Certificate of Coverage

University of Michigan Health

PHP Exclusive Bronze 7500
Limited Cost Sharing

Individual Policy

ENN01800-RX09E710

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Individual Policy.

This Policy is a legal document between Physicians Health Plan 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.

You may access your member materials, such as the Certificate of Coverage (COC), Summary of Benefits and Coverage (SBC), Amendments, claim and appeal forms and provider directory, 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.

Changes to the Document.

We may from time to time modify this COC by attaching legal documents called Amendments, for example, that may change parts of the COC. When that happens at a time other than the renewal of the Policy, we notify you of the change.

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. Physicians Health Plan promptly refunds any Premium paid. If the Policy is cancelled, it is void from the beginning as if no Policy or contract had been issued.

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.

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 COC replaces and overrules any COC that we previously issued to you. This COC in turn is overruled by any COC we issue to you in the future.

The Policy takes effect on the date specified in writing by Physicians Health Plan. Coverage under the Policy begins at 12:01 a.m. and ends at 12:00 midnight Eastern Time. The Policy remains 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. This Policy also complies with all applicable federal law.

This document and any associated documents such as Amendments, describe your Benefits as well as your rights and responsibilities under the Plan.

How to Use this Document.

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

Follow this document if it is different from any summaries given to you by Physicians Health Plan.

Your health care provider does not have a copy of this document. Health care providers are not responsible for knowing or communicating your Benefits. Please call Physicians Health Plan if you have any questions such as about your Benefits or the participation status of a health care provider.

We encourage you to read this document and any associated documents such as Amendments carefully.

We especially encourage you to review the Benefit limitations and Exclusions of this document by reading the chapters, WHAT'S COVERED, BENEFITS AND COVERAGE and GENERAL EXCLUSIONS AND LIMITATIONS. You should also carefully read the chapter, GENERAL LEGAL PROVISIONS to better understand how this document and your Benefits work. You should call Physicians Health Plan if you have questions about the limits of the coverage available to you.

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

Defined Terms.

Certain capitalized words have special meanings. You can find the definitions of these words in the chapter, DEFINED TERMS.

When we use the words "we," "us," and "our" in this document, we mean Physicians Health Plan. 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.

If you purchased this Policy through the Marketplace, you must contact the Marketplace if any of the changes below occur. If you purchased this Policy outside the Marketplace, you must let Physicians Health Plan know if you:

- Have a change of address.
- Get married or divorced.

- Have changes in the eligibility of your Dependents.
- Get other health care coverage.

The Affordable Care Act (ACA).

The Plan follows all sections of the ACA required for plans offered on and off the Marketplace, including the following:

- All State of Michigan established Essential Health Benefits (EHBs).
- 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.

Non-Discrimination.

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats, other formats); and provides free language services to people whose primary language is not English, such as qualified interpreters; and information written in other languages. If you need these services, contact Customer Service at 800.832.9186 (TTY 711). If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Physicians Health Plan Civil Rights Coordinator, mailing address: PO Box 30377 Lansing MI 48909-7877, phone: 800.832.9186, (TTY 711), fax: 517.364.8406 email: phpcompliance@phpmm.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Physicians Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TTD)

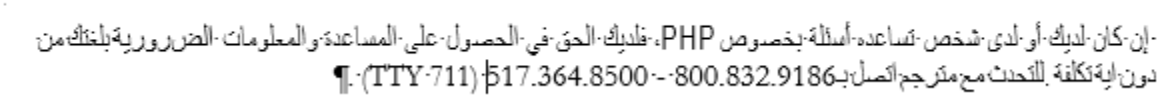
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services.

If you, or someone you are helping, has questions about this Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service Department at 517.364.8500 or 800.832.9186 (TTY 711).

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 (TTY 711).

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 (TTY 711).

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 (TTY 711) 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 (TTY 711).

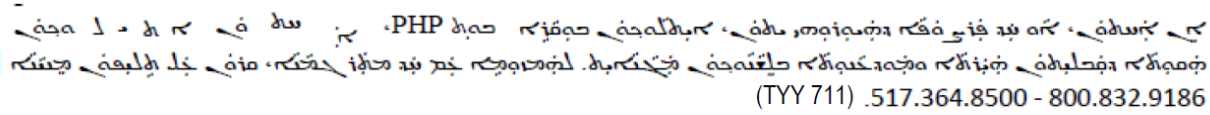
Japanese ご本人様、またはお客様の身の回りの方でも、PHP についてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。 通訳とお話される場合、517.364.8500 - 800.832.9186 (TTY 711) までお電話ください。

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 - 800.832.9186 (TTY 711) 로 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 (TTY 711).

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 (TTY 711).

Syriac



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 (TTY 711).

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 (TTY 711).

Bengali যদি আপদি, 517.364.8500 - 800.832.9186 আপদি অিয কাউকক সহায়তা করকেি, সম্পকক্ে 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 (TTY 711).

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 (TTY 711).

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 (TTY 711).

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 Physicians Health Plan and receive Benefits, both of the following apply:

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

Not All Health Care Services Are Covered.

Your right to Benefits is limited to Covered Health Services. The chapters, WHAT IS COVERED, BENEFITS AND COVERAGE, and GENERAL EXCLUSIONS AND LIMITATIONS tell you what Physicians Health Plan does and does not cover and what your responsibilities are under the Plan. Health care decisions are between you and your health care providers. We do not make decisions about what care you should or should not receive. We do determine, according to our medical policies and nationally recognized guidelines, what Medically Necessary Benefits are covered under the Policy.

Choose Your Health Care Providers.

You must choose the health care providers who 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 you must first pay an Annual Deductible. If a service is not subject to the Annual Deductible, we tell you in the chapter, BENEFITS AND COVERAGE. Annual Deductibles, Copayments and Coinsurance amounts are due at the time of service or when billed by the health care 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 GENERAL EXCLUSIONS AND LIMITATIONS to understand the Plan's limitations and Exclusions. You may also pay any amount that exceeds Eligible Expenses for Covered Health Services.

If you make payment for any portion of the Premium directly to us, 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 the Plan for the services you received.

File Claims with Complete and Accurate Information.

You or your health care provider must file a claim to request payment from the Plan. 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 Physicians Health Plan 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 us, our services, and the health care providers in its Network, including their qualifications.
9. Make suggestions regarding our member rights and responsibilities policies.

As a Covered Person, you are expected to:

1. Select or be assigned a Primary Care Physician from our list of Network health care providers and notify us when you have made a change.
2. Be aware that all hospitalizations must be approved in advance by us, except in emergencies or for urgently needed health care services.
3. Use Emergency Department services only for treatment of a serious or life-threatening medical condition.
4. Always present your Plan 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 us 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 we 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 Plan member materials and become familiar with and follow health plan benefits, policies and procedures.
11. Report health care Fraud or wrongdoing to us.

Determine Benefits.

We make decisions regarding whether the Plan pays 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, medication or procedure.

We may share these responsibilities with other persons or entities that provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may change. 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 or limited in the chapters, BENEFITS AND COVERAGE or GENERAL EXCLUSIONS AND LIMITATIONS. This means we only pay our portion of the cost of Covered Health Services. It also means that not all the health care services you receive may be paid for (in full or in part) by the Plan.

Review and Determine Benefits Following our Payment and Reimbursement Policies.

We develop our Payment and 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 Payment and Reimbursement Policies are applied to health care provider billings. Non-Network health care providers may bill you for any amounts we do not pay, including amounts that are denied because one of our Payment and Reimbursement Policies does not reimburse (in whole or in part) for the service billed.

You can find our Payment and Reimbursement Policies on the MyPHP member portal through our web site at www.phpmichigan.com.

Accessing Benefits.

Covered Health Services must be provided by Network health care providers, except for Emergency Health Services or Urgent Care Center visits.

You must choose a Primary Care Physician (PCP) to provide or coordinate the Covered Health Services you receive. Obstetricians/gynecologists and pediatricians may be selected as PCPs.

You must show your Plan identification (ID) card every time you request health care services. If you do not show your ID card, health care providers do not know that you are covered under the Plan. 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 the Plan as described in the chapter, HOW TO FILE A CLAIM. However, you may pay more because the Plan reimburses you at the contracted amount.

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

A health care service or supply is a Covered Health Service under the Plan if it is determined to be Medically Necessary per Plan medical policies and nationally recognized guidelines.

Even if you have already received treatment or services, or even if your health care 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 Plan.

You have the right to request:

- A copy of the clinical review criteria used to determine Medical Necessity.
- A copy of the Benefit Coverage, Drug Determination and/or Payment and Reimbursement Policy and/or nationally recognized guidelines.
- Any other information used in making our determination.

This request must be in writing. The information is provided to you free of charge. Contact Customer Service if you have questions about getting this information.

Benefits are available only if all the following are true:

- Covered Health Services are received while the Plan 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 Plan.

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 the Plan for coverage of these services or products. Health care providers must get the approval on your behalf before they provide these services to you. We recommend you make sure the approval has been received, especially before you see a Non-Network health care provider. If your health care provider does not get approval, Benefits for Covered Health Services may be reduced or not covered at all. You may be responsible for non-covered charges.

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

When Covered Health Services require prior approval, they must meet criteria for coverage. The Plan maintains Benefit Coverage, Drug Determination and Payment and Reimbursement Policies on the MyPHP online portal that are available for your review. You can access the portal at www.phpmichigan.com.

Always make sure that the services you plan to receive are Covered Health Services, even if not specifically listed below as requiring prior approval. For example, in one instance a procedure may be covered but, in another situation, the same procedure is not covered. By calling the Plan 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 the Plan.

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

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

Covered Health Services that Require Approval.

1. Autism Spectrum Disorders treatment.
2. Bariatric surgery.
3. Dental services – accidental – your health care provider does not have to get approval at the time of the initial Emergency treatment but prior to follow up care.
4. Drugs and medications – select group that are subject to meeting criteria for coverage (for example, human growth hormone).
5. Durable Medical Equipment, orthotic/support devices, and medical supplies – certain items only.
6 Facility services – non-Hospital (Skilled Nursing Facility and Inpatient Rehabilitation Facility).
7. Gender affirming care, procedures, and medications.
8. Genetic testing.

9. Home health care, home hospice care and home infusion services.
10. Hospital Inpatient Stay (including extended maternity stays, Emergency admission for behavioral health and non-behavioral health conditions and long-term acute inpatient care).
    - Your health care provider does not have to get approval before you receive care or treatment at an Emergency Department or Urgent Care Center.
    - Your health care provider must get prior 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 if there are extenuating circumstances.
        - 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.
11. Mental Health Services – non-routine services such as:
    - All Inpatient Stays (see under Hospital Inpatient Stay above).
    - Residential Treatment Programs.
    - Intermediate care (day treatment and partial hospitalization).
    - Certain outpatient services: psychoanalysis, intensive outpatient therapy (IOP), electroconvulsive therapy (ECT), and transcranial magnetic stimulation (TMS).
12. Preventive Health Services, certain services only – BRCA mutation testing.
13. Procedures – inpatient or outpatient, as listed here: hyperbaric oxygen therapy, spinal cord stimulation, sacral nerve stimulation, facet joint injections and facet neurotomy, temporomandibular joint syndrome/dysfunction surgery, orthognathic surgery, femoro-acetabular impingement hip surgery, varicose vein treatment, biofeedback training, tissue-engineered skin substitutes, blepharoplasty and repair of brow ptosis, total cervical disc arthroplasty, implantation of neurostimulator electrode array, renal tumor ablation, and revascularization.
14. Prosthetic devices (if cost is over $1,000 including microprocessors for lower extremity prosthetics regardless of cost).
15. Reconstructive procedures, including but not limited to, abdominoplasty, breast reduction, and rhinoplasty.
16. Rehabilitation/habilitation services – outpatient speech therapy services.

17. Substance Use Disorders services – non-routine services such as:
    - All Inpatient Stays (see under Hospital Inpatient Stay above).
    - Residential Treatment Programs.
    - Intermediate care (day treatment and partial hospitalization).
    - Certain outpatient services: outpatient therapy (IOP).
18. Transplant services.

Approval Requirements for Non-Network Health Care Providers.

The Benefits listed above require prior approval whether the services, supplies or drugs are received from Network or Non-Network health care providers. If you have been referred to a Non-Network health care provider you should refer to your document to determine if you have Non-Network Benefit coverage. Even if you do have Non-Network Benefit coverage, not all Benefits are covered when provided by Non-Network health care providers.

The Plan may pay for Covered Health Services at the Network Benefit level from Non-Network health care providers if it is determined that the Network does not include a health care provider that can perform a necessary Covered Health Service. Your health care provider must get prior approval from the Plan so that claims are covered at the Network Benefit level. Otherwise, Benefits are not paid, and you may be responsible for all costs associated with those services.

Utilization Review.

Prior approval is one part of the utilization review process, which also includes concurrent review of ongoing course of treatment, urgent pre-service review and post-service review. For complete information on the process and timelines for review of claims or requests, see the chapter, BENEFIT DETERMINATIONS.

When Medicare or Other Coverage is Primary.

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

Information About Your Cost Share.

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

Your Annual Deductible.

The amount you pay for Covered Health Services in a Policy Year before you receive Benefits. The Annual Deductible does not apply to Copayments unless stated otherwise, Preventive Health Services and Benefits as noted below. Ancillary Charges on outpatient Prescription Drugs (if applicable to your Plan) and charges above Eligible Expenses do not go toward satisfaction of the Annual Deductible.

> $7,500 per Covered Person per Policy Year, not to exceed $15,000 for all Covered Persons in a family.

If one Covered Person meets the individual Annual Deductible but not the family Annual Deductible, the Plan covers services subject to the Annual Deductible only for that member who has met the Annual Deductible. Covered Health Services subject to the Annual Deductible for the remaining family members are covered when the full family Annual Deductible has been met.

Your Annual Out-of-Pocket Maximum.

The most that you pay, out of your pocket, in a Policy Year for your share of the cost of Covered Health Services. Included in this maximum are the Annual Deductible, your Coinsurance amounts and your Copayments. Ancillary Charges on outpatient Prescription Drugs (if applicable to your Plan) and charges above Eligible Expenses do not go toward satisfaction of the Annual Out-of-Pocket Maximum.

> $9,000 per Covered Person per Policy Year, not to exceed $18,000 for all Covered Persons in a family.

If one Covered Person meets the individual Annual Out-of-Pocket Maximum but not the family Annual Out-of-Pocket Maximum, that member does not pay any more cost sharing for the rest of the Policy Year. Cost sharing for the remaining family members must still be paid until the family Annual Out-of-Pocket Maximum has been met.

Your Cost Sharing for Medical Services.

Covered Health Service	Network Provider	Non-Network Provider
ABA services for treatment of Autism Spectrum Disorders	Subject to Deductible, then 50% Coinsurance	Not covered
Allergy testing, evaluation, related office visits, and injections	Subject to Deductible, then 50% Coinsurance	Not covered
Ambulance services – ground, water or air	Subject to Deductible, then 50% Coinsurance	Subject to Deductible, then 50% Coinsurance
Associated services such as radiology and laboratory services received during visits to a Physician, dentist/oral surgeon, Emergency Department, convenience care facility or Urgent Care Center	Subject to Deductible, then 50% Coinsurance	Not covered
Bariatric surgery	Subject to Deductible, then 50% Coinsurance	Not covered
Chiropractic services	Subject to Deductible, then 0% Coinsurance	Not covered
Convenience care facility	$50 Copay/visit, Deductible does not apply	Not covered
Dental-related general anesthesia and facility charges	Subject to Deductible, then 50% Coinsurance	Not covered
Dentist's or oral surgeon's office	Subject to Deductible, then 50% Coinsurance	Not covered
Durable Medical Equipment (DME), including covered orthotic/support devices	50% Coinsurance, Deductible does not apply	Not covered
Select breast pumps for nursing mothers (up to the allowed amount)	No charge	Not covered
Emergency Department (ED) visit	Subject to Deductible, then 50% Coinsurance	Subject to Deductible, then 50% Coinsurance
Facility services – non-hospital:		
-Hospice facility	Subject to Deductible, then 50% Coinsurance	Not covered
-Inpatient Rehabilitation Facility	Subject to Deductible, then 50% Coinsurance	Not covered

Covered Health Service	Network Provider	Non-Network Provider
-Skilled Nursing Facility	Subject to Deductible, then 50% Coinsurance	Not covered
Home health care services	Subject to Deductible, then 50% Coinsurance	Not covered
Home hospice care	Subject to Deductible, then 50% Coinsurance	Not covered
Home infusion services (including nutritional therapy)	Subject to Deductible, then 50% Coinsurance	Not covered
Hospital Inpatient Stays (facility charges)	Subject to Deductible, then 50% Coinsurance	Not covered
Medical supplies	Subject to Deductible, then 50% Coinsurance	Not covered
Mental Health Services:		
-Outpatient therapy visits and testing	$50 Copay/visit, Deductible does not apply	Not covered
-Outpatient services including electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS)	Subject to Deductible, then 50% Coinsurance	Not covered
-Inpatient services	Subject to Deductible, then 50% Coinsurance	Not covered
-Residential Treatment Programs	Subject to Deductible, then 50% Coinsurance	Not covered
-Intermediate services (partial hospitalization and day treatment	Subject to Deductible, then 50% Coinsurance	Not covered
Observation Care at a Hospital or Alternate Facility	Subject to Deductible, then 50% Coinsurance	Not covered
Outpatient diagnostic lab and pathology	Subject to Deductible, then 50% Coinsurance	Not covered
Outpatient diagnostic X-ray and testing	Subject to Deductible, then 50% Coinsurance	Not covered
Outpatient high tech radiology	Subject to Deductible, then 50% Coinsurance	Not covered
Outpatient nuclear medicine	Subject to Deductible, then 50% Coinsurance	Not covered
Outpatient rehabilitation/habilitation therapy	$50 Copay/visit, Deductible does not apply	Not covered

Covered Health Service	Network Provider	Non-Network Provider
Outpatient therapeutic treatment services (such as dialysis)	Subject to Deductible, then 50% Coinsurance	Not covered
Pediatric vision services:		
-Routine eye exam	No charge	Not covered
-Vision hardware	Subject to Deductible, then 50% Coinsurance	Not covered
Physician combined charges for prenatal, delivery and postnatal services	Subject to Deductible, then 50% Coinsurance	Not covered
Physician office visit:		
-Primary Care Physician's (PCP's) office	$50 Copay/visit, Deductible does not apply	Not covered
-Specialist's office	$100 Copay/visit, Deductible does not apply	Not covered
-Injections and infusions	Subject to Deductible, then 50% Coinsurance	Not covered
Preventive Health Services:		
-Including but not limited to: maternity classes (certain classes through our preferred provider), nutritional counseling visits, pediatric routine vision exams, Prescription Drug Products on the ACA Preventive Prescription Drug List, tobacco cessation program	No charge	Not covered
Professional fees for surgical and medical services	Subject to Deductible, then 50% Coinsurance	Not covered
Prosthetic devices	50% Coinsurance, Deductible does not apply	Not covered
Qualified weight management programs	Subject to Deductible, then 50% Coinsurance	Not covered
Substance Use Disorders Services:		
-Outpatient therapy visits and testing	$50 Copay/visit, Deductible does not apply	Not covered

Covered Health Service	Network Provider	Non-Network Provider
-Inpatient services	Subject to Deductible, then 50% Coinsurance	Not covered
-Residential Treatment Programs	Subject to Deductible, then 50% Coinsurance	Not covered
-Intermediate services (partial hospitalization and day treatment	Subject to Deductible, then 50% Coinsurance	Not covered
Surgery – inpatient/outpatient:		
-Special surgeries – breast reduction, orthognathic surgery, temporomandibular joint syndrome/dysfunction (TMJ) surgery, or male mastectomy	Subject to Deductible, then 50% Coinsurance	Not covered
-Female surgical sterilization	No charge	Not covered
-Other surgeries	Subject to Deductible, then 50% Coinsurance	Not covered
TMJ services – non-surgical	Subject to Deductible, then 50% Coinsurance	Not covered
Urgent Care Center visit	$75 Copay/visit, Deductible does not apply	$75 Copay/visit, Deductible does not apply

Your Cost Sharing for Outpatient Prescription Drugs.

	Retail Pharmacy	Mail-Order Pharmacy
Day supply	31	90
Tier 1 – generic drugs	$25 Copay/prescription, Deductible does not apply	$50 Copay/prescription, Deductible does not apply
Tier 2 – preferred brand-name drugs	Subject to Deductible, then $50 Copay/ prescription	Subject to Deductible, then $100 Copay/ prescription
Tier 3 – non preferred brand-name drugs	Subject to Deductible, then $100 Copay/ prescription	Subject to Deductible, then $200 Copay/ prescription
Tier 4 – specialty drugs	Not covered	Subject to Deductible, then $500 Copay/ prescription Only covered up to a 31-day supply from CVS mail-order pharmacy

	Retail Pharmacy	Mail-Order Pharmacy
ACA Preventive Drugs	No charge	No charge

Description of Covered Health Services.

Specific Exclusions and limitations may be listed under the Benefit categories below. A specific Exclusion may apply to more than one Benefit category even though not listed under all categories. Also see the chapter, GENERAL LIMITATIONS AND EXCLUSIONS following this chapter.

Allergy Services.

- Services can be received in a Hospital (inpatient or outpatient), other outpatient settings such as Alternate Facilities, and a Physician's office.
- Coverage for allergy testing when performed by or supervised by a Physician includes but is not limited to:
  - Survey, including history, physical exam, and diagnostic laboratory studies.
  - Intradermal, scratch and puncture tests.
  - Patch and photo tests.
  - Double-blind food challenge test and bronchial challenge test.
- More information on allergy injections can be found under Physician's Office Services for Sickness or Injury below.

Limitations and Exclusions.

- The Plan does not cover:
  - Fungal or bacterial skin tests.
  - Self-administered, over-the-counter drugs.
  - Psychological testing, evaluation or therapy for allergies.
  - Environmental studies, evaluation or control.

Ambulance Services – Ground, Water or Air.

- Coverage for Emergency ambulance transport and Non-Emergency Ambulance Transport.
- Coverage for Non-Emergency Ambulance Transport transfer of the patient to another treatment location such as another Hospital, a Skilled Nursing Facility, a medical clinic or the patient's home.
- Covered Health Services for ambulance services received from Non-Network health care providers are covered at the Network Benefit level.

Limitations and Exclusions.

- Must be a licensed ambulance service.
- Must be to the nearest Hospital where Emergency Health Services can be performed.

- For air or water 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.
  - No other means of transportation is available.
  - The provider is not a commercial airline.
  - The patient is taken to the nearest facility capable of treating the patient's condition.
- The Plan does not cover:
  - Ambulance charges when neither treatment nor transport is provided.
  - Medical services provided by fire departments, rescue squads or other Emergency transport providers whose fees are in the form of donations.
  - Ambulance transport (ground, water or air) that the Plan determines is not to the closest Hospital within a reasonable distance and equipped to treat the condition, including transport to a preferred Hospital or for the convenience of being closer to your home or someone to provide continuing care to you.

Autism Spectrum Disorders Treatment.

- Coverage for diagnosis and treatment of certain Autism Spectrum Disorders.
- Covered Health Services include:
  - Behavioral health treatment, such as Applied Behavioral Analysis (ABA).
  - Pharmacy management.
  - Outpatient psychiatric and psychological visits for assessments, evaluations and tests, including the Autism Diagnostic Observation Schedule.
  - Outpatient Habilitative Services, such as physical, occupational and speech therapy.
  - Nutritional counseling.
  - Genetic testing, if recommended in the Autism Treatment Plan.
  - Services and treatment that is comprehensive and focused on managing and improving the symptoms directly related to the member's Autism Spectrum Disorder.
- Benefit follows the State of Michigan law.

Limitations and Exclusions.

- Covered Health Services for treatment of Autism Spectrum Disorders are not subject to quantitative or non-quantitative limits.
- The Plan does not cover:
  - Sensory integration therapy.
  - Chelation therapy.
  - Treatment of conditions such as Rett's Disorder or childhood disintegrative disorder.

Bariatric Surgery.

- Surgical services must be received in a Hospital on an inpatient basis.
- Coverage for:

- Facility charges.
- Medical supplies and other non-Physician services.
- Surgery.
- Professional fees.

Limitations and Exclusions.

- The Plan does not cover:
  - Bariatric surgery more than once per lifetime unless done to correct or reverse complications from a previous bariatric surgery or for another condition determined to be Medically Necessary by the Plan.

Chemotherapy.

- Services can be received in a Hospital (inpatient or outpatient), other outpatient settings such as Alternate Facilities, in a Physician's office and in the home.
- Coverage for:
  - Food and Drug Administration (FDA)-approved chemotherapy drugs and their administration.
  - Other FDA-approved drugs classified as:
    - Anti-emetic drugs used to combat the toxic effects of chemotherapy drugs.
    - Drugs used to enhance chemotherapy drugs.
    - Drugs to prevent or treat the side effects of chemotherapy treatment.
  - DME such as infusion pumps used for administration of chemotherapy.
  - Medical supplies such as administration sets, and refills.
  - Maintenance of implantable or portable pumps and ports.

Limitations and Exclusions.

- Must be ordered by a Physician for treatment of a specific type of malignant disease.
- Covered Persons may be directed to the site of care for administration of specific medications that is most cost-effective, clinically appropriate and/or can be safely administered such as a Physician's office or through home infusion services.

Chiropractic Services.

- Coverage for:
  - Chiropractic analysis, diagnosis and adjustment of spinal subluxations and spinal misalignments.
  - Adjustment of any bones and tissues related to the spinal condition requiring chiropractic services.
  - Rehabilitative exercise related to spinal subluxations or spinal misalignments.
  - X-rays of the spine.

Limitations and Exclusions.

- Benefits for chiropractic services are limited to a maximum of 30 visits per calendar year.
- The Plan does not cover:
  - Any chiropractic service not related to the spine.
  - Any service not included in the scope of services defined in the Michigan Public Health Code, Chapter 333, Part 164.
  - Supplements, drugs, medical equipment, or supplies dispensed by or prescribed by a chiropractic provider.
  - Laboratory services.
  - Consultations.
  - Rehabilitative exercise not related to spinal subluxations or spinal misalignments.
  - Fracture care.
  - Nutritional advice.

Clinical Trials.

- Services can be received in a Hospital (inpatient or outpatient), other outpatient settings such as Alternate Facilities, and a Physician's office.
- You must be a qualified person participating in an approved clinical trial.
- Coverage for:
  - Services related to treating your condition, excluding the Experimental drugs associated with the clinical trial.
  - Services incurred during Phase I, Phase II, Phase III, or Phase IV clinical trials.
  - Clinical trials that are conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening diseases or conditions.

Limitations and Exclusions.

- Covered Persons may be directed to the site of care for administration of specific medications that is most cost-effective, clinically appropriate and/or can be safely administered such as a Physician's office or through home infusion services.
- The Plan does not cover:
  - The Experimental or Investigational item, device or service itself.
  - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant.
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Convenience Care Facilities.

- Usually retail-based clinics that are staffed by nurse practitioners and physician assistants.

- Coverage for care that is provided outside the Emergency Department, Urgent Care Center or Physician's office for basic medical services and common, non-life-threatening conditions, such as for allergies, athlete's foot, cold and flu symptoms, poison ivy and sunburn.

Dental-Related General Anesthesia and Facility Charges.

- Coverage for dental-related general 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.

Limitations and Exclusions.

- Services must be received in a Hospital (inpatient or outpatient) or Alternate Facility.
- The Plan does not cover:
  - The dental procedures related to the anesthesia and facility charges.

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

- 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 care professional's office such as a dentist or oral surgeon.
- Coverage for:
  - Removal of tumors and cysts of the jaws, cheeks, lips, tongue, and roof or 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 covered medical procedures.
  - Rebuilding or repair of soft tissues of the mouth or lip to correct problems caused by Congenital Anomaly 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.
- Dental services for accidental Injury received from Non-Network health care providers are covered at the Network Benefit level.

Limitations and Exclusions.

- The Plan does not cover:
  - 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.
  - Tooth implants and related services, bone grafts and other implant-related procedures and related services, even when required because of an Injury.
  - Orthodontic services, including braces.
  - 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.
    - Anesthesia and facility charges as described under Dental-Related General Anesthesia and Facility Charges above.
  - Supplies and appliances and all associated expenses (including occlusal splints, dental prosthetics and dental orthotics). Mouth rehabilitation. Bridges. Partial plates. Dentures.
  - Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
  - Services for the treatment of an overbite or underbite. Maxillary and mandibular osteotomies, unless determined by the Plan to be Covered Health Services.

Diabetes Services.

- Services can be received on an inpatient or outpatient basis, including in a Hospital, in a clinic, at a health care professional's office or from a Durable Medical Equipment supplier.
- Coverage for:
  - Durable Medical Equipment (DME) including but not limited to:
    - Blood glucose monitors.
    - Insulin pumps.
    - Therapeutic shoes and shoe inserts for diabetics.
  - Covered medical supplies used in the home such as test strips, lancets and spring powered lancet devices, syringes and needles.
  - Educational training to provide necessary skills and knowledge to manage the disease.

Limitations and Exclusions.

- DME must meet the minimum specifications for your needs. If you want equipment above the minimum specifications, you must pay any difference in cost.

- Therapeutic shoes are limited to one pair per Policy Year and shoe inserts are limited to three pair per Policy Year.

Durable Medical Equipment (DME).

- Coverage includes but is not limited to:
  - Select breast pumps for nursing mothers (covered at no cost share up to the allowed amount).
  - Orthotic/support items such as a knee or back brace.
  - Some disposable equipment if, for example, it is necessary for proper functioning or application of covered DME. Please refer to the medical policies on the Plan's website.
  - Gradient compression stockings.
  - Implantable devices such as insulin and infusion pumps and bone stimulators.
  - Power wheelchairs and mobility devices.
  - Automatic external defibrillators.
  - Chest wall oscillation vests.

Limitations and Exclusions.

- Gradient compression stockings are limited to three pair per Policy Year.
- Must be ordered or provided by a Physician and received from a certified DME vendor.
- 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.
- DME is limited to a single purchase (including repair or replacement) of a type of DME once every three Policy Years.
- Repair or replacement is covered only when Medically Necessary:
  - Due to change in your medical condition.
  - Due to change in body size due to growth.
  - To improve physical function.
- The Plan does not cover:
  - DME that can be used for physical appearance.
  - DME used as safety, comfort or convenience items.
  - DME used to affect performance in sports-related activities such as treadmills, weights or stationary bikes.
  - Disposable and some non-disposable related items unless necessary for proper functioning or application of DME.
  - Shoe or foot orthotics, except for shoe inserts prescribed for a person with diabetes (see Diabetes Services above), or those determined to be habilitative and covered under the Plan.

- Shoes, except for therapeutic shoes prescribed for a person with diabetes (see Diabetes Services), or those determined to be habilitative and covered under the Plan.
- Duplicate DME items.
- Penile implants for the treatment of impotence having a psychological origin.
- Mouth orthotics, mouth splints, and mouth appliances.
- 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, unless for approved power-operated wheel chairs.
- 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.
- Oral appliances for snoring.
- Powered exoskeleton devices.

Emergency Department (ED) Visits.

- Coverage when required to stabilize or initiate treatment in an Emergency.
- Covered Health Services for Emergency Department visits received from Non-Network health care providers are covered at the Network Benefit level.

Facility Services (Non-Hospital).

Hospice Facility Care.

- Coverage for:
  - Comfort and support services for the terminally ill in a hospice facility.
  - Physical, psychological, social and spiritual care for the terminally ill person.
  - Short-term grief counseling for immediate family members.
  - Professional fees, medical supplies and equipment.

Skilled Nursing Facility (SNF) and Inpatient Rehabilitation Facility (IPR) Services.

- Coverage for:
  - Sub-acute rehabilitation (SAR) services provided during an Inpatient Stay in a Skilled Nursing Facility for a patient who is medically stable.
  - Acute rehabilitation program in an Inpatient Rehabilitation Facility for patients with conditions such as stroke, trauma or brain Injury.
  - Facility charges, professional fees, medical supplies and equipment.

Limitations and Exclusions.

- Benefits for facility services – non-Hospital are limited to 45 days per Policy Year.
- Must be ordered by a Physician.
- The Plan does not cover:
  - Custodial Care.
  - Care for senility or developmental disability

Gender Affirming Care.

- Services can be received in a Hospital (inpatient or outpatient), other outpatient settings such as Alternate Facilities, and a Physician's office.
- Coverage for Medically Necessary Covered Health Services to treat Gender Dysphoria include but are not limited to, reconstructive surgery, hormone therapy and mental health services.

Limitations and Exclusions.

- The Plan does not cover:
  - Services considered by the Plan to be a Cosmetic Procedure or that are Experimental or Investigational.
  - Services for the reversal of gender reassignment surgery.

Genetic Testing.

- Services can be received in a Hospital (inpatient or outpatient), other outpatient settings such as Alternate Facilities and clinics, and a Physician's office.
- Coverage for:
  - Genetic Counseling.

- Medically Necessary Genetic Tests, including for pregnant women.
- Outpatient laboratory services.
- Health care professional consultations and office visits.

Home Health Care.

- Coverage for:
  - Necessary medical supplies.
  - Skilled Care that is provided by or supervised by a registered nurse in your home.
- More information on outpatient rehabilitation/habilitation services provided in your home is under Rehabilitation Services – Outpatient Therapy later in this chapter.

Limitations and Exclusions.

- Must be ordered by a Physician.
- The Plan does not cover:
  - Custodial Care.
  - Private duty nursing.

Home Hospice Care.

- Coverage for:
  - Comfort and support services for the terminally ill in the home.
  - Physical, psychological, social and spiritual care for the terminally ill person.
  - Short-term grief counseling for immediate family members.
  - Professional fees.

Limitations and Exclusions.

- Must be ordered by a Physician.
- The Plan does not cover:
  - Custodial Care.
  - Care for senility or developmental disability.

Home Infusion Services.

- Coverage for:
  - Treatment of an acute condition.
  - Management of an incurable or chronic condition.
  - Durable Medical Equipment.
  - Medical supplies and solutions needed for home infusion services.
  - Administration of infusion therapy medications.
- When appropriate, Covered Person and/or caregiver will learn to administer home infusion therapy medications.

- Home health care services provided along with home infusion therapy are described above under Home Health Care.

Limitations and Exclusions.

- Covered Person may be directed to the site of care for administration of specific medications that is most cost-effective, clinically appropriate and/or can be safely administered such as a Physician's office or through home infusion services.
- Must be ordered by a Physician.
- Care must be provided by or supervised by a registered nurse on an intermittent basis in your home.
- The Plan does not cover:
  - Megavitamin and nutrition-based therapy.
  - Food, nutritional supplements, protein or caloric boosting supplements (for example, Boost, Ensure, Glucerna, Osmolite, or PediaSure).
  - Herbal preparations or supplements.

Hospital Inpatient Stays.

- Coverage for:
  - Facility charges.
  - Medical supplies and other non-Physician services received during the Inpatient Stay.
  - Surgery.
  - Long-term acute inpatient services.
  - Professional fees.

Mammography (Diagnostic) and Breast Cancer Services.

- Services can be received in a Hospital (inpatient or outpatient), other outpatient settings such as Alternate Facilities, and a Physician's office.
- Coverage for:
  - Diagnostic mammography.
  - Breast cancer diagnostic services.
  - Breast cancer outpatient treatment services.
  - Breast cancer rehabilitative services.
- Routine screening mammography is covered under Preventive Health Services later in this chapter.

Maternity and Pregnancy Services.

- Services can be received on an inpatient or outpatient basis, including in a Physician's office, in a Hospital, in an Alternate Facility, or other outpatient settings such as for covered maternity classes.
- Coverage for:
  - Prenatal care, postnatal care, delivery, and any related complications.

- Facility charges.
- Medical supplies and other non-Physician services received during the Inpatient Stay.
- Diagnosis and treatment of the underlying causes of infertility.
- Family planning services.
- Maternity classes. Call Customer Service for details.

Limitations and Exclusions.

- The Plan does not cover:
  - Medical services and supplies for home births.
  - Freestanding birthing centers.
  - Any treatment, procedure or prescription medication designed to create a Pregnancy.
  - The reversal of surgical sterilization.
  - Any form of preservation or long-term storage of reproductive materials.

Medical Supplies.

- Coverage includes but is not limited to:
  - The following ostomy supplies that are required because of a colostomy, ileostomy or urostomy.
    - Pouches, face plates and belts.
    - Irrigation sleeves, bags and catheters.
    - Skin barriers.
  - Diabetic supplies (see Diabetes Services above).
  - Some disposable and non-disposable related supplies if, for example, they are necessary for proper functioning or application of covered Durable Medical Equipment. Please refer to the medical policies on the Plan's website.

Mental Health Services.

- Services can be received on an inpatient basis, at Residential Treatment Programs, on an intermediate basis (partial hospitalization and day treatment) and on an outpatient basis (including intensive outpatient therapy [IOP], testing, electroconvulsive therapy [ECT], transcranial magnetic stimulation [TMS], and behavioral health therapy visits). Coverage includes Emergency and non-Emergency treatment.
- Coverage for evaluation and treatment of mental health conditions.
- Treatment must be provided by a licensed Physician or other licensed behavioral health professional and received in a facility accredited by COA, CARF, AOA, or The Joint Commission.
- The Plan complies with the federal Mental Health Parity and Addictions Equity Act.

Limitations and Exclusions.

- The Plan does not cover:

- Treatment for mental, neurological and other disorders when such conditions are solely medical in nature and that may be covered under other Benefit categories of the Plan.
- Treatment for conduct and impulse control disorders, and paraphilias.
- Treatment provided to comply with involuntary commitments, police detentions and other similar arrangements.
- Services provided outside of an inpatient, intermediate or outpatient setting.
- Services for the following:
  - Sleep disorders.
  - Delirium, dementia, and amnesic and other cognitive disorders (unless noted otherwise).
  - 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.

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

Nutritional Therapy.

- Services can be received in a Hospital on an inpatient basis or in the home.
- Coverage for:
  - Enteral formula administered via tube.
  - Parenteral nutrition administered via IV.
  - Prescribed formulas, nutrients, medical supplies, equipment and accessories needed to administer these types of nutritional therapy.

Limitations and Exclusions.

- Covered Person may be directed to the site of care for administration of specific medications that is most cost-effective, clinically appropriate and/or can be safely administered such as a Physician's office or through home infusion services.
- The Plan does not cover:
  - Megavitamin and nutrition-based therapy.
  - Food, formula and nutritional supplements, except for prescribed formula specifically administered via tube feeding and nutrients necessary for IV feeding. Non-covered items include:
    - Infant formula.
    - Donor breast milk.
    - Protein or caloric boosting supplements (for example, Boost, Ensure, Glucerna, Osmolite, or PediaSure).

- Herbal preparations or supplements.
- Feeding therapy for food aversion.

Orthognathic Surgery.

- Orthognathic surgery must be done on an inpatient Hospital basis. Related services can be received in a Hospital (inpatient or outpatient), other outpatient settings such as Alternate Facilities, and a Physician's office.
- Coverage for:
  - Surgery if provided along with a course of orthodontic treatment to correct bodily dysfunction, deformities or malposition of the jaw.
  - Physician office visits.
  - Outpatient diagnostic services such as cephalometric study and X-rays.

Outpatient Diagnostic Tests and Procedures.

- Services can be received in a Hospital on an outpatient basis, and other outpatient settings such as Alternate Facilities,
- Coverage for:
  - Laboratory and pathology tests.
  - Radiology such as X-rays, ultrasounds and mammography.
  - Surgical procedures, such as colonoscopy, esophagogastroduodenoscopy (EGD), and cardiac catheterization.
  - Services such as Holter monitoring.
  - Facility charges, medical supplies and equipment.
  - Professional fees.

Outpatient High Tech Radiology and Nuclear Medicine.

- Services can be received in a Hospital on an outpatient basis, and other outpatient settings such as Alternate Facilities.
- Coverage for:
  - CT scans, MRIs, and MRAs.
  - Nuclear medicine such as PET scans, radioactive isotope studies and use of radium.
  - Facility charges, medical supplies and equipment.
  - Professional fees.

Outpatient Surgery Services.

- Services can be received in a Hospital on an outpatient basis, and other outpatient settings such as ambulatory surgical centers.
- Coverage for:
  - Facility charges (can be at an ambulatory surgical center).
  - Medical supplies and equipment.

- Professional fees.

Outpatient Therapeutic Treatment Services.

- Services can be received in a Hospital on an outpatient basis, and other outpatient settings such as Alternate Facilities.
- Coverage for:
  - Dialysis.
  - Intravenous chemotherapy or other intravenous infusion therapy.
  - Radiation therapy.
  - Medical education services to manage chronic disease states such as diabetes or asthma.
  - Facility charges, medical supplies and equipment.
  - Observation Care.
  - Professional fees.
  - Nutritional counseling (non-preventive):
    - Must be provided by a qualified health care professional.
    - Conditions for which nutritional counseling is a Covered Health Service include, but are not limited to:
      - Weight management.
      - Diabetes mellitus.
      - Coronary artery disease.
      - Congestive heart failure.
      - Severe obstructive airway disease.
      - Gout.
      - Renal failure.
      - Phenylketonuria.
      - Hyperlipidemias.

Limitations and Exclusions.

- Covered Person may be directed to the site of care for administration of specific medications that is most cost-effective, clinically appropriate and/or can be safely administered such as a Physician's office or through home infusion services.
- The Plan does not cover:
  - Megavitamin and nutrition-based therapy.
  - Food, nutritional supplements, protein or caloric boosting supplements (for example, Boost, Ensure, Glucerna, Osmolite, or PediaSure).
  - Herbal preparations or supplements.

Pain Management.

- Services can be received in a Hospital on an outpatient basis, other outpatient settings such as Alternate Facilities or in a Physician's office,
- Coverage for:
  - Chronic pain that persists without relief from standard methods of treatment.
  - Evaluation and treatment of chronic pain.
  - Durable Medical Equipment.
  - Health care professional office visits.
  - Insertion of spinal cord stimulators.
  - Facet joint injections and facet neurotomy.

Physician's Office Services for Sickness or Injury.

- Coverage for:
  - Services received in a Primary Care Physician's (PCP's) or specialist's office that may be freestanding, located in a clinic or located in a Hospital.
  - Associated services such as radiology, pathology and other diagnostic services.
  - Consultations.
    - Medical education services to manage chronic diseases such as diabetes or asthma.
  - Injections and infusions such as:
    - Allergy immunotherapy shots.
    - Therapeutic injections of anti-allergen, antihistamine, bronchodilator or antispasmodic agents.
    - Infusible drugs.
- Some Physician offices are Hospital-owned and considered outpatient Hospital locations. Covered Health Services may apply to your Annual Deductible and Coinsurance instead of or in addition to a Physician office visit Copayment. For clarification of the Physician's billing practices, please contact the provider.
- Covered Health Services received at a Non-Network Physician's office outside the Service Area to treat emergent or urgent conditions are covered at the Network Benefit level.

Limitations and Exclusions.

- Covered Person may be directed to the site of care for administration of specific medications that is most cost-effective, clinically appropriate and/or can be safely administered such as a Physician's office or through home infusion services.
- The Plan does not cover self-administered and/or over-the-counter drugs received in a Physician's office.

Prescription Drugs – Outpatient.

- You have outpatient Prescription Drug coverage under the Plan. The list of approved drugs makes up the Prescription Drug List (PDL), which you can find on www.phpmichigan.com.
- Copayments or Coinsurance amounts vary depending on which of the six tiers of the Prescription Drug List (PDL) the outpatient Prescription Drug is listed.
- If your Physician prescribes a Prescription Drug Product that is not available to you or a preventive Prescription Drug Product that is not available to you at no cost, the Plan can conduct, at your or your Physician's request, a review to determine if the drug is medically appropriate in your specific circumstances. You and your health care provider are notified of the coverage decision within Department of Labor timeframes. If your request is denied, you can file an Appeal.
- To accommodate the needs of new members, the Plan may, upon clinical review, cover a one-time transitional fill of a non-covered Prescription Drug.
- Covered outpatient Prescription Drugs received from Non-Network Pharmacies are covered at the Network Benefit level if it is determined that you received the drugs due to an emergent or urgent condition.

If a Brand-Name Drug Becomes Available as a Generic.

If a Generic Prescription Drug Product becomes available for a Brand-Name Prescription Drug Product, the tier placement of the Brand-Name Prescription Drug Product may change, and therefore your Copayment or Coinsurance amount may change. You pay the Copayment or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Ancillary Charge.

The Plan includes the Ancillary Charge provision. This means that an Ancillary Charge may apply when a covered Brand-Name Prescription Drug Product is dispensed at your or the provider's request and there is a covered Generic drug available that is chemically the same. When you choose the Brand-Name instead of the Generic, you must pay the difference between the two drugs in addition to your applicable Copayment or Coinsurance amount.

Preventive Drugs Under the ACA.

- Covered at no member cost share.
- Considered preventive under the Affordable Care Act.
- Coverage for:
  - 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 45 through 74.
  - Low-dose aspirin to prevent cardiovascular disease and colorectal cancer for adults ages 50 through 59 and low-dose 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 through age 50; and select low-dose statins for adults ages 40 to 70.

- A select group of Preferred Tobacco Cessation Products that are only available 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.

- The list of these medications and the criteria for coverage are subject to change.

Tier Status Determines What You Pay.

- The Copayment or Coinsurance amount you pay is determined by the tier to which our Pharmacy and Therapeutics ("P&T") Committee has assigned the Prescription Drug Product.
- Tiers are described in the table listing your cost shares earlier in this chapter. Specialty Drugs are in more than one tier.
- The tier placement of a Prescription Drug Product may periodically change. These changes may occur without prior notice to you. Because of such changes, you may be required to pay more or pay less for that Prescription Drug Product.

Supply Limits.

- At a retail Network Pharmacy:
  - Tier 1A Preferred Generic drugs and select Brand-Name drugs to treat certain chronic conditions are available in 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.
  - Tier 1B other Generic drugs, Tier 2 Preferred Brand-Name drugs, and Tier 3 Non-Preferred Brand-Name drugs are available in up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
  - Covered contraceptives are available in up to a consecutive three-cycle supply of a covered contraceptive for three Copayments.
- Through a mail-order Network Pharmacy – Tier 1A, Tier 1B, Tier 2 and Tier 3 drugs are available in 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 regardless of tier placement are only dispensed in up to a consecutive 31-day supply through CVS mail-order specialty pharmacy.
- Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification.
- To receive the maximum Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply (not a 31-day supply with two refills), with refills when appropriate.

Limitations and Exclusions.

- Must be prescribed by a Physician even if the product is available as an over-the-counter product.

- The Plan may not permit you to use certain coupons or offers from pharmaceutical manufacturers to meet or reduce your Annual Deductible or go towards your Annual Out-of-Pocket Maximum.
- The Plan does not cover:
  - Brand-Name drugs when a Generic equivalent is available.
  - Prescription Drug Products when comparable products are available over-the-counter, including but not limited to, cough/cold products.
  - Medications, products and devices that are not FDA-approved.
  - Prescription Drug Products not listed in the PDL.
  - Self-injectable medications, except as covered from a Network Pharmacy or stated as covered.
  - 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.
  - Over-the-counter drugs and treatments, unless stated as covered.
  - Compounded Medications.
  - Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
  - Products dispensed for appetite suppression and other weight loss products, unless stated as covered.
  - A Specialty Prescription Drug Product that must typically be administered or supervised by a qualified health care provider or licensed/certified health care professional in an outpatient setting.
  - General vitamins, unless listed on the ACA Preventive Prescription Drug List.
  - Unit dose packaging or re-packaged Prescription Drug Products.
  - Replacement for a previously dispensed Prescription Drug Product even if lost, stolen, broken or destroyed.
  - Prescription drugs that are not Medically Necessary and/or may cause significant patient harm and/or are not appropriate for the patient’s documented medical condition.
  - Prescription Drug Products related to infertility such as in-vitro fertilization, reversal of sterilization, artificial insemination or to test fertility, except to continue or support a Pregnancy.

Preventive Health Services.

- No cost share to the member (no Annual Deductible, no Copayments or no Coinsurance amounts) when provided by a Network health care provider.
- For detailed coverage of ACA preventive Prescription Drugs, see above under Prescription Drugs - Outpatient.
- The Plan complies with the Affordable Care Act. The Preventive Health Services Benefit is subject to change.

Covered Preventive Health 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 45, including a select group of Prescription Drug Products for bowel prep (for adults ages 45 through 74).
  - 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:
  - Low-dose 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.
  - Nutritional counseling (considered to be Preventive Health Services).
- 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 (call Customer Service for information about our tobacco cessation counseling program for members age 18 or older).

Covered Preventive Health 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 pregnant women and 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 Genetic Counseling 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.
  - Nutritional counseling (considered to be Preventive Health Services).
- Other services such as:

- Tobacco use interventions for all women (call Customer Service for information about our tobacco cessation counseling program for members age 18 or older).
- Breast feeding interventions to support and promote breast feeding.
- 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.
- Maternity classes provided by our preferred vendor.

Covered Preventive Health 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.
  - Obesity counseling.
  - Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk.

- Nutritional counseling (considered to be Preventive Health Services).

- 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.

Professional Fees for Surgical and Medical Services.

- Services can be received in a Hospital on an inpatient or outpatient basis, other outpatient settings such as Alternate Facilities, or in the home,
- Coverage for:
  - Surgical procedures.
  - Inpatient or outpatient consultations.
  - Physician house calls.
  - Pre-natal, delivery and post-natal care.
  - Other medical care by a Physician.

Prosthetic Devices.

- Coverage for:
  - Surgically implanted and externally worn prosthetic devices to replace a limb or body part lost by traumatic Injury or missing from birth.
  - 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 sleeves for the arm.
  - Repair or replacement when needed due to a change in your medical condition, or a change in body size due to growth, or to improve physical function.

Limitations and Exclusions.

- Prosthetic devices must meet the minimum specifications for your basic functional needs. If you want a prosthetic device above the minimum specifications, you must pay any difference in cost.
- The Plan does not cover:
  - Nonrigid devices and supplies such as garter belts, arch supports, and corsets.
  - Hearing aids and related services.
  - Spare prosthetic devices.
  - Routine maintenance of the prosthetic device.
  - Hair prostheses such as wigs, hair pieces, hair implants, etc.
  - All devices to assist in communication, speech and Telemedicine Services, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
  - Mouth prosthetics.
  - Items used specifically for physical appearance or as safety items or to affect performance in sports-related activities.

Reconstructive Procedures.

- Services can be received in a Hospital on an inpatient or outpatient basis, other outpatient settings such as Alternate Facilities or in a Physician's office.
- Coverage for:
  - Surgery or other procedures when associated with an Injury, Sickness or Congenital Anomaly.
  - Breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry.
  - Other services required by the Women's Health and Cancer Rights Act of 1998, including treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service.
  - Medically Necessary plastic surgery such as blepharoplasty of upper lids, brow ptosis repair, surgical treatment of male gynecomastia, breast reduction, male mastectomy, panniculectomy, and sleep apnea treatments (for example, septorhinoplasty).
  - Inpatient or outpatient facility charges.
  - Professional fees.

Limitations and Exclusions.

- The Plan does not cover:
  - Cosmetic Procedures.
  - Removal or replacement of an existing breast implant if it was initially performed as a Cosmetic Procedure, unless due to complications and determined by the Plan to be Medically Necessary.

Rehabilitation/Habilitation Services – Outpatient Therapies.

- Services can be received in a Hospital on an outpatient basis, other outpatient settings such as Alternate Facilities, in a Physician's office or in the home,
- Coverage for:
  - Short-term outpatient rehabilitation services.
  - Physical therapy.
  - Occupational therapy.
  - Speech therapy, including post-cochlear implant aural therapy (must meet criteria).
  - Pulmonary rehabilitation therapy.
  - Phase II cardiac rehabilitation therapy.
- Surgery is not a prerequisite for receiving outpatient rehabilitation therapy.

Limitations and Exclusions.

- Physical therapy and occupational therapy are limited to a combined 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 a combined 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 and occupational therapy and 30 combined visits per Policy Year for habilitative physical therapy and occupational therapy, as applicable).
- Rehabilitation/habilitation therapy for autism is not included in the limits shown above.
- The Plan does not cover:
  - Inpatient or outpatient recreational therapy.
  - Patient education and home programs.
  - Audio therapy.
  - Eye exercise therapy or vision therapy.
  - Biofeedback training, unless determined by the Plan to be Covered Health Services.
  - Craniosacral therapy.
  - Prolotherapy.
  - Sensory integration therapy.

Substance Use Disorders Services.

- The Plan complies with the federal Mental Health Parity and Addictions Equity Act.

Inpatient Detoxification Services.

- Coverage for:
  - Acute medical services for physical detoxification from abusive chemicals or substances.
  - Facility charges.
  - Treatment that is provided by a licensed Physician or other licensed behavioral health professional and received in a facility accredited by COA, AOA, CARF or The Joint Commission.

Outpatient and Intermediate Services.

- Coverage for services received on an outpatient or intermediate basis in a health care provider's office or an Alternate Facility that has a State-approved or State-licensed primary treatment program, including:
  - Substance Use Disorders and chemical dependency evaluations and assessment.
  - Diagnosis.
  - Treatment planning.
  - Referral services.
  - Medication management.
  - Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
  - Crisis intervention.
  - Residential Treatment Program.
  - Partial hospitalization.
  - Day treatment.

Limitations and Exclusions.

- Treatment must be provided by a licensed Network Physician or other licensed Network behavioral health professional and received in a Network facility accredited by COA, AOA, CARF or The Joint Commission.
- Coverage for Substance Use Disorders treatment is limited to the most appropriate method and level of treatment that is Medically Necessary as determined by Plan medical policies and nationally recognized guidelines.
- The Plan does not cover:
  - Treatment provided to comply with involuntary commitments, police detentions and other similar arrangements.
  - Services provided outside of an inpatient, intermediate or outpatient setting.
  - Transitional living centers, wrap-around care services, halfway or three-quarter-way houses, non-licensed programs, therapeutic boarding schools or milieu therapies.

Surgical Sterilization.

- Services with the intent to cause sterilization in men and women can be received in a Hospital on an inpatient or outpatient basis, other outpatient settings such as Alternate Facilities, or in a Physician's office.
- Coverage for:
  - Facility charges.
  - Professional fees.
  - Medical supplies and equipment.

Limitations and Exclusions.

- The Plan does not cover reversal of surgical sterilization.

Telemedicine Services.

- Services can be received in a Hospital on an outpatient basis, other outpatient settings such as Alternate Facilities, in a Physician's office or in the home.
- "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.

Limitations and Exclusions.

- Not all Covered Health Services are covered telemedically such as, but not limited to, new patient examinations, Preventive Health Services, surgery, substance use disorders treatment, reporting of normal test results, provision of educational materials, and handling of administrative issues (such as registration, scheduling of appointments, or updating billing information)..

Temporomandibular Joint (TMJ) Syndrome/Dysfunction Treatment.

- Services can be received in a Hospital on an inpatient or outpatient basis, other outpatient settings such as Alternate Facilities, or in a Physician's office.
- TMJ Syndrome/Dysfunction means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction.
- Coverage for:
  - Health care professional fees for Covered Health Services to treat TMJ resulting from a medical cause or Injury.
  - Facility charges.
  - Surgery directly to the temporomandibular joint.
  - Related anesthesia services.
  - Arthrocentesis performed for the treatment of TMJ dysfunction.

- Diagnostic X-ray.
- Physical therapy.
- Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint).

Limitations and Exclusions.

- The Plan does not cover:
  - Routine dental services, dental X-rays and dental appliances such as bite splints.
  - Dental implants and related services, including repair and maintenance of implants and surrounding tissue.

Transplantation Services.

- The Plan has specific guidelines regarding Benefits for transplant services listed below.
- Transplantation programs include three phases: pre-transplant services, the transplant period and post-transplant services.
- Coverage for:
  - Donor expenses for a donor who is not a Covered Person under the Plan and if not covered by the donor's plan. If both the donor and the recipient are covered under the Plan, all Covered Health Services are covered under the recipient.
  - Computer organ bank searches and any subsequent testing necessary after a potential donor is identified unless covered by another health benefit plan or policy.
  - Facility charges, inpatient or outpatient.
  - Medical supplies and other non-Physician services received during the Inpatient Stay.
  - Surgery.
  - Long-term acute inpatient services.
  - Professional fees including consultations.
  - Office visits and associated charges.
  - Transplants that include:
    - Hematopoietic stem cell transplants.
    - Heart transplants.
    - Heart/lung transplants.
    - Lung transplants.
    - Kidney transplants.
    - Kidney/pancreas transplants.
    - Liver transplants.
    - Liver/small bowel transplants.
    - Pancreas transplants.
    - Small bowel transplants.

Limitations and Exclusions.

- Transplants must be done at a Designated Facility (except for corneal transplants).
- The Plan does not cover:
  - Removal of an organ or tissue from you (the donor) for purposes of a transplant to another person.
  - Health care services for transplants involving animal organs.
  - Transplant services that are not performed at a Designated Facility, except for corneal transplants.

Urgent Care Center Visits.

- Covered Health Services for Urgent Care Center visits from Non-Network health care providers are covered at the Network Benefit level.

Vision Services - Pediatric.

- Benefits are available for dependent children up to the day they turn age 20.

Examinations.

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

Eyeglasses.

- Lenses – limited to one pair per Policy Year.
- Frames – limited to one frame per Policy Year.

Contact Lenses.

- Contact lenses are covered for a one-year's supply per Policy Year in lieu of eyeglasses.

Other Vision Services.

- Optional lenses and treatments.
- Low Vision Services.

Limitations and Exclusions.

- The Plan does not cover:
  - Eye exercise therapy or vision therapy.
  - Surgery intended to allow you to see better without glasses or other vision correction.
  - 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.
  - Any other vision treatment or services except for treatment of medical conditions and diseases of the eye as provided under the Plan.
  - Covered or non-covered vision services for members over the age of 20.

Weight Management Services.

- Coverage for:
  - Physician office visits.
  - Outpatient behavioral health therapy visits.
  - Nutritional counseling.
  - Outpatient laboratory and pathology services.
  - Qualified weight management programs.

Limitations and Exclusions.

- The Plan does not cover nutritional supplies, body fat testing, or educational materials that are not included in the qualified weight management program fees.

GENERAL EXCLUSIONS AND LIMITATIONS

Many non-covered services are listed in the chapter, BENEFITS AND COVERAGE, under Benefit categories. The services listed in this chapter are in addition to those stated earlier.

1. Health care services, medical supplies and medications that do not meet the definition of a Covered Health Service.
2. Health care services, medical supplies and medications that require prior approval when prior approval has not been obtained.
3. Health care services, medical supplies and medications for which medical criteria have not been met.
4. 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 does 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.
5. Complementary and Alternative Medicine (CAM) testing and treatment as defined by the National Center for Complementary and Alternative Medicine. Examples include but are not limited to:
   - Acupressure.
   - Acupuncture.
   - Aromatherapy.
   - Environmental testing and analysis.
   - Hair testing and analysis.
   - Herbal or vitamin therapies.
   - Hypnosis.
   - Massage therapist services.
   - Music therapy.
   - Reflexology.
   - Rolfing.
   - Saliva testing and analysis.
6. Cosmetic Procedures and services including but not limited to:
   - 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, unless determined to be Medically Necessary.
- Hair removal by any means.
- Plastic surgery, unless stated as covered.
- Collagen implants
- Diastasis recti repair.

7. Travel, lodging and/or meals necessary while receiving health care services even though prescribed by a Physician or necessary because of where treatment is received.
8. Beauty/barber services.
9. Guest services.
10. Medical supplies, equipment, and similar incidental health care services and supplies for personal comfort, or for the convenience of either the Covered Person or his or her Physician.
11. Physical conditioning programs.
12. Any hair replacement product or process.
13. Services performed by a health care provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the health care provider may perform on himself or herself.
14. Services performed by a health care provider with your same legal residence.
15. Health care services provided at a diagnostic facility without a written order by a Physician or other qualified health care provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other health care provider who is an employee or representative of a diagnostic facility, when that Physician or other health care 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.
16. Foreign language and sign language interpreters.
17. Academic services including school tuition for or services that are school-based for children or adolescents provided under the Individuals With Educational Disabilities Act (IDEA).
18. Health care 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 are not paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
19. Health care services for treatment of military service-related disabilities, when you are enrolled for coverage through the Veterans Administration (VA).

20. Health care services while on active military duty.
21. Health care services provided in a foreign country, unless required as Emergency Health Services.
22. 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 that are not Medically Necessary.
    - Conducted for purposes of medical research, except for qualified clinical trials.
    - Required to get or maintain a license of any type.
23. Health care services received because of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
24. 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 Plan.
25. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
26. Benefits when a health care provider waives Copayments, Coinsurance amounts and/or the Annual Deductible for a health care service.
27. 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.
28. Respite care, except as part of hospice care services.
29. Rest cures.
30. Work hardening.
31. Autopsy.
32. Long term (more than 30 days) storage.
33. Psychosurgery.
34. Medical and surgical treatment of excessive sweating (hyperhidrosis), unless determined to be Covered Health Services.
35. Medical and surgical treatment for snoring or daytime sleepiness, except when part of treatment for documented obstructive sleep apnea.
36. Gym memberships. Aquatic exercise programs or classes. Personal trainers. Exercise equipment, including pools even if prescribed by a Physician.
37. 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 the Plan.

38. Legal/court fees, copy/fax fees, late fees, shipping charges, long distance phone charges, and fees for copying X-rays.
39. Charges for missed appointments.
40. Items or services furnished, ordered, or prescribed by any health care provider that involves Fraud.
41. 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.
42. Food replacements, electrolyte supplements, infant formula and donor breast milk; even if any are the sole source of nutrition or as part of treatment.
43. Routine eye exams and vision hardware for members over 20 years of age.
44. Hearing aids and related services.

Network Benefits.

The Plan pays Network Benefits for Covered Health Services that are:

- Provided by Network health care providers.
- Prior approved, if required.
- Emergency Health Services, such as ambulance charges and Emergency Department visits.
- Urgent Care Center visits.
- 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 the 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 the member portal, MyPHP, or by contacting Customer Service.

Limitation on Selection of Health Care Providers.

If the Plan determines 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.

Health Care Provider Network.

Physicians Health Plan contracts with health care providers to form a Network. Network health care providers are independent practitioners. They are not employees of Physicians Health Plan.

A directory of Network health care providers is available to you. You must choose your Network health care 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 www.phpmichigan.com.

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

Please visit the member portal, MyPHP, using the link at www.phpmichigan.com for any of the following:

- The current provider network directory, including names and locations by specialty and a listing of which health care providers accept new patients.

- The professional credentials of participating health care professionals.
- The licensing verification phone number for the Michigan Department of Licensing and Regulatory Affairs.
- Benefit Coverage, Drug Determination and Payment Reimbursement Policies, which contain clinical guidelines, any prior approval requirements, and coverage details.
- Ordering of ID cards, or printing of temporary ID cards.
- Viewing medical and pharmacy claims.
- Viewing Annual Deductible and Out-of-Pocket Maximum accumulators.
- Viewing, downloading and printing of Explanation of Benefits (EOBs).
- Viewing, downloading and printing of claim history reports.
- Changing your PCP.
- Changing your address.
- Submitting a question to the Plan.
- Submitting a Grievance or Appeal to the Plan.

Medical Resource Management.

Your Network health care providers must get prior approval from the Medical Resource Management Department for coverage of certain health care services. The Plan can work together with your health care providers 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 has been determined to require special services, the Plan may direct you to a Designated Facility or other health care provider. If you require Covered Health Services not available from a Network health care provider, the Plan may direct you to a Non-Network facility or Physician.

Non-Network Covered Health Services Paid as Network Benefits.

Physicians Health Plan's goal is to provide a comprehensive Network of health care providers that can meet all your health care needs. If it is decided 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 the Plan has approved the request. If you see a Non-Network health care provider without approval, Network Benefits are not paid unless it is an Emergency Health Service. You may be responsible for all non-covered charges.

You may receive services from Non-Network health care providers at Network facilities, such as for pathology, anesthesiology, radiology and Emergency Department Physicians. The Plan may cover these services provided by Non-Network health care providers at the Network Benefit level. The Plan also covers Emergency Health Services provided at Non-Network facilities under the Network Benefit level.

Emergency Health Services.

Your health care provider does not have to get prior approval from the Plan before you receive care or treatment at an Emergency Department (ED), even if the Emergency Department is not in the Network.

The Plan covers 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. However, Non-Network health care providers may bill you for any portion of their charges not covered by the Plan.

If you are formally admitted as an inpatient to a Hospital after you receive Emergency Health Services, the Plan must be notified within one business day or on the same day of admission or as soon as reasonably possible if there are extenuating circumstances.

Continuing Care when Physician Leaves Network.

If you have regularly been seeing a Physician who is no longer in the Network, the Plan may continue to cover the services you receive from that Physician at Network Benefit levels while you are covered under the Plan. 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 second or third 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 while covered under the Plan).
- 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 the Network, please contact the Customer Service Department.

How to Enroll.

If you purchase this Policy on the Health Insurance Marketplace, you must complete the enrollment process through the Marketplace. Physicians Health Plan must receive the required Premium before coverage becomes effective.

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

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

We do 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.

We do not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any Covered Health Services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such Covered Health Services are ordinarily or exclusively available.

Genetic Information.

Eligible Persons and Dependents are not required to:

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

The Plan does not:

- Limit your coverage based on any information received 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.

Eligibility for Coverage.

Eligible Person.

Eligible Person means a person who has applied for coverage through the Health Insurance Marketplace or directly to Physicians Health Plan. When an Eligible Person actually enrolls under a Physicians Health Plan 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).

Dependents (Not Applicable for Child Only Policy).

Eligible Dependents are covered as long as the Subscriber is covered under the Plan and include:

- A legal spouse; or
- A Domestic Partner (as defined by the Plan); 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 or she applies for dependent coverage when he or she enrolls in the Plan. A new Dependent may be enrolled in the Plan if the Subscriber submits written or electronic application within 31 days after he or she acquires that Dependent.

The Plan covers Hospital and professional inpatient claims for an eligible newborn child's initial stay in connection with the delivery for up to 48 hours for a vaginal delivery and up to 96 hours following a cesarean section. In order to continue coverage for a newborn child beyond the initial 48 hours following a vaginal delivery or the first 96 hours following a cesarean, the baby must be 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 health care 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 complies 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 Physicians Health Plan is effective on the date specified by Physicians Health Plan.

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 Plan before leaving for military service to have these rights.

Plan Exclusions and waiting periods may be imposed for any Sickness 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 Plan.
- Legal guardianship.

- Court or administrative order.

Coverage begins on the date of the event if the Health Insurance Marketplace or the Plan 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.
- Changes in residence such as moving to a new home in a new zip code or county.
- Loss of qualifying health care coverage in the past 60 days or expecting to lose coverage in the next 60 days.
- Loss of eligibility under a Medicaid plan by an Eligible Person or state children's health insurance program (CHIP) by a Dependent child. You must apply for Plan coverage within 60 days.
- Eligibility gained by an Eligible Person or Dependents for a premium assistance subsidy under Medicaid or a CHIP (subsidy to be used toward payment of premiums for a group health plan).
- Gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.
- Becoming newly eligible for coverage because of U.S. Citizenship.
- Leaving incarceration.
- Starting or ending service as an AmeriCorps State and National, VISTA, or NCCC member.
- Individuals who are enrolled in off Marketplace group health plans or individual plans that meet the criteria for "minimum essential coverage" and who have a change in tax household composition so become eligible for APTC. You must apply for Plan coverage within 60 days.
- Enrollment or plan error.
- A natural disaster.
- COBRA continuation coverage ends.
- Start of military service.

This is not a complete list. See healthcare.gov for more information.

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 the Plan receives 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 because 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.

End Stage Renal Disease (ESRD).

The Plan coordinates with Medicare to cover ESRD treatment. Members with ESRD should apply for Medicare, which starts on the first day of the fourth month of dialysis. The time before Medicare coverage begins is the "Medicare waiting period," which last for three months.

There is no waiting period if the member begins self-dialysis training within three months of when dialysis starts. If so, Medicare coverage begins the first day of the month dialysis begins. There is no waiting period if the member goes in the Hospital (approved by Medicare) for a kidney transplant or for services needed before the transplant. Medicare coverage begins the first day of the month the member is admitted to the Hospital. The transplant must be done within three months of going in the Hospital.

If the transplant is delayed more than two months after the member goes in the Hospital, Medicare coverage begins two months before the month of the transplant.

The Plan is primary over Medicare for up to 33 months (the three-month waiting period and 30-month coordination period). After the coordination period, Medicare is the primary plan.

This order of benefits continues when you become entitled to Medicare due to age or other disability.

Payment of Clean Claims.

A clean claim for Covered Health Services received from a health care provider is paid immediately upon receipt by the Plan. 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 the Plan to a health care provider to the date of receipt of a response by the Plan from the health care 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 health care 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 the Plan determines that one or more services listed on a claim are payable, the Plan pays for those services and does not deny the entire claim. This does not apply if the health care provider and the Plan have an overriding contractual reimbursement arrangement.

As used in this chapter a "clean claim" means a claim that does all 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 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 the Plan.

Covered Health Services from a Network Health Care Provider.

Network health care providers are responsible for filing claims directly to the Plan. The Plan pays Network health care providers directly. You are responsible for meeting the Annual Deductible, if applicable, and for paying required Copayments or Coinsurance

amounts to a Network health care provider at the time of service, or when you receive a bill from the health care provider. If a Network health care 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 required to pay the claim. The Plan does not require a claim form be submitted with a claim, but a completed claim form usually gives the Plan all the information needed to process your claim. Claim forms are available on the Member Reference Desk, which you can access at www.phpmichigan.com. If the Plan requires you to submit a completed claim form,you are provided with the appropriate form within 15 days of receiving notice of a claim from you.

Medical Claims.

When you request payment of Benefits from the Plan for medical Covered Health Services provided by Non-Network health care providers, you must provide the Plan with all 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 health care 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 health care provider before Benefits are considered for payment.

Prescription Drug Product Claims.

In certain situations you may request reimbursement for covered Prescription Drug Products received from a pharmacy. Please keep in mind that if you request reimbursement 30 days or less from the date you paid for the medications, you receive 100% minus any cost share you have under the Plan. If your reimbursement request is

over 30 days, you receive the contracted rate minus any cost share. When requesting reimbursement, you must provide 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 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 (submit the receipt to Physicians Health Plan directly at the address below); or
   - You have not yet received your ID card (submit to CVS Caremark at the 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 health care provider must receive it from the Plan before you submit your request, or the request is denied.
7. For reimbursement because you have not yet received your ID card, return the completed claim form and receipts to:

   CVS CAREMARK
   PO BOX 52136
   PHOENIX AZ 85072-2136
8. To request reimbursement in an emergency or urgent situation, return the completed claim form and receipts to:

PHYSICIANS HEALTH PLAN
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 care services, it is best that requests for reimbursement be submitted within 90 days of the date of service. If the Plan does not receive a claim within one year of the date of service, the health care services may not be covered. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

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

Post-Service Claim Requests.

Post service claim requests are submitted to the Plan after medical care has been received. If your post-service claim request is denied, you receive a written notice from the Plan within 30 days of receipt of the claim request, if all needed information was provided with the claim request. The Plan notifies you within this 30-day period if additional information is needed to process the claim request. The Plan 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 the needed information is received within the 45-day timeframe and the claim request is denied, the Plan notifies 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 post-service claim request is denied.

A denial notice:

- Explains the reason for the denial.
- Refers to the part of the benefit document and/or Benefit Coverage, Drug Determination or Payment and Reimbursement 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, COMPLAINTS, GRIEVANCES AND APPEALS, contains information on your rights if you do not agree with the Benefit determinations.

Pre-Service Requests.

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

Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day timeframe, the Plan notifies 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 pre-service request is denied.

A denial notice:

- Explains the reason for the denial.
- Refers to the part of the benefit document and/or Benefit Coverage, Drug Determination or Payment and Reimbursement Policies 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, COMPLAINTS, GRIEVANCES AND APPEALS, contains information on your rights if you do not agree with the Benefit determinations.

Urgent Pre-Service Requests that Require Immediate Action.

Urgent pre-service requests require quicker service because:

- A delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function.

Medical Requests.

You receive notice of the Benefit determination in writing or electronically within 72 hours following receipt of an approved request, considering 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 medical request without all the information the Plan needs to review your request, the Plan notifies you of what is missing within 24 hours after the urgent pre-service request was received. If additional information is needed to process the request, the Plan notifies you of the information needed within 24 hours after the request is received. You then have 48 hours to provide the requested information.

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

- The Plan receives 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 benefit document and/or Benefit Coverage, Drug Determination or Payment and Reimbursement Policies 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, COMPLAINTS, GRIEVANCES AND APPEALS, contains information on your rights if you do not agree with the Benefit determinations.

Outpatient Prescription Drug Requests.

If you are prescribed a Prescription Drug Product that is either excluded or that requires prior approval for coverage, the Plan will review your request and inform you and your provider within 72 hours of receiving all information necessary to make the determination.

If the request is urgent, the Plan will inform you and your provider within 24 hours of receiving all information necessary to make the determination.

If the Plan approves the request, the Plan will cover the drug during the review period and for as long as required by law.

A denial notice:

- Explains the reason for the denial.
- Refers to the part of the benefit document and/or Benefit Coverage, Drug Determination or Payment and Reimbursement Policies on which the denial is based.
- Describes any additional information needed.
- Explains why the information is required.
- Provides the claim appeal procedures, if applicable.

Concurrent Care Claim Requests.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments it is considered a concurrent care claim request. If you request on an urgent basis to extend the treatment, your request is decided by the Plan within 24 hours from receipt of your request only if your urgent request is made at least 24 hours prior to the end of the approved treatment. If your urgent request for extended treatment is not made at least 24 hours before the end of the approved treatment, the request is treated as an urgent pre-service request and decided according to the timeframes described previously under Urgent Pre-Service Requests.

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 is considered a new claim request and decided according to post-service or pre-service timeframes, whichever applies.

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

Payment of Premiums.

Premiums are due to Physicians Health Plan each month. 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, Physicians Health Plan 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, Physicians Health Plan is permitted to terminate your coverage **only**:

- If you are no longer eligible for coverage through the Health Insurance Marketplace;
- If you do not pay your Premium after the grace period ends;
- For an allowed Rescission;
- If this entire Policy is terminated; or
- If 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 does 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 three-month Special Grace Period to pay Premiums. To be eligible for the three-month Special Grace Period, members must pay the full Premium in the month prior to being granted the three-month Special Grace Period. Benefits continue to be covered during the first month of the Special Grace Period but all claims are pended during the second and third 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 second and third 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 Physicians Health Plan, and if any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by Physicians Health Plan or by any agent duly authorized by Physicians Health Plan 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 issues a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of such application by Physicians Health Plan 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 ten days after such date. In all other respects the member and Physicians Health Plan 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.

COMPLAINTS, GRIEVANCES AND APPEALS

Physicians Health Plan welcomes your comments and suggestions so that we can continue to improve our service to you. If you have a problem, we want to solve it. There is 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, under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929, and under the Affordable Care Act.

Any Grievance/Appeal 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.

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. Means:

- 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 example, for a specific period of time or number of treatments.

Grievance/Appeal. A written expression of dissatisfaction by a Covered Person or Authorized Representative concerning an Adverse Benefit Determination of a Pre-Service Request, Post-Service Claim, or Concurrent Care Request. The terms "Appeal" and "Grievance" mean the same thing in the Plan.

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

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

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.

Urgent Pre-Service Request. A request that may require prior 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 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, please contact Customer Service at the phone number shown on your ID card. All complaints are followed up on.

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 phone, 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. Appeal forms are also available on the Member Reference Desk that you can access on the website.

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 Plan ID card.
- The date(s) of medical service(s).
- The health care provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Grievance Process – Step 1.

The Plan lets you know by letter within five calendar days from the date your Grievance is received that the Grievance has been received. The Plan informs you or your Authorized Representative of the review outcome by letter within 15 calendar days for Pre-Service Requests or 20 calendar days for Post-Service Claims. If your Grievance is related to clinical matters, the review is 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 the Plan receives additional information during the review, the Plan can provide you a copy of this information free of charge. You or your Authorized Representative has 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 the review outcome in Step 1. You may come to the hearing in person or join the Plan by phone. If you request a Grievance hearing, a committee of qualified individuals, who were not involved in the decision being appealed, are appointed by the Plan 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 is informed of the outcome of the hearing within ten calendar days.

Grievance Determinations.

Pre-Service Request and Post-Service Claim Appeals.

Once the Grievance process 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 is sent within 15 calendar days for Pre-Service Requests or within 20 calendar days for Post-Service Claims, and notification of the determination of Step 2 is sent within ten calendar days.

Urgent Grievances/Appeals of Pre-Service Request Determinations.

Your appeal of a Pre-Service Request determination 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.

In these urgent situations:

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

The Plan provides you with a written or electronic determination within 72 hours following receipt of your request for review of the determination. The Plan considers the seriousness of your condition.

External Review Rights.

If you are not satisfied with the final Grievance determination:

- You may seek external review through DIFS, under the Patient's Right to Independent Review Act (PRIRA), 2000 PA 251, MCL 550.1901 to 550.1929. A request for external review must be filed in writing through one of the methods below.
- If your request has been deemed urgent, the request for external review may be filed at the same time with DIFS. If not filed at the same time, the request for urgent external review with DIFS must be filed no later than ten days after the Plan denies your request.
- If your request has been deemed non-urgent, the request may not be made until either the internal Plan review process is complete, or the time allowed for the process has expired. Non-urgent requests must be filed no later than 127 days after you receive the denial or the expiration of the time allowed for the process.
- The Plan can provide you with a copy of the DIFS Health Care Request for External Review Form (FIS-0018). For additional information about external review, you can contact the Director of DIFS at the address shown below.

Mail:

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

Phone: 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 Physicians Health Plan, its successor, or their affiliates, agents and/or employees, must be brought within three years of the date you are notified of the final decision on your appeal of the Adverse Benefit Determination. If you do not initiate any such legal proceeding or other action within the three-year time period, you give up your rights to bring any such proceeding or action.
- The Plan complies with PRIRA. You can request external review through DIFS at https://difs.state.mi.us/Complaints/ExternalReview.aspx. No Surprises Act (NSA) extended the external appeal process to include an issuer's compliance with surprise billing protections under the NSA.

Benefits When You Have Coverage under More than One Plan.

This chapter describes how Benefits under the Plan are 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 as amended by PA 275 effective July 1, 2016.

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 plan pays as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan may make an additional payment, but in the case of the Plan, only to bring the cumulative total paid by both plans combined to the amount that the Plan would pay if it were the only plan. Each time an expense is submitted when the Plan pays second, the amount that would have been payable under the Plan is calculated as if it were the only coverage.

Outpatient Prescription Drug Product Benefits are not coordinated with those of any other health coverage plan. If you have primary health care coverage and the Plan is your secondary coverage, you must use your primary outpatient prescription drug coverage. You are not eligible for this outpatient prescription drug coverage.

Definitions.

For purposes of the Plan, terms are defined as follows:

1. "Allowable expense" means a health care expense, including coinsurance and copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the individual. The amount of a reduction may be excluded from allowable expense if a covered person's benefits are reduced under a primary plan for either of the following reasons:
    a. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services.
    b. Because the covered person has a lower benefit because the covered person did not use a preferred provider.
2. "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of any of the following:

a. Services including supplies.
    b. Payment for all or a portion of the expenses incurred.
    c. A combination of items (a) and (b) above.
    d. An indemnification.

3. "Closed panel plan" means a 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 insurer that issues the plan and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
4. “Coordination of benefits” or “COB” means a provision that establishes an order in which insurers or HMOs pay claims, and that permits benefits paid under secondary plans to be reduced so that the combined benefits paid under all plans do not exceed 100% of the total allowable expenses of the claims.
5. "Custodial parent" means any of the following:

a. The parent awarded custody of a child by a court order or judgment.

b. In the absence of a court order or judgment, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

6. “Dental care corporation” means a nonprofit dental care corporation incorporated under 1963 PA 125, MCL 550.351 to 550.373.
7. “Group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group=type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deductible at a premium savings to the insured, because the insured would have the right to maintain or renew the policy independently of continued employment with the employer.
8. “Health maintenance organization” or “HMO” means that term as defined in section 3501 of the insurance code of 1956, 1956 PA 218, MCL 500.3501.
9. “Insurer” mean that term as defined in section 106 of the insurance code of 1956, 1956 PA 218, MCL 500.106.
10. “Plan” means a form of health care coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts and that are intended to be part of a coordinated package of benefits are considered one plan and there is not COB among the separate parts of the plan. If benefits are coordinated under a plan, the contract must state the types of coverage that will be considered in applying the COB provision of the contract. Whether the contract used the term “plan” or some other term such as “program,” the contractual definition must not be broader than the definition of “plan.” Plan includes any of the following:

a. Group and nongroup insurance contracts and subscriber contracts.

b. Uninsured arrangements of group or group-type coverage.

c. Group and nongroup coverage through closed panel plans.

d. Group-type contracts.

e. The medical care components of long-term care contracts, including skilled nursing care.

f. Medicare or other governmental benefits, as permitted by law, except as provided in item 7 above. Plans under this section may be limited to the hospital, medical, and surgical benefits of the governmental program.

g. Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

h. Group and nongroup dental insurance contracts and subscriber contracts issued by a dental care corporation.

i. Individual no-fault automobile insurance, by whatever name called. Except that, this does not apply to the extent that any auto insurance policy issued pursuant to the Automobile No-Fault Insurance Act of the State of Michigan contains a deductible or is by these terms secondary to (or excess over) the benefits provided under this Plan.

   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.

j. Plan does not include any of the following:

   i. Hospital indemnity coverage benefits or other fixed indemnity coverage.

   ii. Accident-only coverage or disability income insurance.

   iii. Specified disease or specified accident coverage.

   iv. 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.

   v. Benefits provided in long-term care insurance policies for nonmedical services, including personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.

   vi. Medicare supplement plans.

   vii. A state plan under Medicaid.

   viii. A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

k. Plans can be issued by any of the following:

   i. A health maintenance organization under which health services are provided, either directly or through contracts with affiliated providers, to individual or group enrollees.

   ii. A dental care corporation under which dental benefits are provided to individual or group enrollees.

   iii. An insurer that provides for hospital, medical, surgical, dental, or sick care benefits.

11. “Primary plan” means a plan under which benefits for an individual’s health care coverage are determined without taking into consideration the existence of any other plan. A plan is a primary plan under either of the following circumstances:

a. The plan either has no order of benefit determination rules or its rules differ from those authorized under this act.

b. All plans that cover the individual use the order of benefit determination rules required under this act and, under those rules, the benefits payable under the plan are determined to be payable first.

12. “Secondary plan” means a plan that is not a primary plan.

Order of Benefit Determination Rules.

If an individual is covered by two or more plans, the rules for determining the order of payment are as follows:

A. The insurer that issues the primary plan pays or provides its benefits as if the secondary plan does not exist.

B. If the individual is covered by more than one secondary plan, the order of benefit determination rules under this provision determine the order under which secondary plan benefits are determined in relation to each other. An insurer that issues a secondary plan shall take into consideration the benefits of the primary plan and the benefits or any other plan that are, under this provision, determined to be payable before those of the secondary plan.

C. A plan that does not contain coordination of benefits determination provisions that are consistent with this provision is always the primary plan unless the provisions of both plans, regardless of this item, state that the complying plan is primary.

D. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the insurer that issues the secondary plan shall pay or provide benefits as if it were the primary plan if a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the insurer that issued the primary plan.

E. The order in which benefits are payable by insurers that issue plans are determined by using the first of the following rules that applies:

1. The Non-Dependent or Dependent Rule. If the individual is not a dependent but is an employee, member, subscriber, policyholder, or retiree under one plan and is a dependent under another plan, the order of payment of benefits under the plans is determined as follows:

   a. The plan that covers the individual other than as a dependent is the primary plan and the plan that covers the same individual as a dependent is the secondary plan.

   b. If the individual is a Medicare beneficiary and, as a result of the provisions of title XVII of the social security act, 42 USC 1395 to 1395lll, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent, then the order of benefits is reversed and the plan covering the individual as other than a dependent is the secondary plan and the plan covering the individual as a dependent is the primary plan.

2. The Dependent Covered Under More Than One Plan Rule. If the individual is a dependent child, unless there is a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the dependent child is as follows:

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

i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.

ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

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

i. 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 plan. This item does not apply with respect to a plan year during which benefits are paid or provided before the insurer has actual knowledge of the terms of the court order or judgment.

ii. 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 items 3.a.i or ii above.

iii. If a court order or judgment states that the parents have joint custody without specifying that 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 items 3.a.i or ii above.

iv. 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:

1) The plan covering the custodial parent.

2) The plan covering the custodial parent's spouse.

3) The plan covering the noncustodial parent.

4) The plan covering the noncustodial parent's spouse.

c. 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 items 3.a or b above, as applicable, as if those individuals were parents of the child.

d. If the 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 dependent 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 benefits is determined by applying the birthday rule prescribed in item 3.a above to the child's parents, as applicable, and his or her spouse.

3. The Active, Retired, or Laid Off Employee Rule. 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 plan. The plan that covers the same individual as a

laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the secondary plan.

b. The above item 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 plan.

4. The Continuation Coverage Rule. If the individual has coverage under a right of continuation pursuant to federal or state law, 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 employee, member, subscriber, enrollee, or retiree or as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan. The plan that covers the individual under the continuation coverage is the secondary plan.

   b. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply.

   c. This rule does not apply if the order of benefits can be determined by Rule 2 above.

5. The Longer or Shorter Length of Coverage Rule. If none of the rules above determine the order of benefits, the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. To determine the length of time an individual has been covered under a plan, two successive plans are treated as one if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended. Any of the following changes do not constitute the start of a new plan:

   a. A change in the amount or scope of a plan's benefits.

   b. A change in the entity that pays, provides, or administers the plan's benefits.

   c. A change from one type of plan to another, such as from a single-employer plan to a multiple-employer plan.

F. 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.

G. If the insurers that issued plans cannot agree on the order of benefits within 30 calendar days after the insurers have received all the information needed to pay the claim, the insurers shall immediately pay the claim in equal shares and determine their relative liabilities following payment. An insurer is not required to pay more than it would have paid had the plan it issued been the primary plan.

H. Except as provided in section I below, in determining the amount to be paid on a claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, the insurer 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 under its plan that is unpaid under the primary plan. The insurer that issued the secondary plan may

reduce its payment by the calculated amount so that, when combined with the amount paid under the primary 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.

I. If an insurer that issues 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.

J. 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 the Plan.

A. When this Coverage Plan is secondary, like the primary plan, it also pays as if it were the only plan. If Benefits are paid, they are then charged against any applicable Benefit limit of the Plan.

B. The Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary 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. Physicians Health Plan may get the facts needed from, or give them to, other

organizations or persons to apply these rules and determine Benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

Physicians Health Plan need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Coverage Plan must give Physicians Health Plan any facts needed 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, Physicians Health Plan may pay that amount to the organization that made the payment. That amount is then treated as though it were a Benefit paid under this Coverage Plan. Physicians Health Plan does 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 the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons who have been 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.

The Plan can be terminated at any time for the reasons explained in the document, as permitted by law. The Plan shall give you 90 days' prior notice of any termination. The notice includes 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, the Plan still pays 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 Plan.

Events Ending Your Coverage.

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

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

Subscriber.

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

- If you decide to discontinue coverage, Physicians Health Plan 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 Physicians Health Plan appropriate notice.
- The date the Subscriber no longer resides in the Service Area. (You must notify Physicians Health Plan 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 date you are no longer eligible.
- The last day of the calendar month in which the Subscriber fails to make any required contribution for coverage unless eligible for the 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).

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 as defined by the Plan.
- 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 Plan.

Other Events Ending Your Coverage.

When any of the following happen, the Plan provides written notice to the Subscriber that coverage has ended on the date identified in the notice:

Fraud, Misrepresentation or False Information.

- Fraud, misrepresentation or false information may be:
  - An act, practice or omission that involves Fraud related to the Plan.
  - Intentional misrepresentation, of material fact related to the Plan, whether such act, practice, or omission was on the part of the Subscriber.
  - Providing false information or withholding accurate information
- Termination of this Plan for these reasons may be retroactive to the effective date of the Policy or to some other date. During the first three years the Plan is in effect, we have the right to demand that you pay back all Benefits paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
- After the first three years from the date of issue of the Plan no misstatement, except fraudulent misstatements, made by you in the application for the Plan shall be used to void the Plan 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 Plan shall be reduced or denied because a disease or physical condition that was 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 Plan.

Improper Use of ID Card.

If you permit a person who is not you or your Dependent to use your ID card, or you use another person's card, such an act may lead to retroactive termination of this Plan back to the date the Fraud occurred.

The Entire Policy Ends.

Your coverage ends on the date the Policy ends. That date is either:

- The date we specify, after we give you 90 days' prior written notice, that we are terminating this Policy because we are no longer issuing 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 are terminating this Policy because we are no longer issuing 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 is 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 does not end just because the child has reached the limiting age. The Plan extends 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 continues as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

The Plan shall ask you to furnish proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached the limiting age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan would pay for that examination.

The Plan 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, the Plan shall 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 ends.

Guaranteed Renewability.

Coverage is guaranteed renewable. The Plan may not deny, nor may the Plan cancel coverage except:

- When the 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 Physicians Health Plan.

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 all decisions about whether we 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 are 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 are 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 may use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We may use de-identified data for commercial purposes including research.

Our Relationship with Health Care Providers.

The relationships between Network health care providers and Physicians Health Plan are solely contractual relationships between independent contractors. Network health care 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 health care providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the health care 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 health care providers such as principal-agent or joint venture. We are **not** liable for any act or omission of any provider.

Your Relationship with Health Care Providers.

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

- You are responsible for choosing your own health care provider.
- You are responsible for paying directly to your health care 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 health care provider, the cost of any non-Covered Health Service.
- You must decide if any health care provider treating you is right for you. This includes Network health care providers you choose and providers to whom you have been referred.
- You must decide with your health care provider what care you should receive.
- Your health care 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 Health Care Providers.

The Plan pays Network health care 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.

An example of financial incentives for Network health care providers would be bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.

The Plan uses various payment methods to pay specific Network health care providers. From time to time, the payment method may change. If you have questions about whether your Network health care provider's contract with the Plan includes any financial incentives, Physicians Health Plan encourages you to discuss those questions with your health care provider. You may also contact Customer Service who can advise whether your Network health care 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.

The Plan does not specifically reward health care 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.

Interpretation of Benefits.

We do all the following:

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

We may share these administrative responsibilities with other persons or entities who provide services regarding the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan 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 the Plan to do so in other similar cases.

Administrative Services.

The Plan may arrange for various persons or entities to provide administrative services regarding the Plan, 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. The Plan is not required to give you prior notice of any such change, nor is the Plan required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Plan.

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

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

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

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

Clerical Error.

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

Information and Records.

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

The Plan may use your individually identifiable information to administer the Plan and pay claims, to identify procedures, products or services that you may find valuable and as otherwise permitted or required by law. The Plan may request additional information from you to decide your claim for Benefits. The Plan keeps this information confidential. The Plan may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how the Plan may use or disclose our information is found in the Notice of Privacy Practices available on the Member Reference Desk accessed on the web site.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan with all information or copies of records relating to the services provided to you. The Plan has 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. The Plan agrees that such information and records are considered confidential.

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

For complete listings of your medical records or billing statements, it is recommended 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 the Plan, and the Plan also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Plan may designate other persons or entities to request records or information from or related to you, and to release those records as necessary. These designees have the same rights to and responsibilities for this information as Physicians Health Plan does.

Examination of Covered Persons.

In the event of a question or dispute regarding your right to Benefits, the Plan and at the Plan’s expense shall have the right and opportunity to require that a Network Physician examine you when and as often as may be reasonably required during the pendency of a claim hereunder.

Workers' Compensation Not Affected.

Benefits provided under the Plan 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 Plan. If you become eligible for Medicare after the effective date of this Plan, you may retain both coverages.

If you become eligible for or enroll in Medicare after the effective date of this Plan, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), 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 the Plan is the secondary payer as described in the chapter, COORDINATION OF BENEFITS, Benefits are paid under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you are responsible for the costs that Medicare would have paid, and you shall 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 this Plan is the secondary payer, any Benefits available to you under this Plan are paid as if you had followed all rules of the Medicare Advantage plan. You are responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you shall 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. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, the Plan has the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. Immediately upon paying or providing any Benefit, the Plan 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 of or all the following listed below.

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

You agree as follows:

- That you will cooperate with Physicians Health Plan in protecting legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information to Physicians Health Plan about any recovery that you or your legal representatives obtain from any Third Parties or any related information requested by the Plan,
  - Signing and/or delivering such documents as Physicians Health Plan 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 Physicians Health 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 the Plan has 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 the Plan is 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, the Plan 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 the Plan may also be Benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party because 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 the Plan, 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 the Plan may set off from any future Benefits otherwise provided by the Plan the value of Benefits paid or advanced under this chapter to the extent not recovered by the Plan.
- That you will not accept any settlement that does not fully compensate or reimburse the Plan without its written approval, nor will you do anything to prejudice its rights under this provision.

- That you will assign to Physicians Health Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits 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 the Plan 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 is 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 are payable to the insured.

Refund of Overpayments.

If the Plan pays Benefits for expenses incurred because of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan 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 made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

If a refund is owed, it equals the amount paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help Physicians Health Plan 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, the Plan may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions equal the

amount of the required refund. The Plan 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 Plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Plan. 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 Physicians Health Plan 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 Physicians Health Plan.

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

Limitation of Liability.

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

Non-Assignment.

The coverage provided under the Plan 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 Plan. Any attempt by you to assign the Plan 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 Physicians Health Plan 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 Physicians Health Plan 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 Physicians Health Plan 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.

Health Care Provider Communications.

The Plan does 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, COMPLAINTS, GRIEVANCES AND APPEALS pursuant to MCL 500.2213. The Plan also does 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 the Plan and the Network health care provider, including all the following, as applicable:
  - Whether a fee for service arrangement exists, under which the health care 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 health care provider for all Covered Health Services that are or may be rendered to each Covered Person.
  - Whether payments to health care providers are made based on standards relating to cost, quality, or patient satisfaction.

Excluded or Sanctioned Health Care Providers.

Consistent with the federal guidelines for payment of sanctioned health care providers, the Plan does not pay claims for items or services furnished, ordered, or prescribed by any health care provider listed on the Office of Inspector General's (OIG's) List of Excluded Individuals/Entities, sanctioned by Physicians Health Plan or the Government Services Agency, the Centers for Medicare and Medicaid Services (CMS), or state licensing boards. 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 are responsible for the full payment of items or services furnished, ordered, or prescribed by any provider that has been excluded or sanctioned. 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 https://oig.hhs.gov/exclusions.

Physicians Health Plan notifies you if any provider you have received services from during the previous 12 months has been sanctioned by Physicians Health Plan or other entities causing removal from the Network. You have 30 days from the date you are notified to submit claims for services you received prior to the provider being sanctioned. After that 30 days has passed, we do not process claims from that provider.

ACA Preventive Prescription Drug List. Our list of ACA mandated preventive Prescription Drug Products that are covered at no charge under a non-grandfathered Plan. This list is subject to review and change.

Alternate Facility. A freestanding health care facility that is:

- Not a Physician's or dentist's/oral surgeon's office.
- Not a Hospital.
- Not a facility that is attached to a Hospital.
- Is designated by the Hospital as an Alternate Facility.
- Can be an ambulatory surgical center or dialysis center, for example.

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

Ancillary Charge. If part of your outpatient Prescription Drug Plan, a charge, in addition to the Copayment or Coinsurance amount, that you are required to pay when a Brand-Name Prescription Drug Product is dispensed at your or the health care provider's request when a chemically equivalent Generic Prescription Drug Product is available.

The Ancillary Charge is calculated as the difference between the Brand-Name Prescription Drug Product price for Network Pharmacies and the Prescription Drug Cost or MAC list price of the chemically equivalent Generic Prescription Drug Product.

Annual Deductible. The amount you may pay in a Policy Year before Benefits begin to be paid. There may be separate Network and Non-Network Annual Deductibles depending on your specific Plan. The Annual Deductible does not apply to:

Copayments unless stated otherwise.

Preventive Health Services.

Other Covered Health Services as noted (see the Information About Your Cost Share section of the BENEFITS AND COVERAGE chapter).

Ancillary Charges on outpatient Prescription Drug Products, if applicable, and charges above Eligible Expenses do not go toward satisfaction of the Annual Deductible.

If a Benefit has a visit or day limit, these limits are calculated while you are satisfying the Annual Deductible.

Annual Out-of-Pocket Maximum. The most that you pay for your share of Covered Health Services every Policy Year. There may be separate Network and Non-Network maximums depending on your specific Plan. 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 following costs do not apply to the Annual Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.

- The amount of any reduced Benefits if you are responsible when your health care provider has not obtained prior approval from the Plan.
- Ancillary Charges on outpatient Prescription Drug Products, if applicable.
- 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 Diagnostic Observation Schedule. The protocol available through Western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the Director of the Department of Insurance and Financial Services, if the Director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

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.

Autism Treatment Plan. A written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed Network health care provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an Autism Spectrum Disorder is first prescribed or ordered by a licensed Physician or licensed psychologist.

Behavioral Analyst. A board certified therapist who directly supervises and is responsible for acquiring, training, and overseeing the work of lay workers who deliver the intensive behavioral/educational interventions.

Benefits. Your right to payment for Covered Health Services that are available to you. Your right to Benefits is subject to the terms, conditions, limitations and Exclusions of the Plan, including this document and any associated documents such as Amendments.

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 may be required to pay when you receive services such as Physician office visits, outpatient behavioral health visits, Emergency Department visits, Urgent Care Center visits, convenience care facility visits, outpatient rehabilitation/habilitation therapy visits, outpatient high tech radiology or nuclear medicine procedures, or outpatient Prescription Drug Products. If the Eligible Expense of a service, drug or supply is lower than the Copayment, you pay the Eligible Expense.

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

Covered Health Service(s). Those health services that are determined to be Medically Necessary per Plan medical policies and nationally recognized guidelines. They are all the following:

- Provided to prevent, diagnose or treat a Sickness, Injury, mental illness, substance use disorder, or their symptoms.
- Consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines.
- 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 Plan. References to "you" and "your" throughout this document are references to a Covered Person.

Custodial Care. Non-covered 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 legal spouse (or Domestic Partner) or the dependent child of the Subscriber or the dependent child of the Subscriber's legal 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 conditions and limitations:

- A Dependent includes a legal spouse (or Domestic Partner) who resides within the Service Area.
- A Dependent includes any child who has not reached the limiting age.
- A Dependent includes an unmarried Dependent child over the limiting age 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 the Plan for any Benefits that we pay for a Dependent at a time when the Dependent did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Plan 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 the Plan or with an organization contracting on its 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 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 the following:

- Can withstand repeated use.
- Is not disposable (unless stated as covered).
- 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.

Eligible Expenses. The amount paid for Covered Health Services, incurred while the Plan is in effect. When Covered Health Services are received from Network health care providers, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. When Covered Health Services are received from Non-Network health care providers, even when paid at the Network Benefit level, you may be responsible for paying, directly to the Non-Network health care provider, any difference between the amount the provider bills you and the amount the Plan pays for Eligible Expenses. Eligible Expenses are determined solely in accordance with reimbursement policy guidelines, as described in this document and in Payment and Reimbursement Policies available on the MyPHP portal.

Network Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network health care providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from Non-Network health care providers but approved by the Plan to be covered at the Network Benefit level, Eligible Expenses are based on a percentage of Medicare reference-based pricing, unless a lower amount is negotiated by the Plan.
- When Covered Health Services are received from Non-Network health care provider because of an emergent/urgent condition, Eligible Expenses are based on the greater of:
  - The median Network rate.
  - The usual customary and reasonable rate.
  - The Medicare rate.

Non-Network Eligible Expenses are determined based on the lesser of the following:

- Fee(s) that are negotiated with the health care provider.
- A fee schedule developed as follows:
  - Except for services from the specific health care providers identified below, Eligible Expenses are based on a percentage of Medicare reference-based pricing for the same or similar service within the geographic market.
  - For Covered Health Services received on a non-Emergency basis from a radiologist, anesthesiologist, and pathologist, the Eligible Expense is based on a percentage of Medicare reference-based pricing for the same or similar service within the geographic market.

— When a rate is not published by CMS for the service, the Plan uses an available gap methodology to determine a rate for the service as follows:

- For services other than pharmaceutical products, the Plan uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service.
- For pharmaceutical products, the Plan uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale prices for the pharmaceuticals.
- When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the health care provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50 percent of the provider's billed charge.

The Plan updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 90 days after CMS updates its data.

Eligible Person. A person who meets the eligibility requirements as described in the Plan. An Eligible Person except for a Dependent child must reside within the Service Area. Covered Dependents living outside the Service Area are covered for emergent/urgent conditions, unless Non-Network coverage is available to them. If the Plan includes Network only coverage, then coverage for any other services must be approved in advance by the Plan.

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 Plan.

Essential Health Benefits (EHBs). As identified in the ACA, Essential Health Benefits make up the following ten 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), the Plan 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 that 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 health care 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 a Plan identification (ID) card.
- Providing false information or withholding accurate information relating to eligibility for coverage under the Plan.

Gender Dysphoria. A broad diagnosis that covers a person's emotional discontent with the gender they were assigned at birth. A clinical diagnosis is made when a person meets the specific criteria set out in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Generic. A covered Prescription Drug Product:

- That is chemically equivalent to a Brand-Name drug; or
- That the Plan identifies as a Generic product.

Genetic Counseling. Services provided by a health care professional specially trained in genetics and counseling to give information and support to people who have, or may be at risk for genetic disorders or having a baby at risk for a genetic disorder.

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 health care plans from which individuals may purchase health insurance eligible for federal subsidies. The plans do not deny coverage because of a pre-existing condition, and all the plans 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 the following:

- Primarily engaged in providing health care 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 Plan.

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

Inpatient Rehabilitation Facility (IPR). 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 members with low vision. Covered low vision services include one comprehensive low vision evaluation every five 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 determined to be medically appropriate per Plan medical policies 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 the Plan.
- 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 health care 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 Plan.

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.

Mental Illness. Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association unless the service is specifically excluded under the Plan.

Motor Vehicle. A vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular, which has at least two wheels. Motor vehicle does not include a farm tractor or other implement of husbandry that is not subject to the registration requirements of the Michigan Vehicle Code.

Network. A group of health care providers of health care services who have participation agreements in effect with Physicians Health Plan or its designee to participate in the Network. A health care provider may agree to provide only certain Covered Health Services, or to be a Network health care provider for only some of the offered products. The participation status of health care providers changes from time to time.

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

Network Pharmacy. A pharmacy that has:

- Entered into an agreement with Physicians Health Plan or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Plan as a retail or a mail-order Network Pharmacy.

No-Fault Motor Vehicle Plan. A compulsory motor vehicle plan that may provide payments for medical, dental care, or wage loss, which are payable, in whole or in part, without regard to fault.

Non-Emergency Ambulance Transport. Services that are:

- Recommended by the attending Physician.
- Received from a licensed ambulance service between facilities when the following criteria are met:
  - The patient's condition must be such that any other form of transportation would not be medically recommended and
  - Any of the following circumstances exists:
    - Transfer from an acute care facility to a patient's home or Skilled Nursing Facility; or
    - Transfer to and from a patient's home to an acute care facility to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, dialysis, etc.).
    - Transportation to or from one acute care facility to another acute care facility, Skilled Nursing Facility or free-standing dialysis center to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, intensive care services including neonatal ICU, acute interventional cardiology, radiation therapy, etc.), provided such services are:
      - Not available at the transferring facility where the patient is being treated; and
      - The patient cannot be safely transported in another way; and
      - The patient requires continued acute inpatient medical care.
    - Ground ambulance for a deceased patient in the following circumstances:
      - The patient was pronounced dead while in route or upon arrival at the Hospital or final destination; or
      - The patient was pronounced dead by a legally authorized individual (Physician or medical examiner) after the ambulance call was made, but prior to pick-up.

Non-Network. Describes those health care providers who do not participate in the Network.

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

Non-Preferred Brand-Name. Covered Brand-Name drugs on Tier 3 for which there is either a Generic alternative, or a more cost-effective Preferred Brand-Name drug available on a lower tier. This tier does not include Specialty Drugs.

Non-Preferred Specialty. Covered Specialty Drugs on Tier 5 that include Non-Preferred Specialty Drugs used to treat various health conditions at the highest cost share to you. There may be either Generic drugs, Preferred Brand-Name drugs or Preferred Specialty Drugs available.

Observation Care. A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as Hospital inpatients or if they can be discharged from the Hospital. Observation status is commonly assigned to patients who present to the Emergency Department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

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

Pharmacy and Therapeutics ("P&T") Committee. Maintains a Prescription Drug List (PDL). The P&T Committee regularly reviews new and existing medications. The P&T Committee also maintains Drug 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/oral surgeon, psychologist, Chiropractor, optometrist, nurse midwife, or other health care provider who acts within the scope of his or her license is considered on the same basis as a Physician. The fact that the Plan describes a health care provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

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 Generic. Select covered Generic drugs on Tier 1A that have a proven clinical value essential for treatment of chronic conditions such as diabetes and hypertension. These Generic drugs have been determined by the FDA to be bioequivalent to Brand-Name drugs and are not manufactured or marketed under a registered trade name or trademark. These drugs have the lowest cost sharing compared to other tiers.

Preferred Brand-Name. Covered Single Source Brand-Name drugs on Tier 2 that have a proven record for safety and effectiveness. These drugs generally are more expensive than Generic drugs. Generic drug alternatives may be available, offering more cost-effective therapies. This tier does not include Specialty Drugs.

Preferred Specialty. Covered Generic or Single Source Brand-Name Specialty Drugs on Tier 4 that have a proven record for safety, clinical effectiveness and cost efficacy.

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 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 that the Plan has agreed to pay its 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 the Plan identifies as those Prescription Drug Products covered under the Plan. This list is subject to 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);
- Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF; and
- Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.

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

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

Recreational Therapy. Non-covered 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. The Plan 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 document does not include Mental Illness or Substance Use Disorders, regardless of the cause or origin of the Mental Illness or Substance Use Disorder.

Single Source Drug. A drug that is produced or distributed under an original new drug application approved by the FDA.

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

- It must be delivered or supervised by licensed technical or professional medical personnel 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 to assist 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 to be delivered safely and effectively; and
- It is not Custodial Care.

The 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 is not determined to be "skilled" simply because there is not an available caregiver.

Skilled Nursing Facility (SNF). 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.

Covered Persons may be directed to the site of care for administration of specific Specialty Drugs that is most cost-effective, clinically appropriate and/or can be safely administered such as a Physician's office or through home infusion services.

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.

Substance Use Disorders. Alcoholism and other Substance Use Disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded.

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), the Plan 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 because of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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