Certificate of Coverage

PriorityHealth®

CERTIFICATE OF COVERAGE

Agreement in Michigan 2012

SECTION 1. About This Certificate

This Certificate is a contract between you and Priority Health. It describes your benefits and explains your rights and responsibilities. It also describes the rights and responsibilities of Priority Health. This Certificate is part of the Agreement between Priority Health and your Employer, which sets the terms and conditions of the Coverage that your Employer has purchased on your behalf. It replaces and supersedes any Certificate we might have issued in the past.

NOTE: The Schedule of Copayments and Deductibles lists the cost sharing between you and Priority Health for Covered Services

Words that are capitalized in this Certificate are terms that are defined in Section 15. The terms "we," "us" and "our" refer to Priority Health. The terms "you," "your" and "yourself" refer to the Member, whether enrolled with Priority Health as a Subscriber or Covered Dependent. "Employer" means the Subscriber's employer or other entity through which you have obtained Coverage under this Certificate.

If you have any questions about Coverage, first contact your Employer. If you need more help, contact our Customer Service Department at:

Customer Service Department, MS 1105
PO Box 269
Grand Rapids, MI 49501-0269
or
1231 E. Beltline NE
Grand Rapids, MI 49525-4501
616 942-1221 or 800 446-5674
or use our secure e-mail form in the Member Center on our website *priorityhealth.com*

SECTION 2. Eligibility

You may enroll as a Member of this plan if you meet the eligibility requirements described in this Section 2. If there is any conflict between the requirements described below and the terms of your Employer's Agreement with us, the terms of the Agreement will govern eligibility. Additional eligibility requirements may be described in Riders or amendments to this Certificate.

A. Subscriber.

You are eligible to enroll and are considered the Subscriber if you:

(1) are an Active Employee of your Employer; and

(2) reside in the Service Area or work the required number of hours at a location in the Service Area; and

(3) meet your Employer's eligibility and waiting period requirements as listed in the Agreement.

B. Covered Dependents.

You are eligible to enroll as a Covered Dependent if:

(1) the Subscriber is an Active Employee with the Employer and has enrolled or is enrolling as the Subscriber; and

(2) you are legally married to the Subscriber; or

(3) you are the Subscriber's child (including a stepchild, legally adopted child, natural child or Child Placed for Adoption), or have the Subscriber or the Subscriber's spouse as your court-appointed permanent or limited guardian. You may not enroll as a Covered Dependent if the Subscriber or Subscriber's spouse has been appointed as your temporary guardian.

In addition, you may only enroll as a Covered Dependent child if:

(a) you are under age 26 on the effective date of Coverage; or

(b) you are an Incapacitated Dependent, and your incapacitation began before you reached age 26: and

(c) you are unmarried if over age 26 and Covered as an Incapacitated Dependent.

NOTE: See Section 2.C for Coverage information for Covered Dependent Children who reside outside of the Service Area.

Qualified Medical Child Support Order or "QMCSO"

The Subscriber's child is eligible to enroll in this plan outside of the Open Enrollment Period if you provide us with a copy of a court or administrative order which requires you to provide health coverage for the child in accordance with state and federal law (a "Qualified Medical Child Support Order" or "QMCSO"). The QMCSO must name the Subscriber as the participant in order to enroll the child. The child must be otherwise eligible for Coverage as a Covered Dependent. If we receive a copy of the QMCSO but you fail to enroll the child for Coverage, the child may be enrolled by the Friend of the Court or by the Child's other parent or guardian through the Friend of the Court. We will not terminate the Coverage of a child who is enrolled under a QMCSO unless:

(a) the child is no longer eligible as a Covered Dependent,

(b) Premiums have not been paid as required by the Agreement; or

(c) we receive satisfactory written proof that the QMCSO is no longer in effect or that the child has or will have comparable health coverage beginning on or before the date the child's Coverage with us is terminated.

Contact our Customer Service Department if you, or your Covered Dependents would like to obtain, without charge, a copy of Priority Health's procedures governing QMCSO determinations.

Court-Appointed Guardianship

Special rules apply to a child for whom the Subscriber or the Subscriber's spouse is the court-appointed permanent or limited guardian. The child may be enrolled from the moment he or she is in your physical custody. We will not Cover any expenses incurred for the child's care before he or she is in your physical custody. "Physical custody" means that the child is legally and physically placed in your home. If we ask for proof that the child meets the above requirements, you must give us acceptable proof, such as a court order, within 31 days. The child is eligible for Coverage until the end of the day on which he or she turns 18 years of age.

C. Out-of-Area Residents.

If you meet all eligibility requirements described above but you reside outside of the Service Area, you may enroll in this plan. If you reside outside of the United States, you may only enroll in this plan if:

(1) You are the Subscriber and you work in the Service Area; or

(2) You are a Covered Dependent and you live with the Subscriber who resides outside of the United States.

You are Covered outside of the Service Area for Medical Emergencies and Urgent Care as described in Section 5.G of this Certificate. All other care must be received inside the Service Area according to the requirements of this Certificate or approved by us in advance.

A child who enrolls as a Covered Dependent and who resides outside of the Service Area, but within the United States, has Coverage outside the Service Area as described in the Out-of-Area Dependent Child Benefit Rider. All other care must be received inside the Service Area according to the requirements of the Certificate or approved by us in advance. The Out-of-Area Dependent Child Benefit Rider does not apply when the child is outside of the United States.

D. Incarceration or Detention.

You or your dependents are not eligible for Coverage while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers. You are also not eligible for Coverage when on release for the sole purpose of receiving medical treatment.

E. Full Time Participation in the Military, Navy, or Air Force.

You or your dependents will no longer be eligible for Coverage if you enter the military, navy, or air force of any country or international organization on a full time basis, unless you elect to continue Coverage at your own cost in accordance with federal law (see Section 12.G). You are eligible for Coverage if you are participating in scheduled drills or other training that does not last longer than one month in any calendar year.

SECTION 3. Enrollment

To enroll, you must fill out an Enrollment Form, sign it, and return it to your Employer. On the Enrollment Form, you must list each person being enrolled, and give the information asked for about each person. If your Employer permits you to enroll electronically, you still must give us this information. You may enroll regardless of age, health status or medical needs.

NOTE: If your Coverage has previously been terminated for cause, you may not re-enroll even if you follow these steps. Termination for cause is explained in Section 10.C.

A. Open Enrollment Period for Employees and Eligible Dependents.

You may enroll yourself and your eligible dependents in this plan during an Open Enrollment Period. Ask your Employer when your Open Enrollment Period takes place.

B. Special Enrollment of Newly Eligible Employees and Dependents.

Certain events, explained in more detail below, may qualify you to enroll in this plan outside of the Open Enrollment Period. You are entitled to a 31 day Special Enrollment Period when you gain a new dependent or lose other coverage to which you were previously entitled. You are entitled to a 60 day Special Enrollment Period if there is a change in your eligibility for Medicaid or CHIP coverage. Your Coverage may be effective retroactively to the day following the qualifying event if you tell us about the change within 31 days. All terms and provisions of this Certificate, such as Prior Approval requirements and use of Participating Providers, apply for services to be Covered during that time.

NOTE: If you do not enroll yourself and/or your eligible dependents during the specified timeframe, you cannot enroll until the next Open Enrollment Period.

(1) New dependents.

If you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself, if you have not done so before, your new dependent, your spouse and your other eligible dependents, during a Special Enrollment Period. If you are already enrolled and you gain a new dependent as a result of marriage, birth, adoption or placement for adoption, you may add your new dependent, as well as your spouse and any of your other eligible dependents, to your existing Coverage.

You must fill out and return to your Employer a completed Enrollment Form if you and your dependents are enrolling in this plan for the first time or a completed Change Form if you are adding one or more new dependents to your existing Coverage. The applicable form must be returned within 31 days after the marriage, birth, adoption, or placement for adoption. You must do this even if the addition or change does not require you to pay a higher Premium. If you submit the Enrollment or Change Form within 31 days, Coverage will be effective on the date of the marriage, birth, adoption or placement for adoption. To enroll with us, you and your dependent(s) must meet the eligibility requirements of your Employer and Priority Health.

This plan Covers a Subscriber's Newborn child, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, for the first 31 days from birth even if you do not submit a Change Form. If you want the Newborn's Coverage to continue beyond the first 31-day period, fill out and return a Change Form to us within 31 days after the child is born.

(2) Loss of Other Coverage.

If you did not previously enroll with us because you had other health insurance coverage and that coverage is lost, you may enroll yourself and/or your dependents during a Special Enrollment Period if you meet the following requirements:

(a) You chose not to enroll in this plan during previous Open Enrollment Periods because you had other coverage; and

(b) If required by your Employer, you provided a written statement that you chose not to enroll for Coverage because you had other coverage; and

(c) The other coverage ended because you lost eligibility or because an employer stopped making contributions; or the other Coverage was COBRA continuation coverage and it ran out; and

(d) You return to your Employer a completed Enrollment Form no more than 31 days after the other coverage ends; and

(e) You provide proof of the loss of other coverage that is acceptable to us, such as a termination letter or Certificate of Creditable Coverage.

(3) Medicaid or CHIP Coverage.

If you and/or your dependents are eligible for, but not enrolled for Coverage under this plan, you may enroll during a Special Enrollment Period if any of the following requirements are met:

(a) The Medicaid coverage of you or your dependents is terminated as a result of loss of eligibility and you request Coverage no later than 60 days after the date the Medicaid coverage terminates; or

(b) The CHIP coverage of your eligible dependent children is terminated as a result of loss of eligibility and you request Coverage no later than 60 days after the date the CHIP coverage terminates; or

(c) You or your eligible dependents become eligible for a premium assistance subsidy for coverage under a Medicaid plan or CHIP (including any waiver or demonstration project) and you request Coverage no later than 60 days after the date you are determined to be eligible for such assistance.

CHIP is a state's Children's Health Insurance Plan under the Children's Health Insurance Program Reauthorization Act of 2009. Michigan's plan is called MIChild

NOTE: If you lose coverage under another health plan for the following reasons, you and your dependents are not eligible for Special Enrollment under Section 3.B(2) or (3):

(i) You did not pay your share of the premiums on a timely basis; or

(ii) Your coverage was terminated for cause such as for making a fraudulent claim or giving false information; or

(iii) You voluntarily drop your other coverage mid-year for any reason, including an increase in premium or change in benefits. EXCEPTION: You drop the other coverage during the annual open enrollment period for that other coverage. If you voluntarily drop your other coverage during this time, you are eligible to enroll in this plan during a Special Enrollment Period.

C. Late Enrollment.

Anyone who is eligible but does not enroll as described in Sections 3.A or B may only enroll during the next Open Enrollment Period.

D. Notification of Change in Status or Other Changes that Affect Coverage.

Notify us about any changes that affect your Coverage under this Certificate by:

(1) filling out a Change Form and returning it to your Employer, or

(2) visiting the Member Center on our website at *priorityhealth.com*, or

(3) calling our Customer3Service Department.

For example, notify us if any of the following happens to anyone Covered under this plan:

(a) change of Primary Care Provider (PCP);

(b) change of address or state of residence;

(c) eligibility for Medicare, Medicaid and Children's Special Health Care Services; or

(d) coverage by any other insurance or health plan.

These are examples only. Let us know about any change that, according to this Certificate, affects your Coverage or Coverage for your Covered Dependents.

Tell us about the change, such as losing coverage under another plan, within 31 days. This allows us to make sure you and your eligible dependents are enrolled correctly. We will review services you have received since the effective date of the change to determine if the services are Covered and how they should have been paid.

E. Loss of Eligibility.

Your Coverage will terminate if you no longer meet the eligibility criteria listed in Section 2 of this Certificate or in the Agreement.

F. Genetic Testing

Enrollment under this Section 3 and continuation of Coverage under this plan is not contingent on undergoing genetic testing or disclosing results of any genetic testing to us.

SECTION 4. Effective Dates Of Coverage

Your Coverage begins on the latest of:

(1) The effective date of the Agreement; or

(2) The first day of the month that your Employer has established as the effective date for those enrolling during an Open Enrollment Period; or

(3) The date of eligibility stated in the Agreement for all newly eligible employees; or

(4) The day after your other coverage ended, if you are eligible to enroll during a Special Enrollment Period because you lost coverage (See Section 3.B(2) and (3)); or

(5) The date of marriage or the date of a dependent's birth, adoption or placement for adoption, if you are eligible to enroll during a Special Enrollment Period because of gaining a dependent (See Section 3.B(1)).

(6) The date a child is placed in your physical custody if Coverage is being provided as a result of a QMCSO or court-appointed permanent or limited guardianship.

SECTION 5. Obtaining Covered Services

A. Primary Care Provider (PCP).

Your PCP

Your PCP provides your primary health care, orders lab tests and x-rays, prescribes medicines or therapies and arranges hospitalization when necessary. Your PCP may be a family practitioner, a general practitioner, an internal medicine specialist, a pediatrician, an obstetrician/gynecologist, a nurse practitioner or a physician assistant.

You may choose to seek services from a Participating Provider without referral from your PCP at any time. For example, a woman can see a participating obstetrician/gynecologist without referral from her PCP. However, we recommend you talk with your PCP about any issues concerning your medical care, and contact him or her before you receive medical services, except in a Medical Emergency. Working with your PCP improves the coordination and continuity of care you receive. When necessary, your PCP will work with other Participating Providers and Specialist Providers to ensure you receive the care you need.

We recommend you receive a physical examination from your PCP within one year of joining Priority Health.

Choosing a PCP

When you enroll, select a PCP and let us know who you have chosen by listing it on your Enrollment Form, by calling our Customer Service Department at 800 446-5674 or 616 942-1221 or by visiting the Member Center on our website *priorityhealth.com*. You can also call Customer Service or visit the Member Center to request a list of Participating Providers from whom you can choose or to ask for help in selecting a PCP. Each member of your family enrolled in this plan may elect a different PCP. If you do not select a PCP, we will assign one to you.

Changing a PCP

You can change your PCP at any time, including one assigned to you, except while you are in the Hospital. You may also change the PCP of a minor or Covered Dependent who is incapable of choosing a PCP.

To make a change, fill out and return a Change Form to us, contact our Customer Service Department by phone or go to the Member Center on our website. All changes are effective on the first day of the month after we receive your request unless you are changing a child's pediatrician. Pediatrician changes are effective immediately.

B. Referral Care.

Referral care is care provided by a Health Professional or Physician other than your PCP. This care may be provided by both Participating and Non-Participating Providers, including Specialists. Participating Providers are those listed in our Provider Directory. The Provider Directory is available on our website as part of the Find a Doctor tool or by calling our Customer Service Department.

Participating Providers

You do not need approval from your PCP or Priority Health to see a Participating Provider. Your PCP may refer you to another Participating Provider when it would be more appropriate for you to receive care from a different type of Health Professional or Specialist. Certain services provided by your PCP or upon referral to another Provider do require Prior Approval from Priority Health. See Section 5.D for more information on the Prior Approval process and requirements.

Non-Participating Provider

All Covered Services you receive from Non-Participating Providers must be Prior Approved by us. If the standard of care (medically appropriate treatment) for your condition is not available from a Participating Provider, your PCP may ask Priority Health for approval to refer you to a Non-Participating Provider. If you do not receive approval from Priority Health prior to seeking Covered Services from a Non-Participating Provider, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, you will be responsible for payment. A referral from your PCP or another Participating Provider is not enough if you want the services to be Covered. If Priority Health approves the referral, we will notify your PCP or the Participating Provider who makes the request.

A Second Medical Opinion

It is often appropriate to ask for a second medical opinion before receiving certain treatments for health conditions and before many proposed surgeries. You may request a second medical opinion from a Participating Specialist Provider who has skills and training substantially similar to those of the Physician making the original treatment recommendation without Prior Approval. If there are no Participating Providers with the skills and training needed to provide a second opinion on the proposed treatment, we may Cover a second medical opinion from a Non-Participating Specialist Provider. Prior Approval from Priority Health is required before the second opinion is obtained. Any tests, procedures, treatments or surgeries recommended by the consulting Provider must be performed by a Participating Provider unless we approve the services in advance.

Occasionally, Priority Health may require that you get a second opinion from a Specialist Provider that we have chosen. This second medical opinion is used to assist us in determining whether services or supplies are Medically/Clinically Necessary according to our medical and behavioral health policies or adopted criteria.

C. Your Treatment Options.

We require your PCP and other Participating Providers to discuss all treatment options available to you whether the treatment or services are Covered or not Covered . Providers are not expected to know when services have limitations or are excluded from Coverage. Your Certificate of Coverage provides you with this information. Our Customer Service Department can help you with any questions.

Your PCP or other Health Professionals may recommend and you may choose treatment options even if they are not Covered or are limited by this Certificate. You are required to pay for any services you receive that are not Covered or that exceed your maximum benefit.

D. Prior Approval Requirements.

Some services and supplies require Prior Approval by Priority Health in order to be Covered under this plan. The complete and detailed list of these services is available by calling our Customer Service Department or on our website at *priorityhealth.com*. This list may change throughout the Contract Year as new technology and standards of care emerge. Below are the general categories of services and supplies that require Prior Approval by Priority Health:

(1) All inpatient services.

You do not need Prior Approval from your PCP or Priority Health to seek care in a Medical Emergency or when Urgent Care is needed. Additionally, Inpatient Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section do not require Prior Approval. However, we encourage you to notify us at least 60 days before your due date so we are better prepared to assist you at that time.

(2) Outpatient services as outlined on our website.

(3) Referrals to Non-Participating Providers.

(4) Durable Medical Equipment (DME) charges over $1,000 and all rentals.

(5) Prosthetics and orthotics charges over $1,000 and all shoe inserts.

(6) Stimulators.

(7) High-tech radiology examinations, including but not limited to:

(a) positron-emission tomography (PET) scans

(b) magnetic resonance imaging (MRI)

(c) computed tomography (CT scans)

(d) nuclear cardiology studies.

(8) Selected injectable drugs.

(9) Home Health Care, including home infusion services and intermittent skilled services.

(10) Supplemental feedings administered via tube or IV.

(11) Transplants and evaluations for transplants.

(12) Genetic testing.

(13) Clinical trials for cancer care.

(14) Comprehensive pain and headache programs.

(15) Additional items as outlined on our website.

Non-Urgent Requests

Contact Priority Health as soon as a Provider recommends a service or supplies that require Prior Approval. In most cases, we will approve, partially approve, or deny a request for Prior Approval within 15 days of receipt. In some cases we may ask you for additional information or additional time in which to make our determination. Based on our approval or denial, you and your Provider can decide if you want to go forward with the proposed services or obtain the supplies.

Urgent Requests

For urgent requests, we must respond within 72 hours. A request is considered urgent if delaying treatment would put your life in serious danger, interfere with your full recovery or delay treatment for severe pain.

For both urgent and non-urgent requests you may contact our Customer Service Department to find out our decision. You and the Provider recommending the services will receive a letter from us if the services will not be Covered.

If you obtain services that we say are not Covered or services in excess of what we say is Covered, you are responsible for payment for those services. If you want our decision to be reviewed, you may contact us. Section 11 tells you how to do that.

Reevaluation of Decision on Prior Approval

At any time, your Physician may ask us to reevaluate a Prior Approval decision we have made.

Retrospective Review

It is important to get Prior Approval so you know ahead of time if the services or supplies you seek will be Covered. If the required Prior Approval is not obtained, we may review the claim after you receive the services. If we determine that the care received was Medically/Clinically Necessary and provided by a Participating Provider, the care will be Covered. If we determine that the care received was Medically/Clinically Necessary and provided by a Non-Participating Provider, the care may only be Covered if the necessary care is unavailable from a Participating Provider. If we determine that the care received was not Medically/Clinically Necessary or the care was provided by a Non-Participating Provider when it could have been provided by a Participating Provider, the services will not be Covered.

Contact Information

To obtain Prior Approval, call the applicable number below:

- for mental health or substance abuse services – 800 673-8043
- for any other Covered Services that require approval – 800 828-8302.

E. Termination of Provider's Participation.

Participating Providers contract with us to provide Covered Services to Members. Either the Participating Provider or Priority Health can terminate that contract at any time. We cannot guarantee that you will be able to receive services from a specific Participating Provider while you are Covered under this plan. We will notify you if your PCP is no longer a Participating Provider so you can select another PCP. If your Specialist Provider terminates his or her participation with Priority Health, you can contact your PCP for a recommendation of a new Specialist Provider to visit. Our Customer Service Department is also available to assist you in finding another Participating Provider and in receiving care during the transition to a new Provider. If you have any questions, please call our Customer Service Department.

If you are being treated by a Participating Provider whose contract with us is terminated, you may be allowed to continue seeing that Provider for a limited time. So long as the Provider is able to continue treating you, you can receive Covered Services if, at the time of the Provider's contract termination:

(1) you are receiving on-going care. You may continue to see this Provider for up to 90 days or until Priority Health makes other arrangements for you to receive the same services from another Participating Provider.

(2) you are undergoing treatment for a chronic or disabling condition, or are in the second or third trimester of pregnancy. You may continue to see this Provider for up to 90 days, or through completion of postpartum care.

(3) you are undergoing treatment for a terminal Illness. You may continue to be treated by this Provider for the remainder of your life.

NOTE: If the Participating Provider's contract with Priority Health has been terminated for quality of care reasons, we will not Cover any care you receive from him or her.

F. Non-Emergent Care After Regular Office Hours.

If you become Ill or are Injured after regular office hours, call your PCP's office and tell them you are a Member of Priority Health. Your PCP or another Participating Provider acting on his or her behalf must be available 24 hours a day, 7 days a week to help you determine the best place to go for care.

G. Medical Emergency or Urgent Care.

Medical Emergency care and Urgent Care services are Covered under this Certificate. You do not need Prior Approval from your PCP or Priority Health to seek care in a Medical Emergency or when Urgent Care is needed. Prior Approval is not required even when this care is provided by a Non-Participating Provider.

(1) Urgent Care

When you have an Illness or Injury that needs immediate attention, such as cuts or sprains, but it is not as serious as a Medical Emergency, call your PCP before you seek any services. Your PCP will help you determine the best place to go for care. If you are out of the Service Area at that time, your PCP will determine if you can wait for those services and supplies until you could reasonably return to receive them from a Participating Provider. If you cannot reach your PCP's office and your Illness or Injury needs Urgent Care, go to an Urgent Care Center or Hospital emergency room. Present your ID Card and be prepared to pay the required Copayment or Deductible.

Urgent Care services received from a Non-Participating Provider who is located <u>in</u> our Service Area are not Covered. Urgent Care services received from a Non-Participating Provider who is located <u>outside</u> of our Service Area are Covered.

If you receive Urgent Care services from a Non-Participating Provider, contact your PCP's office as soon as possible so your PCP can arrange follow-up treatment. Do not return to the Urgent Care Center or emergency room for follow-up care unless it is an urgent situation or Medical Emergency. Any follow-up care that is provided by a Non-Participating Provider must be Prior Approved by Priority Health in order to be Covered.

(2) Medical Emergency

If you have a Medical Emergency, seek help immediately. All care needed to treat a Medical Emergency will be Covered. This includes care provided by Non-Participating Providers.

If you are confined in a Hospital as an inpatient after a Medical Emergency, you (or someone on your behalf) must let your PCP and Priority Health know about your confinement as soon as it is reasonably possible. Once your inpatient stay is no longer a Medical Emergency, Priority Health must approve your continued inpatient stay at any Non-Participating Hospital in order for it to be Covered. Once your condition has stabilized, Priority Health may require you to be transferred to a Participating Facility to continue to be Covered.

Following a Medical Emergency, your PCP can provide or arrange all follow-up care with Participating Providers. Follow-up care with Non-Participating Providers will only be Covered if you receive Prior Approval from us.

(3) Ambulance Services.

"Ambulance" includes a motor vehicle or aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

In a Medical Emergency, we will Cover EMT and ambulance service to the nearest medical facility that can provide Medical Emergency care.

We will Cover ambulance transfers between facilities that we approve in advance. Any other non-emergent transportation is not Covered unless approved in advance by us.

H. Additional Information.

The following information is available from our Customer Service Department:

(1) Our current Provider Directory.

(2) The professional credentials of our Participating Providers. This includes, but is not limited to, Participating Providers who are board certified in the specialty of pain medicine and the evaluation and treatment of chronic or acute pain.

(3) The telephone number of the Michigan Department of Licensing and Regulatory Affairs where you can call to find out information regarding disciplinary actions or formal complaints filed against a Provider.

(4) Prior Approval requirements and any limitations, restrictions or exclusions on services, benefits or Providers.

(5) The type of financial relationships between us and our Provider Network.

(6) How we evaluate new technology for inclusion as a Covered Service.

(7) How we evaluate new drugs for inclusion on our Approved Drugs List.

(8) A printed version of this Certificate of Coverage.

Request this information by calling or writing to our Customer Service Department at the phone numbers or address below.

Priority Health
Customer Service Department, MS 1105
P. O. Box 269
Grand Rapids, MI 49501-0269
616 942-1221 or 800 446-5674

or

use our secure e-mail form in the Member Center on our website at *priorityhealth.com*

I. Providers Included on the Office of Inspector General's List of Excluded Individuals/Entities.

As required by law, Priority Health will not pay claims for items or services furnished, ordered, or prescribed by any Provider listed on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities. A Provider or entity may be on this exclusions list due to convictions for program-related fraud and abuse, licensing board actions or default on Health Education Assistance Loans.

You will be responsible for the full payment of items or services furnished, ordered, or prescribed by any Provider included on the OIG List of Excluded Individuals/Entities. This includes items or services such as prescriptions written by or medical equipment ordered by a Provider included on this list. This list is available on the OIG website at www.hhs.gov/oig.

SECTION 6. Covered And Non-Covered Services

Covered and Non-Covered Services are listed below. The Schedule of Copayments and Deductibles specifies applicable benefit limits, Copayments and Deductible amounts. There may be additional Covered Services and limitations described in Riders or amendments to this Certificate. Benefit limits and maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

IMPORTANT NOTE

This Certificate only Covers services that are Medically/Clinically Necessary as defined in this Certificate and according to medical and behavioral health policies established by us, with the input of Physicians not employed by us, or according to criteria developed by reputable external sources and adopted by us. Additionally, certain services require Prior Approval from us before they will be Covered. See Section 5.D for detailed information about Prior Approval requirements. If you do not follow the necessary steps in the Prior Approval process or obtain services in excess of what is approved, certain services may not be Covered. You are responsible for paying for services we do not Cover, whether received from Participating or Non-Participating Providers.

The headings used in Section 6 are intended to provide a convenient listing of Covered and Non-Covered Services. If you cannot find a particular service, please contact our Customer Service Department. The services are organized alphabetically within each of the following categories:

A. Professional Services
   1. Preventive Health Care Services
   2. Other Services Provided by Health Professionals
B. Prescription Drugs and Supplies
C. Hospitals, Diagnostic Tests and Other Facilities Services
D. Medical Emergency and Urgent Care Services
E. Durable Medical Equipment (DME) and Supplies
F. Behavioral Health Services
   1. Mental Health Services
   2. Substance Abuse Services
G. Family Planning and Maternity Care Services
H. Dental, Vision and Hearing Services
I. Additional Coverage Information

Services described in this Section 6 will be Covered when those services are:

(1) Routine or preventive health care services or Medically/Clinically Necessary health care services as described in this Certificate; and

(2) Provided by your PCP, a Participating Physician, or a Participating Provider and with Prior Approval from us when required; or

(3) Provided by a Non-Participating Provider upon referral from your PCP with Prior Approval from us when required; and

(4) Not excluded elsewhere in this Certificate or in an amendment to this Certificate.

Sometimes your PCP or other Participating Physician may refer you for or suggest a service that we do not Cover. This referral or suggestion does not mean that service will be Covered.

A. Professional Services

1. Preventive Health Care Services

Preventive health care services are listed in Priority Health's Preventive Health Care Guidelines available in the Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department. Covered preventive health care services include:

(a) Immunizations (doses, recommended ages, and recommended populations vary)
- Certain vaccines – children from birth to age 18
- Certain vaccines – all adults

(b) Certain Drugs
- Aspirin – men and women of certain ages

- Folic Acid supplements – women who may become pregnant
- Fluoride Chemoprevention supplements – children without fluoride in their water source
- Gonorrhea preventive medication – all Newborns
- Iron supplements – children ages 6 to 12 months at risk for anemia

(c) Screening and Counseling Services for Adults

- Abdominal Aortic Aneurysm – men of specified ages who have ever smoked (one-time only)
- Alcohol Misuse – all adults
- Blood Pressure – all adults
- Cholesterol – adults of certain ages or adults at higher risk
- Colorectal Cancer – adults over 50
- Depression – all adults
- Type 2 Diabetes – adults with high blood pressure
- Diet counseling – adults at higher risk for chronic disease
- HIV – all adults at higher risk
- Obesity – all adults
- Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk
- Tobacco Use – all adults (includes cessation interventions for tobacco users)
- Syphilis – all adults at higher risk

(d) Screening and Counseling Services for Women Only (Including Pregnant Women)

- Anemia – on a routine basis for pregnant women
- Bacteriuria (urinary tract or other infection screening) – pregnant women
- BRCA (counseling about genetic testing) – women at higher risk
- Breast Cancer Mammography – every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention – women at higher risk
- Breast Feeding – interventions to support and promote breast feeding
- Cervical Cancer – sexually active women
- Chlamydia Infection – younger women and other women at higher risk
- Gonorrhea – all women at higher risk
- Hepatitis B – pregnant women at their first prenatal visit
- Osteoporosis – women over age 60 depending on risk factors
- Rh Incompatibility – all pregnant women and follow-up testing for women at higher risk
- Tobacco Use – all women, and expanded counseling for pregnant tobacco users
- Syphilis – all pregnant women or other women at increased risk

(e) Assessments and Screenings for Children

- Alcohol and Drug Use Assessments – adolescents
- Autism Screening – children at 18 and 24 months
- Behavioral Assessments – children of all ages

- Cervical Dysplasia Screening – sexually active females
- Congenital Hypothyroidism Screening – Newborns
- Developmental Screening – children under age 3, and surveillance throughout childhood
- Dyslipidemia Screening – children at higher risk of lipid disorders
- Hearing Screening – all newborns
- Height, Weight and Body Mass Index Measurements – children of all ages
- Hematocrit or Hemoglobin Screening – children of all ages
- Hemoglobinopathies or Sickle Cell Screening – all Newborns
- HIV Screening – adolescents at higher risk
- Lead Screening – children at risk of exposure
- Medical History – all children throughout development
- Obesity Screening and Counseling – children of all ages
- Oral Health Risk Assessment – young children
- Phenylketonuria (PKU) Genetic Disorder Screening – all newborns
- Sexually Transmitted Infection (STI) Prevention Counseling – adolescents at higher risk
- Tuberculin Testing – children at higher risk of tuberculosis
- Vision Screening – all children

2. Other Services Provided by Health Professionals

Services listed in this Section 6.A.2 are Covered when provided by a Participating Provider or Non-Participating Provider during an office, home or Hospital visit for the diagnosis and treatment of a Covered Illness or Injury and approved in advance by us if required, including:

(a) Services necessary to treat a Medical Emergency or Urgent Care situation, and

(b) Services and supplies received from a Participating obstetrician/gynecologist for an annual well-woman examination or routine pregnancy services.

Allergy Testing and Treatments

Covered Services

Allergy testing, evaluations and injections, including serum costs.

Non-Covered Services

Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine autoinjections, bronchial or oral allergen sensitization and provocative and neutralization testing for allergies.

Clinical Ecology and Environmental Medicine

Non-Covered Services

"Clinical ecology" and "environmental medicine" means medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems. This plan does not Cover services or supplies needed to make changes to your physical environment even when those changes are recommended as treatment for an Illness or Injury.

Diabetic Services, Supplies, and Medications

Covered Services

(a) Blood glucose monitors and diabetes test strips.

(b) Syringes and lancets.

(c) Diabetes educational classes to ensure that persons with diabetes are trained as to proper self-management and treatment of their diabetes.

(d) Certain diabetic supplies, such as syringes, needles, lancets, and blood glucose test strips, may be purchased at a Participating Durable Medical Equipment (DME) Provider. Your DME Copayment will apply. If you have a prescription drug Rider, these supplies may also be purchased at a Participating pharmacy and your prescription drug Copayment will apply.

(e) Insulin pumps.

(f) Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.

(g) Specialty shoes prescribed for a person with diabetes.

Non-Covered Services

(a) Alcohol and gauze pads.

(b) Insulin and other medications for Members with diabetes are not Covered unless you have a prescription drug Rider.

(c) Services and supplies for the convenience of the Member or caregivers.

Dietitian Services

Covered Services

(a) Consultations with a Participating dietitian, upon referral from your PCP, up to a maximum of 6 visits per Contract Year. Dietitian services must be obtained from a dietitian employed by a Participating Provider.

(b) See Priority Health's Preventive Health Care Guidelines for additional dietitian services that may be Covered as a preventive health care service.

Educational Services

Covered Services

(a) Education conducted by Participating Providers about managing chronic disease states such as diabetes or asthma.

(b) Maternity classes conducted by Participating Providers.

Non-Covered Services

(a) Services for remedial education, including school-based services.

(b) Services, treatment or diagnostic testing related to learning disabilities, cognitive disorders and developmental delays.

(c) Education testing or training, including intelligence testing. Necessary testing and evaluations should be requested from and conducted by the child's school district.

(d) Classes covering such subjects as stress management, parenting and lifestyle changes.

Eye Care

Covered Services

Treatment of medical conditions and diseases of the eye.

Coverage Limitations

Vision care services are Covered as described later in this Section 6.

Foot Care

Non-Covered Services

(a) Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care.

(b) Cleaning, soaking, and skin cream application for the feet.

(c) Shoes unless attached to a brace or prescribed for a person with diabetes.

Home Health Care

Covered Services

Intermittent skilled services furnished in the home by a physical therapist, occupational therapist, respiratory therapist, speech therapist, licensed practical nurse or registered nurse.

Home Health Care is Covered when you are:

(a) confined to the home,

(b) under the care of a Physician,

(c) receiving services under a plan of care established and periodically reviewed by a Physician, and

(d) in need of intermittent skilled nursing care or physical, speech, or occupational therapy.

Non-Covered Services

Custodial Care is not Covered, even if you receive Covered Home Health Care or Skilled Nursing Services at the same time you receive Custodial Care.

Homeopathic and Holistic Services

Non-Covered Services

Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy.

Pain Management

Covered Services

Evaluation and treatment of chronic and/or acute pain as specified in our medical policies.

Reconstructive Surgery

Covered Services

(a) Reconstructive surgery to correct congenital birth defects and/or effects of Illness or Injury, if:

(i.) The defects and/or effects of Illness or Injury cause clinical functional impairment. "Clinical functional impairment" exists when the defects and/or effects of Illness or Injury:

- causes significant Disability or major psychological trauma (psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the Illness or Injury for which the reconstructive surgery is requested),
- interfere with employment or regular attendance at school,
- require surgery that is a component of a program of reconstructive surgery for a congenital deformity or trauma, or
- contribute to a major health problem, and

(ii.) We reasonably expect the surgery to correct the condition, and

(iii.) The services are approved in advance by us and you receive them within two years of the event that caused the impairment, unless either of the following applies:

- The impairment caused by Illness or Injury was not recognized at the time of the event. In that case, treatment must begin within two years of the time that the problem is identified, or
- Your treatment needs to be delayed because of developmental reasons.

We will Cover treatment to correct the functional impairment even if the treatment needs to be performed in stages as long as that treatment begins within two years of the event causing the impairment and as long as you remain a Member.

(b) Reconstructive Surgery Following Breast Cancer

In compliance with the Women's Health and Cancer Rights Act of 1998, we will consult with your PCP or other Participating Provider to determine Coverage for these services:

(i.) Reconstruction of the breast on which a mastectomy was performed;

(ii.) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(iii.) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

The requirement to receive services within two years of the event that caused the impairment does not apply to reconstructive surgery following breast cancer.

Coverage Limitations

See your Schedule of Copayments and Deductibles and any Rider to this Certificate for additional information about limitations on certain procedures, treatments and reconstructive surgeries.

Non-Covered Services

Cosmetic services, prescription drugs, treatment, therapies or procedures done primarily to improve the way any part of the body looks. Coverage is excluded for, among other things:

(a) Blepharoplasty of lower lids.

(b) Breast augmentation except when provided as part of post-mastectomy reconstructive services.

(c) Chemical peel for acne.

(d) Collagen implants.

(e) Diastasis recti repair.

(f) Excision or repair of excess or sagging skin, however, a panniculectomy is Covered according to our medical policies.

(g) Fat grafts, unless an integral part of another Covered procedure.

(h) Hair transplants or repair of any congenital or acquired hair loss, including hair analysis.

(i) Liposuction, unless an integral part of another Covered procedure.

(j) Orthodontic treatment, even when provided along with reconstructive surgery.

(k) Removal for excessive hair growth by any method, even if caused by an underlying medical condition.

(l) Rhytidectomy (wrinkle removal).

(m) Rhinophyma treatment.

(n) Salabrasion.

(o) Spider vein removal.

(p) Tattoo removal.

Rehabilitative Medicine Services

Covered Services

Therapy and/or Rehabilitative Medicine Services that result in meaningful improvement in your ability to perform functional day-to-day activities that are significant in your life roles, including:

(a) cardiac and pulmonary rehabilitation

(b) physical and occupational therapy

(c) speech therapy for treatment of medical diagnoses

(d) biofeedback for treatment of medical diagnoses when Medically/Clinically Necessary, as determined according to our medical policies.

NOTE: Covered physical and occupational therapy services include spinal manipulations by a chiropractor and all manipulations by osteopathic Physicians.

Short-term Rehabilitative Medicine Services are Covered if:

- Treatment is provided for an Illness, Injury or congenital defect for which you have received corrective surgery, and
- they are provided in an outpatient setting or in the home, and
- you cannot receive these services from any federal or state agency or any local political subdivision, including school districts, and
- they result in meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 90 days of starting treatment, and
- a Participating Physician refers, directs, and monitors the services.

Non-Covered Services

(a) Therapy is not Covered if there has been no meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 90 days of starting treatment.

(b) All therapies for developmental delays and cognitive disorders, including physical, occupational, speech, cognitive and sensory integration therapy.

(c) Cognitive rehabilitative therapy (neurological training or retraining).

(d) Craniosacral therapy.

(e) Prolotherapy

(f) Rehabilitation services obtained from non-Health Professionals, including massage therapists.

(g) Relational, educational and sleep therapy and any related diagnostic testing. This exclusion does not apply to therapy or testing provided as part of Covered Hospital Inpatient or Outpatient Care.

(h) Services outside the scope of practice of the servicing provider.

(i) Strength training and exercise programs.

(j) Summer programs meant to maintain physical condition or developmental status during periods when school programs are unavailable.

(k) Therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition including, but not limited to, cerebral palsy and developmental delays.

(l) Therapy to correct an impairment, when the impairment is not due to Illness, Injury or a congenital defect for which you have received corrective surgery.

(m) Visual training and sensory integration therapy.

(n) Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluation and all return to work programs.

(o) Notwithstanding item (h) above, extra-spinal manipulation and related services performed by a chiropractor are not Covered.

Sex Change or Transformation

Non-Covered Services

Any procedure or treatment, including hormone therapy, designed to change your physical characteristics from your biologically determined sex to those of the opposite sex. This exclusion applies despite any diagnosis of gender role or psychosexual orientation problems.

Tobacco Cessation Treatment

Covered Services

(a) Smoking cessation services provided by your PCP or other Participating Physician.

(b) Tobacco cessation drug treatments are Covered if you have a prescription drug Rider. See Priority Health's Preventive Health Care Guidelines for tobacco cessation drug treatments Covered under preventive health care services.

Non-Covered Services

Any other related services and supplies for the treatment of tobacco abuse.

Transplants

Covered Services

Evaluations for transplants and transplants of the following organs at a facility approved by us, but only when we have approved the transplant as Medically/Clinically Necessary and non-experimental:

(a) Bone marrow or stem cell.

(b) Cornea.

(c) Heart.

(d) Kidney.

(e) Liver.

(f) Lung.

(g) Pancreas.

(h) Small bowel.

In addition, we will Cover the following expenses:

(a) Computer organ bank searches and any subsequent testing necessary after a potential donor is identified, unless Covered by another health plan.

(b) Typing or screening of a potential donor only if the person proposed to receive the transplant is a Member.

(c) Donor's medical expenses directly related to or as a result of a donation surgery if the person receiving the transplant is a Member and the donor's expenses are not covered by another health benefit plan.

(d) One comprehensive evaluation per transplant except as permitted by our medical policies.

Non-Covered Services

(a) Community wide searches for a donor.

(b) All donor expenses, even those of Members, for transplant recipients who are not Members.

(c) Transplants of organs when the transplant is considered experimental or investigational.

Weight Loss Services

Covered Services

(a) Physician-supervised weight loss programs that we have reviewed and approved or as outlined in our medical policies.

(b) Certain surgical treatments when co-morbid health conditions exist and all reasonable non-surgical options have been tried. Your Schedule of Copayments and Deductibles gives more detail about which surgeries require our Prior Approval.

NOTE: Surgical treatment of obesity is limited to once per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.

Non-Covered Services

Weight loss services not specifically listed above under *Covered Services* are not Covered. This includes, but is not limited to: food, food supplements, gastric balloons, certain weight loss surgeries, jaw wiring, liposuction, physical fitness or exercise programs.

B. Prescription Drugs and Supplies

Prescription Drugs Received while you are an Inpatient.

Covered Services

Drugs and supplies that are prescribed and received during a Covered inpatient stay are Covered as medical benefits.

Cancer Drug Therapy and Clinical Trials

Covered Services

As required by state law, drugs for cancer therapy and the reasonable cost of administering them are Covered. These drugs are Covered regardless of whether the federal Food and Drug Administration (FDA) has approved the cancer drugs to be used for the type of tumor for which the drugs are being used.

Coverage Limitations

Routine patient costs in connection with certain Phase II and Phase III cancer clinical trials may be Covered if approved in advance by our Medical Director.

Coordination of Benefits for drugs for cancer therapy and cancer clinical trials: If you have prescription drug coverage under a Rider with your Priority Health plan or another plan, drugs for cancer therapy and cancer clinical trials will be Covered by your prescription drug Rider before Coverage under your Priority Health medical plan will apply.

Non-Covered Services

Experimental, investigational or unproven services are not Covered. Additionally, certain drugs for which a majority of experts believe further studies or clinical trials are needed to determine toxicity, safety or efficacy, of the drug are not Covered.

Injectable Drugs.

Covered Services

The following drugs are Covered as medical benefits. Exceptions are outlined in our medical policies.

(a) Injectable and infusible drugs administered in an inpatient or emergency setting.

(b) Injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility.

Coverage Limitations

We may require selected Specialty Drugs be obtained by your Provider through a Specialty Pharmacy.

Selected injectable drugs in certain categories and drugs that are not primarily intended to be administered by a Health Professional are Covered only if you have a prescription drug Rider to this Certificate.

Non-Covered Services

Drugs that are intended to be self-administered as defined by the federal Food and Drug Administration. This includes self-administered drugs for certain diseases, such as arthritis, growth deficiency, hepatitis, multiple sclerosis, and for certain other Illnesses or Injuries.

Outpatient Prescription Drugs

Covered Services

Drugs listed in Section 6.A.1(b) under “Preventive Health Care Services.”

Non-Covered Services

Outpatient prescription drugs and supplies are not Covered unless you have a prescription drug Rider to this Certificate.

C. Hospitals, Diagnostic Tests, And Other Facilities Services

Ambulatory Surgical Services and Supplies

Covered Services

Outpatient services and supplies furnished by a surgery center along with a Covered surgical procedure on the day of the procedure.

Hospice Care

Covered Services

The following Hospice Care services, provided as part of an established hospice program are Covered when your Physician informs Priority Health that your condition is terminal and Hospice Care would be appropriate:

(a) Inpatient Hospice Care. Short-term inpatient care in a licensed hospice facility is Covered when Skilled Nursing Services are required and cannot be provided in other settings. Prior Approval of inpatient Hospice Care is required.

(b) Outpatient Hospice Care. Outpatient care is Covered when intermittent Skilled Nursing Services by a registered nurse or a licensed practical nurse are required or when medical social services under the direction of a Physician are required. Outpatient Hospice Care is any care provided in a setting other than a licensed hospice facility. Hospice Care provided while you are in a Hospital or skilled nursing facility is considered outpatient Hospice Care.

(c) Respite Care. Respite care in a facility setting is Covered as outlined in our medical policies.

Non Covered Services

Custodial Care is not Covered even if you receive inpatient or outpatient Hospice Care along with Custodial Care.

Hospital and Longterm Acute Care

Covered Services

(a) Hospital Inpatient Care. Hospital and longterm acute inpatient services and supplies including services performed by Physicians and Health Professionals, room and board, general nursing care, drugs administered while you are confined as an inpatient, and related services and supplies. Non-emergency inpatient Hospital stays must be approved in advance by us.

NOTE: Inpatient Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section do not require Prior Approval.

(b) Hospital Outpatient Care. Hospital services and supplies listed under Hospital Inpatient Care above that you receive on an outpatient basis. Hospital Observation Care received after an emergency room visit is considered Hospital Outpatient Care.

Coverage Limitations

See your Schedule of Copayments and Deductibles and any Riders to this Certificate for additional information about limitations on certain procedures, treatments and surgeries.

Non-Covered Services

Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.

Private Duty Nursing

Non-Covered Services

Nursing services provided in a facility or private home, usually to one patient. Private duty nursing services are generally provided by independently contracted nurses, rather than through an agency, such as a Home Health Care agency.

Radiology Examinations and Laboratory Procedures

Covered Services

Diagnostic and therapeutic radiology services and laboratory tests not excluded elsewhere in this Section. See Section 5.D for Prior Approval requirements.

(a) All non-emergency laboratory tests, including high-tech radiology examinations, must be performed at a participating laboratory or facility.

(b) Except for preventive health care services and maternity care, radiology services and laboratory tests may be subject to a Deductible even if ordered and performed in a Provider's office.

(c) Radiology services and laboratory tests performed in a Hospital, either while you are an inpatient or an outpatient, are subject to the same Copayment and Deductible as Hospital services even if the service or test is ordered and partially performed in a Provider's office.

Skilled Nursing Services – Skilled Nursing, Subacute, and Inpatient Rehabilitation Facility Care

NOTE: Our admission criteria for Coverage are not the same as Medicare's, therefore, just because Medicare is covering your stay does not mean the services are Covered under this Certificate. Only services listed in this Section 6 are Covered.

Covered Services

Care and treatment, including therapy, and room and board in semi-private accommodations, at a skilled nursing, subacute, or inpatient rehabilitation facility is Covered when we have approved a treatment plan in advance.

Coverage Limitations

See the Non-Hospital Facility Services category of your Schedule of Copayments and Deductibles for the number of days Covered under your plan.

Non-Covered Services

(a) Admission to a skilled nursing, subacute or inpatient rehabilitation facility is not Covered if the necessary care or therapies can be provided safely in a less intensive setting, including the home or a Provider office.

(b) Care provided in a facility required to protect you against self-injurious behavior is not Covered.

(c) Custodial Care is not Covered, even if you receive Skilled Nursing Services or therapies along with Custodial Care.

(d) Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.

(e) Residential Facility or Assisted Living Facility Care. Non-skilled care received in a residential facility or assisted living facility on a temporary or permanent basis is not Covered. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.

D. Medical Emergency and Urgent Care Services

Medical Emergency care and Urgent Care Services are Covered under this Certificate. You do not need Prior Approval from your PCP or Priority Health to seek care in a Medical Emergency or when Urgent Care is needed.

See Section 5.G for detailed information about Medical Emergency and Urgent Care benefits.

E. Durable Medical Equipment (DME) and Supplies

Durable Medical Equipment (DME)

DME is equipment intended for repeated use in order to serve a medical need, is generally not useful to a person in the absence of Illness or Injury, and is appropriate for use in the home. Examples of Covered DME are manual wheelchairs, CPAP machines and glucose monitoring devices. DME charges over $1,000.00 must be approved in advance by us. For a complete list of Covered DME, go to *priorityhealth.com* or call our Customer Service Department.

Covered Services

(a) DME prescribed by your PCP or by a Physician or Health Professional.

(b) Repair or replacement, fitting and adjustment of Covered DME needed as the result of normal use, body growth or body change.

(c) Training or education on the use of DME.

(d) Disposable supplies necessary for the proper functioning or application of the DME.

(e) Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.

(f) Specialty shoes according to the criteria specified in our medical policies.

NOTE: Inhaler assist devices and some diabetic supplies, such as syringes, needles, lancets and blood glucose test stripes may be Covered as a prescription drug benefit depending on where you obtain the supplies. If you do not have a prescription drug Rider, these devices and supplies are Covered as a DME benefit.

Coverage Limitations

(a) Coverage is for standard DME only. Equipment must be appropriate for home use.

(b) Coverage is limited to one piece of same-use equipment. We may substitute one type or brand of DME for another when the items are comparable for meeting your medical needs. Wheelchair Coverage is generally limited to a manually operated, standard wheelchair unless another model is Prior Approved by us according to our medical policies.

(c) DME may be rented, purchased or repaired. The decision to rent, purchase, repair or replace DME is made by Priority Health. We may limit replacement of DME to the expected life of the equipment.

Non-Covered Services

(a) Equipment that is not conventionally used for the medical need for which it was prescribed.

(b) Equipment and devices solely for the convenience of you or your caregiver.

(c) The purchase or rental of personal comfort items, convenience items, or household equipment that have customary non-medical purposes, such as protective beds, chair lifts, air purifiers, water purifiers, exercise equipment, non-allergenic pillows, mattresses or waterbeds, spas, tanning equipment, and other similar equipment even if they are Medically/Clinically Necessary.

(d) Modifications to your home, living area, or motorized vehicles. This includes equipment and the cost of installation of equipment, such as central or unit air conditioners, escalators, elevators, swimming pools, and car seats.

(e) Items designed for self-assistance, safety, communication assistance and other adaptive aids. This includes, but is not limited to, reachers, feeding, dressing and bathroom aids, augmentive communication devices, car seats, and protective beds.

(f) Non-standard DME unless we approve the non-standard equipment in advance.

(g) All repairs and maintenance that result from misuse or abuse.

(h) Replacement of lost or stolen DME.

Food, Supplements and Formula

Covered Services

(a) Supplemental feedings administered via tube. This type of nutrition therapy is also known as enteral feeding. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy, are Covered.

(b) Supplemental feedings administered via an IV. This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies, and equipment needed to administer this type of nutrition are Covered.

Non-Covered Services

Except for formula specifically intended for tube feeding and nutrients necessary for IV feeding, all food, formula and nutritional supplements are not Covered. This includes, but is not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the FDA.

Medical Supplies

Covered Services

(a) Medical supplies received while an inpatient or in connection with a home health visit are Covered at your Hospital benefit level.

(b) Some medical supplies are Covered under your Durable Medical Equipment benefit, including such supplies as catheters, syringes, ostomy supplies, feeding tubes, and lancets.

Non-Covered Services

Certain outpatient medical supplies that are consumable or disposable supplies, including, among other things, gloves, diapers, adhesive bandages, elastic bandages, and gauze.

You may call our Customer Service Department or go to *priorityhealth.com* to find out if the medical supplies you need are Covered.

Prosthetic and Orthotic/Support Devices

Covered Services

(a) Surgically implanted prosthetic devices, such as a replacement hip or heart pacemaker.

(b) Externally worn prosthetic devices.

(c) Purchased, repaired or replaced prosthetics and orthotics.

(d) We will Cover repairs or replacement, fitting and adjustment of Covered prosthetic and orthotic/support devices that is need as the result of normal use, body growth or change.

Non-Covered Services

(a) All repairs and maintenance that result from misuse or abuse.

(b) Appliances that have been lost or stolen.

(c) Prosthetic or orthotic devices that are not conventional, not Medically/Clinically Necessary according to the criteria set forth in our medical policies, or are for the convenience of the Member or caregivers.

You may call our Customer Service Department or go to *priorityhealth.com* to find out if the prosthetic or orthotic/support device you need is Covered.

F. Behavioral Health Services

Mental Health Services

Covered Services

This plan Covers evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for both acute and chronic mental health conditions. Both crisis intervention and solution-focused treatment are Covered. Covered Services must be:

(a) provided by licensed behavioral Health Professionals;

(b) provided in licensed behavioral health treatment facilities; and

(c) clinically proven to work for your condition.

Mental health services are available in a variety of settings. You may be treated as an inpatient or as an outpatient depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know where to go for treatment, call our Behavioral Health Department at 616 464-8500 or 800 673-8043 to speak with a trained clinician who can assist you. Covered treatment settings include:

i. Acute Inpatient Hospitalization. This is the most intensive level of care. Prior Approval from our Behavioral Health department is required for inpatient services except in a Medical Emergency. Upon discharge, you will be referred to a less intensive level of care.

ii. Partial Hospitalization. This is a non-residential level of service that is similar in intensity to acute inpatient hospitalization. You are generally in treatment for more than four hours but less than eight hours daily. Prior Approval from our Behavioral Health department is required for partial hospitalization services.

iii. Intensive Outpatient Treatment. This is outpatient treatment that is provided with more frequency and intensity than routine outpatient treatment. You are generally in treatment for up to four hours per day, and up to five days per week. You may be treated individually, as a family or in a group.

iv. Outpatient Treatment. This is the least intensive, and most common, type of service. It is provided in an office setting, generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day by a licensed behavioral Health Professional. Services provided via telephone, e-mail or Internet are not Covered.

Coverage Limitations

Certain conditions have unique Coverage limitations as stated below. Treatment for medical complications related to these conditions, including but not limited to neuropsychological testing, when appropriate, is Covered under your medical benefits.

NOTE: Prescription Drug Coverage is only available when you are confined as an inpatient unless you have a prescription drug Rider to this Certificate.

(a) Eating disorders, and feeding disorders of infancy or childhood, are Covered at all levels of care described above based on our medical policies.

(b) Attention deficit hyperactivity disorders are Covered for initial evaluation, and follow-up psychiatric medication management. Outpatient behavioral therapy is Covered for children age 12 and under.

(c) Personality disorders are Covered only for specific psychological testing to clarify the diagnosis.

(d) Organic brain disorders are Covered for initial evaluation to clarify the diagnosis and for follow-up psychiatric medication management. Inpatient services for Members with organic brain disorders, such as closed head Injuries, Alzheimer's and other forms of dementia, are Covered based on our medical policies.

(e) Pervasive developmental disorders, including but not limited to autism spectrum disorder, are Covered for initial evaluation and follow-up psychiatric medication management.

Non-Covered Services

(a) Care provided in a home, residential or institutional facility, or other facility on a temporary or permanent basis is not Covered, including:

i. the costs of living and being cared for in:
   1. transitional living centers,
   2. non-licensed programs, or
   3. therapeutic boarding schools.

ii. the costs for care that is:
   1. Custodial,
   2. designed to keep you from continuing unhealthy activities, or
   3. typically provided by community mental health services program.

(b) Counseling and other services for:

i. caffeine abuse or addiction,

ii. sexual/gender identity issues, including sex therapy,

iii. antisocial personality,

iv. insomnia and other non-medical sleep disorders,

v. adoption adjustment issues, including treatment for reactive attachment disorder,

vi. marital and relationship enhancement, and

vii. religious oriented counseling provided by a religious counselor who is not a Participating Provider.

(c) Experimental/investigational or unproven treatments and services.

(d) Scholastic/educational testing is not Covered. Intelligence and learning disability testing and evaluations should be requested and conducted by the child's school district.

Substance Abuse Services

Covered Services

Substance abuse services, including counseling, medical testing, diagnostic evaluation and detoxification are Covered in a variety of settings. You may be treated in an inpatient or outpatient setting, depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know what the most appropriate treatment setting is for your condition, call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance. Priority Health follows the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Outpatient substance abuse services do not require referral from your PCP or us. Inpatient substance abuse services (including partial hospitalization) require Prior Approval from our Behavioral Health Department, except in a Medical Emergency.

Covered treatment includes:

(a) Inpatient Detoxification. These are detoxification services that are provided while you are an inpatient in a Hospital or subacute unit. When provided in a medical setting, services are managed jointly by our Behavioral Health and Health Management Departments.

(b) Medically Monitored Intensive Inpatient Treatment. Following full or partial recovery from acute detoxification symptoms, this type of care is provided at an inpatient facility or subacute unit.

(c) Partial Hospitalization. This is an intensive, non-residential level of service provided in a structured setting, similar in intensity to inpatient treatment. You are generally in treatment for more than four hours but generally less than eight hours daily.

(d) Intensive Outpatient Programs. These are outpatient services provided by a variety of Health Professionals at a frequency of up to four hours daily, and up to five days per week.

(e) Outpatient Treatment. This is the least intensive level of service. It is provided in an office setting generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.

(f) Outpatient/Ambulatory Detoxification. These detoxification services may be provided on an outpatient basis within a structured program when the consequences of withdrawal are non-life-threatening. These services are Covered under your medical benefits.

Coverage Limitations

Prescription Drug Coverage is only available when you are confined as an inpatient unless you have a prescription drug Rider to this Certificate.

Non-Covered Services

(a) The costs of residential treatment programs without medical monitoring, institutional care, non-licensed programs, half-way houses or assisted living settings.

(b) Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.

(c) Services for caffeine abuse or addiction.

(d) Experimental/investigational or unproven treatments and services.

G. Family Planning And Maternity Care Services

Abortions

Non-Covered services

All services and supplies relating to elective abortions.

Contraceptive Medications and Devices

Covered Services

Contraceptive medications and devices are a Covered benefit only with a Rider to this Certificate.

Maternity and Newborn Care

Covered Services

(a) Hospital and Provider care. Services and supplies furnished by a Hospital or Provider for prenatal care, including genetic testing, postnatal care, Hospital delivery, and care for the Complications of Pregnancy.

The mother and Newborn have the right to an inpatient stay of no less than 48 hours following a normal vaginal delivery or no less than 96 hours following a cesarean section. If the mother and her attending Physician agree, the mother and the Newborn may be discharged from the Hospital sooner.

(b) Newborn child care. We will Cover a Subscriber's Newborn child (including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities) for the first 31 days from birth. If you want the Newborn's Coverage to continue beyond the first 31-day period, you must fill out and return to us a Change Form within 31 days after the child is born.

(c) Home care services. Telephone assessment and home visits by a registered nurse shortly after the date of the mother's discharge for evaluation of the mother, Newborn and family. These services are only available if you are discharged within the guidelines of the **Healthy**Encounters℠-Maternity Care program, our short-term stay maternity program, or if your Provider identifies a medical need.

(d) Maternity education programs.

Coverage Limitations

Maternity education services are only Covered at an approved program.

Non-Covered Services

(a) All maternity care, including prenatal services, delivery services and postpartum care, provided while you are outside of the Service Area is not Covered. We do not consider a routine delivery to be a Medical Emergency.

(b) Services and supplies received in connection with an obstetrical delivery in the home or free-standing birthing center.

Reproductive Services.

Covered Services

(a) Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility. Examples of Covered Services are sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.

(b) Advice on contraception and family planning, including childbirth education.

(c) Certain genetic counseling, testing and screening services when approved in advance by us.

(d) Sterilization procedures such as tubal ligations, tubal obstructive procedures and vasectomy. Vasectomy is only Covered when performed in a Physician's office or when performed in connection with another Covered inpatient or outpatient surgery.

NOTE: Reproductive services may be excluded or limited as shown in the Schedule of Copayments and Deductibles or a Rider to this Certificate.

Non-Covered Services

(a) Birth control pills, implantable contraceptive drugs (including insertion and removal), diaphragms or devices, and IUD's unless you have a prescription drug Rider that includes contraceptive management benefits

(b) Condoms, contraceptive foams, and contraceptive jellies and ointments.

(c) Services to reverse voluntary sterilization.

(d) All services and supplies relating to treatments for infertility including, among other things, artificial insemination, in-vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, fees to a surrogate parent, prescription drugs designed to achieve pregnancy, harvest preservation and storage of eggs or sperm.

H. Dental, Vision And Hearing Services

1. Dental Services

Covered Services

(a) Facility, ancillary and anesthesia services for limited dental services may be Covered for pediatric Members when:

(i.) a child under age seven needs multiple extractions or restorations.

(ii.) a total of six or more teeth are extracted in various quadrants.

(iii.) there are dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy.

(iv.) extensive oral-facial and/or dental trauma has occurred causing treatment under local anesthesia to be ineffective or compromised.

(v.) a patient has a serious medical condition that may interfere with routine dental work.

(vi.) medical services, such as suturing of lacerations, are required in connection with an accident.

(b) Facility, ancillary and anesthesia services relating to dental services for adults require Prior Approval by Priority Health.

(c) Removal of sound natural teeth required in preparation for other medical procedures that are Covered under this Certificate.

Non-Covered Services

Unless you have a dental Rider to this Certificate, the following dental services are not Covered, even when needed due to an underlying medical condition or in conjunction with other treatment or surgery:

(a) Routine dental services not listed in Priority Health's Preventive Health Care Guidelines.

(b) Dental x-rays.

(c) Dental surgery, such as root canals and tooth extractions.

(d) Orthodontia and orthodontic x-rays.

(e) Orthognathic surgery unless specifically Covered by this Certificate.

(f) Dental prostheses, including implants and dentures and preparation of the bone to receive implants or dentures.

(g) Bite splints used for dental purposes.

(h) Treatment of congenital dental defects, such as missing or abnormally developed teeth.

(i) Treatment, services and supplies related to periodontal/ inflammatory gum disease.

(j) Dental services required due to accidents.

<u>Oral Surgery</u>

Covered Services

(a) Treatment of fractures of facial bones.

(b) Biopsy and removal of tumors or cysts of the jaw, other facial bones, soft tissues of the mouth, lip, tongue, accessory sinuses, and salivary glands and ducts.

(c) Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury. This includes treatment for abnormalities such as cleft lip or cleft palate, among other things.

(d) Medical and surgical services required to correct accidental Injuries, including emergency care to stabilize dental structures following Injury to sound natural teeth.

(e) Treatment for oral and/or facial cancer.

(f) Treatment for conditions affecting the mouth other than the teeth.

Non-Covered Services

(a) Rebuilding or repair for cosmetic purposes.

(b) Orthodontic treatment, even when provided along with oral surgery.

(c) Dental surgery in preparation for implants or dentures, including preparation of the bone, or dental surgery done in connection with any of the Covered Services listed above.

Orthognathic Surgery

Covered Services

"Orthognathic surgery" is surgical treatment to restructure the bones or the other parts of the jaw to correct a congenital birth defect, the effect of an Illness or Injury or to correct other functional impairments.

We will only Cover the following orthognathic surgery services:

(a) Referral care for evaluation and orthognathic treatment.

(b) Cephalometric study and x-rays.

(c) Orthognathic surgery and post-operative care, including hospitalization, if necessary.

NOTE: These services are only Covered when approved in advance by us, and if we deem necessary, a dental consultant.

Coverage Limitations

See the Orthognathic Surgery category of your Schedule of Copayments and Deductibles for specific limitations to this benefit.

Non-Covered Services

Orthodontic treatment, even when provided along with orthognathic surgery.

Temporomandibular Joint Dysfunction or Syndrome

Covered Services

"Temporomandibular Joint Syndrome" or "TMJS" means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction.

We will Cover the following services:

(a) Medical care or services to treat dysfunction or TMJS resulting from a medical cause or Injury.

(b) Office visits for medical evaluation and treatment.

(c) X-rays of the temporomandibular joint including contrast studies, but not dental x-rays.

(d) Myofunctional therapy.

(e) Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

Coverage Limitations

See the Temporomandibular Joint Dysfunction or Syndrome category of your Schedule of Copayments and Deductibles for specific limitations to this benefit.

Non-Covered Services

Bite splints, orthodontic treatment, or other dental services to treat TMJS are not Covered.

2. Vision Care Services

Covered Services

One vision screening, performed as part of a physical exam, during each calendar year to determine vision loss.

Non-Covered Services

(a) Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses.

(b) Eye exercises, visual training, orthoptics, sensory integration therapy.

(c) Radial keratotomy, laser surgeries and other refractive keratoplasties.

(d) Refractions (tests to determine if eyeglasses are needed, and if so, what prescription).

(e) All other vision care services unless you have a vision care Rider to this Certificate.

3. Hearing Care Services

Covered Services

One hearing screening, performed as part of a physical exam, during each calendar year to determine hearing loss.

Non-Covered Services

(a) Services and supplies related to hearing care, including ear plugs, external BAHA devices, hearing aids and adjustments, unless you have a hearing care Rider to this Certificate.

(b) Examinations for hearing aids, including examinations performed during a Covered hearing screening, unless you have a hearing Rider to this Certificate.

I. Additional Plan Information

Against Medical Advice/Noncompliance

Non-Covered Services

Services that are needed because you left a facility against medical advice or because you are noncompliant with treatment are not Covered.

Examples of services that may not be Covered include, but are not limited to:

(a) Emergency room services shortly after you left a facility against medical advice;

(b) A Hospital stay to treat complications caused by leaving a facility against medical advice;

(c) A Hospital stay to treat complications caused by not taking prescribed medications such as insulin or blood pressure medication.

Court Ordered Services

Covered Services

If a court orders services that are otherwise Covered under this Certificate, they will be Covered. All provisions of this Certificate, such as Prior Approval requirements, still apply when services are ordered by a court.

Non-Covered Services

Services required by court order, services required when filing or responding to an action with a court, including evaluations and testing, or services required as a condition of parole or probation, if these services are not otherwise Covered under this Certificate.

Domestic Violence

Covered Services

Treatment, services and supplies for Injuries resulting from domestic violence.

Experimental, Investigational or Unproven Services

Priority Health uses the following criteria when evaluating new technologies, procedures and drugs:

(a) Evidence of clear therapeutic effectiveness when used in the general population as demonstrated in peer-reviewed clinical trials.

(b) Evidence of patient safety when used in the general population.

(c) Evidence that the medical community in general accepts the safety and effectiveness of the service outside of investigational setting.

(d) Evidence of clinical meaningful outcomes.

(e) Evidence that clinically meaningful outcomes can be attained at a reasonable cost.

Covered Services

(a) Coverage is available for routine patient costs in connection with certain Phase II and Phase III cancer clinical trials. For information about which trials are Covered, your PCP should contact Priority Health's Health Management Department.

(b) Treatment that is experimental, investigational, or unproven may be Covered if the condition being treated is 1) a terminal disease and there are no reasonable alternative treatments, or 2) a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration. An individual case review will be conducted to determine if care or treatment that is investigational, yet promising for the conditions described will be Covered.

Non-Covered Services

Any drug, device, treatment or procedure that is experimental, investigational or unproven. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:

(a) The drug or device has not been approved by the Food and Drug Administration (FDA) and, therefore, cannot be lawfully marketed in the United States.

(b) An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy.

(c) The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy.

(d) Reliable Evidence shows that the drug, device, treatment or procedure is:

(i.) The subject of on-going Phase I or Phase II clinical trials; or

(ii.) The subject of research, experimental study, or the investigational arm of on-going Phase III clinical trials; or

(iii.) Otherwise under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or

(iv.) Believed by a majority of experts to require further studies or clinical trials to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis.

"Reliable Evidence" includes any of the following:

- Published reports and articles in authoritative medical and scientific literature, or technology assessment and cost effectiveness analysis; or
- A written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same or a similar drug, device, treatment or procedure; or
- Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device, treatment or procedure.

Not Medically/Clinically Necessary

Non-Covered Services

Services and supplies that we determine are not Medically/ Clinically Necessary according to medical and behavioral health policies established by Priority Health with the input of Physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health are not Covered.

All of the following are considered not to be Medically/Clinically Necessary:

(a) Those services rendered by a Health Professional that do not require the technical skills of such a Provider;

(b) Those services and supplies furnished mainly for the personal comfort or convenience of you, anyone who cares for you, or anyone who is part of your family;

(c) Those services and supplies furnished to you as an inpatient on any day on which your physical or mental condition could safely and adequately be diagnosed or treated as an outpatient;

(d) Any service or supply beyond those services sufficient to safely and adequately diagnose or treat your physical or mental condition; and

(e) Additional or repeated services or treatments of no demonstrated additional benefit.

NOTE: If we exclude Coverage because a service or supply is not Medically/Clinically Necessary, that decision is a determination about benefits and not a medical treatment determination or recommendation. You, with a Physician, may choose to go ahead with the planned treatment at your own expense. You have the option to Appeal our denial of your claim for Coverage as described in Section 11.

Other Non-Covered Services

Non-Covered Services

(a) Illegal Acts. Priority Health shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

We reserve the right to recover the cost of services and supplies that were initially Covered by us and later determined to be excluded as described in this **Illegal Acts** section.

(b) No Legal Obligation to Pay. Service or supplies are not Covered if you would not be required to pay for them if you did not have this Coverage. That includes, among other things, service and supplies performed or provided by a family member.

(c) No Show Charges. Any missed appointment fee charged by a Provider because you failed to show up at an appointment, except in the case of a Medical Emergency.

(d) Third Party Requirements. Services required or recommended by third parties, such as courts, schools, employers, or accrediting/licensing agencies, related to getting or keeping a job, getting or keeping any license issued by a governmental body, getting insurance coverage, foreign travel, adopting children, obtaining or maintaining child custody, school admission or attendance and participation in athletics. Non-Covered Services include but are not limited to:

(i.) physical examinations in excess of one per year performed by your PCP or other Health Professional,

(ii.) diagnostic services; and

(iii.) immunizations.

(e) Unauthorized Services and Supplies. The following are not Covered:

(i.) Services and supplies that are not performed, prescribed, or arranged according to the guidelines of this Certificate; and

(ii.) Services and supplies that are provided without any required Prior Approval by us.

(f) Services and supplies not directly related to your care, such as guest meals and accommodations, telephone charges, travel expenses, take-home supplies and similar costs.

(g) Items or Services Furnished, Ordered or Prescribed by any Provider included on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities. This list is available on the OIG website at www.hhs.gov/oig.

(h) Non-Participating Providers. Services and supplies received from Non-Participating Providers are not Covered, except in the case of a Medical Emergency or if approved by us prior to obtaining the services and supplies. See Section 5.D for the requirements and the steps of the Prior Approval process, including how to confirm Coverage before receiving services.

(i) Treatment by a Federal, State, or Governmental Provider. The following are excluded to the extent permitted by law:

(i) Services and supplies provided in a Non-Participating Hospital owned or operated by any federal, state, or other governmental entity.

(ii) Services and supplies provided for conditions relating to military service, if you are legally entitled to the services and supplies and if you have reasonable access to the services and supplies at a governmental facility.

(iii) Services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment.

Providers Barred from Reimbursement

Coverage Limitations

Services and supplies received from Providers who either have been terminated from our Provider Network for failing to meet Priority Health's credentialing criteria, or Providers we have identified as being noncompliant with Priority Health's quality standards and programs.

SECTION 7. Limitations

You may only receive services from a Non-Participating Provider if your PCP or other Participating Physician has referred you and the services have been approved by us in advance. Otherwise, the services will not be Covered, and you will have to pay the entire cost. See Section 5.D for requirements and the steps of the Prior Approval process. You also must pay for services you receive in excess of services approved. Please call our Customer Service Department to find out if Priority Health has approved the services. This limitation does not apply to an annual well-woman examination or to routine obstetrical services with Participating Providers as described in Section 6.A.2.

NOTE: Sometimes your PCP or other Participating Physician may refer you for or suggest a service that we do not Cover. A referral from your PCP or another Participating Provider does not mean you will have Coverage for that service. If you receive services that we do not Cover, you must pay for the services.

A. Benefit Maximums.

Some of the Covered Services described in this Certificate are Covered for a limited number of days or visits per Contract Year. This is known as a benefit maximum. The Schedule of Copayments and Deductibles and any Riders to this Certificate list the maximums that apply to certain benefits. Once you have reached a maximum for a Covered Service, you will be responsible for the cost of additional services received during that Contract Year even when continued care is Medically/Clinically Necessary.

B. Out-of-Pocket Maximums.

There may be a limit to the total amount of percentage Copayments that you have to pay for Covered Services in a Contract Year. This limit is called an Out-of-Pocket Maximum. After meeting this maximum, you are still responsible for flat-dollar Copayments. The Schedule of Copayments and Deductibles and any Riders to this Certificate provide more information about Out-of-Pocket Maximums that may apply to you.

C. Work-Related Illness or Injury.

We will not pay for any expenses incurred because of Illness or Injury arising out of or in the course of gainful employment. This is true whether or not you apply for Worker's Compensation benefits. Coverage under this Certificate is not intended to replace, duplicate, or substitute for any Worker's Compensation coverage.

This limitation does not apply to a sole proprietor, partner (or spouse, child, or parent of a sole proprietor or partner), or corporate officer (who is an officer and stockholder owning at least 10% of the stock of a corporation that has 10 or fewer stockholders) if that person has been excluded from Coverage as an "employee" under the Michigan Worker's Compensation Act. If this limitation applies to you, please provide information directly to us.

D. Services Received While a Member.

We will only pay for Covered Services you receive while you are a Member and Covered under the Certificate. A service is considered to be received on the date on which services or supplies are provided to you. We can collect from you all costs for Covered Services that you receive and we pay for after your Coverage terminates, plus our cost of recovering those charges (including attorney's fees).

E. Uncontrollable Events.

A national disaster, war, riot, civil insurrection, epidemic or other similar event we cannot control may make our offices, personnel or financial resources unable to provide or arrange for the provision of Covered Services. If any of these events occur, Priority Health will not be liable if you do not receive those services or if they are delayed. We will make every effort to ensure necessary services are provided.

SECTION 8. Member Rights And Responsibilities

As a Priority Health Member, you have the right to:

- receive prompt medical care appropriate for your condition, including emergency care if necessary.
- discuss all treatment options available to you regardless of Coverage limitations.
- receive information about us, our services, our Providers and your rights and responsibilities.
- collaborate with Physicians and Health Professionals to make informed decisions about the care you receive.
- be treated with respect.
- have your privacy protected.
- have your medical and financial records maintained by us kept confidential, whether in electronic or written form. We will not disclose information from your medical records without your consent, except as allowed in accordance with our Notice of Privacy Practices which is included as Section 17 of this Certificate.
- be notified in a timely manner if we release information about you in response to a court order.
- inspect your medical records and those of your minor dependents. Your right as a parent or legal guardian to access your minor dependent's medical records without the minor's consent may be limited by state or federal law.
- contact us to discuss concerns about the quality of care you have received from a Participating Provider.
- register a complaint or file a Grievance with us, or the Commissioner of the Office of Financial and Insurance Regulation, if you experience a problem with us, or a Provider.
- initiate a legal proceeding if you experience a problem with us or Providers after you have exhausted the Grievance Process.
- register a complaint, file a Grievance, or initiate legal proceedings without retaliation by Priority Health.
- review a summary of Priority Health's annual report, and inspect the full report on file with the Office of Financial and Insurance Regulation.
- suggest changes to our Member Rights and Responsibilities policies.

As a Priority Health Member, you are responsible for:

- reading the Certificate of Coverage and accompanying Member materials.
- understanding and complying with the terms and conditions of your health benefits contained in this Certificate.
- calling us with questions.
- coordinating all medical services through your PCP or other Participating Physician, except in the case of a Medical Emergency.
- obtaining Prior Approval from Priority Health as specified in this Certificate, except in a Medical Emergency, and complying with the limits of any approval of services.
- using Participating Providers for all services and supplies not requiring Prior Approval.
- contacting Providers to arrange for appointments, and notifying Providers in a timely manner if an appointment must be canceled.

- paying Copayments and Deductibles at the time service is provided.
- presenting your ID card to the Provider before you receive a service.
- collaborating with Physicians and Health Professionals to make informed decisions about the care you receive and to understand your risks.
- following instructions and working toward treatment goals that you and your Provider agree upon. You may participate in developing your treatment goals when possible. Priority Health or your Providers may ask you to enter into an explicit written agreement setting forth your treatment plan to ensure you understand it.
- supplying Priority Health and Health Professionals with accurate and complete information to ensure you receive proper care.
- notifying providers and Priority Health if you have other health insurance coverage.
- providing accurate information on your Enrollment Form and in any other information provided to us.
- promptly notifying us of any change in address.
- promptly notifying us if your ID card is stolen.
- cooperating with us to prevent the unauthorized use of your ID card and to prevent anyone from obtaining benefits in your place
- treating Providers and their staff with respect.

See Section 17 for additional rights.

SECTION 9. Claims Provisions

When you receive Covered Services from a Participating Provider, you will not be required to pay any amounts except for applicable Copayments and Deductibles. You will not be required to submit any claim forms for Covered Services received from Participating Providers.

You are responsible for the cost of any services you receive from Non-Participating Providers unless those services were arranged by your PCP and approved in advance by us, or unless you need them to treat a Medical Emergency or Urgent Care situation.

A. If You Pay for Covered Services

If you must pay a Provider for Covered Services, ask us in writing to be reimbursed for those services. A Reimbursement Request Form is available in the Member Center on our website or by calling our Customer Service Department. With your request, you must give us proof of payment that is acceptable to us. You must send a bill that shows exactly what services were received, including applicable diagnosis and CPT codes, and date and place of service. A statement that shows only the amount owed is not sufficient. If you have questions about what to send us, please call our Customer Service Department.

B. Reimbursement Request Time Limit

We ask that you make your request for reimbursement within 60 days of the date you obtained the services. If you do not ask for reimbursement within 60 days, we can limit or refuse reimbursement. But we will not limit or refuse reimbursement if it is not reasonably possible for you to give us proof of payment in the required time, as long as you give us the required information as soon as reasonably possible.

We will only be liable for a claim or reimbursement request if we receive it within one year after the date of service, unless you didn't submit the claim because you are legally incapacitated.

C. Where to Send Your Bills

Send your itemized medical bills promptly to us at:

Priority Health
Claims Department
P.O. Box 232
Grand Rapids, MI 49501-0232

D. Information May Be Required for Payment

Before we pay Providers or reimburse you for services you receive, we may require you to give us more information or documentation to prove they are Covered Services. Unless you are legally incapacitated and, therefore, unable to respond, we will not be liable for a claim or reimbursement request if we ask for additional information from you and you do not respond to our request within 60 days. Our right to that information or documentation may be limited by state or federal law.

E. Overpayment

If we pay an amount under this Certificate and it is later shown that a lesser amount should have been paid, we are entitled to a refund of the excess. This applies to payments made to you or to the Provider of services, supplies or treatment.

SECTION 10. Termination Of Coverage

A. Termination of Agreement.

Either Priority Health or your Employer may terminate the Agreement between us and your Employer. If the Agreement is terminated, all Coverage under this Certificate will terminate at 11:59 p.m. on the effective date of the termination. It is your Employer's responsibility to let you know your Coverage has ended if the Agreement is terminated. If your Employer does not tell you your Coverage has ended, your Coverage will still end on the effective date of the termination.

If you lose your Coverage, we can collect from you all costs for Covered Services that you received after your Coverage terminated and we paid for, plus our cost of recovering those charges (including attorney's fees).

B. Loss of Eligibility.

If you no longer meet the eligibility requirements described in Section 2 of this Certificate or in Riders or amendments to this Certificate, your Coverage will terminate. If there is any conflict between the requirements described in this Certificate and the terms of the Agreement, the terms of the Agreement will govern eligibility.

Your Coverage will terminate at 11:59 p.m. on the date you lose your eligibility. That date may be in the past. However, if you did not know that you were no longer eligible or your Employer did not tell you that you were no longer eligible, we will give you 30 days notice before your Coverage terminates so you have the opportunity to find other coverage.

C. Termination For Cause.

(1) We can terminate your Coverage for cause 30 days after we notify you in writing if any of the following happens:

(a) Multiple Participating Providers ask you to leave their practices due to disruptive behavior.

(b) You fail to pay your share of any required Premium.

(c) You refuse to cooperate with us as required by the terms of this Certificate or the Agreement.

(d) You revoke your consent for us to release information to third parties or to receive information regarding your medical care, if your revocation makes it impossible for us to fulfill our responsibilities under this Certificate.

(2) We can terminate your Coverage for cause immediately if either of the following happens:

(a) You commit or attempt to commit fraud against us or you are dishonest with us about some important or material matter. For example, we may terminate your Coverage if:

(i.) you give us wrong or misleading information that affects the Coverage we provide to you and/or your Covered Dependents,

(ii.) you allow someone else use your ID card or receive benefits in your place.

(iii.) you enroll someone in this plan who is not eligible for Coverage.

Termination may be effective the day you committed the fraud or were dishonest with us. We can collect from you the costs for Covered Services that you received after the effective date of termination and we paid for, plus our cost of recovering those charges (including attorney's fees).

We will only rescind your Coverage as permitted by federal law, which allows rescission for fraud or material misrepresentation. Rescission means terminating your Coverage retroactively to your original effective date with us, with the effect that your Coverage never existed; or

(b) You act so disruptively that you upset our ordinary operations or those of a Participating Provider, including but not limited to verbally or physically threatening us or a Participating Provider.

If we tell you we have terminated or will terminate your Coverage, we will terminate your Coverage on the date stated in the notice. If you file a Grievance within 30 days of the date of the notice, we will reinstate your Coverage until a determination is made under Step 1 in the Grievance Procedure. If the Grievance Committee determines that your Coverage should be terminated for cause under this Section, we will again terminate your Coverage back to the date stated in the original termination notice. If you file an Appeal under Step 2 of the Grievance Procedure within 30 days of the date of the Grievance is determined, we will reinstate your Coverage until the Appeal Committee makes a final determination. If the Appeal Committee determines that your Coverage should be terminated under this Section, we will again terminate your Coverage back to the date stated in the original termination notice. During both steps of the Grievance Procedure, we will only reinstate your Coverage if your Premium is paid up to that time. Section 11 provides more information about the Grievance Procedure.

D. Certificate of Creditable Coverage.

After your Coverage is terminated for any reason, you and/or your Covered Dependent(s) will receive a Certificate of Creditable Coverage that will provide proof of the Coverage you had with us. In addition, you have the right to receive a Certificate of Creditable Coverage if you request one for yourself or your dependent(s) at any time within 24 months after the Coverage terminates. If you become covered by other health insurance, a Certificate of Creditable Coverage may help you to receive the new coverage without a pre-existing condition exclusion or with a shorter exclusion period.

You or your Covered Dependents may request a Certificate of Creditable Coverage by writing or calling Customer Service at:

Priority Health
Customer Service Department, MS 1105
P.O. Box 269
Grand Rapids, MI 49501-0269
800 446-5674 or 616 942-1221
or use our secure e-mail form in the Member Center on our website *priorityhealth.com*

SECTION 11. Inquiry And Grievance Procedure

We hope that you are always happy with the services you receive from Priority Health. We know, however, that from time to time you may have a problem or concern that you want us to address. If you have a question, concern or complaint about Priority Health, please call our Customer Service Department at 800 446-5674 or 616 942-1221. Our Customer Service representatives will help you with your problem as soon as possible.

If you are not happy with answers that our representative has provided or you are unhappy with our decision, you can start the formal Grievance Procedure. You can start Grievance proceedings about any of the following:

- Benefits (including services determined to be experimental or investigational or not Medically/Clinically Necessary),
- Eligibility,
- Rescission of your Coverage,
- Payment of claims (in whole or in part),
- How we've handled payment or coordination of health care services,
- Contracts with our Providers,
- Availability of care or Providers,
- Delivery or quality of health care services, or
- A decision not in your favor. This may include services that have been reviewed by Priority Health and denied, reduced or terminated. It also may include a slow response to a request for a decision from us.

A. Grievance Procedure.

Here is a summary of the steps of the Grievance Procedure:

Step 1: Contact our Customer Service Department or go to our website to file a formal Grievance with us. You must file a formal Grievance within 2 years of an adverse determination or within 2 years of learning of an adverse determination, whichever is later. Our Grievance Committee will meet to discuss your Grievance, and we will mail you a written decision. Our Grievance Committee is comprised of Priority Health employees, and may include senior managers and a Physician, none of whom were involved in the initial determination or are subordinates of someone who made the initial determination.

Step 2: If your Grievance has not been resolved to your satisfaction, you may request a hearing before our Appeal Committee. The Appeal Committee may be comprised of community Physicians, Priority Health members, employers who offer Priority Health to their employees, and Priority Health employees, none of whom were involved in the initial determination or the decision of the Grievance Committee or are subordinates of someone who served on the Grievance Committee.

We will let you know the date and time for the hearing. You may attend the portion of the Appeal Committee hearing that applies to your Grievance. Immediately after the hearing, we will send you a written decision.

If you have not yet received the services for which you are requesting Coverage: Steps 1 and 2 combined must be completed with a final determination made within 30 calendar days after we receive your Grievance and Appeal Forms The 30-day count does not include any days you or your representative may delay the process. Neither Step 1 nor Step 2 may take more than 15 days, respectively.

If you have already received the services for which you are requesting Coverage: Steps 1 and 2 combined must be completed with a final determination made within 35 calendar days after we receive your Grievance and Appeal Forms. The 35-day count does not include any days you or your representative may delay the process. Neither Step 1 nor Step 2 may take more than 30 days, respectively.

Step 3: If you are not satisfied with the resolution of your problem or complaint after completing all the steps of the Priority Health Grievance Procedure, you may request a review by the Michigan Office of Financial and Insurance Regulation. You may direct Appeals to the Commissioner at the following address and telephone number:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, Third Floor
P. O. Box 30220
Lansing, Michigan 48909-7720
(877) 999-6442
www.michigan.gov/ofir

B. Expedited Grievance Procedure.

If your Physician tells us (either in writing or by telephone) that the time it takes for us to review your concern under the normal Grievance Procedure would put your life in serious danger, interfere with your full recovery or delay treatment for severe pain, we will follow an "expedited" Grievance procedure. Steps 1 and 2 in an "expedited" Grievance procedure must be completed within 72 hours of receipt of your request.

C. Obtaining Information about the Grievance Procedure.

To obtain a complete copy of our Grievance Procedure and Grievance Filing Form, or to find out more about your rights under this Section, please contact our Customer Service Department or go to our website.

D. Obtaining Information about your Grievance.

E. You have the right to receive, free of charge, access to and copies of all documents relevant to a claim denial.

F. Filing a Lawsuit against Priority Health.

You have the right to bring an action for benefits under Section 502 of ERISA. However, before filing a lawsuit against us, you must complete our Grievance Procedure as described in this Section 11. In addition, 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 years after the time written proof of loss is required to be furnished.

SECTION 12. Continuation, Conversion or Extension of Benefits

A. Continuation of Coverage for Unmarried and Incapacitated Dependents.

We will continue to provide Coverage for your or your spouse's unmarried and Incapacitated Dependent past the age of 26, unless we have issued the dependent Conversion Coverage. For information on the maximum age for dependent children, see Section 2.B(3)(a). A Covered Dependent is incapacitated if all of the following apply:

(1) The Covered Dependent is the child of you or your spouse;

(2) The Covered Dependent is not capable of self-sustaining employment and is unable to independently socialize without assistance because of a mental or physical Disability that is incapacitating. Certain diagnoses, including but not limited to attention deficit disorder or depression, by themselves, are not evidence of incapacity. Learning disabilities or the inability to "hold a job" alone is not evidence of incapacity. Examples of diagnoses that may constitute an incapacitating condition include Down Syndrome and traumatic brain Injury.

(3) The incapacity must have started before age 26; and

(4) The Covered Dependent relies on you for more than half of his or her support, as determined under Section 152 of the Internal Revenue Code, as amended.

You must provide proof to us that the Covered Dependent is incapacitated no more than 31 days after the Covered Dependent reaches the age of 26. If your Covered Dependent is over the age of 26 at the time of enrollment, proof must be provided within 31 days of initial enrollment. After the initial proof of incapacitation, you must give us proof when we ask for it, from time to time, but not more often than once each year.

Coverage for an Incapacitated Dependent will end if any of the following events occur:

(a) The dependent is no longer a dependent of you or your spouse as described in subsection A(4) above;

(b) The dependent's incapacity ends;

(c) We do not receive proof that the dependent is incapacitated within 31 days of requesting such information;

(d) The dependent no longer meets eligibility requirements for any reason other than reaching 26 years of age; or

(e) The dependent is married after reaching 26 years of age.

B. Extension of Coverage for Family and Medical Leave.

If you are on a qualified leave of absence under the Family and Medical Leave Act of 1993 as amended (the "FMLA"), you may continue Coverage for yourself and any Covered Dependents during that leave. The Coverage will be the same and at the same Premium as if you were an Active Employee. If you fail to return from FMLA leave for any reason other than the continuation, recurrence, or onset of a serious health condition (as defined in the FMLA) or other circumstance, determined by your Employer to be beyond your control, your Employer may recover from you the amount your Employer paid to maintain Coverage for you during the leave. If you fail to pay your required Premium contribution for Coverage during your FMLA leave, your Coverage will be suspended, but you will have the right to the reinstatement of Coverage when you return to work from FMLA leave.

If you do not return to work following FMLA leave, you are eligible for COBRA Coverage if you were Covered under the plan on the day before the FMLA leave began. COBRA Coverage would be effective on the earlier of the day the leave expires or the day you notify your Employer that you are not returning to work. You are eligible for COBRA Coverage following FMLA leave even if you were not Covered under this plan during your FMLA leave.

C. Extension of Benefits if You Are Confined.

If you are confined for medical treatment in a facility, other than your home, at the time the Agreement is terminated or you lose eligibility, we will continue to be responsible for certain Covered Services. We will only Cover services that are necessary to treat the medical condition for which you are confined and which would otherwise be Covered under this Certificate. These services will only be Covered until it is no longer necessary for you to be confined. A move to an alternative care facility, such as a skilled nursing facility, hospice facility or rehabilitation facility, is not considered a discharge from confinement under this provision. As soon as one of the following happens, you will stop receiving benefits under this subsection C:

(1) The confinement is no longer Medically/Clinically Necessary;

(2) You reach the maximum benefit limits for the Covered Services available for that confinement or condition;

(3) You become eligible for similar coverage from another health plan, whether individual, group or governmental; or

(4) 12 months passes from the day your Coverage under the Agreement ended.

If you are eligible for Coverage under this subsection C, your Coverage will be COBRA Coverage. If you are not eligible for COBRA, your Coverage will be Conversion Coverage.

You must pay the required Premium to maintain your Coverage. As stated in Section 12.D, the 31 day period you have to elect Conversion Coverage begins on the date of termination. The election period will not be extended or delayed because you are Confined.

D. Conversion.

Upon termination, you may have the right to obtain coverage under an individual health care plan ("Conversion Coverage").

(1) Eligibility for Conversion Coverage.

You only have a right to enroll in Conversion Coverage in the following situations:

(a) You are the Subscriber or Covered Dependent under the Agreement and your Coverage terminates because the Subscriber's employment terminates or because the Subscriber no longer meets the eligibility requirements for Coverage.

(b) You are the Subscriber or Covered Dependent under the Agreement and your Coverage terminates because the Agreement is terminated, unless the terminated Coverage is replaced with other group coverage.

(c) You are a Covered Dependent, and although the Subscriber's Coverage under the Agreement continues, your Coverage terminates because you no longer meet the eligibility requirements to be a Covered Dependent.

(d) You are a Covered Dependent and your Coverage under the Agreement terminates because of the Subscriber's death.

In each circumstance, you have the right to obtain Conversion Coverage without giving us evidence of insurability, such as a Certificate of Creditable Coverage.

Conversion Coverage contains no limitations based on health status and does not exclude coverage for a pre-existing condition, unless Coverage is excluded for that condition under the Conversion Coverage plan.

If you want Conversion Coverage, you must send to us a completed **Priority**HMO℠ Conversion Coverage Application. We must receive your application within 31 days after the termination date of Coverage under the Agreement or the date you are notified of termination by your Employer or us, whichever is later. The 31-day period starts running even if you are confined. If we permit you to enroll in Conversion Coverage retroactively, you must pay Premiums back to the day you lost Coverage under the Agreement. There can be no gap in Coverage.

You do not have a right to enroll in Conversion Coverage as a Subscriber or Covered Dependent if any of the following applies:

(a) Your Coverage under the Agreement terminates because:

(i.) You, or if you are a Covered Dependent, the Subscriber, fails to pay any required Premiums;

(ii.) Your Coverage under the Agreement is replaced by other group coverage; or

(iii.) Your Coverage under the Agreement was terminated for cause.

(b) Coverage under the Agreement ends before you have been continuously enrolled under any group plan for at least three months;

(c) On the termination date, you are covered under, or eligible for any group or governmental health care policy, certificate, contract, benefit plan or program, whether insured or self-insured and that coverage provides similar benefits to the Conversion Coverage;

(d) On the termination date, you are covered under any individual health care policy, certificate, contract, benefit plan or program, whether insured or self-insured and that coverage provides similar benefits to the Conversion Coverage;

(e) You are covered under Medicare; or

(f) You live outside of our Service Area.

(2) Terms of Conversion Coverage.

If we issue you Conversion Coverage, it will be our standard HMO Conversion Coverage plan in effect at the time you request to enroll. Your coverage may not contain the same level of Coverage that you have had under the Agreement. The Conversion Coverage will cover, at a minimum, all benefits required by any laws. There may be changes to the standard plan from time to time. If you move outside our Service Area, you will only have coverage for Medical Emergencies and Urgent Care. If you want more details about Conversion Coverage, contact our Customer Service Department.

We must receive payment of the first Premium for Conversion Coverage along with your enrollment request and authorization for electronic funds transfer (automatic payment). Your Premium for Conversion Coverage will be based on the number of dependents, if any, you enroll for Coverage.

If we issue you Conversion Coverage, it will begin on the day after your Coverage under the Agreement ends.

E. Continuation of Coverage.

"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which was enacted to provide for continued coverage for eligible individuals ("Qualified Beneficiaries") who would otherwise lose Coverage due to specific circumstances ("Qualifying Event"). COBRA applies to employers with 20 or more employees on at least 50% of the employer's typical business days during the prior calendar year.

"Qualified Beneficiary" means the Subscriber and Covered Dependent who is Covered under this plan on the day before a COBRA Qualifying Event takes place (described below) and loses Coverage as a result of the Qualifying Event. A Qualified Beneficiary also includes any child born to or placed for adoption with, the Subscriber during the period of COBRA continuation coverage. A retiree who is eligible under this plan may be a Qualified Beneficiary only in the event of a Bankruptcy Qualifying Event (as described below). Each individual Qualified Beneficiary has the same rights under the plan as an Active Employee.

(1) Eligibility for COBRA Continuation Coverage.

If your participation in the plan terminates because you have a Qualifying Event, you may continue Coverage under COBRA for specific periods of time. A "Qualifying Event" happens when:

(a) 18-Month Qualifying Events. Coverage of the Subscriber or Covered Dependent terminates because the Subscriber terminated employment for any reason (except gross misconduct), or because the Subscriber's hours were reduced below the minimum required for Coverage (an "Employee Qualifying Event"); or

(b) 36-Month Qualifying Events. A Covered Dependent's Coverage terminates because of any of the following (a "Dependent Qualifying Event"):

(i.) The Subscriber died; or

(ii.) The Subscriber became divorced or legally separated; or

(iii.) The Subscriber became entitled to Medicare; or

(iv.) A dependent child loses eligibility as a Covered Dependent under the plan.

(c) Bankruptcy Qualifying Event. There is a right to COBRA continuation coverage for any retired Subscriber and any Covered Dependents of the Subscriber if Coverage is lost due to the filing of a Chapter 11 bankruptcy proceeding with regard to your Employer or if there is a substantial elimination of Coverage within one year before or after commencement of such proceeding ("Bankruptcy Qualifying Event"). This only applies if retirees are Covered as Subscribers under the Agreement.

You must be Covered under this plan on the day before the Qualifying Event occurs to be eligible for COBRA Coverage. A child who is born to or placed for adoption with a Covered Subscriber during the COBRA coverage period is also a Qualified Beneficiary eligible for COBRA Coverage from the date of birth or placement for adoption, so long as your Employer is notified of the birth or adoption within 31 days of the event. A Subscriber may be a Qualified Beneficiary only in the event of the Subscriber's termination or reduction in hours of employment.

(2) Type of Coverage.

COBRA Coverage will be the same as the Coverage provided to Members who have not experienced a Qualifying Event. If Coverage under the plan is changed for Members who have not experienced a Qualifying Event, COBRA Coverage will be changed in the same manner.

(3) Duration of COBRA Continuation Coverage.

COBRA continuation coverage will extend for a maximum of 18 months for an Employee Qualifying Event and a maximum of 36 months for a Dependent Qualifying Event except as described below:

(a) 29-Month Disability. If it is determined that you are Disabled under either Title II or Title XVI of the Social Security Act at the time of an Employee Qualifying Event, or at any time during the first 60 days of COBRA Coverage following an Employee Qualifying Event, COBRA continuation coverage for you and your Covered Dependents may extend for up to 11 additional months (beyond the initial 18 months) for a total continuation period of 29 months if you provide the required notice and evidence of the Disability determination to your Employer in a timely manner. You must provide us with written notice of the Disability determination within the 60 day time period described below under "COBRA Notice Requirements, Participants Notice" but no later than the end of the initial 18 months of COBRA continuation coverage. This extended Coverage will terminate on the last day of the calendar month that begins 30 days after the date of a final determination that you are no longer Disabled.

(b) Multiple Qualifying Events. If a second Qualifying Event that is a 36-month Dependent Qualifying Event occurs during an 18-month Employee Qualifying Event, COBRA continuation coverage for Covered Dependents may continue for an additional 18 months. If a Covered Dependent is added after continued Coverage began, the plan will not continue the Covered Dependent's Coverage past the original 18 months (except in the case of a Newborn or newly adopted child who becomes Covered as described above). You must notify your Employer of the second Qualifying Event within the 60 day time period described below under "COBRA Notice Requirements, Participants Notice". The multiple Qualifying Event extension is also available where a second Qualifying Event that is a 36-month Dependent Qualifying Event occurs during the additional 11-month Disability extension. The multiple Qualifying Event extension is available only if the second Qualifying Event would have caused a loss of Coverage under the plan if the first Qualifying Event had not occurred.

COBRA continuation coverage will never extend for more than 36 months, measured from the date of the original Employee Qualifying Event.

(c) 36-Month Medicare Rule. If a Subscriber becomes entitled to Medicare before the occurrence of an Employee Qualifying Event, the maximum COBRA period for Covered Dependents can extend to the later of 36 months from the date of Medicare entitlement or 18 months (29 months if there has been a Disability extension) from the date of the Employee Qualifying Event.

(d) Retiree Coverage. For a Subscriber who is a retiree on the day before a Bankruptcy Qualifying Event, Coverage may continue until death, as long as retirees remain eligible for Coverage under the Agreement. Coverage may also continue until death for a retirees' surviving spouse who is Covered on the day before a Bankruptcy event, as long as retirees are eligible for Coverage under the Agreement. Coverage will continue for 36 months for the Covered Dependent of a Subscriber who is a retiree following the death of that Subscriber.

(4) Termination of COBRA.

Your COBRA continuation Coverage will terminate for any of the following reasons:

(a) The date you reach the end of the 18, 29 or 36 month maximum coverage period; or

(b) The date your Employer no longer offers a group health plan to any of its employees; or

(c) The date as of which your Premium for COBRA continuation Coverage is not timely paid; or

(d) The date after your election of COBRA that you first become covered under another group health plan unless the other group health plan contains a limitation or exclusion for any pre-existing condition you have, other than a limitation or exclusion that does not apply to you due to the Health Insurance Portability and Accountability Act of 1996; or

(e) The date after your election of COBRA, on which you first become enrolled in Part A or Part B of Medicare; or

(f) The date your Coverage is terminated for cause on the same basis as for similarly situated non-COBRA beneficiaries, such as for submission of a fraudulent claim.

(5) COBRA Notice Requirements.

Your COBRA continuation coverage will be effective on the date your regular Coverage ends. For COBRA Coverage to be available you must complete the following steps within the time limits specified below:

(a) notify your Employer, or its designee who handles COBRA administration, of an event permitting a Dependent Qualifying Event as required below;

(b) elect Coverage under this section; and

(c) pay all required Premiums.

(i.) Member Notice. You must notify your Employer or its designee in writing of a divorce, legal separation, child ceasing to have Covered Dependent status, or a second Qualifying Event under this plan within 60 days of the occurrence, or within 60 days after the date Coverage would end because of the Qualifying Event. If you or your Covered Dependent are eligible for a 29-month COBRA continuation coverage because of Disability, you must notify your Employer or its designee of the Social Security Disability determination within 60 days after the latest of: (a) the date of the Social Security Administration Disability determination; (b) the date of the employee Qualifying Event; or (c) the date Coverage would be lost under the plan because of the employee Qualifying Event; and before the end of the initial 18 months of the COBRA continuation coverage. You must also notify your Employer or its designee within 30 days of any final determination by the Social Security Administration that you (or your Covered Dependent) are no longer Disabled. If you do not make the required notifications in writing within the above time frames, COBRA continuation coverage will not be available. You must mail or hand-deliver the above notices to your Employer. If mailed, your notice must be post-marked no later than the deadline described above.

(ii.) Employer Notice. Within 14 days of receiving notice of a Qualifying Event, your Employer or its designee will send a COBRA election notice to each Member whose Coverage would be terminated absent the COBRA continuation coverage right.

(iii.) Member Election. You must elect COBRA continuation coverage within 60 days from the date your Coverage would terminate, or the date that you are sent a COBRA election notice, whichever is later. If you do not elect Coverage within the 60-day period, your Employer will consider this to be a refusal of Coverage. Each Member Covered by the plan on the day before a Qualifying Event has an independent right to COBRA continuation coverage regardless of whether Coverage is elected for any other family member.

(6) COBRA Premiums.

If you enroll for COBRA continuation coverage, you must pay the applicable Premium for that Coverage ("COBRA Premium"). The COBRA Premium will be equal to 102% (150% for each month of the additional 11-month COBRA continuation coverage for Disability if the Disabled individual is part of the coverage group) of the Premium paid by your Employer to us.

(7) Payment of COBRA Premiums.

If you enroll for COBRA continuation coverage, your initial COBRA Premium must be paid no more than 45 days after the date you elect Coverage. The initial Premium is the amount necessary to purchase Coverage retroactive to the date your Coverage would have terminated because of a Qualifying Event. Each additional COBRA Premium is due before the first day of each month of Coverage. You are responsible to insure that your COBRA Premiums are paid timely. If a COBRA Premium is not paid within 30 days after its due date (45 days for the initial COBRA Premium), your COBRA continuation coverage rights will terminate. The termination will be effective as of the last day for which your Employer received a COBRA Premium, and you will have no right to reinstatement. Payment of the Premium is considered to have been made as of the date sent (typically the date postmarked by the Post Office on the mailing envelope).

(8) Reimbursement of Reasonable and Customary Charges.

If you are eligible for COBRA continuation coverage, and you receive Covered Services before you enroll for COBRA continuation coverage and before you pay the required COBRA Premium, you must pay for them yourself. The plan will reimburse you for those Covered Services according to the terms of the plan, minus any required Deductibles and/or Copayments, if you enroll for COBRA continuation coverage within the required 60-day period, you timely pay the COBRA Premium, and you submit a claim for reimbursement of those charges.

(9) Address Changes.

To protect your family's rights, you should keep your Employer informed of any changes in the addresses of you and/or your Covered Dependents.

F. 2002 Trade Act Information.

The Trade Act of 2002 created a health coverage tax credit (HCTC) for certain individuals who become eligible for trade adjustment assistance on account of job loss resulting from increased imports or shifts in production outside the U.S. and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC).

Eligible individuals can either claim a tax credit on their federal tax return or receive advance payment of a percentage of premiums paid for qualified health coverage, including COBRA continuation coverage.

Eligible individuals may also qualify for a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not elect COBRA coverage during the regular COBRA election period following termination of employment). This special second election period lasts for 60 days but may be shorter. It begins on the first day of the month in which an individual becomes eligible for the health coverage tax credit, but the election must in any case be made within six months after group health plan coverage ended.

If you qualify or think you may qualify for these benefits, contact your Employer for additional information promptly in order not to lose your special COBRA rights. If you have questions about the Trade Act, you may call the Health Care Tax Credit Customer Contact Center toll-free at 866 628-4282. More information about the Trade Act is also available at doleta.gov/tradeact/2002act_index.cfm. For additional information on the Health Coverage Tax Credit, go to IRS.gov and enter keyword "HCTC".

G. Continuation of Coverage for Military Service.

If you are absent from work because of military service, you may elect to continue Coverage under the plan for you and your Covered Dependents. The continuation of coverage period will extend for the longer of 24 months from the first day of your absence or the day after you apply for or return to your job. Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (the "USERRA"), your Premium for this Continuation Coverage will be the same as for a COBRA Qualified Beneficiary. If you are absent for 30 days or less, the Premium will be the same as for similarly situated Active Employees.

If you do not elect to be Covered during military service, or if your Coverage terminates because the continuation period expires, you may reinstate Coverage when you return to work as required under the USERRA. Coverage will be reinstated without regard to any waiting period except as would have applied if your Coverage had not terminated because of military service.

These continuation requirements apply to the extent they provide you with better Coverage when you are absent from work because of military service than COBRA continuation coverage (such as coverage for a longer period of time or less costly coverage).

(1) Notice of Absence for Military Service.

You must give your Employer advance written notice of your absence for military service unless providing the notice is impossible, unreasonable or prevented by military necessity.

(2) Election of Continuation Coverage.

You must elect Continuation Coverage in writing no later than 60 days after you leave work for military service. If giving notice within 60 days is impossible, unreasonable or prevented by military necessity, then you must give your Employer written notice of your absence within 60 days after doing so is no longer impossible, unreasonable or prevented by military necessity. If you make a timely election of Continuation Coverage and pay any unpaid Premium amounts due, then your Continuation Coverage will be retroactive to your date of absence.

(3) Termination of Coverage.

If you do not give your Employer notice of your absence for military service, your Coverage will end immediately upon your absence. If you provide your Employer notice of your absence but do not elect Continuation Coverage as provided above, then your Coverage will end after you have been absent for military service for 30 days. If you elect Continuation Coverage but fail to make timely Premium payments, then your Continuation Coverage will be terminated if you fail to make a payment within 30 days of when the payment is due.

SECTION 13. Coordination Of Benefits

A. Purpose of Coordination of Benefits.

Coordination of Benefits (COB) is the system used to determine how benefits are paid when you are covered by more than one health plan. The primary plan is responsible for paying the full benefit amount allowed by that plan. The secondary plan is responsible for paying all or part of the benefit not covered by the primary plan as long as the benefit is covered by the secondary plan. The secondary plan adjusts the amount of benefits paid so that the total benefits available to the Member for the particular service will not exceed the total Allowed Amount for that service. The total paid by both plans may provide payment up to, but not exceeding our Allowed Amount, which may result in Member liability even after the secondary plan's payment.

We will coordinate benefits with the following types of plans:

(1) Group insurance, or any other arrangement of coverage for individuals in a group, whether on an insured or self-insured basis, including government programs such as Medicare and Medicaid. We do not coordinate with specialty plans such as dental, vision or disability insurance, unless your vision plan Coverage is provided under a vision Rider to this Certificate; and

(2) Individual insurance, including government programs such as Medicare and Medicaid. We do not coordinate with specialty plans such as dental, vision or disability insurance, unless your vision plan Coverage is provided under a vision Rider to this Certificate; and

(3) Automobile insurance required by law to be purchased and not provided under a group plan, but only to the extent that automobile insurance law requires coverage of medical benefits. Most automobile insurance in Michigan is written on a "coordinated" 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.

B. Information about Coverage from Other Plans.

You must cooperate to allow us to coordinate our Coverage with coverage from other plans, including providing us with copies of court orders and other documents that may determine which plan is primary. All information provided to us will be kept confidential.

C. Guidelines to Determine Primary Coverage If You Are Covered by Two or More Plans.

(1) A plan without a Coordination of Benefits provision is always primary.

(2) A plan covering you as a Subscriber is always primary.

NOTE: The way the primary payer is determined may be different if you also receive Medicare benefits, as required by the Social Security Act of 1965. See Section 14.B for additional information.

(3) A plan Covering you as an active employee is primary when you are covered as an active employee under one plan and as a retiree under a second plan.

(4) A plan that is non-COBRA or non-continuation coverage is primary when you are covered under a non-COBRA or non-continuation plan and a COBRA or other type of continuation plan.

(5) If you have Prescription Drug Coverage under another plan, drugs for cancer therapy and cancer clinical trials are Covered under your prescription drug plan before Coverage under your Priority Health medical plan applies.

(6) The Birthday Rule applies when determining which plan is primary for dependent children. The Child's primary plan is the plan of the person (parent, stepparent, etc.) whose birthday falls earlier in the calendar year (month and day only). If the birthdays of the persons covering the dependent are on the same date, the plan that has covered the child longer is primary. This subsection (6) does not apply if subsection (7) below applies.

(7) For dependent children of divorced parents, legally separated parents, or unmarried parents who do not reside in the same household, benefits are coordinated as follows:

(a) If a court order assigns responsibility for providing healthcare benefits to one parent, that parent's policy is primary.

(b) If a court order assigns responsibility for providing healthcare benefits to both parents, the primary plan will be determined in the following order:

(i.) Parent with physical custody

(ii.) Stepparent with physical custody

(iii.) Parent without physical custody

(iv.) Stepparent without physical custody

This order above does not apply, however, when parents have joint physical custody. In such cases, the birthday rule in subsection (6) above applies.

(c) If a court order fails to assign responsibility for providing health benefits to either parent or if no court order exists, health benefits are determined according to custody, as described in subsection (7)(b). In cases of joint physical custody, the Birthday Rule in subsection (6) applies.

You are required to provide us with a copy of any court order that affects Coverage of your dependents.

(8) If none of the above rules can be used to determine the order in which benefits are paid, the plan that has covered you longer is primary.

D. Effect on Benefits.

We will follow the above rules to determine which plan is the primary plan. If we are the primary plan, you are entitled to Covered Services as outlined in this Certificate.

If your other plan is the primary plan, then we are the secondary plan. In that case, the primary plan must pay up to its highest benefit level. If your benefits under the primary plan are reduced because of noncompliance with plan requirements, such as seeking a second surgical opinion, getting prior approval of admissions or services, or using Participating Providers, this plan's liability will not be increased to Cover the extra costs you will be required to pay. That means you must follow the rules of your primary plan.

When we are the secondary plan, we will not Cover expenses for inpatient services, drugs Covered as medical benefits, weight loss treatments, or transplants unless all of the requirements for Coverage under this Certificate have been followed. We will pay for such services only when you follow our rules and procedures, including using Participating Providers and obtaining any required approval from us. If our rules conflict with those of your other plan, it may be impossible to receive benefits from both plans. You may only be able to receive benefits from the primary plan. Except as described in subsection (5) below, duplicate coverage will never give you more benefits from us than those available under this Certificate.

Additional rules for coordination of benefits when we are the secondary plan:

(1) A primary plan, as determined above, must provide its covered benefits without considering our Coverage.

(2) If a primary plan does not cover services that we Cover, we will Cover those services as if we are the primary plan.

(3) If we Cover services not fully covered by a primary plan, we will coordinate our Coverage with the primary plan's coverage to pay up to 100% of Allowed Amount, the primary plan's contracted rate or our contracted rate, whichever is less, for those services.

(4) We are not required to pay claims or coordinate benefits for services that are not provided by Participating Providers or approved by us or that are not Covered Services under this Certificate.

(5) We will Cover certain outpatient services, other than prescription drugs, weight loss treatments, and services related to an organ transplant, without prior approval, if you have followed the rules of your primary plan and the services are Covered under this Certificate.

NOTE: If we Cover outpatient services received from Non-Participating Providers without Prior Approval as described in subparagraph (5) above, we may require you to receive any related inpatient services from Participating Providers. For example, if another plan is your primary plan and you receive outpatient physical therapy services while wintering in Florida, we will pay for those services as the secondary plan without requiring Prior Approval. If you then require Hospital Inpatient Care, Prior Approval by us is required in order for that hospitalization to be Covered, even though we are the secondary plan. If the inpatient services are available in our Service Area, we may require you to return to our Service Area to receive those services. In addition, if Priority Health becomes the primary plan, you will be required to receive Covered Services from Participating Providers if the services are available within Priority Health's network.

See Section 14.B for information on coordination with Medicare.

E. Release.

We may release to and obtain from any other insurer, plan or party, any information that we consider necessary for coordination of benefits or recovery of overpayments. You may be required to assist with this process.

F. Recovery of Overpayments; Conditional Benefit Payments.

A payment made by another plan may include an amount that should have been paid under this Certificate. If it does, we may reimburse that amount directly to the other plan. The amount will then be treated as though it were a benefit we had paid, and we will not have to pay that amount again. The term "payment made" includes the reasonable cash value of the benefits provided in the form of services.

If the amount of the payments we made is more than we should have paid under this Section 13, or if we have provided services which should have been paid by a primary plan, we may recover the excess or the reasonable cash value of the services, as applicable, from one or more of: (i) the persons we paid or for whom we have paid a Provider; (ii) insurance companies; or (iii) other organizations. We can recover those amounts as we choose. If you incur medical expenses for which another party is or may be responsible, we may provide Coverage subject to our right to reimbursement. If we ask, you (or your legal guardian) must sign any agreements or other documents and cooperate with us to make sure that we can recover the overpayments or obtain the reimbursement described in this paragraph. Reimbursement will be made to the extent of, but not exceeding, the total amount of recovery payable to or on your behalf (or on behalf of your guardian or estate) from: (i) any policy or contract from any insurance company or carrier (including your insurer); and (ii) any third party, plan or fund as a result of a judgment or settlement.

G. Subrogation and Reimbursement.

When you receive payment for Covered Services, you assign (or transfer) to us all of your rights of recovery from any third party, including your Employer. These rights of recovery include recoveries from tort-feasors, underinsured/uninsured motorist coverage, Worker's Compensation, other substitute coverage, any other group or non-group policy of insurance providing health and/or accident coverage, including automobile insurance. Additionally, we have a right:

(1) to subrogation. This means that we can stand in your or your estate's shoes and sue a third party directly for an Illness or Injury that we Covered.

(2) of reimbursement. This means that we have a right to be reimbursed out of any recoveries you or your estate receives in the future or may have received in the past from third parties relating to your Illness or Injury that we Covered.

(3) to pursue any other right of recovery, whether based in tort, contract, or any other body of law.

This assignment is to the fullest extent permitted by law. Our rights of recovery shall not be limited to recoveries from third parties designated for medical expenses, but shall extend to any and all recovered amounts. In the case of both subrogation and reimbursement, we will be permitted to pursue a recovery amount equal to the total amount paid by us, or the cost of services provided by us, as applicable, plus reasonable collection costs, because of an Illness or Injury for which you (or your estate or guardian) have or has a cause of action. You are required, when requested, to acknowledge our rights of recovery in writing. Our right of recovery, however, is not dependent upon this acknowledgement. Tell us immediately, in writing, about any situation that might let us invoke our rights under this section.

You are expected to cooperate with us to help protect our rights under this section. You agree that these rights will be considered the first priority claim with a first priority lien of 100% of the proceeds of any full or partial recovery against anyone else. Our claim will be paid before any other claims are paid, whether or not you have recovered your total amount of damages. We must be reimbursed in full before any amounts (including attorney's fees incurred by you or your guardian or estate) are deducted from the policy proceeds, judgment or settlement.

Neither you, nor anyone acting for you, will do anything to harm our rights under this section. If you settle a claim or action against a third party, you will be considered to have been made whole by the settlement. We expressively reject the application of any "make whole," common fund or other claim or defense to Priority Health's subrogation and reimbursement rights. We will then have the right to immediately collect the present value of our right to reimbursement, as described above. Our claim will be the first priority claim from the settlement fund. If you receive any proceeds of settlement or judgment, and if we have a right of reimbursement in those proceeds, you must hold those proceeds in trust for us. Transfer of such funds to a third party does not defeat our right of reimbursement if the funds were or are intended for your benefit. We can recover from you expenses we incur because you failed to cooperate in enforcing our rights under this section.

For purposes of this subsection 13.G, the term "you" includes you and any person claiming through or on behalf of you, including relatives, heirs, assigns and successors.

SECTION 14. Medicare And Other Federal Or State Government Programs

A. Nonduplication of Benefits.

Your benefits under this Certificate cannot be doubled up with any benefits you are, or could be, eligible for under Medicare or any other federal or state government program. If we Cover a service that is also covered by one of those programs, any sums payable under that program for that service must be paid to us. We will apply the rules for Coordination of Benefits described in Section 13 after your benefits from us have been calculated under the rules in this section. We will reduce the Allowed Amount by any benefits available for those expenses under Medicare or any other federal or state governmental program. Fill out and return to us any documents we ask for to make sure we receive reimbursement by those programs.

B. Coordination with Medicare.

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

(1) Members Age 65 and Over.

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

(i.) Medicare will be primary if the Employer who is providing this Coverage has less than 20 employees; and

(ii.) this plan will be primary if the Employer who is providing this Coverage has 20 or more employees.

Whether the Employer has 20 or more or less employees will be determined by looking at a typical business day during the previous calendar year.

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

(2) Disabled Members Under Age 65.

If you are Disabled and your Coverage under this plan is due to the current active employment status of you, your spouse or parent:

(i.) this plan will be primary, if this plan is a Large Group Health Plan; and

(ii.) Medicare will be primary, if this plan is not a Large Group Health Plan.

A “Large Group Health Plan” is one that had at least 100 employees on a typical business day during the previous calendar year.

If you are covered by Medicare because of Disability, and if your Coverage under this plan is not due to the current active employment status of you, your spouse or parent, Medicare will be primary. For example, if your Coverage is under COBRA or a retiree plan, Medicare will be primary.

(3) Members Eligible for Medicare ESRD Benefits.

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

(4) Eligibility for Medicare.

In determining benefits payable under Medicare, you will be considered to be enrolled for and covered by both Part A and Part B of Medicare and any other governmental benefits for which you are eligible, whether or not you are actually enrolled. Therefore, you should enroll in and become covered by any of these benefits for which you are eligible. For example, if you are eligible for Medicare Parts A and B, and Medicare is primary, we will pay as if Medicare is primary even if you have not enrolled in both parts of Medicare. By enrolling in Medicare, you will avoid large out of pocket expenses.

(5) Statutory and Regulatory Changes.

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

C. State Medical Assistance Plan.

We will not consider the fact that you may be eligible for medical assistance under the Medicaid program when we enroll you or when we determine whether or how to Cover or pay benefits for you. If Medicaid paid a claim that should have been paid by us, we will pay the claim, so the Provider can reimburse the Medicaid program. We will pay Providers directly on behalf of Members who are Medicaid enrollees if they have signed an Assignment of Rights form.

D. Coordination with Children's Health Insurance Plan (CHIP).

This plan will be primary to any CHIP coverage your child may have that supplements this plan.

SECTION 15. Definitions

(1) Active Employee. An individual who works the required number of hours, as set forth in the Agreement, for the Employer. An individual may also be considered an Active Employee if he or she is on an FMLA leave authorized by the Employer. You must be an Active Employee in order to become a Subscriber.

(2) Agreement. The Group Agreement between your Employer and us. The Agreement is a contract for health benefits that includes this Certificate, the Enrollment form, the Schedule of Copayments and Deductibles, any Riders, any amendments and any attachments.

(3) Allowed Amount. Maximum amount on which payment is based for Covered Services.

(4) Appeal. The second step of our Grievance Procedure. You may file an Appeal if you are unsatisfied with the outcome of your Grievance and would like your case to be reviewed by another committee. A more detailed explanation of the Grievance Procedure is available in Section 11 of this Certificate.

(5) Certificate of Coverage or Certificate. The legal document that describes the rights and responsibilities of both you and Priority Health. It includes this document, the Enrollment Form, the Schedule of Copayments and Deductibles, and any Riders, amendments and attachments to this document.

(6) Certificate of Creditable Coverage. Information about a Certificate of Creditable Coverage is available in Section 10.D of this Certificate.

(7) Child Placed for Adoption. A child in your custody for whom you have assumed and retain a legal obligation to provide partial or total support in anticipation of adoption.

(8) Coinsurance. The percentage of the cost of a Covered Service that you must pay directly to a Provider at the time you receive the Covered Services and supplies. This percentage may also be called a Copayment.

(9) Complications of Pregnancy. Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency cesarean section are not Complications of Pregnancy.

(10) Contract Year. The period of time that starts on the day the Agreement is effective or renewed and ends 12 months later, unless the Agreement says otherwise. The Contract Year generally begins on the date eligibility is effective after an Open Enrollment Period.

(11) Copayments. The amount you must pay directly to a Provider for a Covered Service at the time you receive the services and supplies. A Copayment may be either a flat dollar amount or a percentage, such as $20.00 for a PCP office visit or 20% of the cost of an outpatient surgery. A percentage Copayment may also be called Coinsurance.

(12) Covered Dependent. An individual eligible to enroll in this plan as outlined in Section 2.B of this Certificate and in the Agreement.

(13) Covered Services, Coverage, Cover or Covered. Services and supplies for which this plan will pay all or part of the costs, as listed on your Schedule of Copayments and Deductibles, so long as you meet the eligibility requirements outlined in Section 2 of this Certificate. The services or supplies must be preventive or Medically/Clinically Necessary and not otherwise excluded by this Certificate. When we say we will "Cover" a service or supply, that means we will treat the service or supply as a Covered Service.

(14) Custodial Care. Care you receive if, in our opinion, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. This type of care includes room and board, therapies, nursing care, home health aides and personal care designed to help you in the activities of daily living and home care and adult day care that you receive, or could receive, from a member of your family.

(15) Deductible. An amount that you must pay before Priority Health will pay for certain Covered Services under this Certificate. For example, if your Deductible is $1,000, we won't pay anything until you've paid $1,000 for Covered Services that are subject to the Deductible. If you have a Deductible, it is shown on your Schedule of Copayments and Deductibles or a Rider to this Certificate.

(16) Disabled or Disability. As determined by the Social Security Act, we will consider you to be Disabled or to have a Disability if, a Health Professional has diagnosed a physical or mental impairment or combination of impairments that, based on your age, education and past work experience, prohibit you from performing any substantial gainful activity. The impairment or combination of impairments must have lasted or can be expected to last at least 12 consecutive months or can be expected to result in death.

(17) Durable Medical Equipment (DME). Information about DME is available in Section 6.E of this Certificate.

(18) Employer. The Subscriber's employer or other entity through which you have obtained Coverage under this Certificate.

(19) Grievance. The first step of our Grievance Procedure. You may file a Grievance if you want us to review a benefit or payment decision, are concerned about the quality of care you received, or are unhappy with a Participating Provider. A more detailed explanation of the Grievance Procedure is available in Section 11 of this Certificate.

(20) Health Professional. An individual licensed, certified or authorized under state law to practice a health profession.

(21) Home Health Care. Information about Home Health Care is available in Section 6.A.2 of this Certificate.

(22) Hospice Care. Services for the terminally Ill and their families including pain management and other supportive services.

(23) Hospital. An appropriately licensed acute care institution (including a longterm acute care facility) that provides inpatient and outpatient medical care and treatment for Ill and Injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24 hour-a-day nursing and Physician service.

(24) Hospital Inpatient Care. Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for Hospital Observation Care may be considered outpatient care.

(25) Hospital Observation Care. Short term treatment and monitoring that is provided on an outpatient basis. This type of care is commonly provided after you visit an emergency room to allow Health Professionals to determine if you can be discharged or if you need to be admitted as an inpatient for additional treatment. Hospital Observation Care is typically limited to 24-48 hours. Even when you are required to stay at the Hospital overnight, if you are receiving Observation Care, you have not been admitted as an inpatient. See your Schedule of Copayments and Deductibles for information about your Hospital Outpatient Care benefit.

(26) Hospital Outpatient Care. Care in a Hospital that usually doesn't require an overnight stay.

(27) Ill or Illness. A sickness or a disease, including congenital defects or birth abnormalities.

(28) Incapacitated Dependent. A dependent is eligible for Coverage as an Incapacitated Dependent if the dependent meets the requirements of Section 12.A.

(29) Injury or Injured. Accidental bodily harm.

(30) Medicaid. Title XIX of the Social Security Act, as amended.

(31) Medical Director. A Michigan-licensed Physician, employed by Priority Health, who oversees the plan's medical delivery system.

(32) Medical Emergency. The sudden onset of an Illness or Injury, symptom or condition serious enough that not seeking immediate medical attention could reasonably be expected to result in serious harm to your health, serious jeopardy to a pregnancy, or death.

(33) Medically/Clinically Necessary. The services or supplies needed to diagnose or treat your physical or mental condition. Whether services or supplies are Medically/Clinically Necessary is determined in accordance with Priority Health's medical and behavioral health policies or adopted criteria that have been approved by community Physicians and other Providers. The determination is made by Priority Health's Medical Director, or anyone acting at the Medical Director's direction, in consultation with other Physicians. Medical/Clinical Necessity of mental health and substance abuse services is determined by our Behavioral Health Department. In order to be considered Medically/Clinically Necessary, the services or supplies must be widely accepted as effective, appropriate, and essential, based upon nationally accepted evidence-based standards.

(34) Medicare. Title XVIII of the Social Security Act, as amended.

(35) Member. A person enrolled with us as a Subscriber or Covered Dependent.

(36) Network or Participating Provider. The Physicians, Health Professionals, Hospitals and other facilities that have contracted with Priority Health to provide Covered Services. The Providers that make up our Network are considered Participating Providers and are listed in our Provider Directory.

(37) Newborn. A child 30 days old or younger.

(38) Non-Covered or Excluded Services. Health care services that this plan does not pay for or Cover.

(39) Non-Participating Provider. The Physicians, Health Professionals, Hospitals and other Providers and facilities that have not contracted with Priority Health to provide Covered Services to Members. Non-Participating Providers are not listed in the Priority Health Provider Directory. Covered Services and supplies you seek from a Non-Participating Provider are not Covered.

(40) Open Enrollment Period. An annual period, established by your Employer and us, during which you and your eligible dependents may enroll in this plan or, if you are already enrolled, during which you may change your Coverage elections.

(41) Out-of-Area Services. Those services and supplies provided outside our Service Area.

(42) Out-of-Pocket Maximums. The maximum amount of percentage Copayments you will pay for certain Covered Services. Once you reach this maximum, many Covered Services will be Covered at 100% with no cost to you. Some Copayments, usually flat dollar amounts, are not limited by your Out-of-Pocket Maximum. You will still be required to pay these costs after reaching your maximum. Your Schedule of Copayments and Deductibles specifies which Copayments count toward your Out-of-Pocket Maximum.

(43) Participating Provider. A Physician, Health Professional or licensed facility that contracts with us to provide Covered Services to Members and is listed in Priority Health's Provider Directory. Most Participating Providers offer services within Priority Health's Service Area.

(44) Physician. A licensed medical doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) or surgeon.

(45) Premium. The total amount paid to us for Coverage under this plan, including contributions from your Employer and you.

(46) Prescription Drug Coverage. Prescription Drug Coverage you are entitled to receive under this Certificate. This Coverage is only available in limited circumstances unless you have a prescription drug Rider to this Certificate. More information about drugs Covered under your Priority Health medical plan is available in Section 6.B.

(47) Preventive Health Care Guidelines. A list of immunizations, screenings, lab tests and other services that we Cover to help you maintain optimum health and prevent unnecessary Injury, Illness or Disability. Our guidelines are developed by Health Professionals who are Participating Providers or employed by us, and are based on federal requirements for coverage of preventive health care services contained in Section 1001 of the Patient Protection and Affordable Care Act (PPACA), available at www.healthcare.gov.

(48) Primary Care Provider ("PCP"). The Participating Provider you select or who is assigned to you under Section 5.A. Your PCP provides, arranges and coordinates all aspects of your health care to help you receive the right care, in the right place, at the right time.

(49) Prior Approval. A decision made by Priority Health as to whether a service or supply is Covered or not Covered under the plan. It may also include a decision to partially Cover a service. See Section 5.D for more information about when and how to obtain Prior Approval.

(50) Provider Directory. The names and locations of Participating Providers who comprise our Network. Also included, among other things, are whether the Provider is accepting new Members and quality and performance information. You may call our Customer Service department to obtain a list of Providers in your area, or you can go to the Member Center on our website at *www.priorityhealth.com*.

(51) Provider. A licensed Health Professional or facility that provides health care services.

(52) QMCSO. Information about a Qualified Medical Child Support Order (QMCSO) and how it affects your child's eligibility is available in Section 2.B of this Certificate.

(53) Rehabilitative Medicine Services. Services that are restorative in nature and result in a meaningful improvement in our ability to perform functional day-to-day activities that are significant in your life role. These services may include physical, occupational and speech therapy, cardiac and pulmonary rehabilitation, and osteopathic and chiropractic manipulations.

(54) Rider. A legal document that is part of your Certificate of Coverage, that explains any additional benefits, limitations or other modifications to the Coverage outlined in the Certificate. For example, whether or not you have Coverage for prescription drugs will be determined if you have a prescription drug Rider or not. A Rider may also add a Deductible to your plan or add or remove benefits from those listed in the Certificate.

(55) Schedule of Copayments and Deductibles. The legal document that outlines how benefits will be paid for Covered Services, including Copayments, Coinsurance and Deductibles. It also lists any maximum limitations that apply to your health care benefits.

(56) Service Area. A geographical area, made up of counties or parts of counties, where we have been authorized by the State of Michigan to sell and market our health plans and where the majority of our Participating Providers are located. We publish precise Service Area boundaries that you can find on our website *www.priorityhealth*.com or receive from our Customer Service Department.

(57) Skilled Nursing Services. Information about Skilled Nursing Services is available in Section 6.C of this Certificate.

(58) Special Enrollment Period. A period outside the annual Open Enrollment Period, during which you and your eligible dependents may enroll in this plan or, if you are already enrolled, during which you may change your coverage elections. You are only eligible to enroll or change your coverage elections during a Special Enrollment Period in certain situations as explained in Section 3.B of this Certificate.

(59) Specialist or Specialist Provider. A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

(60) Specialty Drug. Drugs listed on our Approved Drug List that meet certain criteria, such as drugs or drug classes whose cost on a per-month or per-dose basis exceed a threshold established by the Centers for Medicare and Medicaid Services; drugs that require special handling or administration; drugs that have limited distribution; or drugs in selected therapeutic categories.

(61) Specialty Pharmacy. A Pharmacy that specializes in the handling, distribution, and patient management of Specialty Drugs.

(62) Subscriber. An individual eligible to enroll in this plan as outlined in Section 2.A of this Certificate and in the Agreement.

(63) Urgent Care or Urgent Care Center. Care provided at an Urgent Care Center, instead of a Hospital emergency room, when you need immediate care to treat a non-life threatening Illness or Injury to limit severity and prevent complications.

(64) We, us or our. Priority Health.

(65) You, your or yourself. The Member, whether enrolled with Priority Health as a Subscriber or Covered Dependent.

SECTION 16. General Provisions

A. Independent Contractors.

Priority Health does not directly provide any health care services under the Agreement or this Certificate, and we have no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by Health Professionals in consultation with you. Participating Providers and other Health Professionals provide health care services as independent contractors.

We are obligated under the Agreement and this Certificate to provide you with a Network of health care Providers. We are also responsible for making benefit determinations under the Agreement, this Certificate and our contracts with Participating Providers.

B. Entire Agreement.

The Agreement, including this Certificate of Coverage, the Enrollment Form, the Schedule of Copayments and Deductibles, any Riders, and any amendments or attachments, is the entire Agreement between your Employer and us. Beginning on the effective date of Coverage, the Agreement supersedes all other agreements for health care services and benefits between you, your Employer, and us.

C. Non-assignment.

You may not assign or transfer any of your rights to benefits or services under this Certificate, whether as a Subscriber or a Covered Dependent.

D. Conformity with State and Federal Law.

Priority Health will apply this Certificate in accordance with state and federal laws and regulations. If any part of this Certificate does not comply with state or federal laws or regulations, the language of the Certificate will read to comply with such laws and regulations.

E. Clerical Errors.

Clerical errors, such as incorrect transcriptions of effective dates, termination dates, or mailings with incorrect information, will not change the rights or obligations of you or us under this Certificate. These errors will not operate to grant additional benefits, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

F. Governing Law and Severability.

This Certificate is governed by Michigan law and any applicable federal law. If any provision of this Certificate is held to be invalid or unenforceable, the remaining provisions of this Agreement will remain in full force and effect.

G. Notices.

Any notice required or permitted under this Certificate shall be in writing. A notice is considered to be received by you either on the date when delivered in person or by e-mail at an e-mail address given to us by you; or if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and addressed to the address listed on your Enrollment Form. Notify us of any change in address, and we will send all notices to your most current address.

H. Third Parties.

This Certificate shall not give or create any rights, remedies, claims or obligations on third parties except as specifically provided in this Certificate.

I. Waiver.

In the event that you or Priority Health waives any provision of this Certificate, you or Priority Health will not be considered to have waived that provision at any other time or to have waived any other provision. Failure to exercise any right under this Certificate does not act as a waiver of that right.

SECTION 17. Notice of Privacy Practices

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

Our Commitment to You

Priority Health understands the importance of handling protected health information with care. We are committed to protecting the privacy of our members' health information in every setting. State and federal laws require us to make sure that your health information is kept private.

When you enroll with Priority Health or use services provided by one of the Priority Health plans, your protected health information may be released to Priority Health and by Priority Health. This information is used and disclosed to coordinate and oversee your medical treatment, pay your medical claims and assist in health care operations. The use and disclosure of your health information ends when your Coverage ends, except to pay for services received relating to the time that you were Covered or for certain health care operations of Priority Health or our providers.

Federal law requires that we provide you with this Notice of Privacy Practices. This Notice states our legal duties and privacy practices regarding your protected health information. It also states your rights under these laws with respect to the use and disclosure of your health information. Priority Health is required by law to follow the terms of the Notice currently in effect.

Use and Release of Your Health Information

The sections below describe the ways Priority Health uses and releases your health information. Your health information is not shared with anyone who does not have a "need to know" to perform one of the tasks below.

- **Treatment**

We may use your health information or disclose it to third parties to coordinate and oversee your medical care. For example, we may use your health information to help you find a doctor or a hospital that can treat your specific health needs.

- **Payment**

We may use your health information or disclose it to third parties to pay for your medical care. For example, we may use your health information when we receive a claim for payment. Your claim tells us what services you received and may include a diagnosis. We may also disclose this information to another insurer if you are covered under more than one health plan.

- **Health Care Operations**

Priority Health may use your health information and disclose it to third parties in order to assist in Priority Health's everyday work activities such as looking at the quality of your care, carrying out utilization review, confirming benefit eligibility, employee training and review processes, monitoring and auditing activities, and Priority Health's business management and general administrative duties. For example, your health information may be released to members of Priority Health's staff to review the quality of care and outcomes. Your health information may also be released to doctors or doctor groups involved in your care to improve patient care.

Other Permitted or Required Uses and Disclosures

Priority Health may also use or release your health information:

- When required by state or federal law and the use or disclosure complies with and is limited to the requirements of such law
- When permitted for law enforcement purposes
- When permitted to be released to government authorities in cases of abuse, neglect or domestic violence (in which case, you will be notified unless the notification would place you at risk of serious harm)
- When permitted for certain public health activities, such as disease control or public health investigations
- When permitted to be released to public health authorities in child abuse and neglect investigations
- When permitted to be released for certain FDA investigations and activities, such as investigations of product defects or to permit product recalls, repairs or replacements
- When permitted to prevent a serious threat to an individual or a community's health and safety
- When permitted by certain court proceedings (either judicial or administrative)
- When permitted for health oversight activities led by governmental agencies and authorized by law
- When permitted to be released about an inmate to a correctional facility, or otherwise permitted for release in law enforcement custodial situations
- When information about a deceased individual is required by a coroner, medical examiner, law enforcement official or funeral director to carry out their legal duties
- When permitted to be released to cadaveric organ, eye or tissue donation and transplant organizations
- For research purposes when the research has been approved by an institutional review board that has reviewed proposals and established protocols to ensure the privacy of your health information
- When authorized by and to the extent necessary to comply with workers' compensation laws
- When permitted for purposes of providing you with treatment alternatives or other health-related benefits and services
- When permitted to be released to the Armed Forces for active personnel
- When permitted to be released to the Veterans Administration for determining if you are eligible for benefits
- When permitted to be released to Intelligence Agencies for national security
- When permitted to be released to the Department of State for foreign services reasons (e.g. security clearance)
- When permitted to be released to Government Agencies for protection of the President

In order to use or disclose your health information in the above ways, Priority Health may have to follow additional state and federal requirements. Also, in some cases, Priority Health may share your information with one of its "business associates," a person or company that provides certain services to Priority Health. In those cases, Priority Health will have a contract with the business associate, as needed. This contract will require the business associate to confirm they will keep your health information private.

Disclosures to Health Plan Sponsors

(This section of the Notice of Privacy Practices applies to group plans only.)

Priority Health may share information with the sponsor of your group plan (your employer) about whether you are enrolled or disenrolled in the plan. Priority Health may also share summary health information with the sponsor. Summary health information has most identifying information (such as your name, your age and address except for zip code) removed, and provides the sponsor with information about the amount, type and history of claims paid under the sponsor's group health plan. The sponsor may use this information to obtain premium bids for health insurance coverage or to decide whether to modify, amend or terminate the plan. If the sponsor of your group health plan has agreed to follow federal privacy regulations, Priority Health may also share your protected health information to help the sponsor run the group health plan or to seek available subsidies.

Other Uses of Health Information – By Authorization Only

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. Some common examples of when Authorization is typically needed for certain releases of information concern mental health issues, substance abuse issues, prenatal and pregnancy related services, venereal disease or HIV/AIDS and grievences/appeals. We can provide you with a Sample Authorization Form.

If you provide us with an authorization to use or release health information about you, you may end that authorization at any time by writing to Priority Health's Compliance Department. (See Contact Information section.) If you end your authorization, we will no longer use or release health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization.

A parent, legal guardian, or properly named patient advocate may represent you and provide us with an authorization (or may end an authorization) to use or release health information about you if you cannot provide an authorization. Court documents may be required to verify this authority.

Confidentiality in all Settings

We have policies and procedures in place that protect the privacy of your information.

- Every employee signs a statement when they are hired that they understand they are required to keep member information private. They also learn about the actions the company will take if the privacy policies are not followed.
- Priority Health has strict control of access to electronic and paper information specific to members. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for members or for administrative purposes.

Priority Health tells all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours

Priority Health reviews our confidentiality policies and procedures every year. Priority Health also reviews how we collect, use, dispose of and disclose your information. Members (or prospective members) and providers have the right to review Priority Health's confidentiality policies and procedures. You may get copies by contacting Priority Health's Compliance Department. (See Contact Information section.)

Your Rights Regarding Your Health Information

You have the following rights:

Right to Inspect and Copy

You have a right to look at and get a copy of health information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. There are other limited circumstances in which we may deny your request to inspect and copy under federal and state law. If you are denied access to health information, you may request that the denial be reviewed.

To inspect and copy health information, contact Priority Health's Compliance Department in writing. (See Contact Information section)

If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

Right to Amend

You have the right to request that Priority Health amend any health information (medical or billing) we have about you. However, Priority Health will not amend any record that:

- it did not create (unless there is a reasonable basis to believe that the creator of the information is no longer available to act on the requested amendment)
- is not part of the medical or billing information we have about you
- is not part of information which you would be permitted to inspect and copy
- is determined by Priority Health to be accurate and complete

To request that we amend your health information, you must write to Priority Health's Compliance Department (see Contact Information section) and include a reason to support the change.

Right to Know About Disclosures

You have the right to know when your health information is disclosed to third parties. You can request a list of disclosures going back six years from the date of your request. This list will not include disclosures:

- to carry out treatment, payment or health care operations
- that were made to you
- for national security or intelligence purposes
- to correctional institutions or law enforcement officials
- that were incidental to a use or disclosure that was permitted or required
- that were made with an authorization by the individual
- of a subset of information called a "limited data set"
- that were prior to April 14, 2003

To request a list of disclosures, you must send your request in writing to Priority Health's Compliance Department. (See Contact Information section.) Your request must specify the time period desired. There will be no charge for the first list you request within a 12-month period. There may be a small charge for any further requests. We will let you know of the cost involved and you may choose to stop or change your request at that time before any costs occur.

Right to Request Restrictions

You have the right to request a limit on the health information that we use or disclose about you. We are not required by law to agree to your request. If we do agree to your request for restriction, we will comply with it unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to Priority Health's Compliance Department. (See Contact Information section.) In your request, you must tell us:

- what information you want to limit
- whether you want to limit our use, disclosure or both
- to whom you want the limits to apply

Priority Health will notify you of receiving your request, either in writing or by telephone, of the restrictions Priority Health has put in place.

Right to Request Confidential Communications

Priority Health will agree to any reasonable request asking that you receive information from the health plan by different means or at a different location. For Priority Health to honor this request, you must clearly state that the disclosure of all or part of that information without the change could be a risk to you.

To request confidential communications, you must make your request in writing to Priority Health's Compliance Department. (See Contact Information section.)

Right to a Paper Copy of This Notice

You have the right to a paper copy of Priority Health's current Notice upon request. To obtain a paper copy of this Notice, please call our Customer Service Department. (See Contact Information section.) Otherwise, you may also print a copy of this Notice from our website at *priorityhealth.com*.

Changes to this Notice

Priority Health has the right to change the terms of this Notice. We have the right to make these changes apply to health information we already have about you as well as any we receive in the future. We will always post a copy of the current Notice on Priority Health's website. You will also receive materially revised Notices within 60 days of their effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Priority Health and/or the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS). To file a complaint with Priority Health, please call or send a written explanation of the issue to Priority Health's Compliance Department. (See Contact Information section.) You will not be penalized for filing a complaint.

Contact Information

If you have any questions or complaints, please contact Priority Health's Compliance Department or Customer Service Department as noted above at:

Priority Health
1231 East Beltline NE
Grand Rapids MI 49525

616 942-0954
800 942-0954

If this information is unclear or if you do not understand it, please call Priority Health for assistance at 888 975-8102 (for TDD services, please call 616 464-8485).

This Privacy Practices Notice is effective: April 14, 2003

The term "Priority Health" refers to four corporations: "Priority Health Government Programs, Inc. (a Michigan non-profit corporation), "Priority Health" (a Michigan non-profit corporation), "Priority Health Insurance Company (a Michigan non-profit corporation) and "Priority Health Managed Benefits, Inc." (a Michigan business corporation).

Priority Health is a registered trademark and is used by the permission of the owner.

Priority Health is an Equal Opportunity Employer.

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HMO - 100% HOSPITAL SERVICES PLAN

Your Certificate of Coverage provides you with important information about your health care benefits, including Prior Approval requirements. This Schedule of Copayments and Deductibles provides you with information about your costs when you receive health care services and the maximum limitations of your health care benefits. Read the entire Certificate and Schedule of Copayments and Deductibles carefully.

In accordance with the terms and conditions of the Certificate, you are entitled to Covered Services when these services are:

A. Medically/Clinically Necessary (as defined in the Certificate and according to Medical and Behavioral Health policies established by Priority Health with the input of Physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health); and
B. Provided by your PCP or provided by a Participating Provider upon and with approval in advance by us when we consider approval necessary (except in a Medical Emergency) or provided by a Non-Participating Provider (one not listed in our Provider Directory) upon referral from your PCP and approved in advance by us (except in a Medical Emergency); and
C. Not excluded in the Certificate or a Rider or an amendment to the Certificate.

If you seek such services without a referral and Prior Approval when required, you will be responsible for the cost of the services. You will also be responsible for services that are beyond those approved, beyond benefit maximums or excluded from Coverage. You or your Physician must call (800) 269-1260 to obtain Prior Approval for services. Emergency admissions must be reported to us as soon as reasonably possible after admission.

See Section 6 of your Certificate for Covered and Non-Covered Services, including the summary of Covered preventive health care services. Priority Health's complete Preventive Health Care Guidelines are available in our Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department.

Your Plan may have a Deductible. A Deductible is the amount you must pay before Priority Health will pay for Covered Services under this Certificate. The following services are not subject to the Deductible:

- **Routine maternity care (the Deductible does apply to facility charges for delivery).**
- **Services received in your PCP's office during regular office hours,**
- **Services billed by your PCP's office, and**
- **Preventive health care services. See Section 6.A.1 of your Certificate for the summary of Covered preventive health care services. Priority Health's complete Preventive Health Care Guidelines are available in our Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department.**

Deductibles, if any, are detailed in a Rider attached to the Certificate.

Services	Benefits
Hospital Services (Including radiology examinations and laboratory services) (See Other Referral Care section below for additional Copayment information)	
Hospital Inpatient Care and Inpatient Longterm Acute Care Services	• 100% Coverage • Prior Approval is required except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section
Hospital Outpatient Care and Hospital Observation Care Services (Including ambulatory surgery center facility charges)	• 100% Coverage • Prior Approval is required for certain radiology examinations
Medical Emergency and Urgent Care Services	
Emergency Room Services	$10.00 Copayment per visit. (Copayment waived only if you become confined in a Hospital as an inpatient)
Urgent Care Center Services	$20.00 Copayment per visit (Copayment applies to all Urgent Care visits)
Ambulance Services	$10.00 Copayment

Physician Services (Primary and Referral Care) (See Other Referral Care section below for additional Copayment information)	
Office/Home Visits and Consultations (Face-to-face, telephonic, or through secure electronic portal by PCP, other Participating Physician and Referral) -Includes visits *not* Covered under Priority Health's Preventive Health Care Guidelines or routine maternity services	• $10.00 Copayment • Prescription drug Copayment may also apply when selected injectable drugs are provided
Preventive Health Care Services -See Section 6.A.1 of your Certificate for the summary of Covered preventive health care services.	Covered in Full
Maternity Services (Prenatal and postnatal)	$10.00 Copayment per visit up to a maximum Copayment of $60.00 per pregnancy for routine prenatal and postnatal services only. Attendance at an approved maternity education program is Covered with one PCP office visit Copayment.
Inpatient Hospital Visits	Covered in full
Surgery	Covered in full
Ambulatory Surgery Center Services	Physician surgical charges Covered in full in a Hospital surgery center
Vasectomy	• Physician services Covered in full only when performed in Physician's office or when in connection with other Covered inpatient or outpatient surgery • 100% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery.
Tubal Ligation	• Physician services Covered in full • 100% Coverage for outpatient facility charges • 100% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery
Allergy Testing and Serum	Covered in full
Allergy Injections	Covered in full
Other Referral Care (Copayments are for all medical services including, but not limited to, Physician and Hospital services)	
Family Planning/Infertility Services (Limited Coverage)	50% Coverage for diagnostic, counseling and planning services for treatment of the underlying cause of infertility (Prescription drugs for infertility treatment Covered only with prescription drug Rider)
Temporomandibular Joint Dysfunction or Syndrome	50% Coverage
Orthognathic Surgery	50% Coverage

Services	Benefits

Certain Surgeries and Treatments (Physician fees only)
• *Bariatric Surgery*
• Reconstructive surgery
  o Blepharoplasty of upper lids
  o Breast reduction
  o *Panniculectomy*
  o *Rhinoplasty*
  o *Septorhinoplasty*
  o Surgical treatment of male gynecomastia
• Skin disorder treatments
  o Scar revisions
  o Keloid scar treatment
  o Treatment of hyperhidrosis
  o Excision of lipomas
  o Excision of seborrheic keratoses
  o Excision of skin tags
  o Treatment of vitiligo
  o Port wine stain and hemangioma treatment
• Varicose veins treatments
• Sleep apnea treatment procedures
	• Physician fees are Covered at 50% of the first $2,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any Hospital services Copayment also applies.
	• *Prior Approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.*

Dietitian Services -Includes visits *not* listed in Priority Health's Preventive Health Care Guidelines	$10.00 Copayment per visit up to 6 visits per Contract Year*
Behavioral Health Services Prior Approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043	
Mental Health Inpatient Care (Including partial Hospitalization)	• 100% Coverage up to 20 days per Contract Year* (Two partial Hospitalization days count as one inpatient day) • Except in an emergency, Prior Approval required
Mental Health Outpatient Care	• $20.00 Copayment per visit up to 20 visits per Contract Year* ($10.00 Copayment per group therapy visit – Two group therapy visits count as one outpatient visit)
Substance Abuse Care (Including subacute, intermediate care, and outpatient evaluation/therapy)	• 80% Coverage up to the minimum annual benefit of $3,969.00 ** • Except in an emergency, Prior Approval required for subacute and partial Hospitalization services
Rehabilitative Medicine Services	
Physical and Occupational Therapy (Including osteopathic and chiropractic manipulation)	$10.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year*
Speech Therapy	$10.00 Copayment per visit up to a benefit maximum of 30 visits per Contract Year*
Cardiac Rehabilitation and Pulmonary Rehabilitation	$10.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year*

Services	Benefits
Other Services	
Radiology Examinations and Laboratory Procedures (In a non-Hospital facility)	• Covered in full • Prior Approval is required for certain radiology examinations
Prosthetic and Orthotic/Support Devices	• 50% Coverage • Prior Approval required for devices over $1,000.00
Durable Medical Equipment (DME) (Rent, purchase or repair)	• 50% Coverage • Prior Approval required for equipment over $1,000.00
Non-Hospital Facility Services Including Skilled Nursing Care services received in a: • Skilled Nursing Care facility • Subacute facility • Inpatient Rehabilitation Care facility • Hospice Care facility	• 100% Coverage up to the benefit maximum of 45 days per Contract Year* • Prior Approval required
Home Health Care (Including Hospice Care services, excluding Rehabilitative Medicine Services) **Note:** Rehabilitative Medicine Services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described above.	• Covered in full • Prior Approval required except for Hospice Care services in the home

MAXIMUM LIMITATIONS

A. Benefit Maximums:

* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits per Contract Year apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

** **Substance Abuse:** Coverage is provided up to a minimum annual benefit as determined by the State of Michigan per Contract Year. Coverage amount to be adjusted each March 31st in accordance with the average percentage increase in the "Consumer Price Index for All Urban Consumer-Revised" (CCPI). Coverage amount may be adjusted by a Rider.

B. Out-of-Pocket Maximums:

The Out-of-Pocket Maximum applies to certain inpatient and outpatient Hospital services and non-Hospital facility services. The Out-of-Pocket Maximum limits the total amount of Copayments that you will pay during a Contract Year, except as described below.

Out-of-Pocket Maximums	
Individual	$Not applicable
Family	$Not applicable (but not to exceed the Individual Out-of-Pocket Maximum per person)

Amounts paid for any of the following will not apply toward the Out-of-Pocket Maximum. Your cost sharing (Copayment, Coinsurance) applies to these services even after the Out-of-Pocket Maximum has been reached.

- Durable Medical Equipment (DME)
- Prosthetic & Orthotic/Support Devices
- Temporomandibular Joint Dysfunction or Syndrome
- Orthognathic Surgery Services
- Family Planning/Infertility Services
- Mental Health Services
- Substance Abuse Services
- Certain Surgeries and Treatments– Physician Fees
- Any flat dollar Copayments, such as Copayments for office visits, ambulance and emergency services

Additionally, your Out-of Pocket Maximum will not take into account:

- any monies you paid for non-Covered Services; and
- any monies you paid for Covered Services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services.

Note: Copayments and Coinsurance you pay for any Covered Services obtained under a supplemental benefit Rider ntinuation benefit may not be applied toward the above Out-of-Pocket Maximum. If your plan has a Deductible Rider, Deductible amounts you pay will not apply toward the Out-of-Pocket Maximum.

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SUMMARY OF BENEFITS HMO 100% HOSPITAL PLAN

Additional Benefits

Pharmacy Services

Prescription Drugs	**Tier 1-Generic Drugs**	
	$15	Copay per prescription or refill for a Generic Drug
Note: Prescription drug coverage is based on the usage of a medication formulary.	**Tier 2-Preferred Brand-Name Drugs**	
	$50	Copay per prescription or refill for a Preferred Brand-Name Drug
	Tier 3-Non-Preferred Brand-Name Drugs	
	$50	Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy.
	Tier 4-Preferred Specialty Drugs	
	$50	Copay for a preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy.
	Tier 5-Non-Preferred Specialty Drugs	
Certain medications are covered under the Preventive Care Services benefit and not this Pharmacy Services Benefit. See Priority Health Preventive Health Care Guidelines.	$50	Copay for a non-preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy.
	Infertility Treatment	
	50% Copay for drugs used for treating infertility. (Limitations apply)	
	Contraceptive	
	Includes prescription contraceptive drugs and implantable contraceptive drugs. Contraceptive devices administered or supplied in the physician's office are covered at 50%. Does not cover condoms, foams, jellies, ointments and other drugs or devices available over the counter.	
	SPECIALTY DRUGS COPAYMENT MAXIMUM PER CONTRACT YEAR	
	No Copay Maximum	

Prescription Mail Order Filled for up to 90 days		**Tier 1- Generic Drugs**
	$30	Copay per prescription or refill for a Generic Drug
		Tier 2- Preferred Brand-Name Drugs
	$100	Copay per prescription or refill for a Preferred Brand-Name Drug
		Tier 3- Non-Preferred Brand-Name Drugs
	$100	Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy.
		Tier 4- Preferred Specialty Drugs
	$50	Copay Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.
		Tier 5- Non-Preferred Specialty Drugs
	$50	Copay Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.
		Contraceptive
		Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)