices, procedures or services that are Experimental and Investigative.
3. Fees associated with the care, services, supplies, devices, or procedures that are Experimental and Investigative, or are in conjunction with research studies.
4. Medical, Mental Disorder and Chemical Dependency services that are generally regarded by the medical community to be unusual, rarely provided, and not necessary for the protection of health.
5. Services associated with organ or tissue transplantation that is considered Experimental and Investigative.

f. Eye Care and Vision Services

1. Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses, except as listed in Section 4.24 of this Contract or in an attached Rider.
2. Eye examinations for the purpose of prescribing or fitting contact lenses.
3. Surgery to correct refractive error including but not limited to lasik, radial keratotomy and photorefractive keratectomy.
4. Vision therapy or orthoptic treatment (eye exercises).
5 All other eye care and vision services, except as listed in Section 4.24 or in an attached Rider.

g. Ambulance and Transportation Services

1. Non-emergency transportation by Ambulance, unless approved in advance by Us.
2. Transportation to or from a health care facility or Physician's office except for transportation by Ambulance in an Emergency or for an approved transfer.

3. Transportation services when no transport is made.

h. Medical Devices and Equipment, including:

1. Durable Medical Equipment (DME), including Medically Necessary equipment, such as crutches and wheelchairs, that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally needed or used by a person in the absence of Illness or Injury.
2. Supplies or appliances which are disposable or non-durable, such as dressings and support garments.
3. Prosthetic and Orthotic Appliances, including devices or equipment, such as prosthetic limbs, used to replace a missing or malfunctioning body part or external devices used to correct any defect of form or function to the human body.
4. Foot orthotics, corrective shoes or shoe inserts or supports, except as described in section 4.5.
5. Hearing aids and the supplies or the repair of hearing aids.
6. Personal care, comfort, convenience or over-the-counter items.
7. Wigs.
8. Physical fitness and hygiene equipment.
9. Dental appliances.
10. Experimental or research equipment.
11. Convenience items and supplies needed to make changes to Your physical environment, even when those changes are recommended as treatment for an Illness or Injury. This includes, but is not limited to such items as, sauna baths, air conditioners, humidifiers, access ramps and elevators.
12. Eyeglasses (frames and lenses) or contact lenses.
13. Home or vehicle additions, alterations or appliances.
14. Lost or stolen equipment and/or appliances.
15. Batteries, other than for blood glucose machines and insulin infusion pumps.
16. Personal computers and related or similar equipment, communications devices, including but not limited to, TDD and medical alert systems.
17. Physician equipment such as sphygmomanometers, stethoscopes, etc.

i. Foot Care

1. Foot orthotics, corrective shoes or shoe inserts or supports, except as described in Section 4.5.
2. Foot care performed in the absence of an Injury or systemic condition according to with Our Benefit, Referral and Practice Policies.

j. Behavioral Health and Chemical Dependency Services

1. Any unauthorized Inpatient hospitalizations for the treatment of Mental Disorders or Chemical Dependency.

2. Care, services, supplies, devices or procedures related to involuntarily committed or deferred psychiatric admissions that are not rendered by or at an Affiliated Provider except for Emergency Services to the point of Stabilization. Coverage for Emergency services is subject to the limits that generally apply to Your behavioral health or Chemical Dependency benefits.
3. Care, services, supplies, or procedures that We determine to be cognitive in nature.
4. Court-ordered care, services, supplies, devices or procedures.
5. Services provided outside of a covered treatment setting (please refer to Sections 4.13 and 4.14.
6. Residential programs, institutional settings, transitional living centers, therapeutic boarding schools, non-licensed programs, half-way or three quarter-way houses and milieu therapies such as case management, Assertive Community Treatment (ACT), wrap-around-care services, wilderness programs, other supportive housing and group homes.
7. Personal care, room and board, and domiciliary services.
8. Therapy for learning disabilities and developmental delays.
9. Testing for the purpose of education, scholastics, intelligence, developmental delays and learning disabilities.
10. Counseling and/or classes for marital and relationship enhancement.
11 Counseling for religious purposes (advocation of specific religious belief) including counseling provided by a religious counselor.
12. Services for caffeine abuse or addiction.
13. Sex therapy.
14. Treatment for personality disorders and other unclassified diagnoses unless accompanied by a clinical disorder.
15. Custodial care.
16. Treatment of or programs for sex offenders or criminals of sexual or physical violence.
17. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are rendered.
18. Personal comfort and convenience items, which include but are not limited to, telephone and television services during an Inpatient stay.
19. Non-medical services including enrichment programs such as: dance therapy, art therapy, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and educational/preparatory courses or classes.
20. School-based services for the treatment of behavioral disorders/disabilities that supplant the right of the child to their education and/or can be provided by the Dependent child’s school district.

k. Nursing Services

1. Private duty nursing services.

2. Residential and basic nursing services provided in a long-term care facility.

l. Personal Services

1. General housekeeping services.
2. The costs of a private room.
3. Special medical care You need due to Your personal or religious objections to customary, appropriate and usual treatment.
4. Custodial Care.
5. Personal hygiene, comfort and convenience items, including but not limited to, telephone and television services during an Inpatient stay.
6. Home or vehicle alterations or appliances.
7. Lodging and/or meals needed while receiving services either within or outside the Service Area.
8. Services of a person who resides with You.

m. Inpatient Custodial Care

Non-acute care and other services provided while You are receiving Custodial Care in a residential, institutional or other setting that is mainly for the purpose of meeting Your personal needs. This includes services that could be provided by persons without professional skills or training.

n. Oral, Maxillofacial, and Dentistry Services

1. Treatment of periodontal, periapical disease, or any condition (other than malignant tumor) involving the teeth or surrounding tissue or structures.
2. Dental services, dental X-rays, dental prosthesis, oral surgery, and dental surgery in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.
3. Oral or maxillofacial surgery except as specifically listed under Section 4.19.
4. Surgery or treatment other than non-invasive, reversible procedures related to TMJ dysfunction.
5. Endodontic, prosthodontic, and orthodontic treatment.
6. Invasive procedures.
7. Occlusal bite splints.

o. Outpatient Prescription Drugs, Food and Food Supplements

1. Outpatient drugs, except as specifically covered in Sections 4.20 or 4.23 of this Contract, or in an attached Rider.
2. Over-the-counter drugs or their equivalents, except as provided in an attached Prescription Drug Rider.
3. If your coverage includes a Prescription Drug Rider, the following exclusions and limitations apply:

    a. Specialty Drugs are limited to the retail pharmacy supply indicated on the Prescription Drug Rider. Specialty Drugs means outpatient prescription

drugs, including brand name, biosimilar and generic drugs approved by the FDA that are used to treat complex and/or chronic illnesses and require close supervision and monitoring, as designated by Us in Our Formulary, to be a Specialty Drug. Specialty Drugs include injectable/infusible drugs and certain oral and inhaled drugs that require Prior Authorization from Us. To assure safe and quality care, Specialty Drugs must be obtained from a designated specialty pharmacy that is contracted with Us to provide covered Specialty Drugs to You.

b. Coverage is limited to a 30 day supply for any Non-Formulary drug that is approved.

c. We may impose quantity restrictions, Prior Authorization requirements, and exclusions on outpatient prescription drugs to assure quality, safety and cost-effective use consistent with Our Formulary and Benefit, Referral and Practice Policies.

d. Coverage of drugs used for erectile dysfunction is limited to 6 doses per month. All other limitations apply.

4. Drugs may be excluded from coverage when there is a similar alternative outpatient prescription drug therapy or treatment.

5. Outpatient prescription drugs that are self-administered or self-injectable and provided by a retail, mail order or specialty pharmacy, unless a Prescription Drug Rider is included in this Contract.

6. Immunizations recommended or required for travel to specific geographic locations both within and outside the United States, except as provided under the Preventive Services Section in this Contract.

7. All food, formula and nutritional supplements with or without a prescription. This includes, but is not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the Food and Drug Administration

8. Cosmetics, drugs used for cosmetic purposes, medicated soap or devices such as syringes, test kits, and support garments.

9. Drugs used for Experimental and Investigative purposes according to Our Benefit, Referral and Practice Policies.

10. Replacement of medication that has been dispensed, including but not limited to medication that is lost, stolen or destroyed.

11. Needles and syringes that are not prescribed in conjunction with insulin.

12. Non-covered services listed in an attached Prescription Drug Rider.

p. Therapy Services

1. Services beyond the authorized visit limit as approved by Our designee or Us.
2. Massage or aquatic therapy.
3. Services for community-based exercise programs or health and fitness club memberships.

4. Services related to cognitive training and/or retraining.
5. Therapy Services for diagnosis and treatment of disabilities for which another agency or entity, public or private, has responsibility.
6. Therapy Services during school vacation periods for children who would be eligible to receive services though the school system or other public agency.
7. Therapy Services for educational, vocational, hobby or recreational purposes.
8. Functional capacity evaluations and work re-integration programs.
9. Therapy Services that are not Rehabilitative, except for Treatment of Autism Spectrum Disorders.

q. Organ and Tissue Transplant Services

1. Any human organ tissue transplant which is sold rather than donated.
2. Experimental and Investigative procedures or organ transplants performed under a study, grant or research program for either recipient or donor costs, unless approved by Us or Our designee.
3. Services associated with a donor search, except as provided under Section 4.21.
4. Surgical removal of tissue or organs solely because of the probability of developing a malignancy, unless Medically Necessary, according to Our Benefit, Referral and Practice Policies.

r. Autism Spectrum Disorders (ASD) Services

1. Coverage for the treatment of ASD through Applied Behavioral Analysis (ABA) is limited to medically appropriate services according to Our Benefit, Referral and Practice Policies.
2. A Prescription Drug Rider must be included with this Contract for Pharmacy Care coverage of ASD.
3. Coverage is subject to any limitations that otherwise may apply to services under this Contract, including Deductible, Copayment, Coinsurance and Out-of-Pocket Limits.
4. Diagnosis and treatment for anyone covered under the Contract who is 19 years of age or older.
5. Services that are considered primarily related to improving academic or work performance.
6. Treatment that does not demonstrate progress toward the treatment goals and objectives.
7. Procedures and services for the assessment and/or treatment of ASD which are not supported by evidence-based peer-reviewed literature according to Our Benefit, Referral and Practice Policies.

s. Hospice Care Services

1. Funeral arrangements;
2. Financial and/or legal counseling;
3. Homemaker or caretaker services; and

4. Pastoral counseling.

t. Hearing Care Services

1. Hearing exams for fitting and post evaluation of a hearing aid.
2. Hearing aids and supplies or the repair of hearing aids.
3. Tinnitus maskers.

u. Educational Services

1. Services for remedial education, including school-based services.
2. Services, treatment or diagnostic testing related to learning disabilities, cognitive disorders and developmental delays, unless otherwise covered under this Contract.
3. Education testing or training, including intelligence testing. Necessary training and evaluations should be requested from and conducted by the child's school district.
4. Classes covering such subjects as stress management, parenting and lifestyle changes.

v. Dietitian Services

Medical nutritional counseling for services related to a lifestyle choice that is not connected with a medical condition. This includes, but is not limited to, diets to support a vegetarian or vegan lifestyle.

w. Students Away at School

The following services are not considered Urgent Care or an Emergency. These services are not part of the coverage for students away at school. These services must be rendered by an Affiliated Provider located within the Service Area in order to be Covered Services:

1. Routine complete physical exams including gynecological exams;
2. Routine non-emergency psychiatric care and substance abuse care not rendered consistent with section 4.13 and 4.14 in this Contract;
3. All elective surgery or hospitalizations;
4. Routine eye exams;
5. Obstetrical and gynecological services for pregnancy;
6. Physician visits, physical therapy, speech therapy, occupational therapy or other therapies or treatments that are not approved in advance by Us;
7. Non-routine vaccines administered for the sole purpose of travel or school requirements;
8. Screening tests for TB (PPD, intradermal testing, or blood tests to screen for TB);
9. Treatment of certain major complex or acute medical conditions, including but not limited to radiation therapy, chemotherapy, stem cell transplants, organ transplants, and extensive diagnostic evaluations.

x. Services by Providers Included on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities

All health services provided, ordered or prescribed by any health care professional or facility listed on the OIG's List of Excluded Individuals/Entities. These services include but are not limited to, prescriptions and medical equipment.

The OIG's List of Excluded Individuals/Entities is available on the OIG website at **https://oig.hhs.gov/exclusions/.**

5.2 Other Exclusions

a. Services provided by a Non-Affiliated Provider, except for an Emergency, Urgent Care, or when specifically approved in advance by Our designee or Us.

b. Charges for any expenses incurred outside the United States for elective care, testing, procedures or for any services other than Urgent Care or care for an Emergency Medical Condition.

c. Non-Emergency services provided in a Hospital emergency room.

d. Services for military-related injuries or disabilities, for which You are legally entitled to receive services, payment or reimbursement from a federal, state or other government entity.

e. Services rendered or expenses incurred prior to Your Effective Date of enrollment, or after cancellation of coverage.

f. Services or benefits that are not expressly included as Covered Services in this Contract.

g. Fees imposed by any health provider for a missed or no-show appointment or additional Charges for services rendered outside of normal business hours.

h. Fees, Copayments, Deductibles, Coinsurance, or any other monetary requirements and obligations to any entity, other than Us, who makes any form of payment for Covered Services.

i. Any services or items provided by a local, state, or federal government agency, except when payment under this Contract is expressly required by federal or state law, including Medicaid, Medicare or CHIP.

j. Any condition for which benefits are paid, recovered, or can be recovered, either by an adjudication settlement or otherwise, under any worker's compensation, employer's liability law or occupational disease law, even if You do not claim those benefits.

k. Services and supplies for which You have no legal obligation to pay or for which no charge would be made if You did not have health coverage.

l. Charges associated with hypnosis, massage therapy, light therapy, naturopathic drugs, or other alternative drugs or non-standard treatments. This includes but is not limited to, meditation, self-help, acupuncture or biofeedback.

m. Items and services related to chiropractic care.

n. Premarital exams, classes, or marriage counseling.

o. Services, supplies, or procedures related to home delivery of infants outside a licensed medical facility.

p. Services and supplies not Medically Necessary, as defined in this Contract.

q. Services and supplies furnished when You are not under the care of a Physician, as defined in this Contract.

r. Services and supplies not authorized or prescribed by a Physician, according to Our Benefit, Referral and Practice Policies.

s. Services and supplies furnished for Inpatient or outpatient care at a Hospital or qualified treatment facility when the treatment is primarily to provide Rehabilitative services, unless approved by Us.

t. Charges billed by a standby Physician who did not provide any services.

u. Any complications or unfortunate side effects arising from services, procedures, or treatments that are excluded in this Contract.

v. Inpatient Hospital admissions for services and supplies that could have been provided on an outpatient basis, unless approved by Us.

w. An autopsy or any service or supply associated with autopsy or postmortem examination, unless requested by Us.

x. Any Charges, including Physician Charges, which are incurred if You are admitted to a Hospital on a Friday, Saturday or Sunday for reasons other than an Emergency Medical Condition, unless approved by Us.

y. Services, procedures, supplies, drugs or devices related to life style improvements such as wellness programs or physical fitness programs. This includes, but is not limited to, health clubs or health spas, aerobic and strength training, work hardening programs and related materials and products for these programs.

z. Services provided by a volunteer, a person who usually lives in the same household as You, or a member of Your immediate family or the family of Your Spouse, including a Physician.

aa. Inpatient Hospital services for an admission that We were not given timely notification as described under the Emergency Services Section.

bb. Charges for copies of Your records, charts or any costs associated with forwarding/mailing copies of Your records or charts.

cc. Any balance between Allowable Amounts and a Non-Affiliated Provider's Charge for a Covered Service.

5.3 Services Required by a Third Party

a. Examinations, reports, or any other services used to get or maintain employment, licenses or insurance, or for education or recreation.

b. Office visits, exams, treatments and tests relating to requirements or documentation of health status for legal proceedings.

c. Office visits, exams, treatments, tests or immunizations relating to or needed for travel purposes.

d. Court-ordered psychiatric or chemical dependency evaluations, treatments or Confinements, unless such services meet Our Benefit, Referral and Practice Policies and are approved by Us or Our designee.

e. Pre-trial or court testimony and the preparation of court-related reports or services ordered by a court for legal proceedings.

5.4 Illegal Activities

a. Services provided if You are in police custody, unless an Emergency exists or such services are provided at an Affiliated Hospital by an Affiliated Provider.

b. Services for any Injury, Illness, or condition that results from or to which a contributing cause was Your commission of or attempt to commit a felony or to which a contributing cause was Your engagement in an illegal occupation or other Willful Criminal Activity.

We reserve the right to recover the cost of services and supplies that were initially covered by Us and later determined to be excluded as described in this Illegal Activities section.

SECTION 6 - MEMBER RIGHTS AND RESPONSIBILITIES

You have certain rights and responsibilities. They are as follows:

6.1 Rights

a. You have the right to contact Us with questions or concerns about any aspect of Your Contract. You may contact Customer Service at the phone number on Your ID Card. If You are deaf, hard of hearing or speech impaired, You may call 711 for TTY services. We will accommodate Your communication needs if You have a disability or limited English proficiency.

b. You have the right to receive confidential and respectful care regardless of nationality, race, creed, color, age, economic status, gender or lifestyle.

c. You have the right to be treated with respect, dignity and recognition of Your right to privacy.

d. You have the right to review Your own medical records held by an Affiliated Provider by appointment.

e. You have the right to obtain complete and current information about treatment options without regard to cost or benefit coverage. You have the right to ask for and be given information about the Cost-Sharing obligation You face for any specific medical procedure.

f. You have the right to ask questions about Your health problems and to take part in decisions made about Your health care.

g. You have the right to be provided with all the information needed to give informed consent prior to the start of any procedure or treatment. This includes an explanation of procedures, alternative treatments and any benefits and risks involved.

h. You have the right to be informed of the Affiliated Providers available to You to provide health care services. In addition, You have the right to complete and current information about Us and Our services, practitioners and providers, and Your rights and responsibilities. You have the right to have access to Our directory of Affiliated Providers either electronically, or to request and receive a hard copy.

i. You have the right to request a change to another Physician Network or Medical Group based on its availability. If You are an Inpatient at the time of Your request, any such change will become effective following Your discharge from the facility. All changes must be approved by Us before You may receive Covered Services at the newly selected Physician Network or Medical Group. Any services received at the newly selected Physician Network or Medical Group before We approve a change may not be considered by Us to be Covered Services and, therefore, services for which You are responsible for payment.

j. You have the right to choose a PCP (including a pediatrician for a minor child) and to obtain obstetrical or gynecological care without Prior Authorization. You have the right to request to change Your PCP to a different PCP, either within the same Physician Network or Medical Group or a different Physician Network or Medical Group. Requests will be considered by Us based on the current facility assignment of the PCP and the PCP's current patient load and availability.

k. You have the right to expect Us to respond to Your requests within a reasonable timeframe.

l. You have the right to obtain services in an Emergency without the prior approval of Your PCP or Us.

m. You have the right to appoint a patient advocate to carry out Your wishes if You cannot make decisions about Your care, custody and medical treatment.

n. You have the right to receive a second opinion from an Affiliated Provider within Your assigned Physician Network or Medical Group for any diagnosis or recommended medical procedure. If no other Physician practices in the same or similar area of medicine as the original Physician within Your assigned Physician Network or Medical Group, You have the right to receive a second Physician's opinion from another Affiliated Provider practicing in the same or similar area of practice in another Physician Network or Medical Group. To obtain a second opinion, You must have a written Referral, approved by Us or Our designee, from Your PCP.

o. You have the right to ask for and be given, without cost, a copy of the actual benefit provisions, guidelines, protocol, clinical review criteria or other information used to determine Medical Necessity. All requests must be sent in writing to Customer Service, Attention: Correspondence, 2850 West Grand Blvd., Detroit, MI 48202.

p. You have the right to file a Grievance. The Grievance process provides a way for You to seek resolution to situations where You are not satisfied with Your care or coverage. Prior to filing a formal Grievance, We will attempt to resolve Your complaint informally, for example, during Your initial phone call voicing the complaint. You may file a formal Grievance if You are dissatisfied with an Adverse Benefit Determination, or remain dissatisfied with an Adverse Benefit Determination, or remain dissatisfied with Our response to Your informal complaint. Please contact Us at the phone number on Your ID Card, or refer to the Appeal Policy provided with this Contract or the Member Handbook for more information about the Grievance process.

q. You have the right to make recommendations about any changes or additions to these rights and responsibilities.

6.2 Responsibilities

a. You have a responsibility to notify Us as soon as possible regarding any change in Your name, address, or telephone number, and employment status. You also must notify Us as soon as possible if You become enrolled in Medicare or any other health coverage. You must let Your Group know about those changes as well.

b. You have a responsibility to notify the Group or Remitting Agent of any events that might change the Eligibility of You and Your Dependents for coverage under this Contract.

c. You have a responsibility to participate in Your health care by asking questions about Your health problems and developing mutually agreed upon treatment goals with Your Affiliated Provider(s).

d. You have a responsibility to follow the treatment plans and instructions for care that You have agreed upon with those Affiliated Providers providing Your health care.

e. You have a responsibility to respect the rights of other patients, HAP Members and Affiliated Providers.

f. You have a responsibility to review this Contract, Summary of Benefit and Coverage, all Riders and the Member Handbook. You also have a responsibility to review all

relevant material We provide to help You understand Your coverage and the provisions of this Contract.

g. You have a responsibility to notify Your PCP of any unexpected changes in Your health. You have a responsibility to obtain follow-up care from or at the direction of Your PCP after receiving Emergency Services or Urgent Care.

h. You have a responsibility to present Your Identification Card to the providers of care when receiving Covered Services. Possession of an Identification Card does not mean You have a right to benefits under this Contract. You must immediately report theft or loss of Your Identification Card to Us.

i. You have a responsibility to send Claims to Us for services consistent with our Claims Procedures in Section 9 of this Contract.

j. You have a responsibility at the time of enrollment to select a single Physician Network or Medical Group and a single PCP for Your medical care. For selected Physician Networks or Medical Group, most Covered Services require a Referral from Your PCP, and most Referrals from Your PCP will be to Affiliated Providers within Your chosen Physician Network or Medical Group. You may choose any Affiliated family practitioner, general practitioner or internist as Your PCP. A pediatrician may be chosen as the PCP for a Dependent child.

k. You may choose to see any Affiliated obstetrician or gynecologist Specialist without a Referral from Your PCP. These providers, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, procedures for making Referrals.

l. A referral from Your PCP is required to obtain Covered Services from any other type of Affiliated Provider Specialist.

m. You have a responsibility to satisfy all Referral, Prior Authorization and assigned network requirements described in this Contract, regardless of whether We pay as the primary carrier or otherwise.

n. If We are not Your primary carrier, You have a responsibility to ensure that claims are submitted to Your primary carrier before they are submitted to Us.

o. You have a responsibility to notify Us of an Emergency Inpatient Hospital admission within 48 hours of the admission, as described in Section 4.10.

p. You have a responsibility to provide truthful information on Your application, Your enrollment form and in any other information provided to Us and Your Group.

SECTION 7 - COORDINATION OF BENEFITS, SUBROGATION AND REIMBURSEMENT

7.1 Duplicate Coverage

You may be entitled to receive services similar to Covered Services from a Source other than this plan. State laws, Our contracts with Groups and government programs require Us to coordinate Your benefits as a way to reduce the cost of health care. We do not duplicate benefits available from any other Source. In no event will money be paid or credited to You as a result of Coordination of Benefits.

If We pay for Covered Services that are covered by another source, We will automatically be assigned Your right to seek reimbursement and all rights of subrogation against the other Source.

7.2 Your Obligation to Inform HAP of Other Coverage

You must immediately notify Us of any other Source of coverage and provide Us with information We request. Other coverage includes, but is not limited to, coverage under Medicare. Failure to do so may result in the delay of payment for Covered Services. Payment will be delayed until You provide Us with complete and accurate information about any other Source of coverage.

7.3 How We Coordinate Benefits

a. We coordinate Your benefits under the State of Michigan Coordination of Benefits law, the federal Medicare secondary payer law and other applicable law. Unless otherwise required by law, the benefits for Covered Services under this Contract will be deemed secondary to benefits available from any other Source.

b. When You are covered by another Source in addition to this plan, You must send all bills first to the primary plan. The primary plan must pay its full benefits as if You had no other coverage. If the primary plan denies the Claim or does not pay the full bill, You may then submit the balance to Us. Except as required by law, We will not pay more as the secondary plan than We would pay as the primary plan. If We and the other Source cannot agree on which plan is primary within 30 calendar days after both plans have received all of the information needed to pay the Claim, each plan will pay the Claim in equal shares and determine their relative liabilities following payment. We will not pay more than We would have paid had this Contract been the primary plan.

c. We pay for Covered Services only when You follow Our rules and procedures regarding Referrals and authorizations. You are responsible for ensuring that You receive services from Affiliated Providers, regardless of whether We are the primary or secondary payer.

d. We do not pay any fees, Copayments, Deductibles, Coinsurance or other monetary requirements and obligations imposed by the primary plan or other payor.

7.4 Coordination with Medicare

The following rules apply with respect to coordination with Medicare, except as required otherwise by applicable law:

a. You are Age 65 or Over.

If You are working full-time and are at least age 65 (or are the Spouse of the Subscriber who is working full-time and You are at least age 65):

1. Medicare will be primary if the Employer who is providing this Contract has less than 20 Employees; and
2. This plan will be primary if the Employer who is providing this Contract has 20 or more Employees.

The number or Employees an Employer has will be determined by looking at a typical business day during the previous Calendar Year.

If You are covered by Medicare because of Your age and if Your coverage under this Contract is not due to Your (or Your Spouse's) current active employment, Medicare will be primary. For example, if Your Coverage is under COBRA or a retiree plan, Medicare will be primary.

b. You are Disabled and Under Age 65.

If You are disabled and Your coverage under this Contract is due to the current active employment status of You, Your Spouse or parent:

1. This plan will be primary, if this plan is a Large Group Health Plan; and
2. Medicare will be primary, if this plan is not a Large Group Health plan.

A "Large Group Health Plan" is one that had at least 100 Employees on a typical business day during the previous Calendar Year.

If You are covered by Medicare because of disability, and if Your coverage under this Contract is not due to the current active employment status of You, Your Spouse or parent, Medicare will be primary. For example, if Your coverage is under COBRA or a retiree plan, Medicare will be primary.

c. You are Eligible for ESRD Benefits.

Except as provided below, if You are entitled to or eligible for end-stage renal disease (ESRD) Medicare benefits, this Contract will be primary for the first 30 months of eligibility for Medicare ESRD benefits plus any applicable waiting period for those benefits. After that time, Medicare will be primary. If You have primary coverage under Medicare by reason of age or disability and You later become eligible for Medicare ESRD coverage, Medicare will remain primary.

d. Eligibility for Medicare

Coordination with Medicare depends on a number of things. The size of Your Group, whether You are an active Employee or a retiree or whether You are covered under Your Spouse's group health plan can all affect coordination with Medicare. You should always check with Your Employer to make sure You understand all of Your options for Medicare and health plan coverage.

When We determine payment of Your Covered Services We consider You to be enrolled in Medicare if You are eligible for Medicare and Medicare is the primary payer. This means, for example, that if You are eligible for Medicare Parts A and B, and Medicare is primary, We will pay for Your Covered Services as if Medicare was primary. We do this even if You have not enrolled in Medicare. That's why it is important for You to enroll in and become covered by Medicare as soon as You are eligible.

If You are a retiree You must enroll in Medicare Parts A and B as soon as You are eligible for those programs. If You are an active Employee and Your Employer Group has less than twenty (20) Employees, You must enroll in Medicare Parts A and B as soon as You are eligible if You are age 65 or older. If You are an active Employee and Your Group has less than 100 Employees, You must enroll in Medicare Parts A and B as soon as You are eligible if Your Medicare eligibility is based on Your disability.

e. Statutory and Regulatory Changes.

Despite any other provision of this Contract, if the law changes, permitting this plan to be secondary to Medicare in any circumstances not stated above, this plan will be secondary to Medicare as permitted by the new law.

7.5 Subrogation and Reimbursement

a. We may try to recover the amounts paid for Covered Services to the extent that You have a right to recover those amounts from any other party. We are automatically assigned to all of Your rights to recover the amounts We paid for such Covered Services. We will not repay You for expenses, including, attorney fees and costs that You incur to recover these amounts from any other party. By accepting Our payment for Covered Services, You agree to the terms contained in this section. You also agree to repay Us for all expenses paid for Covered Services within 30 days of obtaining a monetary recovery.

b. If You file a claim for benefits or request payment against any person or Source related to any accident, Injury, or condition that We paid, or may pay in the future, You must provide written notice to Us. The notice must include a copy of any documents sent to the other person or Source. The notice must be given to Us within 10 days after You filed the claim. You must provide Us with complete and accurate information for Us to enforce Our rights of recovery. You cannot compromise or settle a claim that could prejudice Our recovery rights unless We agree in writing. We may stop or offset present or future payment for Covered Services if You do not give Us complete and accurate information and other assistance reasonably required by Us to enforce Our rights of recovery.

c. If You receive or are entitled to receive payment from another person or Source that is legally responsible for the Injury or Illness or for payment of Your medical expenses, You are obligated to repay Us for all medical expenses We paid. If You receive or are entitled to receive payment under a settlement agreement which neither admits nor denies liability for the Injury or Illness, You are obligated to repay Us for all medical expenses We paid for Covered Services.

d. You will hold any amounts received or recovered from another person or Source as Our trustee until Our rights under this Section have been satisfied or released in writing by Us.

e. You do not have the right to engage legal counsel or to act on Our behalf without Our written agreement.

f. If You engage legal counsel to pursue a claim against any person or Source, You must inform Your legal counsel of Our rights under this Section.

g. You assign Us a first dollar lien (i.e., priority over other rights) against the proceeds of any recovery by You or on Your behalf. This lien applies whether the recovery is due to judgment or verdict in a civil action or as a result of arbitration, mediation,

settlement, or other remedy. This lien will extend to any and all amounts recovered by You or on Your behalf even if the amounts recovered are for losses or damages other than the Covered Services We paid. This lien will also apply even if the amount recovered is less than, equal to, or greater than Your total losses or damages.

h. If any recovery by You or on Your behalf includes amounts for future damages or loss, You agree to hold the recovery amount in trust, subject to a continuing lien in Our favor. You agree to promptly repay Us for all future Covered Services We pay that are related to the Illness or Injury that gave rise to the recovery.

SECTION 8 - CANCELLATION AND RESCISSION OF COVERAGE

8.1 When You Wish to Cancel Coverage

You must notify Your Group or Remitting Agent if You wish to cancel coverage under this Contract. We must receive written notice of cancellation from Your Group or Remitting Agent. Cancellation of coverage is effective on the date We receive notice from Your Group or the cancellation date specified, whichever is later. If requested by Your Group or Remitting Agent, We will cancel Your coverage retroactive to the first day of the month in which the notice of cancellation is received by Us.

8.2 Cancellation of Coverage by the Group

The Group may cancel coverage under this Contract with respect to any or all Subscribers and their Dependents. Cancellation of coverage is effective on the date We receive the cancellation request from the Group or the cancellation date specified by the Group, whichever is later.

8.3 Cancellation of Coverage

a. We may cancel Your coverage if:

1. Your Group or Remitting Agent notifies Us that Your coverage is to be cancelled.
2. We do not receive the full, required Premium from the Group or Remitting Agent within 30 days after the Premium Due Date. Such cancellation will be retroactive to the last day of the period for which a Premium was paid.
3. Your Group's membership in an association that contracts with Us on behalf of its members ceases. Such cancellation shall be effective as of the date of membership in the association ends.
4. Your Group or Remitting Agent intentionally furnishes incomplete, inaccurate or false information of a material fact to Us, or commits an act, practice or omission that constitutes fraud. Such cancellation may be retroactive to the date such information was received.
5. Your Group or Remitting Agent fails to follow Our rules relating to Group contribution or Group participation. Such cancellation shall be effective immediately upon notice to You or Your Group or the Remitting Agent.
6. We decide to discontinue offering all coverage in the large group market or the particular product represented by this Contract in the state of Michigan in accordance with state and federal law.

b. We may ask Your Group to terminate Your coverage if:

1. You intentionally furnish incomplete, inaccurate or false information of a material fact to Us, an Affiliated Provider, Your Group or the Remitting Agent or You perform an act, practice or omission that constitutes fraud. Such cancellation may be retroactive to the date we determine is appropriate based on the information received.
2. You no longer meet the Subscriber and Dependent Eligibility Criteria listed in Section 2.1 of this Contract.

3. You behave in a way that is unruly, uncooperative, disruptive or abusive and this behavior affects Our ability to arrange medical care for You or administer Your coverage.
4. You fail to establish or maintain, after repeated attempts, a satisfactory relationship with a PCP.
5. You act in an abusive or threatening manner toward Us, Our Affiliated Providers, their staff or other patients.

We will provide You with 30 days advance notice of cancellation and will include the reasons for the cancellation, unless otherwise required by applicable laws.

8.4 Rescission

We reserve the right to rescind the coverage offered through this Contract. We are entitled to rescind coverage when You or the Group perform an act, practice or omission that constitutes fraud or intentional misrepresentation of material fact. For purposes of this Contract the following are considered examples of fraudulent activities or those involving misrepresentation of material fact:

a. You or the Group intentionally furnish incomplete, inaccurate information or misrepresent an important fact to Us, or commit an act, practice or omission that constitutes fraud.

b. You misuse Your coverage or Your Identification Card by helping an ineligible person obtain services under this Contract, using another Subscriber's or Dependent's Identification Card or requesting payment for services You did not receive.

c. You or the Group perform an act that shows an intent to deceive in order to obtain coverage for yourself or others when You have no legal right to coverage under this Contract.

We will provide You or the Group with 30 days advance notice of Our intent to rescind coverage. If We rescind coverage and no Claims have been paid by Us, We will refund all Premiums paid for the rescinded coverage. If Claims have been paid by Us, We reserve the right to subtract the amount of the Claims paid from the Premium refund.

8.5 Effect of Cancellation

If You become ineligible for coverage because the arrangement between Us and Your Group is canceled, the Contract ends on the effective date of cancellation. If We cancel Your coverage under Section 8.3 a. 4 or 8.3 b.1-5, We may refuse to enroll You in the future for coverage offered by Us or Our subsidiaries.

8.6 Automatic Cancellation

a. Coverage under this Contract will be cancelled for the Subscriber and any Dependents automatically in the following circumstances:
    1) When the Subscriber ceases to be an Employee of the Group through which the Premium is paid.
    2) When the Subscriber no longer meets Our Eligibility requirements or the eligibility requirements of the Group.
    3) Upon the death of the Subscriber.

b. Coverage under this Contract will be cancelled for the following Dependents automatically in the following circumstances:
   1) The Subscriber's Spouse in the event of divorce.
   2) A Dependent child who no longer meets the Eligibility requirements due to age.

8.7 Guaranteed Renewability

The coverage under this Contract is guaranteed renewable, subject to the applicable terms and conditions. Non-renewal is only allowed for:

a. Nonpayment of Premiums;

b. Fraud;

c. Your Group does not comply with any Employer contribution or group participation rules permitted under applicable state law;

d. Our decision to no longer offer coverage of the type represented by this Contract according to state and federal law;

e. There is no longer anyone covered under this Contract who lives, resides or work in Our Service Area.

Exception: At the time of coverage renewal We may make a uniform modification of coverage under this Contract as described in the provision entitled Changes in Contract in Section 10.

8.8 Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage

If Your Group employs at least 20 full-time equivalent Employees on at least half of the working days during the previous year, You may be eligible for temporary continuation of Your health coverage under COBRA if You no longer meet Our Eligibility requirements. Your continued coverage under COBRA will be based on the qualifying event that caused You to lose coverage.

Your Group is responsible for administering its COBRA plan. We will not act as the plan administrator under the provisions of COBRA. Please contact Your Group for questions regarding Your eligibility and the procedures for electing COBRA coverage.

SECTION 9 - CLAIMS PROCEDURES

In this Claims Procedures section, when We talk about "You" We are also referring to Your Authorized Representative. See the Definitions section to understand who may be Your Authorized Representative.

9.1 Filing a Claim

If You receive Covered Services from an Affiliated Provider, You should not have to file a Claim. Benefits are paid directly to Your Affiliated Provider. However, You should always check with Your Affiliated Provider to make sure that the Claim has been filed and that the services have been Prior Authorized.

Some Non-Affiliated Providers may also file Claims for You. When You receive services from a Non-Affiliated Provider, You are responsible for ensuring that the Pre-Service Claim, Urgent Care Claim, or Concurrent Care Claim is filed correctly and that the services have been Prior Authorized, even if the Non-Affiliated Provider offers to file the Claim for You. However, You may need to file a Claim if You see a Non-Affiliated Provider. Or there may be other reasons You need to file a Claim.

If You must file a Claim, follow these instructions.

You must send Us Your Claim within 1 year after You receive services. We will not process any Claim if We receive it more than 1 year after You receive the services. The only exception is if You were legally incapacitated and can show proof that You were incapacitated. If You can provide this proof We will process the Claim.

You may send Claims to Us at 2850 West Grand Boulevard, Detroit, MI, 48202. Write "Attention Member Reimbursement" on the envelope.

Fill out the Direct Member Reimbursement form available on Our website. Log in at hap.org and click on Member Resources under Quick Links. You may also call Us and ask for the form. All claims must include a description of the services provided and the diagnosis or other information that establishes Medical Necessity.

A Claim is considered filed when We receive it even if We don't have all of the information We need to decide the Claim. If the Claim does not have all the information and We need to make a benefit determination, We may ask You to give Us additional information. If You do not provide that information in the time periods We describe in any notices, We may deny the Claim, in whole or in part.

9.2 Notices

Regardless of the type of Claim, You will receive a written or electronic notice of any Adverse Benefit Determination.

Notice of Initial Benefit Determination

Each time a Claim is submitted You will receive a written or electronic notice that explains how much was paid and whether the Claim was denied, in whole or in part. If any part of the Claim is denied We will send You a written or electronic notice of the denial and the reason for the denial.

If Your Claim is denied We will send You a notice of Adverse Benefit Determination. The notice will do the following:

a. Explain the reason for the denial.

b. Tell You what part of the Contract is the reason for the denial.

c. Describe any other information necessary to reverse the denial - or complete an incomplete Claim - and tell You when the information is necessary.

d. Explain the Appeals procedures and any right You may have under certain laws.

e. Tell You if We used internal guidelines, protocols or other information. If You ask, We will provide, free of charge, a copy of the rule, guideline, protocol or other information, as well as reasonable access to documents, records and other information on the Claim.

f. Tell You if the Claim denial was based on a professional opinion, including a decision about whether a service is Experimental or Investigative or not Medically Necessary or appropriate. We will provide an explanation of the scientific or clinical opinion used in the decision, if You ask, free of charge.

g. If the Claim was an Urgent Care Claim We will describe the Expedited Appeal process.

h. Give You sufficient information to identify the Claim.

i. Any other information required by law.

We will send You the notice within certain timeframes. The timing depends on the kind of Claim.

These are the different kinds of Claims and the timeframes.

Urgent Care Claims

For Urgent Care Claims We will notify You of the benefit determination, whether adverse or not, as soon as possible considering the urgency of Your medical situation but no later than 72 hours after receipt of the Claim. However, if necessary information is missing or You failed to follow Our procedures for filing Urgent Care Claims, We will tell You within 24 hours what information We need or what procedures You must follow. You will have at least 48 hours to respond to Us. We will decide the Claim within 48 hours of receiving the information or within 48 hours after Your time to respond has expired, whichever time is earlier. We can notify You orally of the benefit determination but We will send a written notification to You no later than 3 days after the oral notification.

Pre-Service Claims:

For Pre-Service Claims We will notify You of the benefit determination, whether adverse or not, within a reasonable period of time, appropriate to the medical circumstances, but no later than 15 days after We receive Your request for a benefit determination. We may extend the time period up to an additional 15 days if, for reasons beyond Our control, We cannot make the decision with the first 15 days.

We must notify You prior to the expiration of the first 15-day period. We will explain the reason for the delay and request any additional information. We will also tell You when We expect to make the decision. If We need more information We will give You at least 45 days to send it to Us.

We will decide the Claim no later than 15 days after You supply the additional information or after the period of time allowed to supply it ends, whichever comes first. If We want more time, We need Your consent. We must give You written notice that Your Claim has been approved or denied before the end of the time allotted for the decision.

If a service requires Prior Authorization to receive Covered Services but the service is provided before You receive Our approval, the Claim will be reviewed as a Post-Service Claim.

Casual questions about Your benefits or the situations about when Your benefits may be covered are not considered Pre-Service Claims.

Post Service Claims

For Post Service Claims We will notify You of an Adverse Benefit Determination within a reasonable period of time, but no later than 30 days after receipt of the Claim. We may extend the time period up to an additional 15 days if, for reasons beyond Our control, We cannot make the decision within the first 30 days.

We must notify You prior to the expiration of the first 30-day period that We need an additional 15 days. We will explain the reason for the delay and request any additional information. We will also tell You when We expect to make the decision. If We need more information We will give You at least 45 days to send it to Us. We will make Our decision no later than 15 days after the end of the 45 day period or after We receive Your information or after the period of time allowed to supply it ends, whichever comes first.

Concurrent Care Claims (Claims for Ongoing Course of Treatment)

Concurrent Care Claims may fall under the following categories, and different notice and Appeal time frames apply:

a. We will notify You in sufficient time to Appeal if We are going to reduce or terminate an ongoing course of treatment. You will be able to Appeal and obtain a decision on the Appeal before the benefit is reduced or terminated.

b. If You request an extension of ongoing treatment in an urgent circumstance, You will be notified as soon as possible given the medical needs, but no later than 24 hours after We receive Your Claim. You must submit the request to Us at least 24 hours before the end of the prior approved time period or before the end of the prior approved number of treatments. We will notify You if We approve or deny Your request.

c. If You request an extension of ongoing treatment in a non-urgent circumstance, the request will be considered a new Claim and decided according to Post-Service Claim or Pre-Service Claim time frames, whichever applies.

d. If We deny any request for a Concurrent Care Claim We will apply Our Urgent or Expedited Appeals standards.

9.3 Time of Payment of Claims

We will pay benefits after We receive Your Claim and process it for payment. Claims are processed for payment as Post Service Claims after You have received services and You or a provider has submitted the Claim.

9.4 Payment of Claims

Unless You tell Us in writing, all or a portion of any benefits provided for medical care or treatment may, at Our option, be paid directly to the provider of such services. Any such payment made in good faith will fully discharge Us to the extent of such payment.

All other Claims will be payable to You if You filed the Claim and have provided proof that You paid the provider.

Claims that have not been paid at Your death may, at Our option, be paid either to Your beneficiary or to Your estate if Your beneficiary or estate has followed these Claims procedures.

9.5 Notification of Claims Determinations

We will notify You or Your Authorized Representative of Claim determinations for a Pre-Service Claim, Post-Service Claim, Concurrent Care Claim and an Urgent Care Claim. For more information on how to Appeal any Claims determination that is denied (an Adverse Benefit Determination) see the Appeal policy included with this Contract.

9.6 Failure to Follow Claims Procedures – Pre-Service Claims, Urgent Care Claims and Concurrent Care Claims

If You do not follow these claims procedures, We will notify You and tell You about the proper procedures. The notice may be oral unless You specifically ask for written notice.

For Pre-Service Claims We will notify You within 5 days from the date We received the request.

For Urgent Care Claims We will notify You as soon as possible but no later than 24 hours from the time We received the request.

For Concurrent Care Claims We will follow the Pre-Service Claim and Urgent Care Claim time lines, depending on the kind of Concurrent Care Claim request.

9.7 Claims Procedures for Affiliated Providers

Your Affiliated Providers follow the claims procedures and Appeals requirements in the provider manual and billing manual that the Affiliated Providers can access on Our website. Non-Affiliated Providers may contact Us directly.

SECTION 10 - GENERAL PROVISIONS

10.1 Contract Term

This Contract begins on the first day of the month for which Premium was paid and shall remain in effect for one month. This Contract will be renewed on a monthly basis with timely payment of the Premium.

10.2 Benefits Provided

Your Premium for coverage under this Contract is stated in the Application and associated materials. We will make available, or cause to be provided, the benefits in this Contract and any attached Riders or amendments. We will give You a copy of this Contract and any applicable Riders and/or amendments which will state the benefits, the limitations to those benefits, and the conditions under which those benefits will be provided.

10.3 Changes in Contract

We reserve the right to change benefits, terms and conditions provided under this Contract at the time of renewal, by giving Your Group not less than a 30 day notice prior to the effective date of such change. If additional notice is required by law for Your Group, We or Your Group will provide You with that notice.

10.4 Changes in Amount of Coverage

A change in the amount of Your coverage due to a change in benefits will be effective at 12:01 a.m. of the first day of the Contract Month coinciding with the date of the change in benefits or the first day of the Contract Month following the date of the change in benefits. The change is subject to the payment by You or Your Group of any required Premium contribution.

10.5 The Contract and Interpretation

This Contract, including any Riders or amendments, the information provided by the Group in the Application and the individual enrollment applications and reclassifications submitted with regard to Subscribers and Dependents in connection with this Contract constitute the entire agreement between the parties and are hereby incorporated by this reference. All statements made by You will, in the absence of fraud, be deemed representations and not warranties, and no statement will be used in defense of a claim under this Contract unless it is contained in a written application.

You will have only the rights and benefits, subject to the terms and conditions, stated in these documents. All statements contained in the individual enrollment applications and reclassifications submitted by Employees in connection with this Contract will be deemed as material representations and warranties. No such statements will void the coverage or reduce any benefits provided under this Contract, unless contained in a written application. No waiver or change in any terms of this Contract will be effective unless approved in writing by Us and supported by an amendment or Rider attached to this Contract. This Contract will be governed by and construed in accordance with the law of the State of Michigan, and when applicable, federal law, as amended.

10.6 Successors and Assigns

This Contract will be binding upon and inure to the benefit of HAP, its successors and assigns. This Contract may be assigned by Us to another company authorized to provide coverage. No other assignments are permitted.

10.7 Invalidity

Any provision of this Contract that is found to be invalid or illegal will not affect any other provision of this Contract. This Contract will be construed as if the invalid or illegal provision was never included in the Contract.

10.8 Conformity with State Statutes

If, on the Effective Date, any provision of this Contract is in conflict with the statutes of the state in which the Contract was issued, the provision is automatically amended to meet the minimum requirements of the statute.

10.9 Release of Information

You agree to the release of personal and health information by Affiliated Providers and by Us for the administration of this Contract. This includes releases for the purposes of treatment, payment and health care operations.

10.10 Amendments

Except as otherwise provided for in this Contract, no officer or agent of HAP, Affiliated Provider, Group or Remitting Agent, nor any other individual or entity, is authorized to change or waive the terms and conditions of this Contract. No such change, waiver, promise or agreement will be binding upon Us.

10.11 Your Privacy

We take the security of Your personal or health information very seriously. We have established safeguards and procedures to stop improper access to, use of and disclosure of Your information. We reserve the right to share Your information as allowed by law. Federal law permits Us to use and disclosed personal or health information for treatment, payment and health care operations. We will not use or disclosed Your personal or health information for any other purpose without Your written authorization.

For additional information on Our privacy practices, contact Customer Service and request a copy of Our Privacy Statement or visit Our website at **hap.org.**

10.12 Entire Contract; Changes

This Contract, including the applicable Riders and amendments, the information provided by the Group in the Application and the individual enrollment applications and reclassifications submitted with regard to Subscribers and Dependents in connection with this Contract constitute the entire agreement between the parties and are hereby incorporated by this reference.

The provisions of this Contract replace all previous Contracts between Us and You regarding all aspects of coverage. No changes in this Contract will be valid until approved by Us in writing.

10.13 Notification

Any notice required or permitted to be given by Us will be considered to have been properly given, if in writing and deposited in the United States postal mail with postage prepaid, addressed to the Group, Remitting Agent or You at the last address on record with Us. The required notice will be considered given within three days of mailing. Certain notifications will be sent to Your Group for distribution consistent with applicable law. Some of these notifications may be delivered electronically. You may have also given us permission to communicate with You through electronic mail at a selected email address. Such email notice will be considered ample notice for all purposes under this Contract.

10.14 Applicable Law

This Contract is made in, and will be interpreted under, the laws of the State of Michigan without regard to any conflict of laws provisions. Federal law will govern the interpretation of this Contract when applicable.

10.15 Our Policies and Procedures

We may adopt reasonable policies, procedures, rules and interpretations for this Contract. We may amend such policies from time to time.

10.16 Identification Cards

Your Identification Card shall be considered Our property and its return may be requested at any time. Possession of an Identification Card does not mean that You have a right to Covered Services. If Your Identification Card is lost or stolen, please immediately contact Customer Service.

10.17 Responsibility for Care

We do not practice medicine or any other licensed health profession. The Physician treating You is solely responsible for the care provided to You. In no event will We be liable for any professional acts or failures to act by any Affiliated Provider or for the acts or failures to act by a third party review entity. We will not be liable for any Claim or demand for Injury. We will not be liable for any damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any medication or injectable insulin under this Contract.

10.18 Assignment of Contract

You may not assign or transfer any of Your rights or responsibilities under this Contract without Our prior written consent. Any attempt to make such an assignment without Our consent is void. The right to receive Covered Services under this Contract may not be assigned.

10.19 Coverage Determinations

We will make determinations that are required to carry out the terms and conditions of this Contract. This includes determinations regarding Medical Necessity and Covered Services, to make factual findings and to explain and interpret this Contract whenever necessary according to Our Benefit, Practice and Referral Policies.

10.20 Legal Action

Any legal action against Us arising under ERISA must be brought within 120 days from the date of Our alleged violation of law. For all other legal actions, no such legal action shall be brought after the expiration of 3 years after the time written proof of loss is required to the furnished.

10.21 Unavailability of Certain Providers

You should select coverage under this Contract as your Group Health Plan option because You prefer the benefits offered under the plan, not because a particular provider is an Affiliated Provider. You cannot change to another health plan or insurer because a provider is no longer an Affiliated Provider. We cannot guarantee that any one Physician, Hospital or other provider will be available and/or remain Affiliated with Us.

10.22 Continuity of Care

We will comply with state law regarding continuity of care if Your treating provider ends their affiliation with Us during the course of treatment. We ensure continuity of care if You have a voluntary or involuntary change in carrier or health plan or if Your Affiliated Provider ended a contract with Us. Continuity of care does not apply if the contract was ended due to failure to meet quality standards or for fraud. A provider, who is no longer an Affiliated Provider, may continue to treat You and We will pay for Covered Services under the conditions and timeframes listed below:

a. If You are receiving an active course of treatment for an acute episode of chronic Illness or an acute medical condition, We will continue to pay for Covered Services provided by Your treating provider for up to 90 days after the date You were informed of the intent to end the contractual relationship. Active course of treatment is defined as one in which discontinuation of care could cause a recurrence or worsening of the condition being treated and interfere with expected outcomes.

b. If You are receiving care for a terminal illness, We will continue to pay for Covered Services provided by Your treating provider for the rest of Your life for care directly related to the terminal illness.

c. If You are in Your second or third trimester of pregnancy, We will continue to pay for Covered Services provided by Your treating provider through post-partum care directly related to the pregnancy, but not more than 6 weeks after delivery.

Your treating provider must agree to accept Our contracted rate as payment in full. Your treating provider must adhere to Our quality standards and Our utilization policies and procedures.

10.23 Vesting

There is no vesting of benefits under this Contract. You are entitled only to the Covered Services in effect under this Contract at the time services are received. If Covered Services are reduced or modified, then You will be entitled only to the Covered Services in effect after the effective date of the reduction or modification, even if You previously were receiving a higher level or type of Covered Services.

10.24 Independent Contractors

We do not directly provide any health care services. We do not have the right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by health professionals in consultation with You. Affiliated Providers are responsible for making medical treatment decisions as independent contractors.

We are only obligated to provide You with access to a network of Affiliated Providers to provide health care services. We are also responsible for making benefit determinations under this Contract.

Together with Your health professionals, You may choose to continue medical treatment even if We deny coverage for those treatments. In this case, You will be responsible for the cost of those treatments. Health professionals, on Your behalf, and You may appeal any Adverse Benefit Determination by following the Appeals Policy provided with this Contract.

10.25 Pre-Existing Conditions

This Contract does not contain any terms regarding pre-existing conditions that would delay or reduce Covered Services.

10.26 Annual and Lifetime Limits

This Contract or associated Riders do not place any annual or lifetime dollar limits on Essential Health Benefits.

10.27 Genetic Testing

This Contract does not limit coverage based on genetic information. We will not request or require any genetic testing. We will not collect genetic information at any time for underwriting purposes. We will not adjust Premium based on genetic information.

10.28 Payment for Out of Network Emergency Services

In paying for Emergency services provided by out-of-network providers, We will pay the greatest of:

a. The median in-network rate;

b. The usual customary and reasonable rate; or

c. The Medicare rate.

10.29 Non-Discrimination

HAP does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

10.30 Uncontrollable Events

A national disaster, war, riot, civil insurrection, epidemic or other similar event may make Us unable to provide or arrange for the provision of Covered Services. If one of these events occur, We will not be liable if You do not receive those services or if they are delayed. We will make every effort to ensure necessary services are provided.

SECTION 11 - DEFINITIONS

11.1. Adverse Benefit Determination means that You, a provider or Your Authorized Representative make a request for a benefit and We, or our utilization review designee decides that an admission, availability of care, continued stay, or other health care service that is a Covered Service is reviewed and, based on the information provided, does not meet Your Group Health Plan requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness. The requested service or payment for the service by Your Group Health Plan is therefore denied reduced or terminated.

An Adverse Benefit Determination may be based on:

a. Medical Necessity

b. Appropriateness

c. Health Care Setting – such as the place where You receive services.

d. Level of Care

e. Effectiveness

f. Utilization Review – which means making sure health care services are being used appropriately. The goal of utilization review is to make sure You get the care You need. And that the care is administered via proven methods, provided by an appropriate health care provider and delivered in an appropriate setting.

g. A decision that the services You requested are Experimental and Investigative under Your Group health Plan.

h. Coverage decisions including Your Group Health Plan limitations or exclusions from Covered Services.

i. Your Eligibility for coverage under Your Group Health Plan.

j. Rescission of coverage based on fraud or intentional misrepresentations by You.

k. Our failing to respond in a timely manner to a request for a determination of a benefit.

11.2. Affiliated means a Physician, Hospital or other provider has signed a contract with Us or Our designee agreeing to provide Covered Services to You and to accept payment by Us for Covered Services as payment in full, other than Coinsurance, Copayments or Deductibles.

11.3. Affiliated Provider means a health professional, licensed Hospital, licensed pharmacy or any other institution, organization, or person having a contract with Us or Our designee agreeing to provide Covered Services to You and to accept payment by Us for Covered Services as payment in full, other than Coinsurance, Copayments or Deductibles**.**

11.4. Affordable Care Act (ACA) means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 and as the same may be further amended and interpreted.

11.5. Allowable Amount means Our reasonable payment for Medically Necessary services and supplies that are identified as Covered Services under this Contract. For Affiliated Providers the Allowable Amount will be set by contract. For Non-Affiliated Providers the Allowable Amount will be a reasonable amount set by Us. Allowable Amounts are the

most We will pay for a Covered Service. The Allowable Amount will be subject to Coinsurance, Copayments, Deductibles and Out-of-Pocket Limits. If a Non-Affiliated Provider charges more than the Allowable Amount for Covered Services, You may have to pay the difference. See Balance Billing for additional information.

11.6. Ambulance means a vehicle specially equipped and licensed for transporting wounded, injured, or sick persons and to provide limited medical services during such transport.

11.7. Aphakia means the absence of the lens of an eye. The condition can be the result of a congenital cause, surgical removal of cataracts or trauma to the eye.

11.8. Appeal means the process used when You or an Authorized Representative make a request for reconsideration of an Adverse Benefit Determination as set forth in the Appeal Policy provided with this Contract.

11.9. Application means a formal request made by the Group, on paper or in electronic format, for coverage of its Employees under this Contract.

11.10. Assisted Reproductive Technologies (ART) means procedures that involve harvesting, storage, or manipulation of eggs and sperm. These include, but are not limited to, artificial insemination, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, embryo selection, embryo transfer, embryo freezing and drug treatment.

11.11. Authorized Representative means

a. A person to whom You have given express written consent to represent You in an Appeal or External Review;

b. A person authorized by law to provide substitute consent for You, or

c. If You are unable to provide consent, Your family member or Your treating health care professional.

d. We will also consider Affiliated Providers as Your Authorized Representatives for purposes of any Pre-Service Claim, Concurrent Claim or Urgent Care Claim or urgent (expedited) Appeals and Grievances. For purposes of any prescription drug Claims any provider will be considered Your Authorized Representative. If You are admitted to a Hospital in an Emergency, We will consider the treating provider and admitting Hospital to be Your Authorized Representative.

11.12. Balance Bill or Balance Billing happens when a Non-Affiliated Provider bills You for the difference between their Charge for a Covered Service and the Allowable Amount. For example, if a Non-Affiliated Provider charges $100 for a Covered Service and the Allowable Amount is $80, the Non-Affiliated Provider may bill You for the remaining $20. An Affiliated Provider may not Balance Bill You.

11.13. Benefit Period means the period of time during which this Contract pays benefit for Covered Services. A Benefit Period can be based on a Calendar Year or on a Fiscal Year as determined by the Employer.

a. If the Benefit Period is based on a Calendar Year, the initial Benefit Period begins on the Effective Date and ends on December 31st of the same Calendar Year, unless coverage is Terminated prior to that date. All Benefit Periods after the initial Benefit Period begin on January 1st and end on December 31st during the same Calendar Year, unless coverage is Terminated prior to that date.

b. If the Benefit Period is based on a Fiscal Year, the initial Benefit Period begins on the Effective Date and ends on the day before the 12 month anniversary of the Effective Date, unless coverage is Terminated prior to that date. For example, if the Effective Date is May 1, 2017, the Benefit Period would be May 1, 2017 through April 30, 2018, unless coverage is Terminated prior to that date. All Benefit Periods after the initial Benefit Period would begin on the anniversary of the Effective Date and end on the day before the next anniversary of the Effective date, unless coverage is Terminated prior to that date.

To find out when Your Benefit Period begins, contact Your Group or Customer Service at the phone number on Your ID Card.

11.14. Benefit, Referral and Practice Policies means those administrative policies that We use to implement the medical management aspects of this Contract according to Section 10.15.

11.15. Calendar Year means the period of time from January 1st of any year through December 31st of the same year.

11.16. Charge means the fee charged for medical services and/or supplies. A charge is considered incurred on the date the services are rendered or the supplies are delivered.

11.17. Chemical Dependency means a condition characterized by a physiological or psychological dependence, or both, on alcohol or a controlled substance. It is further characterized by a frequent or intense pattern of pathological use, to the point that the user:

a. Loses self-control over the amount and circumstances of use;

b. Develops symptoms of tolerance, or psychological and/or physiological withdrawal if use is reduced or stopped; or

c. Substantially impairs or endangers his/her health or substantially disrupts his/her social or economic function.

Chemical Dependency includes alcohol and drug psychoses, and alcohol and drug dependence syndromes.

11.18. Child or Children means individuals who satisfy the definition of Child contained in section 152(f) of the Internal Revenue Code.

11.19. CHIP means the Children's Health Insurance Program operated through the State of Michigan and federal government, as authorized by the Children's Health Insurance Program Reauthorization Act and the ACA.

11.20. Chronic and Seriously Debilitating means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

11.21. Claim means the written demand to Us by You or a provider for the payment of health care services

11.22. Coinsurance means the percentage of the Allowable Amount for certain Covered Services paid by You after the Deductible has been met. Coinsurance may vary depending upon the Covered Services received. Coinsurance percentages are listed in the Rider(s) and Summary of Benefits and Coverage.

11.23. Coinsurance Maximum means the maximum Coinsurance amount paid by You for Covered Services during a Benefit Period**.**

11.24. Concurrent Care Claim (Claim for Ongoing Course of Treatment) means a Claim for services that We have previously approved for an ongoing course of treatment over a period of time, or a previously approved Claim for a specific number of treatments.

11.25. Confinement means a Medically Necessary Inpatient stay that is due to Injury or Illness.

11.26. Congenital Birth Defect means a deviation from the normal standards for growth or function as a direct result of conditions, clinical disease or attributes recognizable at birth.

11.27. Contract means the document(s) defining the relationship between Us and Our Members, including: (1) this HMO Subscriber Contract and other Member materials, (2) any applicable Rider(s), (3) the Application, questionnaires, forms and statements as completed by a Subscriber and submitted to Us, or the Remitting Agent, to enroll.

11.28. Contract Month means the period that starts on a Premium Due Date and ends on the day prior to the next Premium Due Date.

11.29. Coordination of Benefits means the process used to determine which of two or more insurance carriers has the first responsibility of payment. This process can be found in Section 7.

11.30. Copayment or **Copay** means the set dollar amount You must pay for certain Covered Services each time You obtain the Covered Service. Applicable Copayment amounts are described in the Rider(s) and Summary of Benefits and Coverage. Not all Covered Services have a Copayment. Copayments do not count toward the Deductible or Coinsurance. Copayments are counted toward the Out-of-Pocket Limit.

11.31. Cosmetic Surgery means surgery to reshape anatomical structures of the body in order to improve the patient's appearance and self-esteem, as determined by Us or Our designee. Cosmetic Surgery includes but are not limited to:

a. Surgery and services related to gynecomastia that is not Medically Necessary;

b. Rhinoplasty;

c. Liposuction;

d. Face lifts;

e. Treatment of vitiligo unless Medically Necessary;

f. Electrolysis;

g. Abdominal skin flap reduction (tummy tuck);

h. Skin tag or keloid removal or modification;

i. Breast implants, except as required after a mastectomy;

j. Collagen or Botox injections, unless Medically Necessary;

k. Dermabrasion or chemobrasion and

l. Surgery to upper and/or lower eyelids such as blepharoplasty.

11.32. Cost-Sharing means Charges required to be paid by You or on Your behalf with respect to the Covered Services provided under this Contract. This includes Deductibles, Coinsurance, Copayments, or similar Charges. Cost-Sharing does not include Premiums, the cost of services provided by Non-Affiliated Providers, and spending for non-covered services.

11.33. Covered Services means preventive services and the Medically Necessary diagnostic and treatment services described in Section 4 of this Contract, when approved and provided in accordance with the terms of this Contract.

11.34. Custodial Care means supportive, home-based care or basic care including Physician services and other ancillary services in a residential, institutional, or other setting or Durable Medical Equipment provided in such settings that are primarily for the purpose of meeting the patient's personal needs and which could be provided by persons without professional skills or training. Examples of Custodial Care include, but are not limited to, assistance with the activities of daily living such as bathing, dressing, eating, walking, getting in and out of bed, taking medication, housecleaning and home maintenance.

11.35. Deductible means the set dollar amount of Allowable Amounts for certain Covered Services that must be paid by You before payment of benefits under this Contract begins. The Deductible applies to each Subscriber and Dependent and must be met each Benefit Period. Copayments are not applied to the Deductibles. The Deductibles are listed in the Rider(s) and Summary of Benefits and Coverage.

a. **Individual Deductible**

This is the Deductible amount that You pay each Benefit Period for certain Covered Services. The Allowable Amounts for these Covered Services are applied toward the Deductible for the Subscriber and each Dependent individually. Once Your Individual Deductible is met, benefits are payable for You only during that same Benefit Period.

b. **Family Deductible**

This is the Deductible amount that the Subscriber and all Dependents must collectively pay each Benefit Period for certain Covered Services. The Allowable Amounts for Covered Services that are applied toward each Individual Deductible are also applied toward the Family Deductible until the Family Deductible is met. Once the Family Deductible is met, benefits are payable for the Subscriber and all Dependents during that same Benefit Period.

11.36. Dependent means a Subscriber's family member who satisfies the Eligibility requirements contained in Section 2 of this Contract.

11.37. Durable Medical Equipment (DME) means equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally needed by a person in the absence of Illness or Injury.

11.38. Effective Date means the day on which the Subscriber or Dependent is entitled to receive Covered Services under this Contract as determined by Your Group and Us.

11.39. Eligibility means the provisions contained in Section 2 of this Contract that state requirements Employees of the Group must satisfy to become (or remain) covered Subscribers with respect to themselves and their Dependents.

11.40. Emergency or Emergency Medical Condition means a medical condition that starts suddenly and includes signs and symptoms so severe, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to Your health or to a pregnancy in the case of a pregnant woman, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. Emergency services are Medically Necessary services provided to diagnose, treat and Stabilize an Emergency Medical Condition. Emergency services end when Your Emergency Medical Condition is Stabilized.

11.41. Employee means any individual employed by an Employer.

11.42. Employer means any person acting directly as an Employer, or indirectly in the interest of an Employer, in relation to an employee benefit plan; and includes a group or association of Employers acting for an Employer in such capacity.

11.43. Expedited Appeal means the Appeal of an Urgent Care Claim or Concurrent Claim.

11.44. Experimental and Investigative means any drug, treatment, device, procedure, service or benefit that is experimental or investigational. A drug, treatment, device, procedure, service or benefit may be considered Experimental and Investigative by Us if it meets any one of the following criteria:

a. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.

b. It is the subject of a current investigational new drug or new device application on file with the FDA.

c. It is being provided pursuant to a written protocol that describes, among its objectives, determinations of safety, effectiveness and effectiveness in comparison to conventional alternatives or toxicity.

d. It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services.

e. The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings.

f. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, efficacy or efficacy in comparison to conventional alternatives.

g. It is not investigational in itself pursuant to any of the foregoing criteria and would not be Medically Necessary but for the provision of a drug, device, treatment, or procedure that is investigational or experimental.

11.45. External Review means a review of an Adverse Benefit Determination, including a Final Internal Adverse Benefit Determination, conducted by the Michigan Department of Insurance and Financial Services.

11.46. Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld at the completion of the internal appeals process or as a result of deemed exhaustion of the internal appeals process.

11.47. Formulary means a listing of generic and brand name outpatient prescription drugs that We cover. The Formulary is updated on an on-going basis and published on Our website, hap.org.

11.48. Gender Dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).

11.49. Grievance means a formal complaint by You (or submitted on Your behalf by Your Authorized Representative) concerning any of the following:

a. The availability, delivery or quality of health care services, including a complaint regarding an Adverse Benefit Determination.

b. Benefits or Claims payment, handling, or reimbursement for health care services.

c. Matters pertaining to the contractual relationship between You and Us.

11.50. Group means the Employer, association or other entity that has contracted with Us on behalf of its Employees, retirees, or group members and their Dependents for Covered Services under this Contract.

11.51. Group Health Plan means an employee welfare benefit plan established or maintained by an Employer or by an Employee organization (such as a union) or both, that provides medical care for Subscribers or their Dependents directly or through insurance, reimbursement or otherwise.

11.52. Habilitative Services means health care services that help a person diagnosed with an Autism Spectrum Disorder to keep, learn or improve skills and functioning for daily living. Services include Applied Behavioral Analysis, physical and occupational therapy, speech language pathology and other services as required by state law.

11.53. Health Maintenance Organization (HMO) means an entity licensed by the State of Michigan that provides coverage for health care services that are preventive services and/or Medically Necessary, subject to the terms of a subscriber's contract, in exchange for a fixed prepaid sum or per capita prepayment.

11.54. Home Health Care means alternate skilled care provided in a home environment. Home Health Care must be ordered by an Physician and be part of a formal treatment plan filed with and approved by Us before the first day of care. We have the right to request a new treatment plan and written confirmation from the Physician of the Medical Necessity for continued Home Health Care.

11.55. Hospice means a facility that:

a. Is licensed, accredited or approved by the proper licensing authority to provide a Hospice Program;

b. is Medicare certified;

c. Administers care to sick or injured individuals who have, in the opinion of the attending Physician:

1. No reasonable prospect of a cure;

2. A life expectancy of 210 days or less; and

d. Provides care by coordinating its service with the attending Physician and the patient's family.

11.56. Hospice Program means a coordinated program as approved by Us and provided by a Hospice for meeting the special physical, psychological, spiritual and social needs of dying individuals and their families. A Hospice Program provides palliative and supportive counseling and medical, nursing and other health services through home, Inpatient or outpatient care during the Illness and bereavement.

11.57. Hospital means a state licensed institution which:

a. Provides diagnosis, treatment and medical care of injured and sick individuals on an Inpatient basis;

b. Has a staff of 1 or more Physicians available at all times;

c. Provides 24 hours nursing service;

d. Complies with all applicable licensing and other statutes; and

e. Is not, other than incidentally, a skilled nursing facility or a place for aged individuals.

An institution accredited by the Joint Commission (or any successor organization) as a Hospital meets the requirements of this definition.

11.58. Identification Card or ID Card means a printed card issued to persons covered under this Contract. Possession does not guarantee coverage. The card provides information for obtaining Prior Authorization of health services as required by Us.

11.59. Illness means any disorder or disease of the body or mind.

11.60. Injury means an unexpected occurrence causing bodily harm by an external means. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity or other cause.

11.61. Inpatient means an uninterrupted stay of 24 hours or more in a Hospital, or licensed acute or subacute care facility which results in Charges for room and board.

11.62. Life-Threatening means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

11.63. Maximum Benefit means the maximum number of days or visits covered under this Contract for certain benefits. Maximum Benefits are listed with the Covered Service, under Exclusions and Limitations, and in the Rider(s).

11.64. Medical Necessity or Medically Necessary means a determination, made in accordance with well-established professional medical standards as reflected in scientific and peer-reviewed medical literature, that Covered Services are:

a. Consistent with and essential for diagnosis and treatment of Your condition, disease, ailment or Injury;

b. The most appropriate supply or level of service that can be provided safely;

c. Provided for the diagnosis or direct care and treatment of Your condition, disease, Injury or ailment;

d. Not provided primarily for Your convenience, or the convenience of Your family, Physician or other caretaker; and

e. More likely to result in benefit than harm.

When applied to hospitalization, Medical Necessity includes the determination that You require acute care as an Inpatient due to the nature of the services rendered or Your condition.

You may obtain clinical review criteria used to determine Medical Necessity. All requests must be sent in writing to Customer Service, Attention: Correspondence, 2850 West Grand Blvd., Detroit, MI 48202.

11.65. Medicare means the health insurance programs under Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

11.66. Member means a Subscriber or an eligible Dependent who is entitled to receive Covered Services under this Contract.

11.67. Mental Disorder means a disorder or disease that impairs judgment, behavior, and capacity to recognize reality, or the function or ability to cope with the ordinary demands of life. The specific disorder should be specified in the most current version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM).

11.68. Non-Affiliated Provider means a health professional, licensed Hospital, licensed pharmacy or any other institution, organization, or person that does not have a contract with Us to provide Covered Services to You and to have those Covered Services paid by Us.

11.69. Off-Label means the use of a drug for clinical indications other than those stated in the labeling approved by the FDA.

11.70. Open Enrollment means the period (usually annual) specified by the Group or Remitting Agent during which the Subscriber is eligible to enroll, switch, or change their level of coverage in any of the available health care programs offered by the Group.

11.71. Orthognathic Surgery means surgical treatment to restructure the bones or the other parts of the jaw to correct a Congenital Birth Defect, the effect of an Illness or Injury or to correct other functional problems.

11.72. Orthotic Appliance means an external device intended to correct any defect of form or function to the human body.

11.73. Out-of-Pocket Maximum or Out-of-Pocket Limit is the most You will pay for the combined total of all Copays, Coinsurance and Deductibles for Covered Services in a Benefit Period. The Out-of-Pocket Limits are listed in the Rider(s) and Summary of Benefits and Coverage.

a. Individual Out-of-Pocket Limit

This is the Out-of-Pocket Limit amount You must pay for Covered Services each Benefit Period. The Cost-Sharing amounts are applied toward the Out-of-Pocket Limit for the Subscriber and each Dependent individually. Once Your Individual Out-of-Pocket Limit is met, benefits are payable for Your only at 100% during that same Benefit Period.

b. Family Out-of-Pocket Limit

This is the Out-of-Pocket Limit amount that the Subscriber and all Dependents must pay collectively for Covered Services each Benefit Period. The Cost-Sharing amounts that are applied toward each Individual Out-of-Pocket Limit are also applied to the Family Out-of-Pocket Limit until the Family Out-of-Pocket Limit is met. Once the Family Out-of-Pocket Limit is met, benefits are payable for the Subscriber and all Dependents at 100% during that same Benefit Period.

The following amounts paid by You do not count toward the Out-of-Pocket Limit:

a. Charges in excess of the Allowable Amounts for Your Covered Services.

b. Charges in excess of any Maximum Benefits described in this Contract or any attached Rider.

c. Charges for services that are excluded in the Contract or any attached Rider.

d. Premiums.

11.74. Permanently Disabled or Permanent Disability means a person is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

11.75. Physician means a qualified, licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires be recognized as a Physician and practicing within the scope of his or her license by the jurisdiction in which services are rendered.

11.76. Physician Network or Medical Group means providers who form a partnership or association and have an agreement with Us to provide Covered Services to You through PCPs and other health care providers within the group.

11.77. Post-Service Claim means any Claim for payment or reimbursement of costs for medical care that has already been provided. It includes any Claim that is not a Pre-Service Claim or an Urgent Care Claim.

11.78. Premium means the rate set by Us and paid by the Group or Remitting Agent for the right of the Subscriber and his or her Dependent to receive Covered Services under this Contract**.**

11.79. Premium Due Date means the day of each month on which the Premium payment is due and payable to Us, usually the first day of each month.

11.80. Pre-Service Claim means a Claim for a benefit for which We require Prior Authorization of the benefit before You obtain care or services.

11.81. Primary Care Physician (PCP) means the Affiliated Provider in a Physician Network or Medical Group who is primarily responsible for providing or arranging for Your health care needs under this Contract. You may choose an Affiliated family practitioner, general practitioner, or internist as Your PCP. A pediatrician may be chosen as the PCP for a Dependent Child.

PCP does not include an obstetrician or gynecologist; however, You can access services from any Affiliated obstetrician or gynecologist without a referral from Your PCP. These providers, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, procedures for making Referrals.

11.82. Prior Authorized or Prior Authorization means the approval process wherein We are contacted to authorize services to be provided to You before the services are performed.

11.83. Prosthetic Appliance means an artificial device which replaces an absent part of the body or which aids in the performance of a natural function of the body without replacing a missing part.

11.84. Qualified Medical Child Support Order means any judgment, decree or order (including approval of a settlement order) which satisfies the requirements of Section 609(a) of the Employee Retirement Income Security Act (ERISA), as amended and which is issued by a court of competent jurisdiction requiring a Group Health Plan to provide coverage to an eligible Dependent of the Subscriber.

11.85. Referral means the recommendation or written pre-authorization by an Affiliated Provider (usually the PCP) for a Member to receive Covered Services from another health care provider. Referrals are subject to the approval of HAP or its designee prior to receiving Covered Services.

11.86. Rehabilitative Services means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of Inpatient and/or outpatient settings.

11.87. Remitting Agent means the individual or organization authorized and designated by Your Group to collect and remit Premiums to Us and to receive notices from and deliver notices to the Group.

11.88. Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. Your coverage will not be rescinded unless You (or a person seeking coverage on Your behalf) perform an act, practice or omission that is fraud, or You make an intentional misrepresentation of material fact, as prohibited by the terms of Your Group Health Plan and this Contract.

11.89. Rider means a written attachment to this Contract that provides for additional, different or reduced Covered Services or that otherwise modifies or supplements the terms of this Contract. In the event of a conflict between the terms and conditions stated in a Rider and the terms and conditions stated in this Contract, the terms and conditions in the Rider will control.

11.90. Service Area means the geographic area in which We are authorized to sell this Contract by the State of Michigan.

11.91. Source means any coverage for medical care, except this Contract, that You have or may have a Claim against for medical benefits. Source includes, without limitation, other health plans or insurers, automobile insurers, homeowner's insurance, prepaid group practices or other prepaid coverage, Employer self-insurance plans, Worker's Compensation insurers, and government programs.

11.92. Special Enrollment Period means a period outside of Your Group's Open Enrollment Period during which You may enroll in or change enrollment in any of the available healthcare programs offered by the Group. You are only eligible for a Special Enrollment Period when You experience certain qualifying events as explained in Section 2.7 of this Contract, or as otherwise allowed under applicable laws.

11.93. Specialist or **Specialty Care Physician** means an Affiliated Physician practicing in a specific area of medicine other than the fields listed in the definition of Primary Care Physician (PCP).

11.94. Spouse means the opposite sex or same sex partner to whom the Subscriber is married if such marriage was performed in and recognized by a domestic or foreign jurisdiction having the legal authority to sanction marriage.

11.95. Stabilize, Stabilized or Stabilization means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient.

11.96. Standard Appeal means an Appeal that is not an Expedited Appeal and that is handled using standard time frames.

11.97. Subrogation and Reimbursement refers to Our right to recover from a third party or insurance company, medical expenses paid on Your behalf as a result of Illness or Injury that was caused by any act or omission of a third party and/or complications incident thereto. Our recovery is limited to the amount We paid for Covered Services under this Contract.

11.98. Subscriber means the Employee or other Group member who is eligible for coverage under the Group and this Contract who submitted the application for coverage through the Group.

11.99. Substance Use Disorder has the same meaning as Chemical Dependency.

11.100. Summary of Benefits and Coverage means a supplement to this Contract outlining Covered Services, Deductibles, Copayments, Coinsurance, Out-of-Pocket Limits, Maximum Benefits and other coverage provisions. In the event of a conflict between the

terms and conditions stated in the Summary of Benefits and Coverage and the terms and conditions of this Contract, the terms and conditions of this Contract and any attached Riders will control.

11.101. Therapy Services means the following prescribed medical services performed either in or out of the Hospital when such services are Medically Necessary for the diagnosis or treatment of a condition due to Illness or Injury:

Physical, occupational, pulmonary, cardiac, and speech therapy benefits are payable for care or treatment as long as the:

a. Care is rendered by a licensed therapist acting within the scope of the therapist's state license;

b. Treatment is prescribed in writing by a Physician;

c. Treatment is post-operative or for the convalescent stage of an active Illness or Injury;

d. Treatment is to restore function lost as a result of an Illness or Injury; and

e. Treatment is necessary as a result of an Illness or Injury for rehabilitation purposes.

11.102. Urgent Care means care for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

11.103. Urgent Care Claim means any Pre-Service Claim or request for medical care or treatment in which applying the time periods for Prior Authorization or other timelines for determining non-urgent Claims:

a. Could seriously jeopardize Your life or health or Your ability to regain maximum function; or

b. In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

11.104. We, Us, Our means Health Alliance Plan of Michigan (HAP).

11.105. Willful Criminal Activity includes, but is not limited to, any of the following:

a. Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state.

b. Operating a methamphetamine laboratory as this term is defined in section 1 of 2006 PA 255, MCL 333.26371.

Willful Criminal Activity does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

11.106. You, Your, Yours means the Subscriber and any Dependents covered under the Contract.

HEALTH ALLIANCE PLAN

COMMERCIAL GROUP AND INDIVIDUAL APPEAL POLICY

PURPOSE

This policy provides any Health Alliance Plan Member or the Member's Authorized Representative a way to find a solution to a situation where the Member is not satisfied or feels wronged by the services, benefits and/or policies and procedures of HAP or its providers or receives an Adverse Benefit Determination (collectively "Appeal Process"). This policy applies to both pre-service and post service Appeals.

SUMMARY

The Policy allows You to file an Appeal when You receive a denial for payment or services or if Your coverage is cancelled (rescinded) for certain reasons. If You are in an Individual Plan You have a one level Appeal Process. If You are in a Group Plan, You have a two level Appeal Process.

You, Your Authorized Representative or Your health care practitioner may start the Appeal Process by sending a request in writing to:

Health Alliance Plan

Attention: Manager of Appeal and Grievance Department

2850 West Grand Boulevard

Detroit, MI 48202

You may also submit Appeals by fax to 313-664-5866 or in person at Our offices located at 2850 West Grand Boulevard, Detroit, MI 48202 or 21700 Northwestern Highway, Southfield, MI 48034.

You may receive this policy in an alternative language (Arabic, Farsi, Spanish or another language) by contacting our Customer Service Department at the number listed in this policy.

You may submit an Appeal in writing within 180 days from the date you receive the initial denial. If You are in a Group Plan You may submit a request for Your second level Appeal within 60 days from the date of the first level Appeal decision.

You should include any extra information such as:

- Medical evaluation report
- Medical records
- Your explanation of benefits
- Other important facts to support the request.

Once We receive the Appeal, We will send a letter telling You that We have accepted the Appeal. We have **thirty (30)** calendar days for Pre-Service Appeals, and sixty (60) calendar days for Post-Service Appeals, to make a final determination if You are an Individual Plan Member. Individual Members have a one-step internal Appeal Process. If You are a Group Member, We have fifteen (15) calendar days for Pre-Service Appeals, and thirty (30) calendar days for Post-Service Appeals, to make a decision at each level. Group Plan Members have a two-step internal Appeal Process.

If You approve Our request for an extension of time, We may take up to ten (10) additional business days for review if We have not received necessary and requested information from a health care facility or health professional. Additional extensions are available to You upon Your request. If We go past the allowable time frame, You can go straight to the State for an External Review or if You are a Member of a Group Plan subject to ERISA You may bring a lawsuit under section 502(a) of ERISA. Ask Your employer if You are part of an ERISA Group Plan.

We also offer an expedited Appeal Process where We will make a decision within 72 hours. You may make a request for an Expedited Appeal if You believe that waiting for the routine timeframe for an internal appeal would seriously threaten You, Your health or Your ability to regain maximum function. We will ask an appropriate health care practitioner, usually a physician, to review the request and decide if Your medical condition needs a decision within 72 hours. If Your physician makes the request for an Expedited Appeal or indicates that You need an Expedited Appeal, We will provide You with a decision within 72 hours.

You are allowed to have continued coverage during the Expedited Appeal Process for **approved** ongoing courses of treatment pending the outcome of an internal Appeal.

You or Your Authorized Representative may file a request for an Expedited External Review, with the Department of Insurance and Financial Services (DIFS), at the same time You file a request for an Expedited Appeal with Us. If this happens and DIFS accepts the external review request, You are considered to have exhausted Our Internal Appeal process.

You or your Authorized Representative may file a request for an external review with the Department of Insurance and Financial Services (DIFS) if We:

- Fail to comply with the requirements of Our Internal Appeal Policy, unless the failure is based on a trivial or minor violation that does not cause prejudice or harm to You; or
- Fail to issue a written decision to You or Your Authorized Representative within the required time, and without You requesting or agreeing to an extension; or
- Waive Our Internal Appeal Process and the requirement for You to exhaust the process before filing a request for an external review.

If this happens and DIFS accepts your request for an external review you are considered to have exhausted HAP's internal appeal process.

When filing for a request for an external review, you will be required to authorize the release of medical records that may be required to be reviewed to reach a decision on the external review.

You will not have to bear any costs for an external review, including any filing fees.

You may request and receive, at no cost, copies of documents, records and other information relevant to Your Appeal.

During the Internal Appeal Process, You or Your Authorized Representative have the option to present the Appeal in person, by phone or using other ways of communication. Individual Plan Members may present their one level Appeal to one of Our designated appeals persons. Group Plan Members may present their Appeal to an Appeals Committee at their second level Appeal.

A health care practitioner who has appropriate training and experience in the field of medicine involved in Your case will review the Appeal, if the initial denial was based on medical necessity.

People who were involved in the initial denial will not be included in making the decision for the Appeal. People who were involved in a level one Appeal for a Group Member will not be included in making a decision for a level two Appeal.

Before your Internal Appeal may be denied based on a new or additional rational, or any new or additional evidence considered, relied upon, or generated in connection with the Appeal, You will be provided with the new rational and/or evidence to you, at no cost, within a sufficient amount of time to allow You a reasonable opportunity to respond to the new rational and/or evidence. This information will be provided to You before You are provided with a final determination on your Appeal.

If You are still not satisfied with the final decision after the internal Appeal Process or if You meet the requirements for an External Review, as described above, You can ask for an External Review under the Patient's Right to Independent Review Act. After you receive the final decision or exhaust the internal appeal process You can request an External Review by contacting the Director of the Department of Insurance and Financial

Services within **sixty (60) days, on or before December 31, 2016, or one-hundred and twenty (120) days, on or after January 1, 2017,** by writing to:

Department of Insurance and Financial Services

Healthcare Appeals Section

Office of General Counsel

P.O. Box 30220

Lansing, MI 48909-7720

You may also call the Director toll-free at (877) 999-6442.

We will automatically provide You with the **FIS 0018 (4/13) - Health Care Request for External Review form after the final appeal decision.** This form is necessary to ask for an External Review. You can also get a copy of the form anytime by going to the Department of Insurance and Financial Services website listed below. You can also call the number listed below and ask for the form.

Other Rights:

If You are a Member of a Group Plan subject to ERISA, You may bring a lawsuit under section 502(a) of ERISA if You have exhausted Our internal Appeal Process. Ask Your employer if You are part of an ERISA Group Plan.

For more information:

- Members can call Our Client Services at (800) 422-4641.
- If You are deaf, hard of hearing or speech impaired, please call 711 for TTY services.
- Call the Department of Insurance and Financial Services directly at the number listed above or visit their website at www.michigan.gov/difs.
- For assistance You may contact the Michigan Health Insurance Consumer Assistance Program, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933 at 877-999-6442 or email at DIFS-HICAP@Michigan.gov.

Nondiscrimination Notice

Health Alliance Plan of Michigan (HAP) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. HAP does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HAP provides:

- Free aids and services to help people communicate effectively with us
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, others)
- Free language services to people whose primary language is not English
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact HAP's customer service manager:

General - (800) 422-4641 **Medicare -** (800) 801-1770

If you believe that HAP has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability or sex, you can file a grievance with HAP's director of grievance and appeals. Use the information below:

- **Mail:** 2850 West Grand Boulevard, Detroit, Michigan 48202
- **Phone:** **General -** (800) 422-4641 **Medicare -** (800) 801-1770
  TTY: 711
- **Fax:** (313) 664-5866
- **Email:** msweb1@hap.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- **Online:** Use the Office for Civil Rights' Complaint Portal Assistant at: **ocrportal.hhs.gov/ocr/portal/lobby.jsf.**

- **Mail:** U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

- **Phone:** (800) 368-1019 or TTY: (800) 537-7697.

Complaint forms are also available at **www.hhs.gov/ocr/filing-with-ocr/**

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Për ndihmë të përgjithshme, telefononi numrin (800) 422-4641 (TTY: 711). Për ndihmë nga "Medicare", telefononi numrin (800) 801-1770 (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. للحصول على المساعدة العامة اتصل بالرقم 4641-422 (800) (خدمة الهاتف النصي:711). للحصول على المساعدة المتعلقة بتغطية Medicare، اتصل بالرقم 1770-801 (800) (خدمة الهاتف النصي: 711).

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। সধারণ সহায়তার জন্য (800) 422-4641(TTY: 711) নম্বরে ফোন করুন। Medicare সহায়তার জন্য (800) 801-1770 (TTY: 711) নম্বরে ফোন করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。如需一般援助，請致電 (800) 422-4641 或 TTY 用户請致電 711。如需 Medicare 援助，請致電 (800) 801-1770 或 TTY 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Allgemeine Hilfe erhalten Sie unter der Rufnummer (800) 422-4641 (TTY: 711). Für Medicare-Unterstützung wenden Sie sich bitte an folgende Rufnummer: (800) 801-1770 (TTY : 711).

ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Per assistenza generica, chiamare il numero (800) 422-4641 (TTY: 711). Per assistenza Medicare, chiamare il numero (800) 801-1770 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。一般支援については、(800) 422-4641 まで（TTY ユーザーは 711 まで）、お電話にてご連絡ください。Medicare 支援については、(800) 801-1770 まで（TTY ユーザーは 711 まで）、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 일반 지원은 (800) 422-4641(TTY: 711)번으로 전화해 주십시오. Medicare 지원은 (800) 801-1770(TTY: 711)번으로 전화해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 (TTY: 711) w celu uzyskania pomocy w sprawach ogólnych. W celu uzyskania wsparcia Medicare zadzwoń pod nr (800) 801-1770 (TTY: 711).

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. По вопросам получения общей помощи обращайтесь по номеру (800) 422-4641 (телетайп: 711). Обращайтесь в Medicare по номеру (800) 801-1770 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Za opću podršku nazovite na broj (800) 422-4641 (tekstualni telefon za osobe oštećena sluha: 711). Za podršku vezano za program Medicare nazovite na broj (800) 801-1770 (tekstualni telefon za osobe oštećena sluha: 711).

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Para obtener ayuda general, llame al (800) 422-4641 (los usuarios TTY deben llamar al 711). Para obtener ayuda de Medicare, llame al (800) 801-1770 (los usuarios TTY deben llamar al 711).

ܙܘܗܪܐ: ܐܢ ܐܚܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܗ ܠܫܢܐ ܐܣܘܪܝܝܐ\ܐܬܘܪܝܐ، ܬܡܢ ܒܠܐ ܕܡܫܠܡܬܘܢ ܚܕܡܬܐ ܕܗܝܪܬܐ ܠܫܢܝܬܐ ܡܓܢܐܝܬ. ܠܚܕܡܬܐ ܕܗܝܪܬܐ ܓܘܢܝܬܐ، ܡܚܘܢ ܥܠ ܡܢܝܢܐ (800) 422-4641 (TTY: 711). ܠܚܕܡܬܐ ܕܗܝܪܬܐ ܕܒܝܬ Medicare، ܡܚܘܢ ܥܠ ܡܢܝܢܐ (800) 801-1770 (TTY: 711).

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Para sa pangkalahatang tulong, tumawag sa (800) 422-4641 (TTY: 711). Para sa tulong sa Medicare, tumawag sa (800) 801-1770 (TTY: 711).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Để được trợ giúp chung, hãy gọi (800) 422-4641 (TTY: 711). Để được trợ giúp về y tế (Medicare), hãy gọi (800) 801-1770 (TTY: 711).