



HMO PLUS

Certificate of Coverage

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Certificate of Coverage

Physicians Health Plan

Certificate is Part of Group Policy

This Certificate of Coverage (also referred to as this “Certificate”) is part of the Group Policy that is a legal document between Physicians Health Plan and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, Exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this Certificate, the Policy includes:

- The Group Policy.
- The Enrolling Group's application.
- Any Amendments and Riders.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Certificate. When that happens, we will notify you of the change. **NOTE:** You may access your member materials online at our “Member Packet Portal” using your Subscriber identification (ID) number. This site may be accessed through our web site at www.phpmm.org.

No one can make any changes to the Policy unless those changes are in writing and approved by the State of Michigan.

Other Information You Should Have

Only we have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this Certificate replaces and overrules any Certificate that we may have previously issued to you. This Certificate will in turn be overruled by any Certificate we issue to you in the future.

The Policy will take effect on the date specified in the Group Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight Eastern Time. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Michigan. The Policy is governed by Employee Retirement Income Security Act of 1974 (ERISA) unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Michigan are the laws that govern the Policy.

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Introduction to Your Certificate

We are pleased to provide you with this Certificate of Coverage. This Certificate and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your Certificate and any attached Riders and/or Amendments carefully. You are responsible for understanding all provisions of this document, including Riders and/or Amendments.

We especially encourage you to review the Benefit limitations of this Certificate by reading Section 1: What's Covered--Benefits and Section 2: What's Not Covered—Limitations and Exclusions. You should also carefully read Section 9: General Legal Provisions to better understand how this Certificate and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the Certificate are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Certificate and any attachments in a safe place for your future reference.

This Certificate will rule if there is a conflict between this Certificate and any summaries provided to you by the Enrolling Group,

Please be aware that your Physician does not have a copy of your Certificate of Coverage and is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Certificate is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms. You can refer to Section 10 as you read this document to have a clearer understanding of your Certificate.

When we use the words "we," "us," and "our" in this document, we are referring to Physicians Health Plan. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in Section 10: Glossary of Defined Terms.

Your Contribution to the Required Premiums

The Policy may require the Subscriber to contribute to the required Premiums. You can contact your Enrolling Group for information about any part of the Premium cost you are responsible for paying.

Don't Hesitate to Contact Us

Throughout the document, you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call Customer Service at 517-364-8500 or 800-832-9186. It will be our pleasure to assist you.

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Please notify us of any changes in address, changes in eligible family members and marital status, or if you acquire other health insurance coverage.

Health Management Programs

We offer health management programs for Covered Persons who have specific health conditions. These programs are voluntary and may be available at no cost to you. These programs are not Covered Health Services or Benefits under the terms of the Policy. Health management programs can provide important, value-added services. Health management programs focus on a specific health issue such as diabetes, Pregnancy, or asthma. New programs may be added and existing programs may be modified or eliminated at any time. Please visit our web site at www.phpmm.org or contact Customer Service for more information regarding health management programs.

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Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in Section 10: Glossary of Defined Terms.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in Section 1: What's Covered—Benefits and Section 2: What's Not Covered—Limitations and Exclusions. Care decisions are

between you and your Physicians. We do not make decisions about the kind of care you should or should not receive. We do determine, according to PHP medical policy and nationally recognized guidelines, what Medically Necessary Benefits are covered under this Policy.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We can assist you to find Network Physicians and facilities. Should you choose a Physician or facility not in our Network, you may have additional out of pocket expenses.

Pay Your Share

You may first have to pay an Annual Deductible before we will provide Benefits for Covered Health Services. You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in Section 1: What's Covered—Benefits. You may also pay any amount that exceeds Eligible Expenses for Non-Network services.

Pay the Cost of Limited and Excluded Services

You must pay the cost of all services and items that exceed the benefit limitation or are excluded from coverage. Review Section 2: What's Not Covered--Limitations and Exclusions to become familiar with this Benefit plan's limitations and Exclusions.

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Show Your ID Card

To make sure you receive your full benefit, you should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill us for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

You or your provider is responsible for requesting payment from us. The claim must be filed in a format that contains all of the information we require, as described in Section 5: How to File a Claim.

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Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We do the following:

- Interpret Benefits and the other terms, limitations and Exclusions set out in this Certificate of Coverage and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.
- Make decisions about the Medical Necessity of a service or procedure.

We may delegate these responsibilities to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time. In order to receive Benefits, you must cooperate with those service providers.

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Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in Section 1: What's Covered--Benefits, unless the service is excluded in Section 2: What's Not Covered—Limitations and Exclusions. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. Non-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one

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of our reimbursement policies does not reimburse (in whole or in part) for the service billed.

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments, Coinsurance and Eligible Expenses.
- Annual Deductible, Annual Out-of-Pocket Maximum and Maximum Policy Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in Section 2: What's Not Covered – Limitations and Exclusions.
- Authorization Requirements. Certain Covered Health Services require you or your provider to obtain authorization from us before you receive them. In general, Network providers are responsible for obtaining authorization from us before they provide certain health services to you. You are responsible for obtaining authorization from us before you receive certain health services from a Non-Network provider.

Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility. For facility services, Network Benefits apply to Covered Health Services that are provided at a Network facility by or under the direction of either a Network or Non-

Network Physician or other provider. For details about when Network Benefits apply, see Section 3: Description of Network and Non-Network Benefits.

You must select a Primary Care Physician to provide or coordinate the Covered Health Services you receive.

You must show your identification card (ID card) every time you request health care services. If you do not show your ID card, providers have no way of knowing that you are enrolled under a PHP Policy. As a result, they may bill you for the entire cost of the services you receive.

Do not permit another person who is not a Covered Person under this Policy to use your ID card. You must immediately report the loss or theft of your ID card to us and be sure to destroy any old cards.

For Network and Non-Network Benefits, a health care service or supply is considered to be a Covered Health Service if we determine that it is Medically Necessary per PHP medical policy and nationally recognized guidelines.

The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Sickness or Mental Illness, or the fact that the Physician has determined that a particular health care service or supply is medically necessary or medically appropriate, does not mean that the procedure or treatment is a Covered Health Service under the Policy.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Group Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 8: When Coverage Ends occurs.

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- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

Benefits for Covered Health Services are not subject to any limitation or Exclusion related to a preexisting condition.

Copayment

Copayment is the set dollar amount that you are required to pay for certain Covered Health Services such as Physician office visits, Emergency Department Health Services and urgent care services. For a complete definition of Copayment, see Section 10: Glossary of Defined Terms. Copayment amounts are listed on the following pages next to the description for each Covered Health Service subject to a Copayment. The Copayment you are required to pay for Network Benefits will not exceed 50% of the cost for providing Basic Health Services.

Coinsurance

Coinsurance is the charge, stated as a percentage of Eligible Expenses that you pay each time you receive certain Covered Health Services. For a complete definition of Coinsurance, see Section 10: Glossary of Defined Terms. Coinsurance amounts are listed on the following pages next to the description for each Covered Health Service that is subject to Coinsurance. Please note that when Coinsurance amounts are calculated, the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For a complete definition of Eligible Expenses that describes how we determine payment, see Section 10: Glossary of Defined Terms. For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the

Non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Authorization Requirements

Certain Covered Health Services require authorization prior to receiving services. In general, Network providers are responsible for obtaining authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization.

When you choose to receive certain health services from Non-Network providers, you are responsible for obtaining prior authorization from us before you receive these services.

Services for which you must obtain authorization appear in this section under the *Is Authorization Required?* column.

You do not need authorization from us or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a Network provider who specializes in obstetrics or gynecology. However, the Network provider may be required to obtain authorization prior to certain services, which appear in this section under the *Is Authorization Required?* column.

To request authorization, call the telephone number on your ID card for Customer Service.

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

When you choose to receive services from Non-Network providers, we urge you to confirm with us that the services you plan to receive are

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Covered Health Services, even if not indicated in the Is Authorization Required? column. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or Exclusions such as:

- The Cosmetic Procedures Exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven Services Exclusion.
- Any other contract limitation or Exclusion.

Authorization is required for the Non-Network Covered Health Services below. If authorization is not obtained as required, Benefits will be reduced as described.

Prior authorization is not a guarantee of Benefits. Coverage depends on the services that are actually received, your eligibility status, and any Benefit limitations or Exclusions.

Covered Health Service	Non-Authorization Impact on Non-Network Benefits
Ambulance services – non-emergency	No Benefits will be paid.
Dental anesthesia – pediatric/adult	No Benefits will be paid.
Dental services – accident	Benefits will be reduced to 50% of Eligible Expenses

Covered Health Service	Non-Authorization Impact on Non-Network Benefits
Durable Medical Equipment over \$500	No Benefits will be paid.
Genetic testing	No Benefits will be paid.
Home health care	Benefits will be reduced to 50% of Eligible Expenses.
Hospice care	Benefits will be reduced to 50% of Eligible Expenses.
Hospital Inpatient Stay (including extended maternity stay and Emergency admissions)	Benefits will be reduced to 50% of Eligible Expenses.
Prosthetic devices over \$1,000	No Benefits will be paid.
Reconstructive procedures	Benefits will be reduced to 50% of Eligible Expenses.
Skilled Nursing Facility/ Inpatient Rehabilitation Facility	Benefits will be reduced to 50% of Eligible Expenses.
Specialty Pharmaceuticals NOTE: This list is subject to change.	No Benefits will be paid if certain criteria are not met.
Transplant services	No Benefits will be paid.
Behavioral Health Services – Inpatient Stay/intermediate care	Benefits will be reduced to 50% of Eligible Expenses.
Behavioral Health Services – residential treatment program for substance use disorders	Benefits will be reduced to 50% of Eligible Expenses.
Behavioral Health Services –	No Benefits will be paid.

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Covered Health Service	Non-Authorization Impact on Non-Network Benefits
outpatient care NOTE: certain services such as intensive outpatient, ECT, extended psychotherapy, and neuro/cognitive/psycho-diagnostic testing require authorization. Please call PHP or the Behavioral Health Designee for more information.	

Special Note Regarding When Medicare or Other Coverage is Primary

If you are enrolled for Medicare or other health insurance on a primary basis (Medicare or other health insurance pays before we pay Benefits under the Policy), the authorization requirements described in this Certificate of Coverage apply to you. Since Medicare or another health insurance is the primary payer, we will pay as secondary payer as described in Section 7: Coordination of Benefits.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	<p>The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see Section 10: Glossary of Defined Terms. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The Annual Deductible will never apply to Preventive Health Services.</p>	<p>Network</p> <p>None</p> <p>Non-Network</p> <p>\$200 per Covered Person per calendar year, not to exceed \$400 for all Covered Persons in a family.</p>
Annual Out-of-Pocket Maximum	<p>The maximum you pay, out of your pocket, in a calendar year. For a complete definition of Annual Out-of-Pocket Maximum, see Section 10: Glossary of Defined Terms.</p>	<p>Network</p> <p>\$3,000 per Covered Person per calendar year, not to exceed \$6,000 for all Covered Persons in a family.</p> <p>Non-Network</p> <p>\$3,000 per Covered Person per calendar year, not to exceed \$3,000 for all Covered Persons in a family.</p> <p>The Annual Out-of-Pocket Maximum does not include the Annual Deductible.</p>
Maximum Policy Benefit	<p>The maximum amount we will pay during the entire period of time you are enrolled under the Policy. For a complete definition of Maximum Policy Benefit, see Section 10: Glossary of Defined Terms.</p>	<p>No Maximum Policy Benefit</p>

Benefit Information

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>1. Ambulance Services</p> <p>Authorization Requirements</p> <p>Authorization must be obtained prior to receiving non-emergency ambulance services or within one business day if services are provided during non-business hours. If you or your provider does not obtain authorization from us, no Non-Network Benefits will be paid and you will be responsible for all charges.</p> <p>Description</p> <p>The Benefit plan covers Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.</p> <p>Network Benefits are provided for Medically Necessary non-Emergency ambulance transportation services when:</p> <ul style="list-style-type: none"> • Services are recommended by the Primary Care Physician or other Network Physician; and • Coordinated by us. <p>Non-Emergency Medically Necessary ambulance transportation by a licensed ambulance service between facilities is covered when the following criteria are met:</p> <ul style="list-style-type: none"> • The patient's condition must be such that any other form of 	<p>Network</p> <p>Yes, but only for non-Emergency ambulance.</p> <p>Non-Network</p> <p>Yes, but only for non-Emergency ambulance.</p>	<p>0%</p> <p>Same as Network Benefit</p>	<p>No</p> <p>Same as Network Benefit</p>	<p>Not applicable</p> <p>Same as Network Benefit</p>

<p align="center">Description of Covered Health Service</p>	<p align="center">Is Authorization Required?</p>	<p align="center">Amount You Pay <small>Coinsurance % is based on a percent of Eligible Expenses</small></p>	<p align="center">Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?</p>	<p align="center">Do You Need to Meet Annual Deductible?</p>
<p>transportation would not be medically recommended and</p> <ul style="list-style-type: none"> • Any of the following circumstances exists: <ul style="list-style-type: none"> — Transfer from an acute care facility to a patient’s home or Skilled Nursing Facility; or — Transfer to and from a patient’s home to an acute care facility to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, dialysis, etc.). • Transportation to or from one acute care facility to another acute care facility, Skilled Nursing Facility or free-standing dialysis center in order to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, intensive care services including neonatal ICU, acute interventional cardiology, radiation therapy, etc.), provided such services are: <ul style="list-style-type: none"> — Not available at the transferring facility where the patient is being treated; and — The patient cannot be safely transported in another way; and — The patient requires continued acute inpatient medical care. • Ground ambulance for a deceased patient in the following circumstances: <ul style="list-style-type: none"> — The patient was pronounced dead while in route or upon arrival at the Hospital or final destination; or 				

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— The patient was pronounced dead by a legally authorized individual (Physician or medical examiner) after the ambulance call was made, but prior to pick-up.				
<p>2. Antineoplastic Therapy (Chemotherapy)</p> <p>The Benefit plan covers federal Food and Drug Administration (FDA) approved Medically Necessary drugs used in antineoplastic therapy and the reasonable cost of administration of the drug. Benefits are 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 approval by the federal FDA, if all of the following are true:</p> <ul style="list-style-type: none"> • The drug is ordered by or under the direction of a Physician for the treatment of a specific type of neoplasm; and • The drug is approved by the federal FDA for use in antineoplastic therapy; and • The drug is used as part of an antineoplastic drug regimen; and • Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and • The Physician has obtained informed consent from the patient for the treatment regimen, which includes federal FDA approved drugs for off-label indications. 	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p> <p>No</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for antineoplastic therapy will be the same as those stated under each Covered Health Service category in this section.</p> <p>Depending upon where the Covered Health Service is provided, Benefits for antineoplastic therapy will be the same as those stated under each Covered Health Service category in this section.</p>		

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<p>3. Behavioral Health Services</p> <p>Authorization Requirements</p> <p>All Inpatient Stays, residential Treatment Programs for substance use disorders, intermediate care (such as day treatment and partial hospitalization) and certain outpatient services (such as intensive outpatient therapy, ECT, extended psychotherapy [more than 50 minutes], and neuro/cognitive/psycho-diagnostic testing) require prior authorization. You or your provider must call the Behavioral Health Designee at the telephone number listed in our provider directory to obtain authorization to receive Benefits in advance of treatment as specified above.</p> <p><u>Inpatient Hospital Stays, Residential Treatment Programs for substance use disorders and other intermediate treatment:</u> you or your provider must notify the Behavioral Health Designee as follows:</p> <ul style="list-style-type: none"> • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within one business day or the same day of admission. <p>If authorization from the Behavioral Health Designee is not obtained for an Inpatient Stay, a Residential Treatment Program for substance use disorders or other intermediate care, Non-Network Benefits will be reduced to 50% of Eligible Expenses. You are responsible for any charges not covered due to non-authorization penalties if the provider</p>	<p><i>Network</i></p> <p>Yes, call the Behavioral Health Designee as noted.</p>	<p><i>Inpatient/ Intermediate Care:</i></p> <p>0%</p> <p><i>Residential Treatment Program for Substance Use Disorders:</i></p> <p>0%</p> <p><i>Outpatient Therapy Visits & Testing:</i></p> <p>Mental Health: \$0 per visit for the first 20 visits in a calendar year. For each visit (21 or more) in a calendar year: \$10 per visit.</p> <p>Substance Use</p>	<p>No</p> <p>No</p> <p>No</p>	<p>Not applicable</p> <p>Not applicable</p> <p>Not applicable</p>

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<p>is a Non-Network provider.</p> <p><u>Outpatient Services:</u> if authorization from the Behavioral Health Designee is not obtained for certain outpatient Behavioral Health Services as listed above, no Non-Network Benefits will be paid. You are responsible for any charges not covered due to non-authorization penalties if the provider is a Non-Network provider.</p> <p style="text-align: center;">Description</p> <p>The Benefit plan covers Medically Necessary Behavioral Health Services in a provider's office, a Hospital or at an Alternate Facility (depending on the service provided), including:</p> <ul style="list-style-type: none"> • Mental health and substance use disorder evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. • Inpatient detoxification from abusive chemicals or substances that 	<p>Non-Network</p> <p>Yes, call the Behavioral Health Designee as noted.</p>	<p>Disorders: \$0 per visit</p> <p><i>All Other Outpatient Items & Services:</i> 0%</p> <p>20%</p>	<p>No</p> <p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Not applicable</p> <p>Yes</p>

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<p>is limited to medical services for physical detoxification when necessary to protect your physical health and well-being.</p> <ul style="list-style-type: none"> • Residential Treatment Program for substance use disorders. • Partial hospitalization. • Day treatment. • Electroconvulsive therapy (ECT). • Neuro/cognitive/psycho-diagnostic testing. <p>The Behavioral Health Designee, who will arrange for the services, will determine if the treatment is Medically Necessary and the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>Covered treatment settings are as follows:</p> <ul style="list-style-type: none"> • Acute Inpatient Hospitalization and Detoxification – the highest level of intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers. • Residential Treatment Program – a program that provides medically or clinically supervised therapies in a 24-hour setting and that is designed to treat groups of patients with similar substance 				

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<p>use dependency.</p> <ul style="list-style-type: none"> • Intermediate/Day Treatment/Partial Hospitalization – an intensive, non-residential level of service where multidisciplinary medical and nursing services are required. This care is provided in a structured setting, similar in intensity to inpatient, meeting for more than four hours (and generally less than eight hours) daily. • Intensive Outpatient Treatment – multidisciplinary, structured services provided at a greater frequency and intensity than routine outpatient treatment. These are generally up to four hours per day, up to five days per week. Common treatment modalities include individual, family, group and medication therapies. • Outpatient/Ambulatory Detoxification – detoxification services delivered within a structured program having medical and nursing supervision where physiological consequences of withdrawal have non-life-threatening potential. • Outpatient Treatment – the least intensive level of service, typically provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day. Services provided over the telephone are not covered. • Observation – a period of less than 24 hours during which services are provided at less than an acute level of care. It is indicated for those situations where full criteria for inpatient hospitalization are not met because of external factors relative to information 				

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<p>gathering or risk assessment yet the patient clearly is at risk for harm to self or others.</p> <p>Treatment must be provided by a licensed Physician or other licensed behavioral health professional and received in a facility accredited by COA, AOA or JCAHO.</p> <p>Coverage for Behavioral Health Services is limited to the most appropriate method and level of treatment that is Medically Necessary as determined by the Behavioral Health Designee. Coverage for outpatient and day treatment services for behavioral health shall not be less than the minimum benefit established by the State of Michigan, Office of Financial and Insurance Regulation.</p> <p>Referrals to all behavioral health providers are determined by the Behavioral Health Designee, who is responsible for coordinating all of your care.</p> <p>Contact the Behavioral Health Designee at the telephone number listed in our provider directory regarding Benefits for Behavioral Health Services.</p>				
<p>4. Chiropractic Services, Treatment or Care</p> <p>The Benefit plan covers Chiropractic Services, Treatment or Care when provided by a Network Chiropractor for treatment of neuro-musculoskeletal disorders related to the spine and joints.</p> <p>Benefits for Chiropractic Health Services, Treatment or Care are</p>	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p>	<p>\$10 per visit</p>	<p>No</p>	<p>Not applicable</p>

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limited to a maximum of 20 visits per calendar year.	Non-Network Benefits are not available.	Non-Network Benefits are not available	Non-Network Benefits are not available	Non-Network Benefits are not available
<p>5. Dental Anesthesia</p> <p>Authorization Requirements</p> <p>Authorization must be obtained by you or your provider prior to receiving dental anesthesia services.</p> <p>Description</p> <p>The Benefit plan covers dental-related anesthesia and associated Hospital and facility charges provided at a Hospital to a Dependent or member when, in the opinion of the treating dentist or oral surgeon, treatment in a dental office under local anesthesia would be ineffective or compromised; and any of the following criteria apply:</p> <ul style="list-style-type: none"> • A total of six (6) or more teeth are extracted in various quadrants. • Dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation, or allergy. • Multiple extractions or multiple restorations if the patient is a child under the age of seven (i.e., through the end of the sixth year). • Patients with a concurrent hazardous medical condition. • Extensive oral-facial and/or dental trauma for which treatment 	<p>Network</p> <p>Yes</p> <p>Non-Network</p> <p>Non-Network Benefits are not available.</p>	<p>Benefits for dental anesthesia are the same as Benefits for any other anesthesia and related Hospital charges.</p> <p>Non-Network Benefits are not available.</p>		

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<p>under local anesthesia would be ineffective or compromised.</p> <p>Benefits under this section are provided only for the anesthesia and related Hospital and facility charge. Benefits are not available for any other related dental procedure (including but not limited to extractions) except as described below. Benefits are provided only if the services are provided by a Network provider at a Network facility and authorization is obtained prior to the treatment taking place to determine if Benefits will be available.</p>				
<p>6. Dental Services – Accidental Dental</p> <p>Authorization Requirements</p> <p>Authorization is required as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins for accidental dental services. (You do not have to obtain authorization at the time of the initial Emergency treatment.) If you or your provider does not obtain authorization from us, Non-Network Benefits will be reduced to 50% of Eligible Expenses for charges related to accidental dental services.</p> <p>Description</p> <p>The Benefit plan covers accidental dental services when all of the following are true:</p> <ul style="list-style-type: none"> • Treatment is Medically Necessary because of accidental damage; and • Dental services are received from a Doctor of Dental Surgery, 	<p>Network</p> <p>Yes, but only prior to follow up care for accidental dental services</p> <p>Non-Network</p> <p>Yes, but only prior to follow up care for accidental dental services</p>	<p>0%</p> <p>Same as Network Benefit</p>	<p>No</p> <p>Same as Network Benefit</p>	<p>Not applicable</p> <p>Same as Network Benefit</p>

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<p>"D.D.S." or Doctor of Medical Dentistry, "D.M.D.;" and</p> <ul style="list-style-type: none"> The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. <p>Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:</p> <ul style="list-style-type: none"> A virgin or unrestored tooth, or A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. <p>In no event are Benefits available for the replacement of a missing tooth (dental implants), even if required as a result of an Injury.</p> <p>Dental services to repair damage caused by accidental Injury must conform to the following time frames:</p> <ul style="list-style-type: none"> Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care). Treatment is completed within 12 months of the accident or start of treatment (unless extenuating circumstances exist). <p>Please note that dental damage that occurs as a result of normal activities of daily living (including biting or chewing) or extraordinary use of the teeth is not considered having occurred as an accident.</p>				

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Benefits are not available for repairs to teeth that are injured as a result of such activities.				
<p>7. Dental Services – Other Medical Services of the Mouth</p> <p>The Benefit plan covers Medically Necessary Covered Health Services provided by a Physician or dentist including:</p> <ul style="list-style-type: none"> • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. • Excision of benign or malignant bony growths of the jaw and hard palate. • External incision and drainage of cellulitis. • Incision of sensory sinuses, salivary glands or ducts. <p>Benefits are not available for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, or preparing the mouth for the fitting of or continued use of dentures.</p>	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p> <p>No</p>		<p>Depending upon where the Covered Health Service is provided, Benefits for other medical services of the mouth will be the same as those stated under each Covered Health Service category in this section.</p> <p>Depending upon where the Covered Health Service is provided, Benefits for other medical services of the mouth will be the same as those stated under each Covered Health Service category in this section.</p>	
<p>8. Diabetes Services</p> <p>Diabetes includes gestational diabetes, insulin-dependent diabetes and non-insulin-dependent diabetes. The Benefit plans covers equipment, supplies and educational training for the treatment of diabetes when ordered by or under the direction of a Physician,</p>	<p><i>Network</i></p> <p>No</p>		<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes services will be the same as those stated under each Covered Health Service category in this section.</p>	

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<p>The Benefit plan covers diabetes equipment that meets the minimum specifications for your needs. If you choose to purchase diabetes equipment that exceeds these minimum specifications, we will pay only the amount that we would have paid for equipment that meets the minimum specifications, and you will be responsible for paying any difference in cost.</p> <p>The Benefit plan covers diabetes self-management training when it is provided by a diabetes outpatient training program that is certified to receive Medicaid or Medicare reimbursement or certified by the Michigan Department of Community Health. Benefits for diabetes self-management training are limited to completion of a certified diabetes education program:</p> <ul style="list-style-type: none"> • Upon the diagnosis of diabetes if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge. • Upon the diagnosis of a significant change, with long-term implications, in the patient's symptoms or conditions that results in a need for changes to the patient's self-management, or a significant change in medical protocol or treatment modalities. 	<p>Non-Network</p> <p>No</p>		<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes services will be the same as those stated under each Covered Health Service category in this section.</p>	
<p>9. Durable Medical Equipment</p> <p>Authorization Requirements</p> <p>Authorization is required before obtaining any single item of Durable Medical Equipment that costs more than \$500 (either purchase price or cumulative rental of a single item). If you or your provider does not</p>	<p>Network</p> <p>Yes, for Durable Medical Equipment that exceeds \$500 in</p>	<p>0%</p>	<p>No</p>	<p>Not applicable</p>

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<p>obtain authorization from us, Non-Network Benefits will not be paid and you will be responsible for all charges.</p> <p align="center">Description</p> <p>The Benefit plan covers Durable Medical Equipment that meets each of the following criteria:</p> <ul style="list-style-type: none"> • Medically Necessary, as determined by PHP medical policy and nationally recognized guidelines; and • Ordered or provided by a Physician for outpatient use; and • Used for medical purposes; and • Not consumable or disposable; and • Of use to a person only in the presence of a disease or physical disability. <p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications that are Medically Necessary for your needs. If you choose to rent or purchase Durable Medical Equipment that exceeds these minimum specifications, we will pay only the amount that we would have paid for equipment that meets the minimum specifications, and you will be responsible for paying any difference in cost.</p> <p>Examples of Durable Medical Equipment include:</p>	<p>cost or rental.</p> <p align="center"><i>Non-Network</i></p> <p>Yes, for Durable Medical Equipment that exceeds \$500 in cost or rental.</p>	<p align="center">20%</p>	<p align="center">Yes</p>	<p align="center">Yes</p>

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<ul style="list-style-type: none"> • Equipment to assist mobility, such as a standard wheelchair. • Benefits may be provided for power operated wheelchairs if: you are capable of safely operating the controls of a power operated wheelchair, have adequate upper body stability to ride safely, and are able to transfer in and out of the wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks). • Delivery pumps for tube feedings (including tubing and connectors). Bi-pap and C-pap machines (including tubing, connectors and masks). • Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize a body part affected by an Injury, Sickness or Congenital Anomaly are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage). • Burn garments. 				

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<ul style="list-style-type: none"> Insulin pumps and all related necessary supplies as described under <i>Diabetes Services</i>. <p>Benefits will never be available for some items and types of equipment. Refer to Section 2: What's Not Covered – Limitations and Exclusions. Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.</p> <p>If we determine that purchase, repair or replacement is Medically Necessary, we provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. Benefits are not available for duplicate Durable Medical Equipment items. Benefits are provided for replacement only when necessitated due to a change in your medical condition or a change in body size, to improve physical function, or when normal wear and tear necessitates replacment.</p> <p>We will pay for tubing, connectors and masks described above as a Covered Health Service (initial purchase and replacement) limited to four of each type per calendar year.</p> <p>Benefits are also provided for orthotic appliances (including shoe orthotics) and elastic, surgical and compression stockings.</p> <p>We will decide if the equipment should be purchased or rented. We will also decide if the equipment should be repaired or replaced.</p>				
10. Emergency Department Health	<i>Network</i> Yes, but only if			

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<p>Services – Outpatient/Observation Stay</p> <p>Authorization Requirements</p> <p>If you are admitted for an Inpatient Stay to a Hospital as a result of an Emergency, you or your provider must obtain authorization within one business day or the same day of admission. If you or your provider does not obtain authorization from us, Benefits for the Non-Network Hospital Inpatient Stay will be reduced to 50% of Eligible Expenses and you will be responsible for the non-covered charges. Benefits will not be reduced for outpatient or observation stay Emergency department health services.</p> <p>Description</p> <p>The Benefit plan covers Emergency department health services that are required to stabilize or initiate treatment in an Emergency. The Emergency department health services Benefit also covers an outpatient observation stay regardless of the length of the observation stay for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay). Both outpatient and observation stay services for Emergency department health services are subject to the Emergency department health services Copayment.</p> <p>Benefits for emergent/urgent health services received in a Physician's Office or in an Urgent Care Center are described later in this section.</p> <p>NOTE: The Copayment is waived if admitted for an Inpatient Stay within 24 hours for the same condition.</p> <p>You will find more information about Benefits for Emergency Health</p>	<p>admitted for an Inpatient Stay</p> <p>Non-Network</p> <p>Yes, but only if admitted for an Inpatient Stay</p>	<p>\$50 per visit</p> <p>Same as Network Benefit</p>	<p>No</p> <p>Same as Network Benefit</p>	<p>Not applicable</p> <p>Same as Network Benefit</p>

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Services in Section 3: Description of Network and Non-Network Benefits.				
<p>11. Genetic Testing</p> <p>Authorization Requirements</p> <p>Authorization is required before obtaining genetic testing services. If you or your provider does not obtain authorization from us, Non-Network Benefits will not be paid and you will be responsible for all charges.</p> <p>Description</p> <p>The Benefit plan covers certain Medically Necessary Genetic Tests.</p>	<p><i>Network</i></p> <p>Yes</p> <p><i>Non-Network</i></p> <p>Yes</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for genetic testing services will be the same as those stated under each Covered Health Service category in this section.</p> <p>Depending upon where the Covered Health Service is provided, Benefits for genetic testing services will be the same as those stated under each Covered Health Service category in this section.</p>		
<p>12. Home Health Care</p> <p>Authorization Requirements</p> <p>Authorization is required before receiving home health care services. If you or your provider does not obtain authorization from us, Non-Network Benefits will be reduced to 50% of Eligible Expenses and you will be responsible for all non-covered charges.</p> <p>Description</p> <p>The Benefit plan covers services received from a Home Health Agency that are all of the following:</p>	<p><i>Network</i></p> <p>Yes</p> <p><i>Non-Network</i></p> <p>Yes</p>	<p>0%</p> <p>20%</p>	<p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Yes</p>

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<ul style="list-style-type: none"> • Medically Necessary as determined by PHP medical policy and nationally recognized guidelines; and • Ordered by a Physician; and • Provided by or supervised by a registered nurse in your home. <p>Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.</p> <p>Skilled care is defined as skilled nursing, skilled teaching, skilled rehabilitation, and home infusion services when all of the following are true:</p> <ul style="list-style-type: none"> • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and • It is ordered by a Physician; and • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and • It requires clinical training in order to be delivered safely and effectively; and • It is not Custodial Care. 				

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<p>Our determination of available Benefits is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.</p> <p>Benefits for outpatient rehabilitation services provided in your home are described under <i>Rehabilitation Services – Outpatient Therapy</i> in this Section 1: What's Covered – Benefits.</p> <p>Any combination of Network and Non-Network Benefits for home health care services is limited to 60 visits per calendar year.</p>				
<p>13. Hospice Care</p> <p>Authorization Requirements</p> <p>Authorization is required before receiving hospice services. If you or your provider does not obtain authorization from us, Non-Network Benefits will be reduced to 50% of Eligible Expenses and you are responsible for all non-covered charges.</p> <p>Description</p> <p>Hospice care must be ordered by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.</p>	<p><i>Network</i></p> <p>Yes</p> <p><i>Non-Network</i></p> <p>Yes</p>	<p>0%</p> <p>20%</p>	<p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Yes</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>15. Infertility Services</p> <p>The Benefit plan covers services for the diagnosis and treatment of infertility when provided by or under the direction of a Network Physician. Covered Health Services include Medically Necessary treatment and procedures that treat the medical condition that results in infertility (e.g., endometriosis, blockage of fallopian tubes, varicocele, etc.). Covered Health Services include artificial insemination.</p> <p>Not all services connected with the treatment of infertility are Covered Health Services. Refer to exclusion <i>L. Reproduction</i> in Section 2: What's Not Covered--Limitations and Exclusions.</p> <p>Benefits for infertility services are limited to \$10,000 per Covered Person per calendar year.</p>	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p> <p>Non-Network Benefits are not available.</p>	<p>0%</p> <p>Non-Network Benefits are not available.</p>	<p>No</p> <p>Non-Network Benefits are not available.</p>	<p>Not applicable</p> <p>Non-Network Benefits are not available.</p>
<p>16. Injections/Infusions Received in a Physician's Office</p> <p>Authorization Requirements</p> <p>Authorization is required for Specialty Pharmaceuticals. If you or your provider does not obtain authorization from us, no Non-Network Benefits will be paid and you will be responsible for all charges.</p> <p>NOTE: The list of approved Specialty Pharmaceuticals is subject to change; please contact us for current information.</p> <p>Description</p>	<p><i>Network</i></p> <p>Yes, as noted.</p> <p><i>Non-Network</i></p> <p>Yes, as noted.</p>	<p>0%</p> <p>0%</p> <p>NOTE: Non-Network Benefits for Preventive</p>	<p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Yes</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
		Covered Health Service category in this section. NOTE: Non-Network Benefits for Preventive Health Services are not available.		
<p>18. Maternity Services</p> <p>Authorization Requirements</p> <p>Authorization is required as soon as reasonably possible if the Non-Network Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you or your provider does not obtain authorization from us that the Inpatient Stay will be extended, your Non-Network Benefits for the extended stay will be reduced to 50% of Eligible Expenses and you will be responsible for all non-covered charges.</p> <p>Description</p> <p>The Benefit plan covers Pregnancy at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.</p> <p>We will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. 	<p>Network</p> <p>Yes, if Inpatient Stay exceeds time frames</p> <p>Non-Network</p> <p>Yes, if Inpatient Stay exceeds time frames</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for maternity services will be the same as those stated under each Covered Health Service category in this section.</p> <p>NOTE: No Copayment/Coinsurance applies to Physician office visits for prenatal care after the first visit, or to post-natal care.</p> <p>Depending upon where the Covered Health Service is provided, Benefits for maternity services will be the same as those stated under each Covered Health Service category in this section.</p>		

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>must be provided under the direction of a Physician. Conditions for which nutritional counseling is a Covered Health Service include, but are not limited to:</p> <ul style="list-style-type: none"> • Educational purposes for preventive Health Services. • Weight management. • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. <p>Benefits are available when nutritional counseling is provided during an individual session. Benefits are limited to three sessions of nutritional counseling per calendar year.</p>	<p><i>Non-Network</i></p> <p>Non-Network Benefits are not available.</p>	<p>Non-Network Benefits are not available.</p>	<p>Non-Network Benefits are not available.</p>	<p>Non-Network Benefits are not available.</p>
<p>21. Ostomy Supplies The Benefit plan covers ostomy supplies required as a result of a</p>	<p><i>Network</i></p>			

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>colostomy, ileostomy or urostomy, including only the following:</p> <ul style="list-style-type: none"> • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. <p>Benefits are not available for gauze, filters, lubricants, tape, appliance cleaners, adhesive, adhesive removers, deodorant, pouch covers, or other items not listed above.</p>	<p>No</p> <p><i>Non-Network</i></p> <p>No</p>	<p>0%</p> <p>20%</p>	<p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Yes</p>
<p>22. Outpatient Surgery, Diagnostic and Therapeutic Services</p> <p><i>Outpatient Surgery</i></p> <p>The Benefit plan provides Benefits for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Benefits under this category include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon's fees related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i> below.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p> <p>No</p>	<p>0%</p> <p>20%</p>	<p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Yes</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay <small>Coinsurance % is based on a percent of Eligible Expenses</small>	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p><i>Outpatient Diagnostic Services</i></p> <p>The Benefit plan provides Benefits for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p> <ul style="list-style-type: none"> • Lab and radiology/X-ray. • Diagnostic mammography testing. <p>Benefits under this category include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p> <p>This category does not include Benefits for CT scans, PET scans, MRIs, MRAs or nuclear medicine, which are described immediately below.</p> <p>NOTE: Non-Network Benefits for Preventive Health Services are not available.</p> <p><i>Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRIs, MRAs and Nuclear Medicine</i></p> <p>The Benefit plan provides Benefits for Medically Necessary Covered Health Services for CT scans, PET scans, MRIs, MRAs and nuclear medicine received on an outpatient basis in a Physician's office or at a Hospital or Alternate Facility.</p>	<p><i>Network</i></p> <p>No</p>	<p>0%</p>	<p>No</p>	<p>Not applicable</p>
	<p><i>Non-Network</i></p> <p>No</p>	<p>20%</p>	<p>Yes</p>	<p>Yes</p>
	<p><i>Network</i></p> <p>No</p>	<p>0%</p>	<p>No</p>	<p>Not applicable</p>
	<p><i>Non-Network</i></p>			

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.</p> <p>NOTE: Non-Network Benefits for Preventive Health Services are not available.</p> <p><i>Outpatient Therapeutic Treatments</i></p> <p>Authorization Requirements</p> <p>Authorization is required for Specialty Pharmaceuticals. If you or your provider does not obtain authorization from us, no Non-Network Benefits will be paid and you will be responsible for all charges.</p> <p>NOTE: The list of approved Specialty Pharmaceuticals is subject to change; please contact us for current information.</p> <p>Description</p> <p>The Benefit plan covers approved Specialty Pharmaceuticals. Specialty Pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. We determine which specific drugs are Covered Health Services and this list is subject to change. The list may include vaccines and chemotherapy drugs used in the treatment of cancer but excludes injectable insulin, which does not require authorization. Please contact us for current information.</p> <p>The Benefit plan provides Benefits for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or</p>	<p>No</p> <p><i>Network</i> Yes, as noted.</p> <p><i>Non-Network</i> Yes, as noted.</p>	<p>20%</p> <p>0%</p> <p>20%</p>	<p>Yes</p> <p>No</p> <p>Yes</p>	<p>Yes</p> <p>Not applicable</p> <p>Yes</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and radiation therapy</p> <p>Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>				
<p>23. Pain Management</p> <p>The Benefit plan covers the evaluation and treatment of chronic pain, when provided by or under the direction of your Physician. Chronic pain is unremitting and has been present for a long period of time without relief.</p>	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p> <p>Non-Network Benefits are not available.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for pain management services will be the same as those stated under each Covered Health Service category in this section.</p> <p>Non-Network Benefits are not available.</p>		
<p>24. Physician's Office Services</p> <p><i>Injury or Illness</i></p> <p>The Benefit plan provides Benefits for Covered Health Services received in a Physician's office regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.</p> <p>Covered Health Services for the diagnosis and treatment of a Sickness</p>	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p>	<p>\$10 per visit</p>	<p>No</p>	<p>Not applicable</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>or Injury, include but are not limited to:</p> <ul style="list-style-type: none"> • Radiology. • Pathology. • Diagnostic testing and services. • Medical education services by appropriately licensed or registered healthcare professionals when both of the following are true: <ul style="list-style-type: none"> — Education is required for a disease in which patient self-management is an important component of treatment; and — There exists a knowledge deficit regarding the disease, which requires the intervention of a trained health professional. <p>NOTE: The Copayment is waived for certain services in the Physician’s office such as routine prenatal health services, or for adult and pediatric immunizations, or for photo-chemotherapy for treatment for an approved diagnosis. Please call Customer Service if you have questions on which services are subject to the Copayment.</p> <p>Network Benefits are also available for Covered Health Services received at a Non-Network Physician’s office outside the Service Area to treat emergent or urgent conditions that require immediate medical attention to limit severity and prevent complications. Network Benefits for follow-up care are available only when provided by a Network provider.</p>	No	20%	Yes	Yes

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p><i>Preventive Health Services</i> The Benefit plan provides Benefits for Covered Health Services for preventive medical care when provided by a Network Physician, including:</p> <ul style="list-style-type: none"> • Routine preventive pathology and radiology services. • Voluntary family planning. • Well-baby and well-child care. • Routine physical examinations. • Vision and hearing screenings. • Immunizations. <p>NOTE: Non-Network Benefits for Preventive Health Services are not available.</p>				
<p>25. Professional Fees for Surgical and Medical Services The Benefit plan covers professional fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are</p>	<p><i>Network</i> No</p> <p><i>Non-Network</i> No</p>	<p>0%</p> <p>20%</p>	<p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Yes</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
described under <i>Physician's Office Services</i> above.				
<p>26. Prosthetic Devices</p> <p>Authorization Requirements</p> <p>Authorization is required before you purchase a prosthetic device that costs more than \$1,000. For Non-Network Benefits, if you or your provider does not obtain authorization from us, you will be responsible for paying all charges and no Benefits will be paid.</p> <p>Description</p> <p>The Benefit plan covers external prosthetic devices that replace a limb or body part including:</p> <ul style="list-style-type: none"> • Artificial limbs. • Artificial face, eyes, ears and noses. • Speech aid prosthetics and tracheo-esophageal voice prosthetics. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. This includes mastectomy bras (up to four per calendar year) and lymphedema stockings for the arm. <p>Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.</p> <p>If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the</p>	<p>Network</p> <p>Yes, for prosthetic devices that exceed \$1,000 in cost.</p> <p>Non-Network</p> <p>Yes, for prosthetic devices that exceed \$1,000 in cost.</p>	<p>0%</p> <p>20%</p>	<p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Yes</p>

<p align="center">Description of Covered Health Service</p>	<p align="center">Is Authorization Required?</p>	<p align="center">Amount You Pay <small>Coinsurance % is based on a percent of Eligible Expenses</small></p>	<p align="center">Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?</p>	<p align="center">Do You Need to Meet Annual Deductible?</p>
<p>The Benefit plan covers Medically Necessary services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures, which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.</p> <p>Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.</p> <p>Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us for more information about Benefits for mastectomy-related services.</p>				<p align="center">provided, Benefits for reconstructive procedures will be the same as those stated under each Covered Health Service category in this section.</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay <small>Coinsurance % is based on a percent of Eligible Expenses</small>	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>28. Rehabilitation Services – Outpatient Therapy</p> <p>Authorization Requirements You or your provider must obtain authorization before you receive outpatient rehabilitation services for speech therapy. If authorization is not obtained, no Non-Network Benefits will be paid and you will be responsible for all charges.</p> <p>Description The Benefit plan covers short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> • Physical therapy. • Occupational therapy. • Speech therapy, including post-cochlear implant aural therapy (subject to specific restrictions and exclusions). • Pulmonary rehabilitation therapy. • Phase I and II cardiac rehabilitation therapy. <p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Rehabilitation services must be performed at a Hospital, Skilled Nursing Facility, Alternate Facility, or through a Home Health Agency.</p>	<p><i>Network</i> Yes, for speech therapy.</p> <p><i>Non-Network</i> Yes, for speech therapy.</p>	<p>\$10 per visit</p> <p>20%</p>	<p>No</p> <p>Yes</p>	<p>Not applicable</p> <p>Yes</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Benefits are not available for inpatient or outpatient Recreational Therapy.</p> <p>Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.</p> <p>Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.</p> <p>Any combination of Network and Non-Network Benefits for any combination of physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation therapy is limited to 60 visits per calendar year.</p> <p>Any combination of Network and Non-Network Benefits for Phase I and II cardiac rehabilitation therapy is limited to 36 visits per calendar year.</p>				
<p>29. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p> <p>Authorization Requirements</p> <p>Authorization is required as follows:</p>	<p><i>Network</i></p> <p>Yes</p>	<p>0%</p>	<p>No</p>	<p>Not applicable</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> For elective admissions: five business days before admission. For non-elective admissions: within one business day or the same day of admission. For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible. <p>If you or your provider does not obtain authorization from us, Non-Network Benefits will be reduced to 50% of Eligible Expenses and you will be responsible for all non-covered charges.</p> <p style="text-align: center;">Description</p> <p>The Benefit plan covers Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility, including Benefits for:</p> <ul style="list-style-type: none"> Supplies and non-Physician services received during the Inpatient Stay. Room and board in a Semi-private Room (a room with two or more beds). <p>Please note that Benefits are available only if both of the following are true:</p> <ul style="list-style-type: none"> If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Hospital Stay; and 	<p style="text-align: center;"><i>Non-Network</i></p> <p style="text-align: center;">Yes</p>	<p style="text-align: center;">20%</p>	<p style="text-align: center;">Yes</p>	<p style="text-align: center;">Yes</p>

<p align="center">Description of Covered Health Service</p>	<p align="center">Is Authorization Required?</p>	<p align="center">Amount You Pay <small>Coinsurance % is based on a percent of Eligible Expenses</small></p>	<p align="center">Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?</p>	<p align="center">Do You Need to Meet Annual Deductible?</p>
<ul style="list-style-type: none"> • You will receive skilled care services that are not primarily Custodial Care. <p>Benefits are available only when skilled care is required. Skilled care is defined as skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:</p> <ul style="list-style-type: none"> • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and • It is ordered by a Physician; and • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and • It requires clinical training in order to be delivered safely and effectively; and • It is not Custodial Care. <p>Our determination of available Benefits is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. These criteria to determine skilled care may differ from criteria used by other payors.</p>				

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>counseling program, the current list of Preferred Tobacco Cessation Products and applicable Copayments and Coinsurance.</p> <p>NOTE: Tobacco Cessation Products are not covered when outpatient prescription drug coverage is not purchased by the Enrolling Group as a rider to the Policy.</p>				
<p>31. Transplantation Services</p> <p>Authorization Requirements</p> <p>You or your Physician must obtain authorization from us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain authorization and if the transplantation services are not performed at a Designated Facility, you will be responsible for paying all charges and no Benefits will be paid.</p> <p>Description</p> <p>Transplantation programs typically include three phases: pre-transplant services, the transplant period and post-transplant services. Under PHP's transplantation services benefit, each phase must be reviewed separately for authorization. Transplant services not covered under the transplant contract and/or not provided at the Designated Facility will be covered under other sections of this Plan.</p> <p>The Benefit plan covers Medically Necessary Covered Health Services for the following organ and tissue transplants when ordered by a Network Physician and received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the</p>	<p><i>Network</i></p> <p>Yes</p> <p><i>Non-Network</i></p> <p>Non-Network Benefits are not available.</p>	<p>0%</p> <p>Non-Network Benefits are not available.</p>	<p>No</p> <p>Non-Network Benefits are not available.</p>	<p>Not applicable</p> <p>Non-Network Benefits are not available.</p>

<p align="center">Description of Covered Health Service</p>	<p align="center">Is Authorization Required?</p>	<p align="center">Amount You Pay <small>Coinsurance % is based on a percent of Eligible Expenses</small></p>	<p align="center">Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?</p>	<p align="center">Do You Need to Meet Annual Deductible?</p>
<p>definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:</p> <ul style="list-style-type: none"> • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants. <p>Benefits are provided for antineoplastic drugs as described under Antineoplastic Therapy earlier in this Section 1: What's Covered – Benefits.</p>				

Description of Covered Health Service	Is Authorization Required?	Amount You Pay Coinsurance % is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Donor expenses for a donor who is not a Covered Person under this Plan are covered if not covered by the donor's plan. If both the donor and the recipient are covered under this Plan, all Covered Health Services will covered under the recipient.</p> <p>Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility.</p> <p>Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.</p> <p>We have specific guidelines regarding Benefits for transplant services. Contact us for information about these guidelines.</p>				
<p>31. Urgent Care Center Services</p> <p>The Benefit plan provides Benefits for Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under <i>Physician's Office Services</i> earlier in this section.</p> <p>Network Benefits are also available for Covered Health Services received at a Non-Network Urgent Care Center. Benefits for follow-up care are available only when provided by a Network provider.</p>	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p> <p>No</p>	<p>\$10 per visit</p> <p>Same as Network Benefit</p>	<p>No</p> <p>Same as Network Benefit</p>	<p>Not applicable</p> <p>Same as Network Benefit</p>

Riders to the Policy

Description of Covered Health Service	Is Authorization Required?	Amount You Pay <small>Coinsurance % is based on a percent of Eligible Expenses</small>	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>1. Hearing Aids/Hearing Aid Services Rider</p> <p>The Benefit plan covers hearing aids and hearing aid services provided by or under the direction of your attending Physician and obtained from a Network vendor or provider. Hearing aids must be required for the correction of a hearing impairment (a reduction in the ability to perceive sound, which may range from slight to complete deafness). Benefits are provided only as described below and are available only after 36 months have elapsed since you obtained Benefits for any previous hearing aid or hearing aid service under the Policy.</p> <ul style="list-style-type: none"> • Benefits include audiometric examinations and hearing aid evaluations to determine actual hearing acuity and the specific type or brand of hearing aid needed. • Benefits also include the purchase and fitting of either a monaural or a binaural hearing aid(s), which must be either of the in-the-ear, behind-the-ear, or on-the-body type. This includes one hearing aid check following the fitting. • Benefits are provided for CROS, BICROS, Canal and eyeglass type hearing aids and other special hearing aids, not to exceed the Benefits we would have provided for a unilateral hearing aid, as 	<p><i>Network</i></p> <p>No</p> <p><i>Non-Network</i></p> <p>Non-Network Benefits are not available.</p>	<p>0%</p> <p>Non-Network Benefits are not available.</p>	<p>No</p> <p>Non-Network Benefits are not available.</p>	<p>Not applicable</p> <p>Non-Network Benefits are not available.</p>

Description of Covered Health Service	Is Authorization Required?	Amount You Pay <small>Coinsurance % is based on a percent of Eligible Expenses</small>	Does Amount You Pay Help Meet Annual Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>described above.</p> <p>Benefits for hearing aids and hearing aid services are limited as follows:</p> <ul style="list-style-type: none"> • \$880 for a monaural hearing aid • \$1,600 for binaural hearing aids <p>This limit applies to the total amount we will pay for hearing aids and hearing aid services and does not include any Coinsurance or Annual Deductible responsibility you may have.</p> <p>What's Not Covered--Exclusions</p> <p>The following exclusions apply:</p> <ol style="list-style-type: none"> 1. Hearing aids except as specified above. 2. Hearing aid batteries. 3. Hearing aid accessories (such as ear molds.) 4. Replacement of hearing aids that are lost or broken. 5. Other hearing aid replacement parts and repairs. <p>100180</p>				

Section 2: What's Not Covered— Limitations and Exclusions

This section contains information about:

- How headings are used in this section.
- Benefit limitations.
- Medical and behavioral health services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Policy.

How We Use Headings in this Section

To help you find specific Exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual Exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an Exclusion or a limitation. Specific Exclusions listed under one heading may be excluded under another heading even if not specifically listed. All Exclusions and limitations in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 1: What's Covered-Benefits or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in Section 1: What's Covered--Benefits, those limits are stated in the corresponding Covered Health Service category. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Testing and Treatment

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Herbal or vitamin therapies
7. Hair testing and analysis.
8. Saliva testing and analysis.
9. Environmental testing and analysis.

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10. Body fat testing and analysis, unless qualifies under our Morbid Obesity benefit.
11. Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM), a component of the National Institutes of Health.

B. Behavioral Health

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Behavioral Health Services as treatment for neurological disorders and other disorders with a known physical basis when such conditions are solely medical in nature.
3. Treatment for conduct and impulse control disorders, personality disorders, and paraphilias.
4. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Behavioral Health Designee.
6. Residential Treatment Programs for mental health conditions.
7. Services provided outside of an inpatient, intermediate or outpatient setting.
8. Behavioral Health Services for the following:
 - Nicotine-related disorders.
 - Sexual and gender identity and functional disorders.

- Personality disorders.
 - Sleep disorders.
 - Delirium, dementia, and amnesic and other cognitive disorders.
 - Therapy for pervasive developmental disorders.
 - Mental retardation.
 - Learning, motor skills, and communication disorders.
 - Psychotherapy for feeding, tic, and elimination disorders.
 - Marital counseling.
 - Transitional living centers, wrap-around care services, halfway or three-quarter-way houses, non-licensed programs, therapeutic boarding schools or milieu therapies.
 - Sex therapy.
 - Psychotherapy for Attention Deficit Disorder and disruptive behavior disorders.
 - Mental disorders due to a general medical condition.
9. Benefits for services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Behavioral Health Designee, are any of the following:
 - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.

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- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Behavioral Health Designee's level of care guidelines or best practices as modified from time to time.

NOTE: The Behavioral Health Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

C. Chiropractic Services

Care that exceeds the visit limit specified in Section 1: What's Covered – Benefits.

D. Dental and Related Oral/Mouth Conditions

1. Dental care and all associated expenses except as specifically described in Section 1: What's Covered--Benefits under the heading *Dental Services*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - Extraction, restoration and replacement of teeth (including extraction of impacted wisdom teeth).

- Medical or surgical treatments of dental conditions except as described in Section 1: What's Covered -- Benefits under the heading *Dental Services*.

- Services to improve dental clinical outcomes.

3. Tooth implants and related services, bone grafts and other implant-related procedures and related services, even when required as a result of an Injury.
4. Orthodontic services, including braces.
5. Dental X-rays, all hospitalization charges, facility charges, and anesthesia charges related to dental care. The only exceptions to this are for any of the following:
 - Transplant preparation.
 - Initiation of immunosuppressives.
 - The direct treatment of acute traumatic Injury, cancer or cleft palate.
 - Dental-related anesthesia and associated Hospital facility charges provided as described under *Dental Anesthesia* in Section 1: What's Covered – Benefits.
6. Supplies and appliances and all associated expenses (including occlusal splints, dental prosthetics and dental orthotics). Mouth rehabilitation. Bridges. Partial plates. Dentures.
7. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are provided as part of a treatment for documented dental conditions.

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E. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill except when an outpatient prescription drug plan Rider has been purchased by the Enrolling Group.
2. Self-injectable medications. (This exclusion does not apply to medications, which, due to their characteristics, as determined by us, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.)
3. Non-injectable medications given in a Physician's office except as required in an emergent or urgent situation and if consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Compounded Medications.

F. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational, or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to antineoplastic drugs for which Benefits are available as described in *Antineoplastic Therapy* in Section 1: What's Covered - Benefits. These terms are defined in Section 10: Glossary of Defined Terms.

G. Medical Supplies, Appliances and Equipment

1. Devices used specifically as safety items and/or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Ace bandages.
 - Disposable dressings used for wound care.
 - Syringes, except as Benefits are provided in *Diabetes Services* in Section 1: What's Covered - Benefits.
3. Cranial helmets.
4. Shoes.

NOTE: These exclusions for medical supplies, appliances and equipment do not apply to orthotics or to elastic, surgical and compression stockings, for which Benefits are provided as described in *Durable Medical Equipment* in Section 1: What's Covered – Benefits.

H. Nutrition

1. Megavitamin and nutrition based therapy.
2. Enteral feedings, food replacements, nutritional and electrolyte supplements, infant formula and donor breast milk; even if any are the sole source of nutrition or as part of treatment.

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I. Personal Services, Comfort or Convenience

1. Custodial care, domiciliary care or basic care, including room and board, provided in a residential, institutional or other setting that is, for the purpose of meeting your personal needs, and that could be provided by persons without professional skills or training.
2. Personal comfort and convenience items, including but not limited to, telephone and television services during an Inpatient Stay, and home or vehicle modifications or appliances.
3. Lodging and/or meals necessary while receiving services either within or outside of PHP's Service Area.
4. Services of personal care attendants.
5. Beauty/barber services.
6. Guest services.
7. Supplies, equipment and similar incidental services and supplies for personal comfort, or for the convenience of either the Covered Person or his or her Physician.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in Section 10: Glossary of Defined Terms. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

- Skin abrasion procedures and other dermatological treatment that is cosmetic in nature.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal by any means.
 - Plastic surgery.
2. Removal or replacement of an existing breast implant if it was initially performed as a Cosmetic Procedure, unless due to Medically Necessary complications.

NOTE: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 1: What's Covered - Benefits.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
5. Any hair replacement product or process, including wigs, regardless of the reason for the hair loss.

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K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a freestanding or Hospital-based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

NOTE: This exclusion does not apply to mammography screening.

4. Foreign language and sign language interpreters.
5. Telephone consultations.

L. Reproduction

1. Health services and associated expenses for in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures or any other treatment or procedure designed to create a Pregnancy, and any related prescription medication treatment. Embryo transport. Donor ovum and semen and related costs including collection and preparation. This exclusion does not apply to artificial insemination, for which

Benefits are provided in *Infertility Services* in Section 1: What's Covered – Benefits.

2. The reversal of surgical sterilization.
3. Cryo-preservation and other forms of preservation of reproductive materials.
4. Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation or similar legislation. This applies whether or not you choose to file a claim. This exclusion does not apply to no-fault automobile insurance.
2. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
3. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in Section 1: What's Covered--Benefits.

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2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Policy).
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. (This Exclusion does not apply to cornea transplants.)
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in Section 1: What's Covered--Benefits.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel, lodging, room and board or transportation expenses, even though prescribed by a Physician or necessitated due to where treatment is received.

P. Vision and Hearing

1. Purchase and fitting of eyeglasses, refractive contact lenses, or hearing aids.
2. Eye exercise therapy.
3. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 10: Glossary of Defined Terms.
2. Non-Network Benefits for Preventive Health Services.
3. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
 - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research.
 - Conducted solely to determine eligibility for a current or future clinical trial.
 - Required to obtain or maintain a license of any type.
4. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
5. Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising before the date your coverage under the Policy ends.
6. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
7. In the event that a provider waives Copayments, Coinsurance amounts and/or the Annual Deductible for a particular health

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- service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or Annual Deductible are waived.
8. Services and supplies, which are provided while member is in the custody of any law enforcement authorities or while incarcerated.
 9. Charges in excess of Eligible Expenses or in excess of any specified limitation.
 10. Surgical treatment of morbid obesity that is not provided at a Designated Facility.
 11. Weight loss programs whether or not they are under medical supervision, unless the Covered Person qualifies under our current "Morbid Obesity Policy."
 12. Ambulance services that are provided by an Emergency responder that does not provide transportation.
 13. Services and supplies for home births.
 14. Freestanding birthing centers.
 15. Sex transformation operations.
 16. Private duty nursing.
 17. Respite care.
 18. Rest cures.
 19. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
 20. Autopsy.
 21. Long term (more than 30 days) storage. Examples include cryo-preservation of tissue, blood and blood products.
 22. Psychosurgery.
 23. Medical and surgical treatment of excessive sweating (hyperhidrosis).
 24. Medical and surgical treatment for snoring or daytime sleepiness, except when provided as a part of treatment for documented obstructive sleep apnea.
 25. Oral appliances for snoring.
 26. Speech therapy (except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly) for:
 - ADD/ADHD.
 - Learning disabilities.
 - Autism.
 - Developmental delays.
 - Hearing loss associated with chronic ear infections.
 27. Audio therapy.
 28. All devices and computers to assist in communication and speech, for example special TV used for closed caption and reading machines, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
 29. Gym memberships. Aquatic exercise programs or classes. Personal trainers. Exercise equipment, including pools even if prescribed by a Physician.
 30. Inpatient or outpatient Recreational Therapy.

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31. Penile implants for the treatment of impotence having a psychological origin.
32. Covered Health Services for which Benefits would otherwise be available under the Policy that are related to a specific condition, when a Covered Person has refused to comply with or has terminated the scheduled service or treatment against the advice of a Physician or the Behavioral Health Designee.
33. Legal/court fees, copy/fax fees, late fees, shipping charges, long distance telephone charges, and fees for copying X-rays.
34. Charges for missed appointments.
35. Power operated wheelchairs if you:
 - Can walk, or
 - Can use a manual wheelchair, or
 - Only need it for leisure activities, or
 - Would not need it for use in your home.
36. Benefits are not payable for any of the following:
 - All bath aids, for example, shower chairs and safety rails
 - Toilet seat riser
 - Grabbers
 - Stair lifts
 - Ramps
 - Diapers
- Home modifications
- Wheelchair lifts
- Lift chairs
- Commodes
- Standing systems, stationary and mobile
- Automobile modifications and adaptive devices, for example, hand grips, hand controls and special foot pedals
- Mobility carts and power-operated vehicles, for example, scooters, motorized carts, and electric scooters
- Car seats and/or safety seats
- Strollers
- Shoe lifts
- Polar packs
- Temper-pedic and all other mattresses or mattress overlays
- Air conditioners. Air purifiers and filters or air cleaning devices. Dehumidifiers and humidifiers
- Batteries and battery chargers
- Hot tubs and whirlpools. Tanning beds, lamps and services. Light bulbs and short and long wave UV light units to be used in the home
37. Services for the treatment of an overbite or underbite. Maxillary and mandibular osteotomies, unless Medically Necessary.

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38. Mouth orthotics, mouth splints, mouth prosthetics and mouth appliances.
39. Medical and surgical services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), unless Medically Necessary.
40. Biofeedback training.

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Section 3: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Emergency Health Services.

Network Benefits

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services, which are:

- Provided by or under the direction of a Network Physician in a Network Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services.
- Covered Health Services received in a Non-Network Physician's office outside the Service Area to treat emergent conditions that require immediate attention.

Please note that Behavioral Health Services must be authorized by the Behavioral Health Designee. Please see Section 1: What's Covered--Benefits under the heading for *Behavioral Health Services*.

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See Section 1: What's Covered--Benefits.	A lower level of Benefits means more cost to you. See Section 1: What's Covered--Benefits.
Who Should Request Authorization From Us	Network providers generally handle the authorization process for you. However, there are exceptions. See Section 1: What's Covered--Benefits, under the <i>Is Authorization Required?</i> column.	You must obtain authorization from us for certain Covered Health Services. Failure to obtain authorization results in reduced Benefits or no Benefits. See Section 1: What's Covered--Benefits, under the <i>Is Authorization Required?</i> column.
Who Should File Claims	The Network provider will file the claim. We pay Network providers directly.	You or the provider must file claims. See Section 5: How to File a Claim.
Outpatient Emergency Health or Urgent Care Services	Emergency Health and Urgent Care Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek emergent or urgent care at a Non-Network facility, you are not required to meet the Annual Deductible, if applicable, or to pay any difference between Eligible Expenses and the amount the provider bills.	

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Selecting a Primary Care Physician

If you wish to receive Network Benefits, you must select a Primary Care Physician from our list of participating providers who are available to accept you or your family member to coordinate your health care services. This helps ensure continuity of care and provides you and your Dependents with a medical home.

If you are the custodial parent of an Enrolled Dependent child, you must select a Primary Care Physician for that child. Your child's PCP may be a Network pediatrician.

You may change your or your family member's Primary Care Physician by visiting our web site, www.phpmm.org, or by contacting Customer Service.

Limitation on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician and/or Network facility to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician and/or Network facility for you. If you fail to use the selected Network Physician and/or Network facility, Network Benefits will not be paid.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees.

A directory of Network providers will be made available to you. It is your responsibility to select your Network provider. Before obtaining

services, you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Customer Service or by accessing our web site at www.phpmm.org.

The Network of providers is subject to change. You might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

Additional important information about our relationship with the provider Network is contained in Section 9: General Legal Provisions.

Medical Resource Management

Your Primary Care Physician and other Network providers are required to obtain prior authorization from the Medical Resource Management Department for certain proposed or scheduled health services. When your Primary Care Physician or other Network provider contacts us to request authorization, we will work together to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy. Covered Health Services, which require authorization are shown in Section 1: What's Covered--Benefits.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or other provider chosen by us. If you require certain Medically Necessary Covered Health Services not available from a Network provider or at a Network facility, we may direct you to a Non-Network facility or provider.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by us.

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You or your Primary Care Physician or other Network Physician must request authorization from us for special service needs (including, but not limited to, transplant, cancer treatment or weight management services) that might warrant referral to a Designated Facility or Non-Network facility or provider. If you do not request authorization from us in advance, and if you receive services from a Non-Network facility (regardless of whether it is a Designated Facility) or other Non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If we determine that specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from Non-Network providers. In this situation, your Network Physician will request authorization from us, and we will work with you and your Network Physician to coordinate care through a Non-Network provider. You are responsible for verifying that we have authorized the request. If you see a Non-Network provider without verifying in advance that we have authorized your services, Network Benefits will not be paid. Non-Network Benefits may be available if the services you receive are Covered Health Services for which Benefits are provided under the Policy.

Non-Network Benefits

Non-Network Benefits have higher out-of-pocket costs to you than Network Benefits. Certain services are not covered when received from Non-Network providers. Refer to Section 1: What's Covered--Benefits. Covered Health Services will apply to your Non-Network Benefit if they are:

- Provided by a Non-Network Physician or other Non-Network provider.
- Provided at a Non-Network facility.

Authorization Requirements

You must contact Medical Resource Management for authorization before receiving certain Covered Health Services from Non-Network providers. The details are shown in the *Is Authorization Required?* column in Section 1: What's Covered--Benefits. If you fail to obtain authorization from us, Benefits are reduced or denied.

Prior authorization is not a guarantee of Benefits. Coverage depends on the services that are actually received, your eligibility status, and any benefit limitations.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Health Services, even if the services are provided by a Non-Network provider.

- If you are confined in a Non-Network Hospital after you receive Emergency Health Services, we must be notified within one business day or on the same day of admission. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Non-Network Hospital after the date it is decided that a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If you are formally admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an

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Emergency Health Service, you will not have to pay the Emergency Department Health Services Copayment. The Copayment/Coinsurance for an Inpatient Stay in a Network Hospital will apply instead, if applicable.

NOTE: Please note that the Copayment for Emergency Department Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition regardless of the length of the outpatient observation stay, rather than being formally admitted as an inpatient in the Hospital. In this case, the Emergency Department Health Services Copayment will apply instead of the Copayment/Coinsurance for an Inpatient Stay.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the properly completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

If You Are Eligible for Medicare

Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B. Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare. You may be responsible for the difference.

Your Benefits under the Policy may also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in Section 9: General Legal Provisions for more information about how Medicare may affect your Benefits.

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Who is Eligible for Coverage

We will not discriminate (e.g., rate, refuse to enroll, cancel coverage, refuse to provide coverage, or cancel or refuse to renew coverage) against an Eligible Person or Dependent solely because he or she is or has been a victim of domestic violence.

Eligible Persons and Dependents are not required to undergo genetic testing, nor to disclose to us whether genetic testing has been conducted or to disclose the result of genetic testing or genetic information.

Who	Description	Who Determines Eligibility
Eligible Person	<p>Eligible Person usually refers to an employee of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see Section 10: Glossary of Defined Terms.</p> <p>Subscribers must reside or work within the Service Area, which is a specific geographic area that we serve, unless we and the Enrolling Group have made arrangements for Subscribers residing outside of the Service Area to be covered.</p> <p>If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.</p> <p>Except as we have described in Section 4: When Coverage Begins, Eligible Persons may not enroll without our written permission.</p>	We and the Enrolling Group determine who is eligible to enroll under the Policy.
Dependent	<p>Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 10: Glossary of Defined Terms.</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.</p> <p>To receive Network Benefits, Dependents living, working or attending school outside of the Service Area must receive non-emergent/non-urgent services from Network providers.</p> <p>If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.</p>	We and the Enrolling Group determine who qualifies as a Dependent.

Who

Description

Who Determines Eligibility

Except as we have described in Section 4: When Coverage Begins, Dependents may not enroll without our written permission.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
<p>Initial Enrollment Period</p> <p>When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the date identified in the Policy if we receive the completed enrollment form from the Enrolling Group and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p>Open Enrollment Period</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>We and the Enrolling Group determine the Open Enrollment Period. Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form from the Enrolling Group and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p>New Eligible Persons</p>	<p>New Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the date agreed to by the Enrolling Group and us if we receive the completed enrollment form from the Enrolling Group and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.</p>
<p>Adding New Dependents</p>	<p>Subscribers may enroll Dependents who join their family because of any of the following events:</p> <ul style="list-style-type: none"> • Birth. • Legal adoption. • Placement for adoption. 	<p>Coverage begins on the date of the event if we receive the completed enrollment form from the Enrolling Group and any required Premium within 31 days of the event that makes the new Dependent eligible.</p>

When to Enroll**Who Can Enroll****Begin Date**

- Marriage.
- Legal guardianship.
- Court or administrative order.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

Life Event

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal Adoption.
- Placement for adoption.
- Marriage.

Other Events

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if one of the following is true:

- The Eligible Person and/or Dependent loses eligibility under a Medicaid plan or state children’s health insurance program (CHIP); or
- The Eligible Person and/or Dependent gains eligibility for a premium assistance subsidy under Medicaid or a CHIP (subsidy to be used toward payment of premiums for a group health plan); or

Event Takes Place

Coverage begins on the date of the event if we receive the completed enrollment form from the Enrolling Group and any required Premium within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period

In the case of loss of eligibility under a Medicaid plan or state CHIP or gaining eligibility for a premium assistance subsidy under Medicaid or a CHIP, coverage begins on the day immediately following the day coverage under Medicaid ends or you become eligible for premium assistance if we receive the completed enrollment form from the Enrolling Group and any required Premium within 60 days of the event.

In the case of loss of coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends if we receive the completed enrollment form from the

When to Enroll**Who Can Enroll****Begin Date**

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| <ul style="list-style-type: none">● The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:<ul style="list-style-type: none">— Loss of eligibility (including, but not limited to, legal separation, divorce or death).— The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.— In the case of COBRA continuation coverage, the coverage ended. | Enrolling Group and any required Premium within 31 days of the event. |
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Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a Non-Network provider, you may be responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

Network Providers are responsible for submitting a request for payment of Eligible Expense directly to us. We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact Customer Service. However, you are responsible for meeting the Annual Deductible, if applicable, and for paying required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a Non-Network provider, you may be responsible for requesting payment from us. If you do file the claim, it must be in a format that contains all of the information we require, as described below.

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us. We recommend that requests for reimbursement be submitted within 90 days of the date of service unless you are legally incapacitated. Failure to provide this information to us within one year of the date of service shall cancel or reduce Benefits for the health service. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. If a Non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission.

When you request payment of Benefits from us for Covered Health Services provided by Non-Network providers, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name, age, and relationship to the Subscriber.
- The member number stated on your ID card.
- An itemized bill from your provider that includes the following:
 - Patient diagnosis;
 - Date(s) of service;
 - Procedure code(s) and descriptions of service(s) rendered;
 - Charge for each service rendered;
 - Provider of service name, address and provider identification number;
 - Indication if related to an accident; and
 - Proof that you paid for the services (if appropriate).
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If

you are enrolled for other coverage, you must include the name of the other carrier(s).

NOTE: additional documentation may be requested of your provider before Benefits will be considered for payment.

Filing Deadline for Network and Non-Network Claims

It is your responsibility to present your ID card when receiving services from all providers or upon request.

If you are required to pay for health services, we recommend that requests for reimbursement be submitted within 90 days of the date of service unless you are legally incapacitated. Failure to provide this information to us within one year of the date of service shall cancel or reduce Benefits for the health service. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. If a Non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If the Non-Network provider submits a claim beyond the filing deadline, we are not responsible for payment of the claim.

Benefit Determinations

Post-Service Claims

Post service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30-day period if additional information is needed to process the claim; and we may issue a one-time extension of not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the plan on which the denial is based, describe any additional information needed and explain why the information is required, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require authorization before receiving medical care as a condition for receipt of Benefits. If your claim is a pre-service claim, and is submitted properly with all needed information, you will receive written notice of the claim decision from us within 15 days of receipt of the claim. If you file a pre-service claim improperly, we will notify you of the improper filing and how to correct it within 5 days after the pre-service claim is received. If additional information is needed to process the pre-service claim, we will notify you of the information needed within 15 days after the claim was received; and we may issue a one-time extension of not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe, we will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the plan on which the denial is based, describe any additional information needed and explain why the information is required, and provide the claim appeal procedures.

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Urgent Pre-Service Claims that Require Immediate Action

Urgent care claims are those claims that require authorization before receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the Benefit determination in writing or electronically within 72 hours following receipt of the authorization request, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within two days.

If you file an urgent care claim improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, we will notify you of the information needed within 24 hours after the claim is received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- We receive the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for the denial, refer to the part of the plan on which the denial is based, describe any additional information needed and explain why the information is required, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided by us within 24 hours from receipt of your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described previously.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Reimbursement of Excess Coinsurance

The amount you are required to pay in Coinsurance is limited as stated in the Annual Out-of-Pocket Maximum explanation in Section 1: What's Covered--Benefits. Because Coinsurance is paid directly to the Network provider, we may not know if you have exceeded the Annual Out-of-Pocket Maximum. We will reimburse the Subscriber for Coinsurance for Network Benefits paid that exceed the Annual Out-of-Pocket Maximum stated in Section 1: What's Covered--Benefits.

To be reimbursed for excess Coinsurance, the Subscriber must notify us in writing that excess Coinsurance has been paid. We must receive this notice no later than 90 days after the end of the calendar year. The notification must include proof of the payment of all Coinsurance, such as a cancelled check or a receipt from the provider.

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Section 6: Questions, Grievances, Appeals, and Complaints

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- We notify you that we will not be paying a claim because we have determined that a service or supply is excluded under the Policy.

We encourage your comments and suggestions so that we continue to improve our service to you. While we hope that there are no problems with our services, one may occasionally arise. In this case, we have a Grievance procedure to resolve your problem as rapidly and efficiently as possible. This procedure is required under MCL Section 500.2213.

We interpret and administer the terms of this Policy. Any adverse decisions regarding Benefits are subject to your right to appeal under applicable law.

NOTE: ANY GRIEVANCE FILED UNDER THIS SECTION DUE TO AN ADVERSE BENEFIT DETERMINATION, MUST BE FILED WITHIN 180 DAYS FOLLOWING NOTICE OF THE ADVERSE BENEFIT DETERMINATION.

Terms Used in This Process

The terms used in this Section mean:

Adverse Benefit Determination – a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit. This includes any such denial, reduction, termination, or failure to provide or make payment that is based on:

- A determination of eligibility to participate in the plan;
- A Benefit resulting from the application of any utilization review; or
- Failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or medically appropriate.

Authorized Representative –

- A person (including but not limited to a Physician) to whom a Covered Person has authorized in writing to act on his or her behalf at any stage in the Grievance process.
- A person authorized by law to provide substituted consent for a Covered Person; or
- A family member of the Covered Person or the Covered Person's treating health care professional, if the Covered Person is unable to provide consent.

Complaint – a written or verbal expression of dissatisfaction about any matter **other than** an action subject to appeal such as a complaint about quality of care, quality of service or an administrative complaint.

Concurrent Care – an on-going course of treatment previously approved for a specific period of time or number of treatments.

Expedited/Urgent Grievance – a Grievance, for which a Physician has substantiated, verbally or in writing, that the timeframe for the normal Grievance procedure would seriously jeopardize the life or

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health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function.

Grievance/Appeal – a written expression of dissatisfaction by a Covered Person or Authorized Representative concerning an Adverse Benefit Determination of a Pre-Service, Post-Service, or Concurrent Care Claim. The terms “Appeal” and “Grievance” are used interchangeably.

Post-Service Claim – a claim that is filed for payment of Benefits after medical care has been received.

Pre-Service Claim – a claim that requires authorization before receiving medical care as a condition for receipt of Benefits.

Urgent Care Claim – a claim that requires authorization before receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain.

What to Do First

If you have a complaint about the quality of service or care that you receive, we want to hear from you. Please contact Customer Service. We follow up on all complaints.

If you have a concern or question about a Benefit determination, you may informally contact Customer Service before requesting a formal Grievance. If the Customer Service specialist cannot resolve the issue to your satisfaction over the telephone, you may submit your question in writing.

However, if you are not satisfied with a Benefit determination you may submit a Grievance as described below, without first informally contacting Customer Service. If you first informally contact Customer

Service and later wish to request a formal Grievance, you can contact Customer Service and a Customer Service specialist will provide you with the appropriate information to request a formal Grievance.

If you are appealing an Urgent Care Claim denial, please refer to “Urgent Claim Appeals of Pre-Service Claims that Require Immediate Action” section below and contact Customer Service immediately.

Customer Service specialists are available to take your call during regular business hours, Monday through Friday.

How to Request a Formal Grievance

If you are not satisfied with the resolution of your Grievance through informal procedures, you have the right to request (in writing) a formal review of your Grievance. Contact our Customer Service Department to obtain the information needed to initiate the internal Grievance process. You may authorize, in writing, an Authorized Representative to act on your behalf at any stage of the Grievance process.

If the Grievance request relates to a claim for payment, your request should include:

- The patient's name and member number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Your request for Grievance must be submitted to us within 180 days after you receive the claim denial.

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Grievance Process

We will let you know within 5 calendar days from the date we receive your Grievance that the Grievance has been received, and will inform you or your Authorized Representative of the date and time for the Grievance hearing, if a hearing is required to make a decision on your request.

If a hearing is necessary, a committee of qualified individuals, who were not involved in the decision being appealed, will be appointed by us to decide the Grievance. If your Grievance is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The committee may consult with, or seek the participation of, medical experts as part of the Grievance resolution process. By requesting a Grievance, you consent to this referral and the sharing of pertinent medical claim information.

Upon request, and free of charge, you have the right to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for Benefits. You or your Authorized Representative will have the right to present your Grievance and to provide written comments, documents, records, or other additional information relating to the claim, at the hearing.

All comments, documents, records and other information submitted, will be taken into account without regard to whether such information was submitted or considered in the Adverse Benefit Determination.

Grievance Determinations

Pre-Service and Post-Service Claim Appeals

The Grievance will be conducted, and you will be provided with written or electronic notification of the determination within 30 days from receipt of the Grievance request.

For procedures associated with urgent Pre-Service claims, see “Urgent Claim Appeals of Pre-Service Claims that Require Immediate Action” below.

We interpret and administer the Policy.

Urgent Claim Appeals of Pre-Service Claims That Require Immediate Action

Your appeal of a Pre-Service Claim may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing.
- You or your Physician should call us as soon as possible.

We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

What to do if You Disagree With Our Grievance Determination

If you are not satisfied with our final Grievance determination, you have rights to either of the following:

- You have the right to seek external review by an independent review organization pursuant to MCL 500.2213. You must submit your request for external review within 60 days from the date you receive our final determination. We will provide you with a copy of the Office of Financial and Insurance Regulation (OFIR) Request for External Review form. For additional information about external review, you can contact the Insurance Commissioner at the address provided at the end of this section.

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- You have rights under Section 502(a) of ERISA. Any legal proceeding or action against Physicians Health Plan, its successor, or their affiliates, agents and/or employees, must be brought within three years of the date Physicians Health Plan notifies you of its final Grievance determination with respect to your appeal. If you fail to initiate any such legal proceeding or other action within the three-year time period, you will forfeit your rights to bring any such proceeding or action against Physicians Health Plan, its successor, or their affiliates, agents and/or employees.

If you wish to seek external review by an independent review organization for an *urgent* claim, you may ask for review at the same time that you go through our internal Grievance process. If you do not request an independent review at the same time as our internal Grievance process, and you later wish to seek external review, the review must be filed with the Office of Financial and Insurance Regulation (OFIR) within 10 days of our final determination. For information about requesting review of an urgent situation by the Insurance Commissioner, you should contact OFIR at the address below:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, Third Floor
P.O. Box 30220
Lansing, MI 48909-7720

Telephone: 877-999-6442 Web Site: www.michigan.gov/ofir

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Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from MCL 550.253, Michigan's Coordination of Benefits law.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
 - a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.
 - b. "Coverage Plan" also includes individual no-fault automobile insurance, by whatever name called, provided through arrangements other than those described in item "a" above. Except that, this will not apply to the extent that any auto insurance policy issued pursuant to the Automobile No-Fault Insurance Act of the State of Michigan contains a deductible or is by these terms secondary to (or excess over) the benefits provided under this policy.

NOTE: Most automobile insurance in Michigan is written on a "coordinated" or excess basis in which the health plan must assume primary responsibility for covered benefits. Some automobile insurance is written on a "full medical" basis, which assumes the automobile insurance carrier is the primary payer.
 - c. "Coverage Plan" does not include: individual insurance (other than such coverage under item "b" above); benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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Each contract for coverage under items “a,” “b” or “c” above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles, coinsurance and copayments that is covered at least in part by any of the Coverage Plans covering the person. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense.

If a Covered Person requests a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room is an allowable expense only if the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or if one of the Coverage Plans routinely provides coverage for Hospital private rooms.

Allowable Expenses are calculated as follows:

- a. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, the Allowable Expense is the highest of the usual and customary fees for a specific benefit.

- b. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, the highest of the negotiated fees is the Allowable Expense.
- c. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Allowable Expense is the Primary Coverage Plan's payment arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

- A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.
- B. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

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1. A Coverage Plan without a coordination of benefits provision is always the Primary Coverage Plan.
2. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent (for example as an employee, member, subscriber or retiree) is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent, and primary to the Coverage Plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.
3. Child Covered Under More Than One Coverage Plan. For a person for whom claim is made as a dependent minor child, benefits shall be determined according to the following:
 - a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year. If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
 - b. Except as provided in item “d” below, if the parents of the minor child are legally separated or divorced, and the parent with custody of the minor child has not remarried, the benefits of a policy or certificate that covers the minor child as a dependent of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a dependent of the noncustodial parent.
 - c. Except as provided in item “d” below, if the parents of the minor child are divorced, and the parent with custody of the child has remarried, the order of benefits is as follows:
 - The plan covering the custodial parent;
 - The plan covering the custodial parent’s spouse;
 - The plan covering the non-custodial parent; and then
 - The plan covering the non-custodial parent’s spouse.
 - d. If the parents of the minor child are divorced, and the decree of divorce places financial responsibility for the medical, dental, or other health care expenses of the minor child upon either the custodial or the noncustodial parent, the benefits of a policy or certificate that covers the minor child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy or certificate that covers the minor child as a dependent.
4. Active or Inactive Employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled B(1).
5. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.

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6. Longer or Shorter Length of Coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
7. Individual Plan. An individual plan with no order of benefit determination rules is always primary.

Effect on the Benefits of this Plan

- A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. When the benefits of this Coverage Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Coverage Plan.
- B. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give us any facts we need to apply those rules and determine benefits payable.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That

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amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Extended coverage.
- Continuation of coverage under federal law (COBRA).
- Conversion.

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends or the date that the Dependent is no longer eligible as an Enrolled Dependent under the terms of the Policy. See Section 10: Glossary of Terms.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table. In no event will a Covered Person's coverage end because of his or her health status or requirements for health services.

Except when coverage ends as described under "The Entire Group Policy Ends," Covered Persons who are notified that coverage will end may utilize the grievance procedure described in Section 6: Questions, Grievances, Appeals, and Complaints.

Ending Event	What Happens
The Entire Group Policy Ends	Your coverage ends on the date the Group Policy ends. The Enrolling Group is responsible for notifying you that your coverage has ended.
You No Longer Reside or Work in Service Area	Your coverage ends on the date you no longer reside or work in the Service Area. Coverage will end on the date of that move, even if you do not notify us. (This does not apply to an Enrolled Dependent child for whom the Subscriber is required to provide health insurance coverage through a Qualified Medical Child Support Order or other court or administrative order, or when we and the Enrolling Group have made arrangements for members residing outside of the Service Area to be covered.) The Subscriber or the Enrolling Group must notify us if you move from the Service Area.
You Are No Longer Eligible	Your coverage ends on the date you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 10: Glossary of Defined Terms for a more complete definition of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."
We Receive Notice to End Coverage	Your coverage ends on the date we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.
Subscriber Retires or Is Pensioned	Your coverage ends the date the Subscriber is retired or pensioned under the Enrolling Group's plan. The Enrolling Group is responsible for providing written notice to us to end your coverage. This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber or Enrolling Group that coverage has ended on the date we identify in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	An act, practice or omission that constituted fraud related to the Policy, or an intentional misrepresentation of material fact related to the Policy, whether such act, practice, or omission was on the part of the Subscriber or Enrolling Group. Examples include providing false information or withholding accurate information relating to residence in the Service Area, employment within the Service Area, eligibility for you or for a Dependent, or eligibility of the Enrolling Group. This list of examples is not exhaustive. Termination of this Policy for these purposes may be retroactive to the effective date of this Policy or to some other date. During the first three (3) years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first three (3) years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.
Material Violation	There was a material violation of the terms of the Policy.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card. Such an act may lead to retroactive termination of this Policy back to the date the fraud occurred.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, a provider, or other Covered Persons.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical disability will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Becomes so incapacitated before reaching the limiting age.
- Depends mainly on the Subscriber for support and maintenance.

Coverage will continue as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of our request as described above, coverage for that child will end.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your employer (who is the plan administrator) to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan, which was then replaced by coverage under this Policy, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified

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Beneficiary is any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.
- A Subscriber's former spouse.
- In certain cases, a retired employee, the retired employee's spouse and the retired employee's dependent children may be Qualified Beneficiaries.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

- A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct, or reduction of hours; or
- B. Death of the Subscriber; or
- C. Divorce or legal separation of the Subscriber; or
- D. Loss of eligibility by an Enrolled Dependent who is a child; or
- E. Entitlement of the Subscriber to Medicare benefits; or

- F. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's designated plan administrator within 60 days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60-day period, the Enrolling Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Enrolling Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Enrolling Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

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Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Policy will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A, then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D).

- C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.
- D. The date coverage terminates under the Policy for failure to make timely payment of the Premium.
- E. The date, after electing continuation coverage that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. qualifying event F).
- G. The date the entire Policy ends.
- H. The date coverage would otherwise terminate under the Policy as described in this section under the heading *Events Ending Your Coverage*.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy, (i.e. qualifying event F) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be

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entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

Conversion

If all of the following are true, you may apply for conversion coverage without furnishing evidence of insurability:

- You have been continuously covered under the Policy for a period of not less than three months.
- Your coverage terminates for one of the reasons described below.
- You continue to reside in the Service Area.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under this Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from

coverage provided under this Policy. Contact Customer Service for more information.

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Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning your Policy.

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. We pay for certain medical costs, which are more fully described in this Certificate. We may **not** pay for all treatments you or your Physician may believe are necessary. If we do not pay, you will be responsible for the cost.
- We do not decide what care you need or will receive. You and your Physician make those decisions. We may **not** pay for all treatments you or your Physician may believe are necessary. If we do not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

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Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the Employee Retirement Income

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Security Act ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

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Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide

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the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact Customer Service. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

We do not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives do not encourage decisions that result in less Covered Health Services to you.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Interpretation of Benefits

We do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and Exclusions set out in the Policy, including this Certificate of Coverage and any Riders and Amendments.
- Make factual determinations related to the Policy and its Benefits.

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We may delegate these administrative responsibilities to other persons or entities.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.

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- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or Amendments to the Policy.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of Benefits under the Policy, nor will it create a right to Benefits. If the Enrolling Group makes a clerical error (including, but not limited to, sending us inaccurate information regarding your enrollment for coverage or the termination of your coverage under the Policy) we will not make retroactive adjustments beyond a 60-day time period.

Information and Records

At times we may need additional information from you. You agree to furnish us with all information and proofs that we may reasonably require regarding any matters pertaining to the Policy. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

We may use your individually identifiable information to administer the Policy and pay claims, to identify procedures, products or services that you may find valuable and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose our information is found in our Notice of Privacy Practices.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable

time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services, which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements, we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

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Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in Section 7: Coordination of Benefits, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you **should** follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Certificate of Coverage, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

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- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - Providing any relevant information to us about any recovery that you or your legal representatives obtain from any Third Parties or any related information requested by us,
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
 - Responding to requests for information about any accident or injuries,
 - Making court appearances, and
 - Obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the right to resolve all disputes regarding the interpretation of the language stated herein, subject to the review and appeal procedures set forth herein and allowed by law.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or

partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.

- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.

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- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

If a refund is owed, it will equal the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. We may also reduce future Benefits for the Covered Person under any other group benefits plan that we administer for the Enrolling Group. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

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

This means you cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a written request for reimbursement as described in Section 5: How to File a Claim. If you want to bring a legal action against us you must do so within three years from the expiration of the time period in which a written request for reimbursement must be submitted or you lose any rights to bring such an action against us.

You cannot bring any legal action against us for any other reason unless you first complete all the steps in the complaint process described in Section 6: Questions, Grievances, Appeals, and Complaints. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our

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final decision on your complaint or you lose any rights to bring such an action against us.

Limitation of Liability

Whether the legal action you bring against us is based in contract, equity, negligence, tort or otherwise, we will only be liable to you for the reasonable value of any Covered Health Services or Benefits we would otherwise owe you under this Certificate of Coverage. We will not be liable to you for, nor will any measure of damages include, any indirect, incidental, special, consequential, punitive or exemplary damages.

Non-Assignment

The coverage provided under this Policy is for your personal benefit. You may not assign or transfer any of your rights to Benefits or services as a Covered Person under this Policy. Any attempt by you to assign this Policy to any third party is void.

Entire Policy

The Policy issued to the Enrolling Group, including this Certificate of Coverage, the Enrolling Group's application, Amendments and Riders, constitutes the entire Policy.

Provider Communications

We do not prohibit or discourage Network health care providers from advocating on behalf of a Covered Person for appropriate medical treatment options as described in Section 6: Questions, Grievances, Appeals, and Complaints pursuant to MCL 500.2213. We also do not prohibit or discourage Network health care providers from discussing with a Covered Person or another provider any of the following:

- Health care treatments and services.
- Quality assurance plans required by law, if applicable.

- The financial relationship between us and the Network provider, including all of the following, as applicable:
 - Whether a fee for service arrangement exists, under which the provider is paid a specified amount for each Covered Health Service rendered to the Covered Person.
 - Whether a capitation arrangement exists, under which a fixed amount is paid to the Network provider for all Covered Health Services that are or may be rendered to each Covered Person.
 - Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

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Section 10: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Certificate.
- Is not intended to describe Benefits.

Alternate Facility - a freestanding health care facility that is not a Hospital or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Urgent care health services
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Behavioral Health Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are subject to all conditions, limitations and Exclusions of the Policy, except for those that are specifically amended.

Annual Deductible – for Benefit plans that have an Annual Deductible, the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year. Amounts paid toward the Annual Deductible for Covered Health

Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. Network Benefits for Preventive Health Services are never subject to payment of the Annual Deductible.

Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Annual Deductible, will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.

Annual Out-of-Pocket Maximum - the maximum amount you pay every calendar year. If you use both Network Benefits and Non-Network Benefits, two separate Annual Out-of-Pocket Maximums apply. Once you reach the Annual Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Annual Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. Once you reach the Annual Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered Health Services that apply to the Annual Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. Copayments do not apply to the Annual Out-of-Pocket Maximum. Coinsurance for some Covered Health Services will never apply to the Annual Out-of-Pocket Maximum, as specified in Section 1: What's Covered--Benefits and those Benefits will never be payable at 100% even when the Annual Out-of-Pocket Maximum is reached.

The following costs will never apply to the Annual Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Coinsurance for Covered Health Services available by an optional Rider.

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- The amount of any reduced Benefits if you don't obtain authorization from us as described in Section 1: What's Covered--Benefits under the *Is Authorization Required?* column.
- Charges that exceed Eligible Expenses.
- Any Copayments or Coinsurance for Covered Health Services in Section 1: What's Covered--Benefits that do not apply to the Out-of-Pocket Maximum.
- The Annual Deductible.

Even when the Annual Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any reduced Benefits if you don't obtain authorization from us as described in Section 1: What's Covered - Benefits under the *Is Authorization Required?* column.
- Coinsurance for Covered Health Services available by an optional Rider.
- Copayments for Covered Health Services.

Assisted Reproductive Technology (ART)— the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).

- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Basic Health Services – as identified in MCL 500.3501, Basic Health Services are the following:

- Physician services including consultant and referral services by a Physician, but not including psychiatric services.
- Ambulatory services.
- Inpatient Hospital services, other than those for the treatment of Mental Illness.
- Emergency health services.
- Outpatient mental health services
- Intermediate and outpatient care for substance use disorders.
- Diagnostic laboratory and diagnostic and therapeutic radiological services.
- Home health services.
- Preventive services.

Behavioral Health Designee - the organization or individual, designated by us, that provides or arranges mental health services and substance use disorders services for which Benefits are available under the Policy.

Behavioral Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses, alcoholism and substance

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use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a condition or disorder is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and Exclusions of the Policy, including this Certificate of Coverage and any attached Riders and Amendments.

Chiropractic Health Services, Treatment or Care— all services and supplies provided by or under the direction of a Chiropractor, including but not limited to chiropractic manipulation and adjustments, adjunctive therapy, examinations, X-rays, tests, diagnostic and therapeutic services, supplies and appliances.

Chiropractor— any doctor of chiropractic who is duly licensed and qualified to provide Chiropractic Health Services, Treatment or Care under the law of jurisdiction in which treatment is received.

Coinsurance— the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Compounded Medications— are those that are not commercially available, and the dispensing pharmacy must prepare them individually by combining, mixing, or altering ingredients or components. Compounded medications are considered experimental or investigational based on PHP medical policy and nationally recognized guidelines because they have not been approved for general use by the Federal Food and Drug Administration (FDA)

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, determined to be Medically Necessary per PHP medical policy and nationally recognized guidelines and which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Certificate of Coverage under Section 1: What's Covered—Benefits.
- Not otherwise excluded in this Certificate of Coverage under Section 2: What's Not Covered—Limitations and Exclusions.

In applying the above definition, “scientific evidence” and “prevailing medical standards” shall have the following meanings:

- “Scientific evidence” means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

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- “Prevailing medical standards and clinical guidelines” means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines and national specialty society guidelines.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Certificate are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services, which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by or supervision by trained medical personnel in order to be delivered safely and effectively; or
- Are provided after stated clinical goals have been achieved.

Dependent - the Subscriber's legal spouse or the dependent child of the Subscriber or the dependent child of the Subscriber's legal spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes a legal spouse who resides or works within the Service Area.
- A Dependent includes any child less than 26 years of age.
- A Dependent includes an unmarried Dependent child over age 26 who is or becomes disabled and dependent upon the Subscriber. For more information, see Section 8: When Coverage Ends.

The Subscriber must reimburse us for any Benefits that we pay for a Dependent at a time when the Dependent did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a ‘Qualified Medical Child Support Order’ or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with us or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area or the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

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Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is of use to a person only in the presence of a disease or physical disability.
- Is appropriate for use in the home.
- Is not implantable within the body.

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from Non-Network providers as a result of an emergent/urgent condition or as otherwise arranged by your Primary Care Physician or other Network Physician and approved by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

For Non-Network Benefits, Eligible Expenses are determined based on:

- Available data resources of competitive fees in that geographic area, or
- Fee(s) that are negotiated with the provider; or
- 100% of the billed charge; or
- A fee schedule that we develop.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside and/or work within the Service Area.

Emergency - the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, or to

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a Pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance use disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices that are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight. This includes diagnostic testing for purposes of possible inclusion in a clinical trial.
- Any service billed with a temporary procedure code.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Genetic Test - the analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome in order to qualify under this definition.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

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Initial Enrollment Period- the initial period of time, as we agree with the Enrolling Group, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (e.g., physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Medically Necessary, Medical Necessity – health care services and supplies, which are determined to be medically appropriate per PHP medical policy and nationally recognized guidelines, and

- Not Experimental or Investigational Services; and
- Necessary to meet the basic health needs of the Covered Person; and
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Health Service; and
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by us; and
- Consistent with the diagnosis of the condition; and

- Required for reasons other than the convenience of the Covered Person or his/her Physician; and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
 - Safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,
 - Safe with promising efficacy:
 - ◆ For treating a life-threatening Sickness or condition; and
 - ◆ In a clinically controlled research setting; and
 - ◆ Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For purposes of this definition, the term “life threatening” is used to describe Sickness or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Sickness, or Mental Illness, or the fact that the Physician has determined that a particular health care service or supply is medically necessary or medically appropriate does not mean that the procedure or treatment is a Covered Health Service under the Policy. The definitions of Medically Necessary and Medical Necessity used in this Certificate relate only to Benefits and may differ from the way in which a Physician engaged in the practice of medicine may define Medically Necessary or Medical Necessity.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

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Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with us. A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a Non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - Benefits for Covered Health Services that are provided by or under the direction of a Network Physician in a Network Physician's office or at a Network facility. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility by a Network Physician or other Network provider. Network Benefits include Emergency Health Services.

Non-Network – when used to describe a provider of health care services, this means those providers who do not participate in our Network.

Non-Network Benefits - Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider, or Covered Health Services that are provided at a Non-Network facility.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. We and the Enrolling Group will agree upon the period of time that is the Open Enrollment Period.

Physician - any Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is properly licensed and qualified by law.

NOTE: Any nurse practitioner, physician assistant, podiatrist, dentist, psychologist, Chiropractor, optometrist, nurse midwife, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The Group Policy.
- This Certificate of Coverage.
- The Enrolling Group's application.
- Amendments.
- Riders.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy as paid by the Enrolling Group.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.

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- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Preventive Health Services – routine or screening Covered Health Services that are designated to keep you in good health and to prevent unnecessary Injury, Sickness or disability in accordance with our current “Preventive Guidelines.” These guidelines include the following as may be appropriate based on your age and/or gender:

- Voluntary family planning.
- Well-baby and well-child care.
- Routine physical examinations (including related pathology and radiology services).
- Diagnostic screenings. (Vision screenings do not include refractive examinations to detect vision impairment.)
- Immunizations.

Primary Care Physician - a Network Physician that you select to be responsible for providing or coordinating all Covered Health Services for Network Benefits.

Recreational Therapy – inpatient or outpatient recreational activities that may be considered to serve a therapeutic purpose including, but not limited to, camp or camping events, sports or sporting events, horseback riding, art therapy services or art instruction, music therapy services or music instruction, boating or other recreational activities.

Residential Treatment Program - substance use disorders treatment, which does not meet the definition of inpatient hospital care, but requires a patient to reside at a certified or licensed residential treatment facility for the duration of the treatment period. Treatment programs are

designed to treat groups of patients with similar substance use disorders, living within a supportive twenty-four (24)-hour community (e.g., a 28-day alcohol rehabilitation program).

Rider - any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums by the Enrolling Group. Riders are subject to all conditions, limitations and Exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Area - the geographic area we serve and that has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Unproven Services – services, including medications that are not consistent with conclusions of prevailing medical research, which demonstrate that the health service has a beneficial effect on health

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outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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To Contact Us:

Physicians Health Plan

P.O. Box 30377

Lansing, MI 48909-7877

General Office: (517) 364-8400

Customer Service: (517) 364-8500 or (800) 832-9186

TTY/TDD Service: (800) 649-3777

HMO PLUS Benefit Summary

Actives Hired Prior to 4/1/10



Plan MPL06900

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE	None	\$200 per individual/\$400 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,000 per individual/\$6,000 per family	\$3,000 per individual/\$3,000 per family
LIFETIME MAXIMUM POLICY	Unlimited	Unlimited
	AMOUNT COVERED	AMOUNT COVERED

PHYSICIAN OFFICE VISITS

Office visits for illness or injury	100% after \$10/visit	80% of Eligible Expenses (EE) after deductible
Routine physical exams	100% after \$10/visit	Not covered
Well baby and well child care	100% after \$10/visit	Not covered
Immunizations	100%	Not covered
Family planning; birth control devices; voluntary sterilization	100% after \$10/visit	Not covered
Maternity care (prenatal and postnatal services)	100%	80% of EE after deductible
Injections/infusions	100%	80% of EE after deductible

INPATIENT HOSPITAL

Unlimited days in a semi-private room	100%	80% of EE after deductible
Special care units	100%	80% of EE after deductible
Necessary ancillary hospital services	100%	80% of EE after deductible
Surgery and related services	100%	80% of EE after deductible
Anesthesia and its administration	100%	80% of EE after deductible
Transplant services (at designated facilities)	100%	Not covered
Maternity care (hospital services)	100%	80% of EE after deductible
Physician services including consultation	100%	80% of EE after deductible
Physician obstetrical services (delivery)	100%	80% of EE after deductible

OUTPATIENT HOSPITAL

Surgery and related services	100%	80% of EE after deductible
Diagnostic X-ray and laboratory	100%	80% of EE after deductible
CT scans, PET scans, MRA, MRI and Nuclear Medicine	100%	80% of EE after deductible

EMERGENCY/URGENT SERVICES

At hospital emergency department	100% after \$50/visit <i>Waived if admitted for an inpatient stay</i>	Same as Network benefit
At urgent care facility (after hour services)	100% after \$10/visit	Same as Network benefit
At non-network physician's office outside the service area	100% after \$10/visit	Same as Network benefit

BEHAVIORAL HEALTH SERVICES

Inpatient treatment (including detoxification)	100%	80% of EE after deductible
Residential treatment program for substance use disorders	100%	80% of EE after deductible
Intermediate treatment	100%	80% of EE after deductible
Outpatient therapy visits and testing for mental health conditions	\$0/visit for first 20 visits in a calendar year. For each visit (21 or more) in a calendar year: \$10/visit	80% of EE after deductible
Outpatient therapy visits and testing for substance use disorders	100%	80% of EE after deductible
All other outpatient items and services (such as ECT)	100%	80% of EE after deductible

HMO PLUS Benefit Summary

Actives Hired Prior to 4/1/10



Plan MPL06900

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
	AMOUNT COVERED	AMOUNT COVERED
OTHER SERVICES		
Home health care	100% <i>Combined network and non-network benefits limited to 60 visits per CY</i>	80% of EE after deductible
Skilled nursing facility/ inpatient rehabilitation facility	100%	80% of EE after deductible <i>Limited to 100 days per CY</i>
Hospice care	100%	80% of EE after deductible
Ambulance services	100%	Same as Network benefit
Prosthetic devices	100%	80% of EE after deductible
Durable medical equipment	100%	80% of EE after deductible
Outpatient rehabilitation therapy	100% after \$10/visit <i>Combined network and non-network limitations apply</i>	80% of EE after deductible
Infertility treatment	100% <i>Limited of \$10,000 per CY</i>	Not covered
Chiropractic services	100% after \$10/visit <i>Limited to 20 visits per CY</i>	Not covered
Nutritional counseling services	100% after \$10/visit <i>Limited to 3 sessions per CY</i>	Not covered
Tobacco cessation program	100%	Not covered
Hearing aids	100% <i>Limited to either one monaural to a maximum benefit of \$880 or one binaural to a maximum of \$1600; every 36 months</i>	Not covered

Certain services must be authorized in advance to receive full coverage. Failure to obtain prior authorization when required may result in reduced or no benefit. Complete details are found in your PHP Certificate of Coverage.

Covered Health Services must be Medically Necessary as determined by PHP medical policy and nationally recognized guidelines. Member materials, including the PHP Certificate of Coverage, can be found online at our Member Packet Portal. Members may use their member ID number to access benefit information on the Member Packet Portal through our web site at www.phpmm.org.

NOTE: This policy is not subject to a pre-existing condition limitation.

Except as may be specifically provided through a Rider to the policy, exclusions include:

- Routine dental care
- Prescription drugs
- Cosmetic surgery
- Custodial care, bed care, convenience care, day care, domiciliary care
- Experimental procedures
- Vision services

For additional information about exclusions and limitations, visit our web site, or contact the PHP Customer Service Department to review the PHP Certificate of Coverage for this benefit plan.

This Summary of Benefits is intended only to highlight the benefits provided under HMO PLUS and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to the PHP Certificate of Coverage for a complete listing of covered services, limitations and exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the policy issued to the enrolling group, the policy will prevail. For answers to questions about information, which appears in the summary, call our Customer Service Department at 517.364.8500 or 800.832.9186.

Important Notice on The Patient Protection and Affordable Care Act

PHP believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was all ready in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to our Customer Service Department.

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on our Prescription Drug List at a Network Pharmacy and are subject to Copayments or Coinsurance amounts that vary depending on which of the tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 or Tier-2. Please access www.medco.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

<u>Retail Copayment</u>	<u>Mail-Order Service Copayment</u>
Tier-1 Prescription Drug Product \$5	Tier-1 Prescription Drug Product \$10
Tier-2 Prescription Drug Product \$10	Tier-2 Prescription Drug Product \$20

40% coinsurance for Prescription Drug Products for the treatment of infertility – Retail or Mail-Order Service.

0% coinsurance for Prescription Drug Products for growth hormone therapy – Retail or Mail-Order Service.

<u>Supply Limits</u>	<u>Mail-Order Service Convenience</u>
<p>- Retail: Up to 31 consecutive day supply</p> <p>- Mail: Up to 90 consecutive day supply</p> <p>Some products may have additional quantity limits.</p> <p>Please consult with your physician. These specific quantity limits may be exceeded in certain situations at the request of your physician.</p>	<p>Mail-Order Service Pharmacy allows you to have your prescriptions filled and delivered directly to your doorstep. You save on out-of-pocket costs too. Call our Customer Service Department for more information. Our phone number is listed on the back of your ID card.</p>

Exclusions

Some of the exclusions that apply to your benefit are listed below. Please look at your pharmacy rider available on the Member Packet Portal at www.phpmm.org for a complete listing of exclusions.

- Experimental products
- Appetite suppressants and other weight loss products
- Over the counter drugs
- Replacement prescriptions
- Medications for cosmetic purposes only

Please contact the PHP Customer Service Department at the number listed on the back of your ID card if you have questions.