Certificate of Coverage

Sparrow PHP Silver 5000 Exclusive HMO Individual Policy

SFN03800-RX08F429

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Individual Policy.

This Policy is a legal document between Physicians Health Plan (PHP) and you to provide Benefits to Covered Persons, subject to the terms, conditions, Exclusions and limitations of the Policy. We issue the Policy based on the Subscriber's application and payment of the required Premium.

Changes to the Document.

We may from time to time modify this Policy by attaching legal documents called Amendments that may change parts of the Policy. When that happens, we will notify you of the change.

You may access your member materials online at our "Member Reference Desk" using your Subscriber identification (ID) number. This site may be accessed through our web site at www.phpmichigan.com.

No one can make any changes to the Policy unless those changes are in writing and approved by the Michigan Department of Insurance and Financial Services (DIFS).

Right to Cancel Coverage.

For ten days after the date the Subscriber receives the Policy, the Subscriber may cancel the Policy by written request. PHP will promptly refund any Premium paid. If the Policy is cancelled, it will be void from the beginning as if no Policy or contract had been issued.

Other Information You Should Have.

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

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

The Policy will take effect on the date specified in writing by us. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight Eastern Time. The Policy will remain in effect as long as the Premium is paid when it is due, subject to termination of the Policy.

We are delivering the Policy in the State of Michigan. The laws of the State of Michigan are the laws that govern the Policy.

Execution of Contract.

We agree that the Subscriber's signature (or parent/guardian's signature if Subscriber is a minor) or completion of the Application for Coverage form means that the Subscriber accepts this agreement.

Meaningful Access.

If you, or someone you are helping, has questions about this Policy, you have the right to get help and information in your language at no cost. To talk to an interpreter, call our Customer Service Department at 517.364.8500 or 800.832.9186.

Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de PHP, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 517.364.8500 - 800.832.9186.

Arabic

Chinese **如果您，或是您正在協助的對象，有關於[插入SBM 項目的名稱]PHP方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話[在此插入數字**517.364.8500 - 800.832.9186.

German Falls Sie oder jemand, dem Sie helfen, Fragen zum PHP haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 517.364.8500 - 800.832.9186 an.

Italian Se tu o qualcuno che stai aiutando avete domande su PHP, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 517.364.8500 - 800.832.9186.

Japanese **ご本人様、またはお客様の身の回りの方でも、**PHP **についてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、**517.364.8500 - 800.832.9186 **までお電話ください。**

Korean 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 PHP에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는517.364.8500 - 800.832.9186로 전화하십시오.

Polish Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie PHP, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 517.364.8500 - 800.832.9186

Russian Если у вас или лица, которому вы помогаете, имеются вопросы по поводу PHP, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 517.364.8500 - 800.832.9186.

Syriac -
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.517.364.8500 - 800.832.9186

Tagalog Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa PHP, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 517.364.8500 - 800.832.9186.

Vietnamese Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về PHP, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 517.364.8500 - 800.832.9186.

Bengali যদি আপদি, 517.364.8500 - 800.832.9186 আপদি অিয কাউকক সহায়তা করকেি, সম্পকর্ক প্রশ্ন আকে PHP, আপিার অদিকার আকে দবিা খরকে আপিার দিজস্ব ভাষাকত সাহাযয পাবার এবং তথয জাি্বার। অিুবাি্ককর সাকথ কথা বলার জিয, কল করুি 517.364.8500 - 800.832.9186.

Albanian Nëse ju, ose dikush që po ndihmoni, ka pyetje për PHP, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 517.364.8500 - 800.832.9186.

Serbo-Croatian Ukoliko Vi ili neko kome Vi pomažete ima pitanje o PHP, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 517.364.8500 - 800.832.9186.

INTRODUCTION

This document describes your Benefits under the Policy.

How to Use this Document.

You are responsible for understanding all provisions of this document, including Amendments.

Follow this Policy if it is different from any summaries given to you by us.

Your health care provider does not have a copy of your Policy. Health care providers are not responsible for knowing or communicating your Benefits.

Defined Terms.

Certain capitalized words have special meanings. We have defined these words in the chapter, DEFINED TERMS.

When we use the words "we," "us," and "our" in this document, we mean PHP. When we use the words "you" and "your" we mean people who are Covered Persons.

How to Contact Us.

If you have a question or concern regarding your Benefits, call Customer Service at 517-364-8500 or 800-832-9186.

Let us know if you have a change of address, get married or divorced, have changes in eligibility of your Dependents, or if you get other health care coverage.

The Affordable Care Act (ACA).

PHP follows all sections of the ACA required for plans offered on and off the Health Insurance Marketplace. The Policy includes the following:

- All State of Michigan established Essential Health Benefits (EHB).
- No dollar limitations on EHBs.
- No pre-existing limitation Exclusions for any members.
- All member cost share in the form of Annual Deductibles, Copayments and Coinsurance amounts go toward satisfaction of the Annual Out-of-Pocket Maximum.

YOUR RESPONSIBILITIES

Be Enrolled and Pay Required Premium.

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

- Your enrollment must follow the eligibility requirements of the Policy.
- You must either be a Subscriber or his or her Dependent as those terms are defined in the chapter, DEFINED TERMS.

Not All Health Services Are Covered.

Your right to Benefits is limited to Covered Health Services. The chapters, WHAT IS COVERED, BENEFITS AND COVERAGE, and WHAT IS NOT COVERED tell you what PHP covers and what your responsibilities are under this Policy. Health care decisions are between you and your providers. PHP does not make decisions about what care you should or should not receive. We do determine, according to PHP medical policy and nationally recognized guidelines, what Medically Necessary Benefits are covered under the Policy.

Choose Your Physician.

You must choose the health care providers who will take care of you. We can assist you to find Network Physicians and facilities. Should you choose a Physician or facility not in our Network, you may have additional out-of-pocket expenses.

Pay Your Share.

For Covered Health Services, usually other than those that you pay a Copayment or for Preventive Health Services, you must first pay an Annual Deductible. Annual Deductibles, Copayments and Coinsurance amounts are due at the time of service or when billed by the provider.

You must pay the cost of all services and items above the Benefit limitation or that are excluded from coverage. Review the chapters, BENEFITS AND COVERAGE and WHAT IS NOT COVERED to understand this Policy's limitations and Exclusions.

If you make payment for any portion of the Premium directly to PHP, you are responsible for paying the Premium each month to us at our office in a timely manner.

Show Your ID Card.

To make sure you receive your full Benefit, show your ID card every time you request health care services. If you do not show your ID card, the health care provider may not bill us for the services you received.

File Claims with Complete and Accurate Information.

You or your health care provider files a claim to request payment from us. The claim must include all information needed to pay the claim, as described in the chapter, HOW TO FILE A CLAIM.

Statement of Your Rights and Responsibilities.

Enrollment with PHP entitles you to:

1. Receive information about your rights and responsibilities as a member.
2. Have access to language interpretation services.

3. Be treated at all times with respect and recognition of your dignity and right to privacy.
4. Choose and change a Primary Care Physician (PCP) from a list of Network Physicians or practitioners.
5. Information on all treatment options that you may have in terms you can understand so you can give informed consent before treatment begins.
6. Participate in decisions involving your health care, such as having treatment or not and what may happen.
7. Voice complaints or file appeals without fear of punishment or retaliation and/or without fear of loss of coverage.
8. Be given information about PHP, its services, and the health care providers in its Network, including their qualifications.
9. Make suggestions regarding PHP's member rights and responsibilities policies.

As a Covered Person, you are expected to:

1. Select or be assigned a Primary Care Physician from PHP's list of Network health care providers and notify PHP when you have made a change.
2. Be aware that all hospitalizations must be approved in advance by PHP, except in emergencies or for urgently needed health services.
3. Use Emergency department services only for treatment of a serious or life-threatening medical condition.
4. Always present your PHP ID card to health care providers each time you receive services, never let another person use it, report its loss or theft to us and destroy any old cards.
5. Notify PHP of any changes in address, eligible family members and marital status, or if you acquire other health care coverage.
6. Provide complete and accurate information (to the extent possible) that PHP and health care providers need in order to provide care.
7. Understand your health problems and develop treatment goals you agree on with your health care provider.
8. Follow the plans and instructions for care that you agree on with your health care provider.
9. Understand what services have cost shares to you, and pay them directly to the health care provider who gives you care.
10. Read your PHP member materials and become familiar with and follow health plan benefits, policies and procedures.
11. Report health care Fraud or wrongdoing to PHP.

Determine Benefits.

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

We do the following:

- Make factual determinations relating to Benefits.
- Make decisions about the Medical Necessity of a service, supply or procedure.

We may share these responsibilities with other persons or entities that provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may change. In order to receive Benefits, you must cooperate with these service providers.

Pay for Our Portion of the Cost of Covered Health Services.

We pay Benefits for Covered Health Services as described in the chapters, WHAT IS COVERED and BENEFITS AND COVERAGE, unless the service is excluded in the chapter, WHAT IS NOT COVERED. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

Review and Determine Benefits Following our Reimbursement Policies.

We develop our reimbursement policy guidelines using one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants following other appropriate sources or determinations that we accept.

After evaluation and validation of health care provider billings (for example, for error, abuse and Fraud reviews), our reimbursement policies are applied to provider billings. Non-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed.

Accessing Benefits.

Covered Health Services must be provided by Network providers. You must choose a Primary Care Physician (PCP) to provide or coordinate the Covered Health Services you receive.

You must show your ID card every time you request services. If you do not show your ID card, health care providers do not know that you are covered under the Policy. They may bill you for the entire cost of the services you receive. At a retail Network Pharmacy, for example, you may have to pay the entire cost of the Prescription Drug Product at the time you pick it up. You can ask for reimbursement from us as described in the chapter, HOW TO FILE A CLAIM. However, you may pay more because we reimburse you at the contracted amount.

Never let another person who is not a Covered Person under the Policy use your ID card. Immediately report the loss or theft of your ID card to us. Be sure to destroy any old cards.

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

Even if you have already received treatment or services, or even if your provider has determined that a particular health care service or supply is medically appropriate, it does not mean that the procedure or treatment is a Covered Health Service under the Policy.

You have the right to request:

- A copy of the clinical review criteria used to determine Medical Necessity.
- A copy of the PHP medical policy and/or nationally recognized guidelines.
- Any other information used in making our determination.

This request must be in writing. We provide the information to you free of charge. Contact Customer Service if you have questions about getting this information.

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

- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received before your coverage ends.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

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

Prior Approval.

Certain Covered Health Services require prior approval from us for coverage of these services or products. Health care providers must get the approval from us before they provide these services to you. We recommend you make sure the approval has been received.

Prior approval is not required before you see a Network provider of obstetrics or gynecology for routine care.

Approval Requirements for Non-Network Providers.

If you have been referred to a Non-Network provider you should contact us to determine if Benefits are available. We may pay for Covered Health Services from Non-Network health care providers only if we do not have a health care provider in the Network that can perform a necessary Covered Health Service. Your health care provider must get prior approval from us so claims are covered at the Network Benefit level. Otherwise, Benefits will not be paid and you may be responsible for all costs associated with those services.

Always make sure services are covered under the Policy. For example, in one instance a procedure may be covered but in another situation the same procedure is not covered. By calling PHP before you receive treatment, you can check to see if the service is:

- A Cosmetic Procedure. An example of a procedure that may or may not be considered Cosmetic is breast reduction and reconstruction. It is covered after cancer surgery but otherwise you must meet criteria for coverage.
- An Experimental, Investigational or Unproven Service.
- A service that is not covered under this Policy.

The list below of Covered Health Services that require prior approval is subject to change and may not include every service, supply or procedure. Please call us for the most current information or access our website at phpmichigan.com.

Covered Health Services that Require Approval.

1. Ambulance – non-emergency services.
2. Autism Spectrum Disorders treatment.
3. Bariatric surgery.
4. Behavioral health services – non-routine services such as:
   - All Inpatient Stays (see under Hospital – inpatient below).
   - Residential Treatment Programs.
   - Intermediate care (day treatment and partial hospitalization).
   - Certain outpatient services (intensive outpatient therapy [IOP], ECT, and neuro-diagnostic/cognitive testing).
5. Dental anesthesia.
6. Dental services – accidental.

   Your provider does not have to get approval at the time of the initial Emergency treatment but prior to follow up care.
7. Durable Medical Equipment – certain items only.
8. Facility services – non-Hospital (hospice facility, Skilled Nursing Facility and Inpatient Rehabilitation Facility).
9. Gender reassignment surgery, procedures, and medications.
10. Genetic Testing.
11. Home health care, home hospice services and home infusion services.
12. Hospital – inpatient (including Emergency admission for behavioral health and non-behavioral health conditions and long-term acute inpatient care).

Your provider does not have to get approval before you receive care or treatment at an Emergency Department.

Your provider must get approval as follows:

- For elective admissions: five business days before admission.
- For non-elective admissions: within one business day or the same day of admission.
- For Emergency admissions: within one business day or the same day of admission or as soon as reasonably possible.
- Maternity admissions – no prior approval is required unless Inpatient Stay is longer than:
  - 48 hours for the mother and newborn child following a normal vaginal delivery.
  - 96 hours for the mother and newborn child following a cesarean section delivery.
  - If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than the federally established minimum time frames above.

If delivery occurs outside of a Hospital, the above time periods begin on inpatient admission to the Hospital.

13. Preventive services, certain services only – BRCA mutation testing and lung cancer screening with low-dose CT scan.
14. Procedures – inpatient or outpatient, such as listed here: endoscopy, intestinal imaging (capsule only), gamma knife procedures, hyperbaric oxygen therapy, spinal cord stimulation, sacral nerve stimulation, joint replacement, Facet injections (after three visits in a Policy Year), rhizotomy, uvulopalatopharyngoplasty, temporomandibular joint dysfunction surgery, orthognathic surgery, and femoral acetabular hip impingement surgery.
15. Prosthetic or orthotic/support devices (certain items only).
16. Reconstructive procedures, including but not limited to, abdominoplasty, breast reduction, jaw surgery, vein surgery and rhinoplasty.
17. Rehabilitation/habilitation services – outpatient (except for spinal treatment services by a D.O. or Chiropractor).
18. Sleep studies (done in other than the home).
19. Specialty Drugs.
20. Transplant services.

Utilization Review.

Prior approval is one part of the utilization review process, which also includes concurrent review of ongoing course of treatment, urgent/expedited review and post-service review. For complete information on the process and timelines for review of claims/requests, see the chapter, HOW TO FILE A CLAIM.

When Medicare or Other Coverage is Primary.

If you have Medicare or other health care coverage that pays before PHP pays, the prior approval requirements described above still apply to you.

Payment Information.

The Policy does not contain an annual or lifetime limit on the dollar amount of Essential Health Benefits.

When Using Network Providers.

- For five types of services you must pay a Copayment that is not subject to the Annual Deductible, unless stated otherwise:
  - Physician's office visit (includes convenience care facilities at PCP Copayment) - $40 Copayment per PCP visit; $60 Copayment per specialist visit.
  - Emergency Department visit - $425 Copayment per visit.
  - Urgent Care Center visit - $50 Copayment per visit.
  - Outpatient behavioral health visit - $40 Copayment per visit.
  - Outpatient prescription drugs:

    Retail Network Pharmacies Copayment per order or refill.

    Tier 1 – $30, Tier 2 – $65, Tier 3 – $150, Tier 4 – $200.

    Mail-order service Copayment per order or refill.

    Tier 1 – $60, Tier 2 – $130, Tier 3 – $300, Tier 4 – $400.
- Preventive Health Services (including Prescription Drugs on the ACA Preventive Drug List, female surgical sterilization, tobacco cessation programs and pediatric routine vision exams) – No charge.
- All other Covered Health Services (including ancillary services received when a Copayment is also incurred) – 30% Coinsurance after Annual Deductible.

When Using Non-Network Providers.

Services from Non-Network providers are not covered unless the service, supply or treatment is for an Emergency or urgent condition or unless prior approved by us.

Annual Deductible.

The amount you pay for Covered Health Services before you are eligible to receive Benefits. The Annual Deductible does not apply to Copayments, unless noted otherwise, and Preventive Health Services.

Network – $5,000 per Covered Person per Policy Year, not to exceed $10,000 for all Covered Persons in a family.

Non-Network services are not covered.

Annual Out-of-Pocket Maximum.

The maximum you pay, out of your pocket, in a Policy Year for all Benefits.

Network – $7,350 per Covered Person per Policy Year, not to exceed $14,700 for all Covered Persons in a family.

Non-Network services are not covered.

Covered Health Services.

1. Ambulance Services – Ground or Air.

- Coverage for Emergency or non-Emergency transport.
- Must be a licensed ambulance service.
- Must be to the nearest Hospital where Emergency Health Services can be performed.
- For air ambulance transport, you must have a potentially life-threatening condition and transport by ground ambulance poses a threat to your survival or seriously endangers your health.
- You must meet PHP's criteria for coverage of air ambulance and non-Emergency ambulance.
- Covered Health Services for Emergency ambulance services and approved non-Emergency ambulance services received from Non-Network providers are covered at the Network Benefit level.

2. Autism Spectrum Disorders Treatment.

- Coverage for diagnosis and treatment of certain Autism Spectrum Disorders for children under the age of 19.
- Covered Health Services include:
  - Behavioral health treatment, such as Applied Behavioral Analysis (ABA).
  - Pharmacy management.
  - Outpatient psychiatric and psychological visits.
  - Outpatient rehabilitation/habilitation therapy services.
- Benefit follows the State of Michigan law.
- Covered Health Services for treatment of Autism Spectrum Disorders are not subject to quantitative or non-quantitative limits.

3. Behavioral Health Services.

- Coverage for evaluation and treatment of mental health conditions and substance use disorders.
- Covered Health Services received on an inpatient, intermediate (including Residential Treatment Programs) and outpatient basis, including on an Emergency basis.
- Treatment must be provided by a licensed Physician or other licensed behavioral health professional and received in a facility accredited by COA, AOA, CARF, or JCAHO.
- The Policy complies with the federal Mental Health Parity and Addictions Equity Act.

4. Chemotherapy.

- Coverage for Food and Drug Administration (FDA) approved chemotherapy drugs.
- Member cost share may vary depending on where the service is received and include, but are not limited to, outpatient administration of chemotherapy drugs, including in a Physician's office, Hospital, Alternate Facility, or a home.

5. Clinical Trials.

- You must be a qualified person participating in an approved clinical trial.

- Covered Health Services related to treating your condition are covered, excluding the Experimental drugs associated with the clinical trial.
- Must be a Phase I, Phase II, Phase III, or Phase IV clinical trial.
- Member cost share may vary depending on where the service is received and includes inpatient or outpatient services for the prevention, detection, or treatment of cancer or other life-threatening diseases or conditions.

6. Convenience Care Facilities.

- Can be retail-based clinics and are usually staffed by nurse practitioners and physician assistants.
- Care that is outside the emergency department, urgent care center or Physician's office for basic medical services and common, non-life-threatening conditions.
- Treatment and services include but are not limited to, allergies, athlete's foot, cold and flu symptoms, poison ivy and sunburn.

7. Dental Anesthesia.

- Coverage for dental-related anesthesia and associated facility charges if.
- A total of six or more teeth are extracted; or
- Local anesthesia would not be effective because of acute infection, anatomic variation, or allergy; or
- Multiple extractions or multiple restorations are needed because the patient is a child under the age of seven; or
- Patient has a concurrent hazardous medical condition; or
- Patient has suffered extensive oral-facial and/or dental trauma.

8. Dental Services – Accidental Injury and Other Medical Services of the Mouth.

- Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Removal of benign or malignant bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of sound, natural teeth to prepare for other medical covered procedures.
- Rebuilding or repair of soft tissues of the mouth or lip to correct problems caused by congenital birth defect or accidental Injury. This includes treatment for cleft lip or cleft palate.
- Medical and surgical services for accidental Injuries.
- Treatment for cancer.
- Treatment for conditions affecting the mouth other than the teeth.
- Member cost share varies depending on where the service is received. These services can be received on an inpatient or outpatient basis, including in the Emergency Department, in a Hospital, in an Alternate Facility or at a health professional's office.

- Dental services for accidental Injury received from Non-Network providers are covered at the Network Benefit level.

9. Diabetes Services.

- Equipment must meet the minimum specifications for your needs.
- If you want equipment above the minimum specifications, you must pay any difference in cost.
- Covered medical supplies used in the home.
- Educational training to provide necessary skills and knowledge to manage the disease.
- Shoe inserts and specialty shoes if meet criteria (limited to one pair of specialty shoes and three shoe inserts, per Policy Year).
- Member cost share varies depending on where the service is received. These services can be received on an inpatient or outpatient basis, including in a Hospital, in a clinic, at a health professional's office or from a Durable Medical Equipment supplier.

10. Durable Medical Equipment (DME).

- Must meet the minimum specifications that are necessary for your needs.
- If you want equipment above the minimum specifications, you must pay any difference in cost.
- Coverage for a single purchase (including repair or replacement) of a type of DME once every three Policy Years.
- Repair or replacement is covered only when necessary:
  - Due to change in your medical condition
  - Due to change in body size due to growth
  - To improve physical function.

11. Emergency Department Health Services – Outpatient/Observation Stay.

- Required to stabilize or initiate treatment in an Emergency.
- Outpatient observation stay services are subject to the Emergency Department visit Copayment.
- The Copayment is waived if admitted for an Inpatient Stay within 24 hours for the same condition.
- Member cost share may vary depending on the service received. In addition to a Copayment, you may receive ancillary services that are subject to Coinsurance after the Annual Deductible.
- Covered Health Services for Emergency Department visits received from Non-Network providers are covered at the Network Benefit level.

12. Facility Services (Non-Hospital).

Hospice Facility Care.

- Must be ordered by a Physician.
- Coverage for comfort and support services for the terminally ill in a hospice facility or in a home setting.
- Physical, psychological, social and spiritual care for the terminally ill person.

- Short-term grief counseling for immediate family members.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.

- Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility.
- Medical supplies and other non-Physician services.
- Room and board in a Semi-Private Room.

Limitations.

- Benefits are limited to 45 days per Policy Year.
- Hospice care in the home is not included in the limit.

13. Gender Reassignment Treatment.

- Covered when all criteria listed in our medical policy (available upon request) are met and prior approval is received.
- Member cost share varies depending on where the service is received. These services can be received on an inpatient or outpatient basis, including but not limited to, reconstructive surgery that is not considered a Cosmetic Procedure under the Policy, hormone therapy and mental health services.

14. Genetic Testing.

- Includes Genetic Testing for pregnant women.
- Member cost share varies depending on where the service is received. These services include but are not limited to, outpatient laboratory services, and health professional consultation.

15. Home Health Care.

- Necessary medical supplies.
- Provided or supervised by a registered nurse in your home.
- Must be Skilled Care (as defined by the Policy).

16. Home Infusion Therapy.

- To manage an incurable or chronic condition.
- Provided or supervised by a registered nurse on an intermittent basis in your home.
- When appropriate, Covered Person and/or caregiver will learn to administer home infusion therapy medications.

17. Hospital - Inpatient Stay.

- Medical supplies and other non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-Private Room.
- Surgery.
- Long-term acute inpatient services.

18. Injections/Infusions Received in a Physician's Office.

- Approved Specialty Drugs.

- Other injections and infusions such as allergy treatment and Facet injections.

19. Mammography (Diagnostic)/Breast Cancer Services.

- Diagnostic mammography.
- Breast cancer diagnostic services.
- Breast cancer outpatient treatment services.
- Breast cancer rehabilitative services.
- Member cost share varies depending on where the service is received. These services can be received on an inpatient or outpatient basis, including at a Hospital, at an Alternate Facility or in a health professional's office.

20. Maternity Services.

- Coverage for prenatal care, postnatal care, delivery, and any related complications.
- Diagnosis and treatment of the underlying causes of infertility.
- Family planning services.
- Maternity classes. Call Customer Service for details or go online to www.sparrow.org.
- Member cost share varies depending on where the service is received. These services can be received on an inpatient or outpatient basis, including but not limited to, in a Physician's office, in a Hospital, in an Alternate Facility, or other outpatient setting such as for maternity classes.

21. Morbid Obesity Treatment – Bariatric Surgery.

- Room and board and other medical services and supplies.
- Must be done in a Designated Facility.
- The Covered Person must qualify under our Morbid Obesity Policy (available upon request).
- Surgical treatment of obesity is limited to once per lifetime unless done to correct or reverse complications from a previous bariatric procedure.

22. Morbid Obesity Treatment – Weight Management Program.

- Must be through a Designated Facility.
- The Covered Person must qualify under our Morbid Obesity Policy (available upon request).
- Member cost share varies depending on where the service is received. Covered Health Services include, but are not limited to, outpatient behavioral health visits, nutritional counseling sessions, and outpatient laboratory services.

23. Nutritional Counseling Services.

- Must be provided by a Hospital-based registered dietician.
- Benefits are limited to six sessions of nutritional counseling per Policy Year.

24. Nutritional Therapy.

- Enteral feeding administered via tube.

- Parenteral nutrition administered via IV.
- Formulas, nutrients, medical supplies, equipment and accessories needed to administer these types of nutritional therapy.

25. Orthognathic Therapy.

- Repositioning (but not removal) of an individual tooth, arch segment, or entire arch.
- Surgery is covered if provided along with a course of orthodontic treatment to correct bodily dysfunction.
- Member cost share varies depending on where the service is received. These services can be received on an inpatient or outpatient basis, including but not limited to surgery, Physician office visits, and outpatient diagnostic services.

26. Ostomy Supplies.

- Medical supplies are required because of a colostomy, ileostomy or urostomy.
- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

27. Outpatient Diagnostic Services.

- Laboratory tests.
- Radiology.
- Procedures, such as colonoscopy and esophagogastroduodenoscopy (EGD).
- Procedures, such as Holter monitoring and cardiac catheterization.

28. Outpatient Advanced Diagnostic Imaging/High Tech Radiology and Nuclear Medicine.

- CT scans, PET scans, MRIs, MRAs.
- Nuclear medicine.
- Facility charge, charge for required services, medical supplies and equipment, and all related health professional fees.

29. Outpatient Surgery Services.

- Facility charges (can be at an ambulatory surgical center).
- Professional services.
- Medical supplies and equipment.

30. Outpatient Therapeutic Treatment Services.

- Approved Specialty Drugs.
- Dialysis.
- Intravenous chemotherapy or other intravenous infusion therapy.

- Radiation therapy.
- Medical education services to manage chronic disease states such as diabetes or asthma.
- Facility charge, the charge for required services, medical supplies and equipment, and all related health professional fees.

31. Pain Management.

- Chronic pain is constant and has been present for a long period without relief.
- Member cost share varies depending on where the service is received. Covered Health Services received on an outpatient basis for evaluation and treatment of chronic pain include, but are not limited to, Durable Medical Equipment, health professional office visits, and injections.

32. Physician's Office Services – Illness/Injury.

- Services received from your Primary Care Physician (PCP) or specialist.
- The Physician's office may be freestanding, located in a clinic or located in a Hospital.
- Radiology.
- Pathology.
- Diagnostic testing and services (including allergy testing).
- Consultations.
- Medical education services to manage chronic diseases such as diabetes or asthma.
- Member cost share varies depending on the service received. In addition to a Copayment, you may receive ancillary services that are subject to Coinsurance after the Annual Deductible.
- Covered Health Services received at a Non-Network Physician's office outside the Service Area to treat emergent or urgent conditions.

33. Prescription Drugs – Outpatient.

- Copayments or Coinsurance amounts vary depending on which of the four tiers of the Prescription Drug List the outpatient Prescription Drug is listed.
- If your Physician prescribes a Prescription Drug Product in a classification or tier that is not available to you or a preventive Prescription Drug Product, which is not available to you at no cost, we will conduct, at your or your Physician's request, a review to determine if the drug is medically appropriate in your specific circumstances. We will notify you and your provider of our coverage decision within 72 hours of receipt of a standard request that includes all information needed to make a decision. If we deny your request, you can request an independent external review.
- To accommodate the needs of new members, we may, upon clinical review, cover a transitional fill of a Non-Preferred Prescription Drug.
- Covered outpatient Prescription Drugs received from Non-Network providers are covered at the Network Benefit level if received due to an emergent or urgent condition.

Preventive Drugs Under the ACA.

- Covered at no member cost share.

- A select group of contraceptive Prescription Drug Products for women. This list includes at least one product in each of the 18 FDA-approved contraceptive methods.
- A select group of bowel prep medications for adults ages 50 through 74. Two prescriptions are covered in 365 days.
- Aspirin to prevent cardiovascular disease and colorectal cancer for adults ages 50 through 59 and aspirin to prevent morbidity and mortality from pre-eclampsia in women ages 12 through 55; fluoride for children from birth to five years of age; folic acid for women of childbearing years up to and including age 55; iron for children six to 12 months of age; and vitamin D2 or D3 for adults age 65 and over. These medications must be prescribed by a Physician.
- A select group of Preferred Tobacco Cessation Products. Preferred Tobacco Cessation Products must be prescribed by a Physician (even if the product is available as an over-the-counter product). You can only get them from a retail Network Pharmacy in up to a 31-day supply. The member must be an adult age 18 or older.
- Tamoxifen or Raloxifene for risk reduction of primary breast cancer for women 35 years of age or older who meet criteria.
- Must be prescribed by a Physician.
- The list of these medications and the criteria for coverage are subject to change.
- See our Benefit Coverage Policy for a complete list of all covered Preventive Health Services available on our web site, www.phpmichigan.com.

Tier Status Determines What You Pay.

- The Copayment you pay is determined by the tier to which our Pharmacy and Therapeutics ("P&T") Committee has assigned the Prescription Drug Product.
- Tier 1 is made up of mostly Generic drugs, Tier 2 is made up of mostly Preferred Brand-Name drugs, Tier 3 is made up of mostly Non-Preferred Brand-Name drugs and Tier 4 is made up of Non-Preferred Specialty Drugs. Preferred Specialty Drugs are mostly in Tier 1 or Tier 2 but some Specialty Drugs such as human growth hormone and to treat the underlying causes of infertility can have types in both tiers.
- We may periodically change the placement of a Prescription Drug Product among the tiers. These changes may occur without prior notice to you. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product.

Supply Limits.

- At a retail Network Pharmacy – up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- At a retail Network Pharmacy – one-cycle supply of a covered contraceptive.
- Through a mail-order Network Pharmacy – up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- Specialty Drugs – up to a consecutive 30-day supply of a Prescription Drug Product through a retail or mail-order Network Pharmacy.
- Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification.

33. Preventive Health Services.

- No cost share to the member (no Annual Deductible, no Copayments or no Coinsurance amounts) when provided by a Network provider.
- The Policy complies with the Affordable Care Act. The Preventive Health Services Benefit is subject to change.

Covered Preventive Services for Adults.

- Annual routine physical exams.
- Screenings such as:
  - Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
  - Alcohol misuse screening.
  - Blood pressure screening for all adults.
  - Cholesterol screening for adults of certain ages or at higher risk.
  - Colorectal cancer screening for adults over 50, including a select group of Prescription Drug Products for bowel prep (for adults ages 50 to 75) (two prescriptions are covered in 365 days).
  - Depression screening for adults.
  - Type 2 diabetes screening for adults with high blood pressure.
  - HIV screening for all adults at higher risk.
  - Obesity screening for all adults.
  - Tobacco use screening for all adults.
  - Syphilis screening for all adults at higher risk.
- Counseling such as:
  - Aspirin use for men and women of certain ages.
  - Alcohol misuse counseling.
  - Diet counseling for adults at higher risk for chronic disease.
  - Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
  - Obesity counseling for all adults.
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A.
  - Hepatitis B.
  - Herpes Zoster.
  - Human Papillomavirus.
  - Influenza.
  - Measles, Mumps, Rubella.
  - Meningococcal.
  - Pneumococcal.
  - Tetanus, Diphtheria, Pertussis.

— Varicella.

- Other services such as cessation interventions for tobacco users.

Covered Preventive Services for Women, Including Pregnant Women.

- Annual routine physical exams.
- Annual well-woman visits.
- HPV DNA testing for women 30 years and older.
- Screenings such as:
  - — Gestational diabetes for pregnant women.
  - — HIV screening
  - — Interpersonal and domestic violence screening.
  - — Anemia screening on a routine basis for pregnant women.
  - — Bacteriuria urinary tract or other infection screening for pregnant women.
  - — Breast cancer mammography screenings (one screening per Policy Year regardless of age).
  - — Cervical cancer screening for sexually active women.
  - — Chlamydia infection screening for younger women and other women at higher risk.
  - — Gonorrhea screening for all women at higher risk.
  - — Hepatitis B screening for pregnant women at their first prenatal visit.
  - — Osteoporosis screening for women over age 60 depending on risk factors.
  - — Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
  - — Tobacco use screening for all women, and expanded counseling for pregnant tobacco users.
  - — Syphilis screening for all pregnant women or other women at increased risk.
- Counseling such as:
  - — Sexually-transmitted infection counseling.
  - — HIV counseling.
  - — Contraceptive counseling.
  - — Breastfeeding support and counseling.
  - — Interpersonal and domestic violence counseling.
  - — BRCA counseling about Genetic Testing for women at higher risk.
  - — Breast cancer chemoprevention counseling for women at higher risk.
  - — Use of folic acid supplements for women who may become pregnant.
- Other services such as:
  - — Tobacco use interventions for all women.
  - — Breast feeding interventions to support and promote breast feeding, including breast pumps supplied by our designated vendor.
  - — Select FDA-approved contraceptive methods on the ACA Preventive Prescription Drug List.

— Tamoxifen or Raloxifene for risk reduction of primary breast cancer for women age 35 years of age or older who meet criteria.

Covered Preventive Services for Children.

- Annual routine physical exams including well baby and well child visits.
- Screenings such as:
  - — Autism screening for children at 18 and 24 months.
  - — Cervical dysplasia screening for sexually active females.
  - — Congenital hypothyroidism screening for newborns.
  - — Developmental screening for children under age three, and surveillance throughout childhood.
  - — Dyslipidemia screening for children at higher risk of lipid disorders.
  - — Hearing screening for all newborns.
  - — Hematocrit or hemoglobin screening for children.
  - — Hemoglobinopathies or sickle cell screening for newborns.
  - — HIV screening for adolescents at higher risk.
  - — Lead screening for children at risk of exposure.
  - — Obesity screening.
  - — Phenylketonuria (PKU) screening for this genetic disorder in newborns.
  - — Vision screening for all children.
- Assessments such as:
  - — Alcohol and drug use assessments for adolescents.
  - — Behavioral assessments for children of all ages.
  - — Height, weight and body mass index measurements for children.
  - — Medical history for all children throughout development.
  - — Oral health risk assessment for young children.
- Counseling such as:
  - — Use of fluoride chemoprevention supplements for children without fluoride in their water source.
  - — Use of iron supplements for children ages six to 12 months at risk for anemia.
  - — Obesity counseling.
  - — Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk.
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - — Diphtheria, Tetanus, Pertussis.
  - — Haemophilus influenzae type b.
  - — Hepatitis A.
  - — Hepatitis B.
  - — Human Papillomavirus.

- Inactivated Poliovirus.
- Influenza.
- Measles, Mumps, Rubella.
- Meningococcal.
- Pneumococcal.
- Rotavirus.
- Varicella.

- Other services such as:
  - Tuberculin testing for children at higher risk of tuberculosis.
  - Gonorrhea preventive medication for the eyes of all newborns.

35. Professional Fees for Surgical and Medical Services.

- Coverage for surgical procedures and other medical care by a Physician.
- Received on an outpatient or inpatient basis or in a home for Physician house calls.

36. Prosthetic and Orthotic/Support Devices.

- Surgically implanted and externally worn prosthetic devices to replace a limb or body part.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. This includes mastectomy bras (up to four per Policy Year) and lymphedema stockings for the arm.
- Must meet the minimum specifications for your basic functional needs.
- If you want a prosthetic or orthotic device above the minimum specifications, you must pay any difference in cost.
- Not used specifically for physical appearance or as safety items or to affect performance in sports-related activities.
- Repair or replacement is covered when necessitated due to a change in your medical condition, or a change in body size due to growth, or to improve physical function.

37. Reconstructive Procedures.

- Reconstructive procedures include surgery or other procedures when associated with an Injury, Sickness or Congenital Anomaly.
- Reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry.
- Medically Necessary plastic surgery such as blepharoplasty of upper lids, surgical treatment of male gynecomastia, panniculectomy, and sleep apnea treatments (for example, rhinoplasty or septorhinoplasty).
- Other services required by the Women's Health and Cancer Rights Act of 1998, including treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service.
- Member cost share varies depending on where the service is received, for example, in a Physician's office, or a Hospital or Alternate Facility.

38. Rehabilitation/Habilitation Services – Outpatient Therapies.

- Physical therapy.
- Occupational therapy.
- Speech therapy, including post-cochlear implant aural therapy (must meet criteria).
- Pulmonary rehabilitation therapy.
- Phase II cardiac rehabilitation therapy.
- Spinal treatment by a Chiropractor or Doctor of Osteopathy, "D.O."
- Surgery is not a prerequisite for receiving outpatient rehabilitation therapy.
- Rehabilitative/habilitative therapy may be received in the home.

Limitations.

- Physical therapy, occupational therapy, and Spinal treatment are limited to 30 visits per Policy Year.
- Speech therapy is limited to 30 visits per Policy Year.
- Pulmonary rehabilitation therapy and Phase II cardiac rehabilitation therapy are limited to 30 visits per Policy Year.
- If the therapies described under this category are available on both a rehabilitative and habilitative basis, there are separate limits, as stated above, for each type (e.g., 30 visits per Policy Year for rehabilitative speech therapy and 30 visits per Policy Year for habilitative speech therapy; and 30 combined visits per Policy Year for rehabilitative physical therapy, occupational therapy and Spinal Treatment and 30 combined visits per Policy Year for habilitative physical therapy, occupational therapy and Spinal Treatment, as applicable).
- Rehabilitation/habilitation therapy for autism is not included in the limits shown above.

39. Surgical Sterilization – Female.

- Female surgical sterilization procedures and related services received in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.
- Facility charge, the charge for required Hospital-based professional services, medical supplies and equipment and for the surgeon's fees.

40. Surgical Sterilization – Male.

- Male surgical sterilization procedures and related services received in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.
- Facility charge, the charge for required Hospital-based professional services, medical supplies and equipment and for the surgeon's fees.

41. Telemedicine Services.

- "Telemedicine" is the use of an electronic medium to link patients with health care professionals in different locations.
- The health care professionals must be able to examine the patient via a real-time, interactive audio and/or video telecommunications system

- The patient must be able to interact with the offsite professional at the time the services are provided.
- Member cost share varies depending on where the service is received, for example, in a Physician's office, or a Hospital or Alternate Facility.
- Not all Covered Health Services are covered telemedically such as, but not limited to, new patient examinations, Preventive Health Services and surgery.

42. Temporomandibular Joint Dysfunction or Syndrome (TMJ).

- TMJ means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction.
- Health professional fees for Covered Health Services to treat TMJ resulting from a medical cause or Injury.
- Member cost share varies depending on where the service is received, for example, in a Physician's office, or a Hospital or Alternate Facility.

43. Tobacco Cessation Program.

- A tobacco cessation counseling program for members age 18 and older.
- Preferred Tobacco Cessation Products (see *Prescription Drugs – Outpatient*).

44. Transplantation Services.

- Transplantation programs typically include three phases: pre-transplant services, the transplant period and post-transplant services.
- Transplant must be done at a Designated Facility (except for corneal transplants).
- Donor expenses for a donor who is not a Covered Person under this Plan are covered if not covered by the donor's plan. If both the donor and the recipient are covered under this Plan, all Covered Health Services will be covered under the recipient.
- Computer organ bank searches and any subsequent testing necessary after a potential donor is identified are covered unless covered by another health benefit plan or policy.
- We have specific guidelines regarding Benefits for transplant services.
- Covered transplants include:
  - Bone marrow transplants.
  - Heart transplants.
  - Heart/lung transplants.
  - Lung transplants.
  - Kidney transplants.
  - Kidney/pancreas transplants.
  - Liver transplants.
  - Liver/small bowel transplants.
  - Pancreas transplants.
  - Small bowel transplants.

45. Urgent Care Center Services.

- Member cost share varies depending on the service received. In addition to a Copayment, you may receive ancillary services that are subject to Coinsurance after the Annual Deductible.
- Covered Health Services for Urgent Care Center visits from Non-Network providers are covered at the Network Benefit level.

46. Vision Benefits - Pediatric.

- Benefits are available for dependent children up to the day they turn age 20.
- Member cost share varies depending on the service received. Routine eye examinations are considered a Preventive Health Service and other covered vision services are subject to Coinsurance after the Annual Deductible.

Examinations.

- Routine refractive eye examinations, including dilation, if professionally indicated – limited to one exam per Policy Year.

Eyeglasses.

- Lenses – limited to one pair per Policy Year:
- Frames – covered once every Policy Year.

Contact Lenses.

- Elective contact lenses are covered for a one-year's supply per Policy Year in lieu of eyeglasses.
- Medically Necessary contact lenses are covered for a one-year's supply per Policy Year in lieu of any other eyewear (eyeglasses or elective contact lenses).

Other Vision Services.

- Optional lenses and treatments.
- Low Vision Services.

How We Use Headings in this Chapter.

To help you find specific Exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual Exclusions appear underneath headings.

We Do Not Pay Benefits for Exclusions.

We do not pay Benefits for any of the services, treatments, items or supplies described in this chapter, unless we state otherwise.

Benefit Limitations.

We show specific Benefit limits in the chapter, BENEFITS AND COVERAGE. We will not pay Benefits for any of the services, treatments, items or supplies over these Benefit limits.

A. Alternative Testing and Treatment.

1. Alternative testing and treatment as defined by the National Center for Complementary and Alternative Medicine.

B. Behavioral Health Services.

1. Treatment for mental, neurological and other disorders when such conditions are solely medical in nature and that may be covered under other chapters of this Policy.
2. Treatment for conduct and impulse control disorders, and paraphilias.
3. Services utilizing methadone treatment as maintenance.
4. Treatment provided to comply with involuntary commitments, police detentions and other similar arrangements.
5. Services provided outside of an inpatient, intermediate or outpatient setting.
6. Behavioral Health Services for the following:
   - — Sleep disorders.
   - — Delirium, dementia, and amnesic and other cognitive disorders (unless noted otherwise).
   - — Therapy for pervasive developmental disorders, except for treatment of certain Autism Spectrum Disorders.
   - — Psychotherapy for elimination disorders.
   - — Marital counseling.
   - — Transitional living centers, wrap-around care services, halfway or three-quarter-way houses, non-licensed programs, therapeutic boarding schools or milieu therapies.
   - — Sex therapy.

C. Dental and Related Oral/Mouth Conditions.

1. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums including:
   - — Extraction, restoration and replacement of teeth (including extraction of impacted wisdom teeth).
   - — Services to improve dental clinical outcomes.

2. Tooth implants and related services, bone grafts and other implant-related procedures and related services, even when required as a result of an Injury.
3. Orthodontic services, including braces.
4. Dental X-rays, all hospitalization charges, facility charges, and anesthesia charges related to dental care. The only exceptions to this are for any of the following:
   — Transplant preparation.
   — Initiation of immunosuppressives.
   — The direct treatment of acute traumatic Injury, cancer or cleft palate.
5. Supplies and appliances and all associated expenses (including occlusal splints, dental prosthetics and dental orthotics). Mouth rehabilitation. Bridges. Partial plates. Dentures.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs.

1. Self-injectable medications except as covered from a Network Pharmacy or stated as covered.
2. Non-injectable medications given in a Physician's office except as required in an emergent or urgent situation and if consumed in the Physician's office.
3. Over-the-counter drugs and treatments, unless otherwise noted.
4. Compounded Medications.
5. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
6. Any product dispensed for the purpose of appetite suppression and other weight loss products.
7. Prescription Drug Products to treat infertility except to continue or support a Pregnancy.
8. A Specialty Prescription Drug Product that must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
9. General vitamins, except for prescribed: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
10. Unit dose packaging of Prescription Drug Products.
11. Replacement for a previously dispensed Prescription Drug Product even if lost, stolen, broken or destroyed.

E. Experimental, Investigational or Unproven Services.

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational, or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

This Exclusion does not apply to chemotherapy drugs.

F. Medical Supplies, Appliances and Equipment.

1. Devices used specifically as safety items or in sports-related activities.

2. Medical and disposable supplies unless covered for diabetics or necessary for proper functioning or application of DME. Examples of non-covered items include:
   - Elastic, surgical and compression stockings (for example TEDs and JOBST stockings)
   - Ace bandages.
   - Disposable dressings such as gauze, filters, lubricants, tape, appliance cleaners, adhesive, adhesive removers, deodorant, and pouch covers and as used for wound care.
   - Syringes, except for treatment of diabetes.
3. Shoe orthotics, except for shoe inserts for peripheral neuropathy, or those determined to be habilitative and covered under the Policy.
4. Shoes, except for specialty shoes prescribed for a person with diabetes, or those determined to be habilitative and covered under the Policy.
5. Cranial helmets.
6. Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.
7. Duplicate DME items.

G. Nutrition.

1. Megavitamin and nutrition based therapy.
2. Food, formula and nutritional supplements are not covered, except for formula specifically intended for tube feeding and nutrients necessary for IV feeding. Non-covered items include:
   - Infant formula.
   - Donor breast milk.
   - Protein or caloric boosting supplements.
   - Ensure.
   - Osmolyte.
   - Herbal preparations or supplements.

H. Personal Services, Comfort or Convenience.

1. Custodial Care, domiciliary care or basic care to meet your personal needs.
2. Personal comfort and convenience items.
3. Lodging and/or meals while receiving health care services either within or outside of PHP's Service Area.
4. Beauty/barber services.
5. Guest services.
6. Medical supplies, equipment, and services for personal comfort, or for the convenience of either the Covered Person or his or her Physician.

I. Physical Appearance.

1. Cosmetic Procedures. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures.

— Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.

— Treatment to improve the appearance of the skin.

— Treatment for spider veins.

— Hair removal by any means.

— Plastic surgery, unless stated as covered.

— Blepharoplasty of lower lids.

— Collagen implants

— Diastasis recti repair.

2. Removal or replacement of an existing breast implant if it was initially performed as a Cosmetic Procedure, unless due to complications.
3. Physical conditioning programs.
4. Any hair replacement product or process, including wigs.

J. Providers.

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a diagnostic facility without a written by a Physician order. Services ordered by a Physician or other provider who is an employee or representative of a diagnostic facility, when that Physician or other provider:

   — Has not been actively involved in your medical care prior to ordering the service, or

   — Is not actively involved in your medical care after the service is received.

   This Exclusion does not apply to mammography screening.
4. Foreign language and sign language interpreters.
5. Telephone consultations that do not meet the criteria as described in Telemedicine Services in the chapter, BENEFITS AND COVERAGE.
6. Academic services including tuition for or services that are school-based for children or adolescents provided under the Individuals With Educational Disabilities Act (IDEA).

K. Reproduction.

1. Elective abortion as defined by state law. The following are not included in the definition of elective abortion:

   — To preserve the life or health of the child after live birth;

   — To remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman;

   — The use or prescription of a drug or device intended as a contraceptive;

   — The intentional use of an instrument, drug, or other substance or device by a Physician to terminate a woman's Pregnancy if the woman's physical condition, in the Physician's reasonable medical judgment, necessitates the termination of the woman's Pregnancy to avert her death;

— Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic Pregnancy.

2. Any treatment, procedure or prescription medication designed to create a Pregnancy.

3. The reversal of surgical sterilization.

4. Any form of preservation or long-term storage of reproductive materials.

L. Services Provided under Another Plan.

1. Health services if other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation or similar legislation. This applies whether or not you choose to file a claim.

   This Exclusion does not apply to no-fault automobile insurance.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health care services for treatment of military service-related disabilities, when you are enrolled for coverage through the Veterans Administration (VA).

3. Health services while on active military duty.

M. Spinal Treatment.

1. Any service not included in the scope of services defined in the Michigan Public Health Code, Chapter 333, Part 164.

N. Transplants.

1. Removal of an organ or tissue from you for purposes of a transplant to another person.

2. Health services for transplants involving mechanical or animal organs.

3. Transplant services that are not performed at a Designated Facility, except for corneal transplants.

4. Any solid organ transplant that is performed as a treatment for cancer.

O. Travel.

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel, lodging, room and board or transportation expenses, even though prescribed by a Physician or necessary because of where treatment is received.

P. Vision and Hearing.

1. Purchase and fitting of hearing aids.

2. Eye exercise therapy or visual therapy.

3. Surgery intended to allow you to see better without glasses or other vision correction.

4. Replacement of lost/stolen eyewear; non-prescription (Plano) lenses; two pairs of eyeglasses in lieu of bifocals; services not performed by licensed personnel; or insurance of contact lenses.

5. Any other vision treatment or services except for treatment of medical conditions and diseases of the eye as provided under the Policy.

Q. All Other Exclusions.

1. Health services and medical supplies that do not meet the definition of a Covered Health Service.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to get or maintain a license of any type.
3. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made if you did not have coverage under the Policy.
4. Benefits when a provider waives Copayments, Coinsurance amounts and/or the Annual Deductible for a health service.
5. Medical services and supplies, which are provided while member is in the custody of any law enforcement authorities or while incarcerated in a facility such as a youth home. Charges involving a member's medical condition, which arise out of the commission of a felony by such a member, if convicted, unless resulting from an underlying medical condition or act of domestic violence.
6. Ambulance services without treatment, unless transport is provided.
7. Medical services provided by Emergency transport providers that are government supported or where fees are in the form of a voluntary donation.
8. Medical services and supplies for home births.
9. Freestanding birthing centers.
10. Private duty nursing.
11. Respite care, except as part of hospice services.
12. Rest cures.
13. Work hardening.
14. Autopsy.
15. Long term (more than 30 days) storage.
16. Psychosurgery.
17. Medical and surgical treatment of excessive sweating (hyperhidrosis), except Covered Health Services.
18. Medical and surgical treatment for snoring or daytime sleepiness, except when part of treatment for documented obstructive sleep apnea.
19. Oral appliances for snoring.
20. Audio therapy.
21. All devices to assist in communication, speech and Telemedicine Services, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
22. Gym memberships. Aquatic exercise programs or classes. Personal trainers. Exercise equipment, including pools even if prescribed by a Physician.
23. Inpatient or outpatient Recreational Therapy.

24. Penile implants for the treatment of impotence having a psychological origin.
25. Covered Health Services when a Covered Person has refused to comply with or has terminated the scheduled service or treatment against the advice of a Physician or PHP.
26. Legal/court fees, copy/fax fees, late fees, shipping charges, long distance telephone charges, and fees for copying X-rays.
27. Charges for missed appointments.
28. Power operated wheelchairs if criteria are not met
29. Benefits are not payable for the following:
    - All bath aids, such as shower chairs and safety rails
    - Toilet seat risers.
    - Grabbers.
    - Stair lifts.
    - Ramps.
    - Diapers.
    - Home modifications.
    - Wheelchair lifts.
    - Lift chairs.
    - Standing systems, stationary and mobile.
    - Automobile modifications and adaptive devices, such as hand grips, hand controls and special foot pedals.
    - Mobility carts and power-operated vehicles, for example, scooters, motorized carts, and electric scooters.
    - Car seats and safety seats.
    - Strollers.
    - Shoe lifts.
    - Polar packs.
    - Temper-pedic and all other mattresses or mattress overlays.
    - Air conditioners. Air purifiers and filters or air cleaning devices. Dehumidifiers and humidifiers.
    - Batteries and battery chargers.
    - Hot tubs and whirlpools. Tanning beds, lamps and services. Light bulbs and short and long wave UV light units to be used in the home.
30. Services for the treatment of an overbite or underbite. Maxillary and mandibulary osteotomies, unless determined by us to be Covered Health Services.
31. Mouth orthotics, mouth splints, mouth prosthetics and mouth appliances.
32. Biofeedback training, unless determined by us to be Covered Health Services.
33. Items or services furnished, ordered, or prescribed by any provider that involves Fraud.

Network Benefits.

PHP pays Network Benefits for Covered Health Services that are:

- Provided by Network health care providers.
- Emergency Health Services.
- Urgent Care Center services.
- Covered Health Services received in a Non-Network Physician's office outside the Service Area to treat emergent/urgent conditions that require immediate attention.
- Non-Network Covered Health Services with prior approval.

Selecting a Primary Care Physician.

You must choose a Primary Care Physician (PCP) in our Network who is available to accept you and your family members. Having a PCP helps ensure continuity of care and provides you and your Dependents with a medical home.

You may select a Network pediatrician for your child's PCP.

You may change your or your family member's PCP by visiting our web site, www.phpmichigan.com, or by contacting Customer Service.

Limitation on Selection of Providers.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network health care providers may be limited.

Provider Network.

We contract with health care providers to form a Network. Network health care providers are independent practitioners. They are not our employees.

A directory of Network health care providers is available to you. You must choose your Network providers. Before going for services, make sure your health care provider is in the Network. A health care provider's status in the Network can change. You can check the health care provider's status by calling Customer Service or by accessing our web site at www.phpmichigan.com.

If a health care provider leaves the Network or is otherwise not available to you, you must choose another Network provider to receive Network Benefits.

Please visit our web site or contact our Customer Service Department for any of the following:

- The current health care provider network directory, including names and locations by specialty and a listing of which providers accept new patients.
- The professional credentials of participating health care professionals.
- The licensing verification telephone number for the Michigan Department of Licensing and Regulatory Affairs.
- Any prior approval requirements, and any limitations, restrictions or Exclusions.

Medical Resource Management.

Your Network health care providers must get prior approval from the Medical Resource Management Department at PHP for coverage of certain health care services. When your health care provider contacts us, we will work together to give you information about additional services that are available to you. These services are disease management programs, health education, pre-admission counseling and patient advocacy.

Designated Facilities and Other Health Care Providers.

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

Health Services from Non-Network Health Care Providers Paid as Network Benefits.

If we decide that Covered Health Services are not available from a Network health care provider, you may be able to see a Non-Network health care provider. Please make sure that we have approved the request. If you see a Non-Network health care provider without approval from us, Network Benefits will not be paid. You may be responsible for all non-covered charges.

Emergency Health Services.

Your health care provider does not have to get prior approval before you receive care or treatment at an Emergency Department.

We cover Emergency Health Services required for stabilization and initiation of treatment. Network Benefit levels are always paid for Emergency Health Services, even if the services are provided by a Non-Network health care provider.

If you are formally admitted as an inpatient to a Hospital within 24 hours of receiving Emergency treatment for the same condition, you do not pay the Emergency Department visit Copayment. Other charges incurred during the Emergency Department visit may be subject to the Annual Deductible and Coinsurance.

The Copayment is not waived for an outpatient observation stay.

Continuing Care when Physician Leaves Network.

If you have regularly been seeing a Physician who is no longer in our Network, PHP may continue to cover the services you receive from that Physician at Network Benefit levels while you are covered under the Policy. In order to receive continued care at Network Benefit levels from a Non-Network Physician, the treating Physician must agree to continue to see you and your situation must be one of the following:

- You are currently involved in an ongoing course of treatment (you may be able to continue for up to 90 days).
- You are in your 2nd or 3rd trimester of pregnancy (you may be able to continue until the end of the postpartum care directly related to the Pregnancy).
- You are diagnosed with a terminal illness and are actively being treated for the illness (you may continue receiving treatment for the illness for the remainder of your life).
- You are currently being treated for a health condition that your treating Physician or health care provider can prove that by stopping treatment with this Physician or health care provider would cause the condition to get worse or reduce the expected results of the treatment.

If you believe that you may qualify for continued care with a Physician who no longer participates in our Network, please contact the Customer Service Department.

How to Enroll.

You must complete the enrollment process through the Health Insurance Marketplace. PHP must receive the required Premium before coverage becomes effective.

If you purchase this Policy directly with PHP, you must complete an enrollment form and return the completed form to us with the required Premium before coverage becomes effective.

You cannot receive Benefits for health services before your effective date under this Policy.

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

Genetic Information.

Neither you nor your Dependents are required to:

- Undergo Genetic Testing.
- Disclose to us whether Genetic Testing has been conducted.
- Disclose the results of Genetic Testing or genetic information (including family medical history).

PHP will not:

- Limit your coverage based on any information we receive related to Genetic Testing you receive.
- Adjust premiums based on your genetic information.
- Collect genetic information from Covered Persons at any time for underwriting purposes.

Who is Eligible for Coverage.

Eligible Person.

Eligible Person means a person who has applied for coverage through the Health Insurance Marketplace or directly to PHP. When an Eligible Person actually enrolls under a PHP policy, that person is now a Subscriber.

A Subscriber:

- Is properly enrolled under this Policy.
- Is the person (who is not a Dependent) to whom this Policy is issued.
- Is not eligible for Medicare under Title XVIII of the Social Security Act prior to the effective date of coverage.
- Resides within the Service Area, which is a specific geographic area that we serve.
- Is under the age of 21 when this Policy becomes effective (if Child Only Policy).
- Is eligible for the child-only Premium rate (if Child Only Policy).

Dependent (Not Applicable for Child Only Policy).

Eligible Dependents include:

- A legal spouse; or

- A Domestic Partner (as defined by this Policy); and
- Any child of you or your legal spouse (or Domestic Partner) until the end of the calendar year in which they turn 26.
- A child may be covered to any age if "totally and permanently" disabled.

Coverage for a dependent is effective on the date the Subscriber's coverage becomes effective if he applies for dependent coverage when he enrolls in the Policy. A new Dependent may be enrolled in this Policy if the Subscriber submits written or electronic application within 31 days after he acquires that dependent.

An eligible newborn child may be covered for the first 31 days after birth without enrolling under the Policy. Coverage will only continue past the first 31 days if the eligible child is formally enrolled within the 31-day period following birth.

An eligible adopted child, or eligible child placed for adoption is covered if enrolled within the 31-day period following adoption, or adoption placement.

If coverage for a Dependent child is applied for more than 31 days following the date that Dependent becomes eligible for coverage, the Dependent may have to wait to enroll at the next Open Enrollment Period.

To receive Network Benefits, Dependents living, working or attending school outside of the Service Area must receive non-emergent/non-urgent services from Network providers.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

This Plan is intended to comply with federal law with respect to dependent child eligibility and Qualified Medical Child Support Orders.

When to Enroll and When Coverage Begins.

Enrollment Periods.

Eligible Persons may enroll themselves and their Dependents:

- During the Initial Enrollment Period, which is the first period of time when Eligible Persons can enroll.
- During each subsequent Open Enrollment Period, as determined by the Health Insurance Marketplace.

Coverage under a plan purchased on the Health Insurance Marketplace for qualified Eligible Persons and any Dependents (if applicable) is effective on the first day of the following month if the plan selection is received by the Health Insurance Marketplace between the first and the 15th day of the previous month. If the plan selection is received by the Health Insurance Marketplace between the 16th and the last day of any month, coverage is effective the first day of the second following month.

Coverage under a plan purchased directly with PHP is effective on the date specified by PHP.

Military Leave.

Eligible Persons going into or returning from military service have Policy rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights include:

- Up to 24 months of extended coverage while performing military service.
- Immediate coverage with no pre-existing condition limitation applied upon return from service.

Benefit coverage shall not cost more than 102 percent of the applicable premium. However, if the Eligible Member performs service in the uniformed services for less than 31 days, the cost of coverage may not be more than the employee share, if any, for such coverage.

Subscribers and their Dependents must be covered under the Policy before leaving for military service to have these rights.

Policy exclusions and waiting periods may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Adding New Dependents (Not Applicable for Child Only Policy).

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Establishment of a Domestic Partnership, as defined by the Policy.
- Legal guardianship.
- Court or administrative order.

Coverage begins on the date of the event if the Health Insurance Marketplace or PHP is notified within 60 days of the event that makes the new Dependent eligible.

Special Enrollment Period.

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

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

- Birth.
- Legal Adoption.
- Placement for adoption.
- Marriage.
- Divorce or legal separation.
- Death.
- Loss of eligibility under a Medicaid plan or state children's health insurance program (CHIP).
- Eligibility gained for a premium assistance subsidy under Medicaid or a CHIP (subsidy to be used toward payment of premiums for a group health plan).
- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.

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

In the case of loss of coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

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

For a Policy purchased through the Health Insurance Marketplace an individual may be able to enroll during a Special Enrollment Period if:

- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a Qualified Health Plan (QHP).
- A qualified individual or member gains access to new QHPs as a result of a permanent move.
- A qualified individual is an American Indian or Alaska Native who may then enroll in a QHP or change from one QHP to another one time per month.
- An enrollee adequately demonstrates to the Health Insurance Marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
- A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an office, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.
- A qualified individual or member demonstrates to the Health Insurance Marketplace that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide.

Payment of Clean Claims.

A clean claim for Covered Health Services received from a health care provider is paid immediately upon receipt by us. A clean claim that is not paid within 45 days includes interest at a rate of 12 percent per annum. We notify the health care provider within 30 days after receipt of the claim of all known reasons that prevent the claim from being a clean claim.

A health care provider has 45 days after receipt of a notice that the claim is not a clean claim to correct and resubmit the claim. The 45-day time period in which we pay a clean claim for Covered Health Services before paying interest covers the date of receipt of a notice from us to a provider to the date of receipt of a response by us from the provider.

If the health care provider's response makes the claim a clean claim, we pay the claim within the 45-day time period. The time while waiting for a clean claim to be submitted is not included.

If the health care provider's response does not make the claim a clean claim, we notify the provider of an Adverse Benefit Determination and of the reasons for the Adverse Benefit Determination within the 45-day time period. The time while waiting for a clean claim to be submitted is not included.

If we determine that one or more services listed on a claim are payable, we pay for those services and do not deny the entire claim. This does not apply if the provider and we have an overriding contractual reimbursement arrangement.

As used in this chapter a "clean claim" means a claim that does all of the following:

- Identifies the health care provider of service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
- Sufficiently identifies the patient and health plan subscriber.
- Lists the date and place of service.
- Is a claim for Covered Health Services for an eligible individual.
- If necessary, confirms the Medical Necessity and appropriateness of the service provided.
- Identifies the service given using a generally accepted system of procedure or service coding.
- Includes additional documentation based upon services given as reasonably required by us.

Covered Health Services from a Network Health Care Provider.

Network health care providers are responsible for filing claims directly to us. We pay Network providers directly. You are responsible for meeting the Annual Deductible, and for paying required Copayments or Coinsurance amounts to a Network provider at the time of service, or when you receive a bill from the provider. If a Network provider bills you for any other charges, contact Customer Service.

Covered Health Services from a Non-Network Health Care Provider.

When you receive Covered Health Services from a Non-Network health care provider, you may have to file a claim. The claim must include all information we require to pay the claim. PHP does not require a claim form be submitted with a claim, but a completed claim form usually gives us all the information we need to process your claim. Claim forms are available on our Member Reference Desk. If we require you to submit a completed claim form,we will provide you with the approriate form within 15 days of receiving notice of a claim.

Medical Claims.

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

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

Additional documentation may be requested of your provider before Benefits will be considered for payment.

Prescription Drug Product Claims.

When you request reimbursement for covered Prescription Drug Products received from a Network Pharmacy, you must provide our Pharmacy Benefits Manager, CVS Caremark (see address below) with the following information and documentation:

- The Subscriber's name and address.
- The patient's name, age, and relationship to the Subscriber.
- The member number stated on your ID card.
- Date the prescription was filled.
- Name and address of the pharmacy.
- Prescribing Physician's name or ID number.
- National Drug Code (NDC) number of the drug.
- Name of the drug and its strength.
- Quantity and days' supply.
- Prescription number.
- DAW (Dispense As Written), if applicable.
- Amount paid.

A pharmacist can provide the necessary information if your claim or bill is not itemized.

You must follow the instructions listed below for submitting your claim:

1. Only use the claim form available on our web site at www.phpmichigan.com when you have paid full price for a prescription drug order at the pharmacy because:
   - — You received a prescription drug for an urgent or emergent purpose and you must submit the receipt to PHP directly (see address below); or
   - — You have not yet received your ID card (submit to CVS Caremark at address below).
2. You must complete a separate claim form for each pharmacy used and for each patient.
3. You must submit claims within one year of date of purchase.
4. Include your receipts (copies accepted).
5. Read the acknowledgement on the claim form carefully, and then sign and date the form.
6. If prior approval is required, your provider must have received it before you submit your request or the request will be denied.
7. For reimbursement because you had not yet received your ID card, return the completed form and receipt to:

   CVS CAREMARK
   PO BOX 52136
   PHOENIX AZ 85072-2136
8. To request reimbursement in an emergency or urgent situation, follow the same instructions as above but return the claim form and receipts to PHP at:

   PHP
   PO BOX 30377
   LANSING MI 48909-7877

Filing Deadline for Claims.

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

If you pay for health services, we recommend that requests for reimbursement be submitted within 90 days of the date of service. If PHP does not receive a claim within one year of the date of service, we may not cover the health services. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. If a Non-Network provider submits a claim on your behalf, you are responsible for meeting the one-year filing deadline.

Written notice of claim must be given to PHP within one year after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the member to PHP at its office at 1400 E. Michigan Avenue, Lansing, Michigan 48912, or to any authorized agent of PHP, with information sufficient to identify the insured, shall be deemed notice to PHP.

Benefit Determinations.

Post-Service Claims/Requests.

Post service claims/requests are submitted to PHP after medical care has been received or for consideration of payment. If your post-service claim/request is denied, you will receive a written notice from us within 30 days of receipt of the claim/request, as long as all needed information was provided with the claim/request. We will notify you within this 30-day period if additional information is needed to process the

claim/request. We may issue a one-time extension of no longer than ten days and pend your claim/request until all information is received.

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

A denial notice:

- Explains the reason for the denial.
- Refers to the part of the Policy or medical policy on which the denial is based.
- Describes any additional information needed.
- Explains why the information is required.
- Provides the claim appeal procedures, if applicable.

The chapter on QUESTIONS, GRIEVANCES, APPEALS AND COMPLAINTS, contains information on your rights if you do not agree with our Benefit determinations.

Pre-Service Claims/Requests.

Pre-service claims/requests are submitted before service is received. They require prior approval. If your claim/request is a pre-service claim/request, and is submitted properly with all needed information, you will receive written or electronic notice of the claim/request decision from us within 15 days of receipt of the claim/request. If you file a pre-service claim/request without all the information we need to review the claim/request, we will notify you of what is missing within five days after the pre-service claim/request is received. If additional information is needed to process the pre-service claim/request, we will notify you of the information needed within 15 days after the claim/request was received. We may issue a one-time extension of no longer than 15 days and pend your claim/request until all information is received.

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

A denial notice:

- Explains the reason for the denial.
- Refers to the part of the Policy or medical policy on which the denial is based.
- Describes any additional information needed.
- Explains why the information is required.
- Provides the claim appeal procedures, if applicable.

The chapter on QUESTIONS, GRIEVANCES, APPEALS AND COMPLAINTS, contains information on your rights if you do not agree with our Benefit determinations.

Urgent Pre-Service Claims/Requests that Require Immediate Action.

Urgent pre-service care claims/requests require quicker service because:

- A delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function; or
- Could result in severe pain.

You will receive notice of the Benefit determination in writing or electronically within 72 hours following receipt of the approval request, taking into account the seriousness of your condition.

Notice of denial may be oral with a written or electronic confirmation to follow within two days.

If you file an urgent pre-service claim/request without all the information we need to review your claim/request, we will notify you of what is missing within 24 hours after the urgent claim/request was received. If additional information is needed to process the claim/request, we will notify you of the information needed within 24 hours after the claim/request is received. You then have 48 hours to provide the requested information.

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

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

A denial notice:

- Explains the reason for the denial.
- Refers to the part of the Policy or medical policy on which the denial is based.
- Describes any additional information needed.
- Explains why the information is required.
- Provides the claim appeal procedures, if applicable.

The chapter on QUESTIONS, GRIEVANCES, APPEALS AND COMPLAINTS, contains information on your rights if you do not agree with our Benefit determinations.

Concurrent Care Claims/Requests.

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

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

The chapter on QUESTIONS, GRIEVANCES, APPEALS AND COMPLAINTS, contains information on your rights if you do not agree with our Benefit determinations.

Payment of Premiums.

Premiums are due each month to us at our office. The first Premium is due on the day before the effective date of the Policy.

Premiums are not pro-rated based upon the Covered Person's effective date of coverage. A full months' Premium is charged for the entire month in which the Covered Person's coverage becomes effective.

If you decide to stop your coverage, PHP or the Health Insurance Marketplace must receive notice within 14 days before the requested date of cancellation to end the Policy. If notice is less than 14 days, you may have to pay another month's Premium.

If you purchase coverage through the Health Insurance Marketplace, PHP is permitted to terminate your coverage **only**:

- If you are no longer eligible for coverage through the Health Insurance Marketplace;
- You do not pay your Premium after the grace period ends;
- For an allowed Rescission;
- If this entire Policy is terminated; or
- You change to a different product.

Adjustments to Premiums.

We reserve the right to change your Premium at the beginning of each Policy Year.

Grace Period.

A grace period of 31 days is allowed for the payment of any Premium. During this time coverage under this Policy continues. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Subscriber is responsible for the cost of services received during the grace period. The grace period will not extend beyond the date this Policy terminates.

Special Grace Period for Members Receiving Advanced Payment of Tax Credits (APTC).

Members who receive APTCs may be allowed a 3-month Special Grace Period to pay Premiums. In order to be eligible for the 3-month Special Grace Period, members must pay the full Premium in the month prior to being granted the 3-month Special Grace Period. Benefits continue to be covered during the 1st month of the Special Grace Period but all claims are pended during the 2nd and 3rd months. If full Premiums are paid by the end of the Special Grace Period, all pended claims are reviewed for coverage. If full Premiums are not received, coverage terminates and claims that were pended during the 2nd and 3rd months are denied. You are responsible for the full payment of these claims.

Reinstatement.

When coverage under this Policy is terminated for any reason by the Health Insurance Marketplace, you must re-apply to the Health Insurance Marketplace for coverage under this or another Policy.

If you purchased this Policy directly through PHP, and if any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by PHP or by any agent duly authorized by us to

accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. However, if we or such agent requires an application for reinstatement and issue a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by PHP or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the member and PHP shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

QUESTIONS, GRIEVANCES, APPEALS AND COMPLAINTS

We welcome your comments and suggestions so that we continue to improve our service to you. If you have a problem, we want to solve it. We have a Grievance procedure with full and fair investigation to resolve your problem as rapidly and efficiently as possible. This procedure is required under MCL Section 500.2213 and under the Affordable Care Act.

Any grievance you file because you received an Adverse Benefit Determination must be filed within 180 days following notice of the Adverse Benefit Determination.

Terms Used in This Process.

The terms used in this chapter mean:

Adverse Benefit Determination. Means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member's eligibility to participate in a plan, and including with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Authorized Representative.

- A person (can be a Physician) to whom a Covered Person has authorized in writing to act on his or her behalf at any stage in the Grievance process.
- A person authorized by law to provide substituted consent for a Covered Person; or
- A family member of the Covered Person or the Covered Person's treating health care professional, if the Covered Person is unable to provide consent.

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

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

Expedited/Urgent Grievance. A Grievance, for which a Physician has substantiated, verbally or in writing, that the timeframe for the normal Grievance procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function.

Grievance/Appeal. A written expression of dissatisfaction by a Covered Person or Authorized Representative concerning an Adverse Benefit Determination of claim. The terms "Appeal" and "Grievance" mean the same thing in the Policy.

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

Pre-Service Claim. A claim that is filed before services are received. Prior approval may be required.

Urgent Pre-Service Claim. A claim that may require approval and is filed before receiving medical care. A delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or could cause severe pain that could not be adequately managed without the care or treatment that is requested.

What to Do First.

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

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

You may submit a Grievance without first informally contacting Customer Service. A Customer Service specialist can provide you with the appropriate information to request a formal Grievance.

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

How to Request a Formal Grievance.

This process must be initiated in writing within 180 days following notice of the Adverse Benefit Determination. You may authorize, in writing, an Authorized Representative to act on your behalf at any stage of the Grievance process.

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

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

Grievance Process – Step 1.

We will let you know by letter within five calendar days from the date we receive your Grievance that the Grievance has been received. We will inform you or your Authorized Representative of the review outcome by letter within 15 calendar days for Pre-Service Claims or 20 calendar days for Post-Service Claims. If your Grievance is related to clinical matters, the review will be done in consultation with an expert health care professional who was not involved in the prior determination. By requesting a Grievance, you consent to this referral and the sharing of pertinent medical claim information.

Upon request, and free of charge, you have the right to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for Benefits. If we receive additional information during the course of our review, we will provide you a copy of this information free of charge. You or your Authorized Representative will have the right to present your Grievance and to provide written comments, documents, records, or other additional information relating to the claim.

All comments, documents, records and other information submitted are considered.

Grievance Process – Step 2.

If you are not satisfied with the decision on your issue in Step 1, you have the right to appear before a Board of Directors, a designated committee, or a managerial level conference to present your Grievance. This is called a hearing.

You must start the hearing process within 60 days from the date of the letter with our review outcome in Step 1. You may come to the hearing in person or join us by phone. If you initiate a Grievance hearing, a committee of qualified individuals, who were not involved in the decision being appealed, are appointed by us to decide the Grievance. The committee may consult with, or seek the participation of, medical experts as part of the Grievance resolution process.

You must complete Step 1 of the Grievance Process before proceeding to Step 2. You or your Authorized Representative will be informed of the outcome of the hearing within 10 calendar days.

Grievance Determinations.

Pre-Service and Post-Service Claim Appeals.

Once the Grievance starts, you are sent written or electronic notification of the determination within a total of 30 days from receipt of the Grievance request. Notification of the determination of Step 1 will be sent within 15 calendar days for Pre-Service Claims or within 20 calendar days for Post-Service Claims, and notification of the determination of Step 2 will be sent within ten calendar days.

Expedited/Urgent Grievances/Appeals of Pre-Service Claims That Require Immediate Action.

Your appeal of a Pre-Service Claim may require immediate action if a delay in treatment could:

- Significantly increase the risk to your health.
- Significantly decrease your ability to regain maximum function.
- Cause severe pain that could not be adequately managed without the care or treatment that is requested.

In these urgent situations:

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

We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination. We take into account the seriousness of your condition. If you wish to seek external review by an independent review organization for an urgent claim, you may ask for review at the same time that you go through our internal Grievance process. If you do not request an independent review at the same time as our internal Grievance process and you later wish to seek external review, the review must be filed with the Department of Insurance and Financial Services (DIFS) within 10 days of our final determination. For information about requesting review of an urgent situation by the Director of DIFS, see *External Review Rights* below.

External Review Rights.

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

- You have the right to seek external review by an independent review organization pursuant to MCL 500.2213. You must submit your request for external review within 120 days from the date you receive our final determination. We will provide you with a copy of the DIFS Health Care Request for External Review Form (FIS-0018). For additional information about external review, you may contact the Director of DIFS at the address below.

Mail:

OFFICE OF GENERAL COUNSEL - HEALTHCARE APPEALS SECTION
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

P.O. BOX 30220
LANSING, MI 48909-7720

Delivery Service:

Office of General Counsel - Healthcare Appeals Section
Department of Insurance and Financial Services
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521

Telephone: 877-999-6442

Fax: 517-284-8838

www.michigan.gov/difs

- You may have rights under Section 502(a) of ERISA, if all required reviews of your claim have been completed and the non-coverage decision has not changed.
- Any legal proceeding or action against PHP, its successor, or their affiliates, agents and/or employees, must be brought within three years of the date PHP notifies you of its final decision on your appeal of the Adverse Benefit Determination. If you do not initiate legal proceeding or other action within the three-year time period, you give up your rights to bring any such proceeding or action.
- This Benefit plan complies with the Patient's Right to Independent Review Act (PRIRA).

COORDINATION OF BENEFITS

Benefits When You Have Coverage under More than One Plan.

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

When Coordination of Benefits Applies.

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

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

Definitions.

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

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

    a. "Coverage Plan" includes: group health plans, individual health plans, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.

    b. "Coverage Plan" also includes individual no-fault automobile insurance, by whatever name called, provided through arrangements other than those described in item "a" above. Except that, this will not apply to the extent that any auto insurance policy issued pursuant to the Automobile No-Fault Insurance Act of the State of Michigan contains a deductible or is by these terms secondary to (or excess over) the benefits provided under the policy.

    Most automobile insurance in Michigan is written on a "coordinated" or excess basis in which the health plan must assume primary responsibility for covered benefits. Some automobile insurance is written on a "full medical" basis, which assumes the automobile insurance carrier is the primary payer.

    c. "Coverage Plan" does not include benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, hospital indemnity coverage benefits or other fixed indemnity coverage, accident-only coverage or disability income insurance, specified disease or specified accident coverage, or school-accident-type coverages that cover students for accidents only including athletic injuries either on a 24-hour basis or on a to-and-from-school basis, unless permitted by law.

    Outpatient Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

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

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

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

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

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

   Allowable Expenses are calculated as follows:

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

   b. If a person is covered by two or more Coverage Plans that provide benefits or services based on negotiated fees, the highest of the negotiated fees is the Allowable Expense.

   c. If a person is covered by one Coverage Plan that calculates its benefits or services based on usual and customary fees and another Coverage Plan that provides its benefits or services based on negotiated fees, the Allowable Expense is the Primary Coverage Plan's payment arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member. If the Primary Coverage Plan is a Closed Panel Plan and the Secondary Coverage Plan is not a Closed Panel Plan, the Secondary Coverage Plan shall pay or provide benefits as if it were the Primary Coverage Plan if a Covered Person uses a non-panel provider, except in cases of emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules.

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

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. A Coverage Plan without a coordination of benefits provision is always the Primary Coverage Plan.

2. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent (for example as an employee, member, subscriber or retiree) is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent, and primary to the Coverage Plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

3. Child Covered Under More Than One Coverage Plan. For a person for whom claim is made as a dependent minor child, benefits shall be determined according to the following:

   a. If the child's parents are married or are living together, whether or not they have ever been married, as follows:

      - The plan of the parent whose birthday falls earlier in the calendar year is the Primary Coverage Plan.

      - If both parents have the same birthday, the plan that has covered the parent longest is the Primary Coverage Plan.

   b. If the child's parents are divorced, separated, or not living together, whether or not they have ever been married, as follows?

      - If a court order or judgment states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the insurer that issued the plan of the parent with responsibility has actual knowledge of the terms of the order or judgment, that plan is the Primary Coverage Plan.

      - If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Coverage Plan.

      - If a court order or judgment states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits is determined in the manner prescribed in subparagraph 3.a above.

      - If a court order or judgment states that the parents have joint custody without specifying the at one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits is determined in the manner prescribed in subparagraph 3.a above.

      - If there is no court order or judgment allocating responsibility for the child's health care coverage, the order of benefits for the child is as follows, in the following order of priority:

         i. The plan covering the custodial parent.

         ii. The plan covering the custodial parent's spouse.

         iii. The plan covering the noncustodial parent.

         iv. The plan covering the noncustodial parent's spouse.

- If the child is covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined in the manner prescribed in subparagraph 3.a above, as applicable, as if those individuals were parents of the child.
- If the adult child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in item 6 below. If the adult child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefit sis determined by applying the birthday rule prescribed in 3.a above to the adult child's parents, as applicable, and his or her spouse.

4. Active, Retired, or Laid Off Employee. If the individual is an active employee, laid-off employee, or retired employee, or is a dependent of an active employee, laid-off employee, or retired employee, the order of payment of benefits under the plans covering the individual is determined as follows:
   a. The plan that covers the individual as an active employee or as a dependent of an active employee is the Primary Coverage Plan. The plan that covers the individual as a laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the Secondary Coverage Plan.
   b. The above subparagraph does not apply if the other plan that covers the individual does not this rule and, as a result, the plans do not agree on the order of benefits.
   c. This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree or the individual as a dependent of an employee, member, subscriber, enrollee, or retiree is the Primary Coverage Plan.
5. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the order of payment of benefits is determined as follows:
   a. The Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary.
   b. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
   c. This rule does not apply if the order of benefits can be determined by the rule in B.2 above.
6. Longer or Shorter Length of Coverage. If covered by two or more Coverage Plans as an employee, member, subscriber or retiree (i.e., not as a dependent), the Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

C. A person's length of time covered under a plan is measured from the person's first date of coverage under the Plan. If that date is not readily available for a group Plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.

D. If the Plans cannot agree on the order of benefits within 30 calendar days after they have received all of the information needed to pay the claim, the Plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment. A Plan is not required to pay more than it would have paid had it been the Primary Coverage Plan.

E. Except as provided in subsection F below, in determining the amount to be paid on a claim by the Plan that issued a Secondary Coverage Plan, if the Plan wishes to coordinate benefits, and the Plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense that is unpaid under the Primary Coverage Plan.

The Secondary Coverage Plan may reduce its payment by the calculated amount so that, when combined with the amount paid under the Primary Coverage Plan, the total benefits paid or provided under all Plans for the claim do not exceed 100% of the total Allowable Expense for the claim.

F. If a Plan is advised by a covered person that all Plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the internal revenue code of 1986, 26 USC 223, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the internal revenue code of 1986 USC 223.

G. A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract.

Effect on the Benefits of this Plan.

A. When this Coverage Plan is secondary, it may reduce its Benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. When the Benefits of this Coverage Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of this Coverage Plan.

B. This Coverage Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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

— The person is entitled but not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

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

— The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.

— The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

— The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information.

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

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

Payments Made.

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

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

General Information.

We may terminate this Policy at any time for the reasons explained in the Policy, as permitted by law. We will give you 90 days' prior notice of any termination. The notice will include the reason for the termination.

Your coverage ends on the date of termination, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your termination date.

An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends or the date that the Dependent is no longer eligible as an Enrolled Dependent under the terms of the Policy

Events Ending Your Coverage.

In no event will a Covered Person's coverage end solely because of his or her health status or requirements for health services.

Except when coverage ends due to the entire Policy ending, Covered Persons who are notified that coverage will end may utilize the grievance procedure described in the chapter, QUESTIONS, GRIEVANCES, APPEALS, AND COMPLAINTS.

Subscriber.

Coverage for a Subscriber ends on the earliest of the dates specified as follows:

- If you decide to discontinue coverage, PHP or the Health Insurance Marketplace must receive notice within 14 days prior to the requested date of cancellation to end this Policy. If we or the Health Insurance Marketplace do not receive your 14-day notice prior to the requested date of cancellation you may be responsible for paying another month's Premium.
- The last day of the calendar month that you terminate your coverage because you get other minimum essential coverage and have given us appropriate notice.
- The date the Subscriber no longer resides in the Service Area. (You must notify us if you move from the Service Area.) This does not apply to an Enrolled Dependent child for whom the Subscriber is required to provide health insurance coverage through a Qualified Medical Child Support Order or other court or administrative order.
- The last day of the calendar month in which the Subscriber fails to make any required contribution for coverage, unless eligible for Special Grace Period (as described in the chapter, PREMIUMS).
- The last day of the calendar year that Subscriber reaches age 21 (if Child Only Policy).
- The date on which the Subscriber dies.

Dependents.

Coverage ends on the earliest of the dates specified below:

- For legal spouses:
  - — Upon coverage ending for the Subscriber (see above).
  - — Upon judgment of separate maintenance or legal separation (if applicable within your State).
  - — Upon divorce.

- For Domestic Partners:
  - Upon coverage ending for the Subscriber (see above).
  - Upon not meeting the criteria for Domestic Partner and/or Domestic Partnership.
- For children:
  - Upon coverage ending for the Subscriber (see above).
  - Upon reaching the end of the calendar year in which they turn 26.
  - In the case of a disabled dependent, upon the dependent being medically certified as no longer totally and permanently disabled by either a physical or mental disability as defined by the Policy.

Other Events Ending Your Coverage.

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

Fraud, Misrepresentation or False Information.

- An act, practice or omission that involves Fraud related to the Policy
- Intentional misrepresentation, of material fact related to the Policy, whether such act, practice, or omission was on the part of the Subscriber.
- Examples of providing false information or withholding accurate information

Termination of this Policy for these reasons may be retroactive to the effective date of the Policy or to some other date. During the first three years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

After the first three years from the date of issue of the Policy no misstatement, except fraudulent misstatements, made by you in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of such three-year period.

No claim for loss incurred commencing after three years from the date of issue of the Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Improper Use of ID Card.

You permitted an unauthorized person to use your ID card, or you used another person's card. Such an act may lead to retroactive termination of this Policy back to the date the Fraud occurred.

The Entire Policy Ends.

Your coverage ends on the date the Policy ends. That date will be either:

- The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will no longer issue this particular type of individual health plan within the applicable market.
- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will no longer issue any health benefit plan within the applicable market.

This Policy can only be rescinded in cases of Fraud or intentional misrepresentation of material fact and a 30-day written notice will be given prior to Rescission of coverage.

Coverage for a Disabled Child.

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

- The child became incapacitated before reaching the limiting age.
- The child depends mainly on the Subscriber for support and maintenance.

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

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

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

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

Guaranteed Renewability.

Coverage is guaranteed renewable. PHP may not renew or PHP may cancel coverage under the Policy only:

- When enrollee is no longer eligible for coverage through the Marketplace, such as movement outside of the Service Area or cessation of association membership.
- For non-payment of Premiums after the Grace Period.
- For Rescission of coverage for a non-prohibited reason such as Fraud.
- When this Qualified Health Plan is terminated or decertified.
- When the enrollee chooses to change to another plan.

Your Relationship with Us.

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand our role in providing your health benefits and how it may affect you. We provide Benefits under the Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

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

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

Our Relationship with Providers.

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

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

Your Relationship with Providers.

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

- You are responsible for choosing your own provider.

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

Statements by Subscriber.

All statements made by a Subscriber shall, in the absence of Fraud, be deemed representations and not warranties

Incentives to Providers.

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

Examples of financial incentives for Network providers are:

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

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

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

Incentives to You.

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

Interpretation of Benefits.

We do all of the following:

- Interpret Benefits under the Policy.

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

We may share these administrative responsibilities with other persons or entities who provide services in regard to the administration of the Policy.

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

Administrative Services.

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

Amendments to the Policy.

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

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

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

- Amendments to the Policy may only be made at renewal of the Policy and are effective 31 days after we send written notice to the Subscriber.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or Amendments to the Policy.

Clerical Error.

If a clerical error or other mistake occurs, that error will not deprive you of Benefits under the Policy, nor will it create a right to Benefits.

Information and Records.

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

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

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to

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

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

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

You have the right to request and inspect your medical forms or records from us, and we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

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

Examination of Covered Persons.

In the event of a question or dispute regarding your right to Benefits, PHP at our own expense shall have the right and opportunity to require that a Network Physician of our choice examine you when and as often as we may reasonably require during the pendency of a claim hereunder.

Workers' Compensation not Affected.

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

Medicare Eligibility.

If you are eligible for Medicare you are not eligible to enroll under the Policy. If you become eligible for Medicare after the effective date of this Policy, you may retain both coverages.

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

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

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

Subrogation and Reimbursement.

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and

shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

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

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

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

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information to us about any recovery that you or your legal representatives obtain from any Third Parties or any related information requested by us,
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances, and
  - Obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the instigation of legal action against you.
- That we have the right to resolve all disputes regarding the interpretation of the language stated herein, subject to the review and appeal procedures set forth herein and allowed by law.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal Injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That Benefits paid by us may also be considered to be Benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an Injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future Benefits otherwise provided by us the value of Benefits paid or advanced under this chapter to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this chapter will apply to your estate, the personal representative of your estate and your heirs.
- That the provisions of this chapter apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Payment of Claims.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Refund of Overpayments.

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

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

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

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

Limitation of Action.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the 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.

This means you cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a written request for reimbursement as described in the chapter, HOW TO FILE A CLAIM. If you want to bring a legal action against us you must do so within three years from the expiration of the time period in which a written request for reimbursement must be submitted or you lose any rights to bring such an action against us.

You cannot bring any legal action against us for any other reason unless you first complete all the steps in the complaint process described in the chapter, QUESTIONS, GRIEVANCES, APPEALS, AND COMPLAINTS. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your complaint or you lose any rights to bring such an action against us.

Limitation of Liability.

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

Non-Assignment.

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

Entire Policy.

The Policy, including application of the Subscriber, and Amendments, constitutes the entire Policy. No change in this Policy shall be valid until approved by an executive officer of PHP and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Proof of Loss.

Written proof of loss must be given to PHP in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which PHP is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Provider Communications.

We do not prohibit or discourage Network health care providers from advocating on behalf of a Covered Person for appropriate medical treatment options as described in the chapter the chapter, QUESTIONS, GRIEVANCES, APPEALS, AND COMPLAINTS pursuant to MCL 500.2213. We also do not prohibit or discourage Network health care providers from discussing with a Covered Person or another provider any of the following:

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

Excluded Providers.

Consistent with the federal guidelines for payment of sanctioned providers, we 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. The basis for exclusion may include convictions for program-related Fraud and patient abuse, licensing board actions and 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 web site at www.hhs.gov/oig.

ACA Preventive Prescription Drug List. Our list of ACA preventive Prescription Drug Products that are covered at no charge under the Policy. This list is subject to review and change.

Alternate Facility. A freestanding health care facility that is

- Not a Hospital
- Not a facility that is attached to a Hospital
- Is designated by the Hospital as an Alternate Facility.

Amendment. Any attached written description of additional or alternative provisions to the Policy. Amendments are subject to all terms of the Policy, except for those that are specifically amended.

Annual Deductible. The amount you may pay in a Policy Year before we will begin paying for Benefits. If a Benefit has a visit or day limit, these limits will be calculated while you are satisfying the Annual Deductible. Benefits for Copayments (unless stated otherwise) and Preventive Health Services are not subject to the Annual Deductible.

Annual Out-of-Pocket Maximum. The maximum amount you pay every Policy Year. Once you reach the Annual Out-of-Pocket Maximum, Benefits are paid at 100 percent of Eligible Expenses for the rest of that Policy Year.

The only costs that do not apply to the Annual Out-of-Pocket Maximum are:

- Any charges for non-Covered Health Services.
- Charges above Eligible Expenses.

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

Autism Spectrum Disorders. Means any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical manual:

- Autistic disorder.
- Asperger's Disorder.
- Pervasive developmental disorder not otherwise specified.

Benefits. Your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to all terms, of the Policy, including this COC and any Amendments.

Brand-Name. A Prescription Drug Product:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- That we identify as a Brand-Name product.

Chiropractor. Any licensed doctor of chiropractic who is qualified to provide chiropractic services as defined in the Michigan Public Health Code, Chapter 333, Part 164.

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

Compounded Medications. Not commercially available so the dispensing pharmacy must prepare them individually by combining, mixing, or altering ingredients or components. Compounded Medications have not been approved for general use by the FDA.

Congenital Anomaly. A physical developmental defect that is present at birth, and is identified within the first 12 months of birth.

Copayment. A flat dollar amount that you are required to pay when you receive these services:

- Physician office visit.
- Outpatient behavioral health visit.
- Emergency Department visit.
- Urgent care center visit.
- Outpatient prescription drugs.

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

Covered Health Service(s). Those health services that we determine to be Medically Necessary per PHP medical policy and nationally recognized guidelines. They are all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, mental illness, substance use disorder, or their symptoms.
- Consistent with nationally recognized scientific evidence, prevailing medical standards and clinical guidelines.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Stated as covered in this document.
- Not stated as excluded in this document.

Covered Person. Either the Subscriber or an Enrolled Dependent who is covered under the Policy. References to "you" and "your" throughout this COC are references to a Covered Person.

Custodial Care. Services that:

- Are non-health related services.
- Do not seek to cure.
- Are provided when the medical condition of the patient is not changing.
- Do not require trained medical personnel.
- Are provided after stated clinical goals have been achieved.

Dependent. The Subscriber's spouse (or Domestic Partner) or the dependent child of the Subscriber or the dependent child of the Subscriber's spouse (or Domestic Partner). A child is any of the following:

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

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

The definition of Dependent is subject to the following:

- A Dependent includes a legal spouse (or Domestic Partner) who resides within the Service Area.
- A Dependent includes any child less than 26 years of age.
- A Dependent includes an unmarried Dependent child over age 26 who is or becomes disabled and dependent upon the Subscriber.
- Coverage does not vary based on the age of a Dependent child.

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

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

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

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

Domestic Partner. A person of the opposite or same gender with whom the Subscriber has established a Domestic Partnership.

Domestic Partnership. A relationship between a Subscriber and one other person of the opposite or same gender. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.
- They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - — They have a single dedicated relationship of at least six months duration.
  - — They have joint ownership of a residence.
  - — They have at least two of the following:
    - ♦ A joint ownership of an automobile.
    - ♦ A joint checking, bank or investment account.
    - ♦ A joint credit account.
    - ♦ A lease for a residence identifying both partners as tenants.

- A will and/or life insurance policies, which designates the other as primary beneficiary.

Durable Medical Equipment (DME). Medical equipment that is all of the following:

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

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

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

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from Non-Network providers because of an emergent/urgent condition or as otherwise approved by us, Eligible Expenses are the greater of billed charges unless a lower amount is negotiated, the Medicare rate, or the median Network contracted rate.

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

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

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines.

Eligible Person. A person who meets the eligibility requirements as described in the Policy. An Eligible Person must reside within the Service Area. Covered Dependents living outside the Service Area are covered for emergent/urgent conditions. Coverage for any other services must be approved in advance by us.

Emergency. Can be:

- The sudden start of a medical condition.
- Severe pain.
- Serious jeopardy to the individual's health.

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

Enrolled Dependent. A Dependent who is properly enrolled under the Policy.

Essential Health Services. As identified in the ACA, Essential Health Services make up the following 10 categories:

- Ambulatory patient services.

- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder service (including behavioral health treatment).
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services (including oral and vision care for eligible dependent children up to the day they turn age 20).

Exclusions. Those health services that are not Covered Health Services.

Experimental or Investigational Services. Health care services or supplies that are any of the following:

- Not approved by the FDA to be lawfully marketed for the proposed use.
- Not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (except for devices that are FDA approved under the Humanitarian Use Device exemption.)
- Any service billed with a temporary procedure code.

This does not include any off-label usage of a Prescription Drug Product, if its use meets our criteria for coverage.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment), we may cover an Experimental or Investigational Service after review of your case.

Fraud. Intentionally, knowingly or willfully attempting to execute or participate in a scheme to falsely receive unfair or unlawful financial or personal gain from any health care benefit program. Fraud may include, but is not limited to:

- Seeking reimbursement for services not rendered.
- Selling prescription drugs to someone they were not prescribed for.
- Misrepresenting the date a service was provided.
- Misrepresentation of services (such as, misrepresenting who rendered the service, the condition or diagnosis of the patient, the charges involved, or the identity of the provider or recipient).
- Seeking reimbursement for excessive, inappropriate or unnecessary testing or other services.
- Receiving kickbacks for making a referral or for receiving services related to the referral.
- Altering claim forms, electronic records or medical documentation.
- Improper use of PHP identification card.

- Providing false information or withholding accurate information relating to eligibility for coverage under the Policy.

Generic. A Prescription Drug Product:

- That is chemically equivalent to a Brand-Name drug; or
- That we identify as a Generic product.

Genetic Test. The analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes.

Habilitative Services. Health care services that help a person keep, learn or improve skills and functioning for daily living. An example is therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance Marketplace. A set of government-regulated and standardized healthcare plans from which individuals may purchase health insurance eligible for federal subsidies. The plans will not deny coverage on the basis of a pre-existing condition, and all of the plans will include an affordable basic benefit package that includes prevention, and protection against catastrophic costs.

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

Hospital. An institution, operated as required by law that is all of the following:

- Primarily engaged in providing health services on an inpatient basis.
- Provides acute care (including at a long-term acute care facility).
- Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24-hour nursing services.
- Is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period. The initial period when Eligible Persons may enroll themselves and their Dependents under the Policy.

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

Inpatient Rehabilitation Facility. A Hospital or a special unit of a Hospital that provides inpatient services such as:

- Physical therapy.
- Occupational therapy.
- Speech therapy.

Inpatient Stay. After formal admission, time spent in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Low Vision Services. Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. You must obtain authorization for coverage of these services. Covered low vision services include one comprehensive low vision evaluation every 5 years; items such as high-power spectacles, magnifiers and telescopes; and follow-up care (limited to one visit per Policy Year).

Medically Necessary, Medical Necessity. Coverage of health care services and supplies that we determine to be medically appropriate per PHP medical policy and nationally recognized guidelines, and are:

- Not Experimental or Investigational Services.
- Necessary to meet the basic health needs of the Covered Person.
- Delivered in the most cost-efficient manner and type of setting that is appropriate.
- Consistent in type, amount, frequency, level, setting, and duration of treatment with scientifically based guidelines that are accepted by us.
- Consistent with the diagnosis of the condition.
- Not done for reasons of convenience.
- Demonstrated through current peer-reviewed medical literature to be safe and effective.

Even if you have already received treatment or services, or even if your provider has determined that a particular health care service or supply is medically appropriate, it does not mean that the procedure or treatment is a Covered Health Service under the Policy.

Medicare. Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq. and as later amended.

Network. A group of providers of health care services who have participation agreements in effect with us or our designee to participate in our Network. A provider may agree to provide only certain Covered Health Services, or to be a Network provider for only some of our products. The participation status of providers will change from time to time.

Network Benefits. Benefits for Covered Health Services that are provided by Network providers. Emergency Health Services are always covered at the Network Benefit level.

Network Pharmacy. A pharmacy that has:

- Entered into an agreement with us or our designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.
- A Network Pharmacy can be either a retail or a mail-order pharmacy.

Non-Network. Describes those providers who do not participate in our Network.

Non-Network Benefits. Covered Health Services that are provided by Non-Network providers.

Non-Preferred. A Non-Preferred Prescription Drug Product:

- That is available at a higher Copayment level than Preferred medications.
- That we identify as a Non-Preferred drug product.

Open Enrollment Period. After the Initial Enrollment Period the period when Eligible Persons may enroll themselves and Dependents under the Policy.

Pharmacy and Therapeutics ("P&T") Committee. Maintains a Prescription Drug List (PDL). The P&T Committee regularly reviews new and existing medications. The P&PT Committee also maintains pharmacy-related medical benefit determination policies.

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

Any nurse practitioner, physician assistant, podiatrist, dentist, psychologist, Chiropractor, optometrist, nurse midwife, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician.

Policy. The Policy and any Amendments make up the entire agreement that is issued to you.

Policy Year. In the document, "Policy Year" means a twelve-month period beginning January 1 and ending December 31.

Preferred. A Preferred Prescription Drug product:

- That is available at the Tier 1 or 2 Benefit level.
- That we identify as a Preferred drug product.

Preferred Tobacco Cessation Products. Our select list of prescription and over-the-counter drugs that are covered for the treatment of tobacco dependence or addiction.

Pregnancy. Includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

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

Prescription Drug Cost. The rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL). A list that identifies those Prescription Drug Products that we cover under the Policy. This list is subject to our periodic review and modification.

Prescription Drug Product. A medication, product or device that has been approved by the FDA. It cannot be dispensed without a Prescription Order or Refill.

Prescription Order or Refill. The instruction to give out a Prescription Drug Product issued by a licensed health care provider whose scope of practice allows this.

Preventive Health Services. Routine or screening Covered Health Services that are designated to keep you in good health and to prevent unnecessary Injury, Sickness or disability, including but not limited to the following as may be appropriate based on your age and/or gender:

- Evidence-based items or services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF), including breast cancer screening, mammography and prevention;
- Immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care screenings for infants, children and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and
- Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF.

The complete list of recommendations and guidelines can be found at http://www.HealthCare.gov/center/regulations/prevention.html (the "List") and will be continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

Primary Care Physician. A Network Physician that you choose to be responsible for providing or coordinating your care.

Recreational Therapy. Inpatient or outpatient recreational activities that may serve a therapeutic purpose. Examples are:

- Camp or camping events.
- Sports or sporting events.
- Horseback riding.
- Art therapy services or art instruction.
- Music therapy services or music instruction.
- Boating or other recreational activities.

Rescission. Means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage is *not* a Rescission if the cancellation or discontinuance of coverage has a prospective effect. Rescission is allowed if it is due to Fraud or intentional misrepresentation of a material fact.

Residential Treatment Program. During the program, a patient resides at a certified or licensed residential treatment facility that is not a Hospital. Programs treat groups of patients with similar behavioral health conditions.

Semi-Private Room. A room with two or more beds. PHP covers a private room during an Inpatient Stay when one is medically necessary or when a Semi-Private Room is not available.

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

Sickness. Physical illness, disease or Pregnancy. The term Sickness as used in this COC does not include mental illness or substance use disorders, regardless of the cause or origin of the mental illness or substance use disorder.

Skilled Care. Skilled nursing, skilled teaching, skilled rehabilitation, and home infusion services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and
- It is ordered by a Physician; and
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- It requires clinical training in order to be delivered safely and effectively; and
- It is not Custodial Care.

Our determination of available Benefits is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

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

Specialty Drugs. Usually more expensive prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Patients using a Specialty Drug often must be monitored closely to determine if the therapy is working and to watch for side effects. Drugs on the Specialty Medication List are regularly reviewed and changed as needed.

Spinal Treatment. The detection or correction (by manual or mechanical means) of subluxations(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxations of, or in, the vertebral column.

Subscriber. An Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued.

Unproven Services. Services that have not demonstrated beneficial effects on health outcomes and that are not based on trials that meet either of the following designs:

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

Decisions about whether to cover new technologies, procedures and treatments are based on the above designs.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), we may, after review, cover an Unproven Service.

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

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