OVERVIEW

The Total Health Care Select Physician Preferred Network Plan is a Point of Service (POS) Plan that allows you the flexibility to select from three networks whenever you need care. The networks have varying out-of-pocket costs, depending on the benefit and network. Amounts that a Member may be responsible for include the following:

**Deductible:** A set amount that you pay each year before Total Health Care USA makes a payment.
- Physician Preferred Network (PPN) and Total Health Care (THC) Network have a combined Deductible.
- PPN/THC and Cofinity Network Deductibles are separate from one another.
- Deductible payments do not carry over into other networks.
- The Deductible applies to the out-of-pocket maximum

**Co-insurance:** A percentage that you pay for certain covered expenses. Coinsurance amounts apply to the out-of-pocket maximum.

**Co-Payment:** The amount a Member must pay per visit or service for certain covered benefits. A Co-Payment applies to the out-of-pocket maximum.

<table>
<thead>
<tr>
<th></th>
<th>PHYSICIAN PREFERRED NETWORK</th>
<th>THC USA NETWORK</th>
<th>COFINITY NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$10</td>
<td>$20</td>
<td>$40</td>
</tr>
</tbody>
</table>

Out-of-Pocket Maximum: Maximum amount of Coinsurance, Co-Payments, and Deductible that a Member and/or family will have to pay during a calendar year. If the out-of-pocket maximum is met, Total Health Care will pay all eligible expenses for covered services for the remainder of the calendar year.

**PHYSICIAN PREFERRED NETWORK**
- Lower Deductible
- Lower Co-Payments
- Lower Out-of-Pocket maximum
- No Coinsurance

**TOTAL HEALTH CARE NETWORK**
- Higher Deductible
- Higher Co-Payments
- Higher Out-of-Pocket maximum
- 20% Coinsurance

**COFINITY NETWORK**
- Highest Deductible
- Highest Co-Payments
- Highest Out-of-Pocket maximum
- 20% Coinsurance

The Physician Preferred Network Point of Service Plan gives you the freedom to select your provider. The example below illustrates the out-of-pocket cost for a Total Health Care Select Member in the Physician Preferred Network Plan. This Certificate of Coverage details this Plan.
ARTICLE I. TOTAL HEALTH CARE USA, INC.

Total Health Care USA, Inc. is a nonprofit corporation organized and licensed under the laws of the State of Michigan, with its address at 3011 W. Grand Blvd., Suite 1600, Detroit MI 48202-3000

ARTICLE II. DEFINITIONS

2.01 When used in this Certificate of Coverage, Riders, the Group Operating Agreement, the Enrollment Application signed by the Subscriber, and the identification card issued to Members, the definitions in Sections 2.02 to 2.58 apply.

2.02 "Affiliated Facility" means any legally qualified and state-licensed intermediate care or skilled nursing facility or Hospice, which has a contract with the Plan to provide services for Members.

2.03 "Affiliated Hospital" means any Hospital that has a contract with the Plan to provide Hospital services to Members.

2.04 "Affiliated Optometrist" means a licensed optometrist who has a contract with the Plan to provide services to Members.

2.05 "Affiliated Physician" means an individual licensed to practice medicine or osteopathy and who has a contract with the Plan or an IPA to provide services to Members.

2.06 "Affiliated Provider" means a health professional, Hospital, licensed pharmacy, or any other institution, organization, or person who has a contract with the Plan or an IPA to render one (1) or more health maintenance services to Members.

2.07 "Affiliated Psychiatrist" means an individual licensed to practice psychiatry and who has a contract with the Plan to provide services to Members.

2.07 "Affiliated Psychiatrist" means an individual licensed to practice psychiatry and who has a contract with the Plan to provide services to Members.

2.08 "Affiliated Skilled Nursing Facility" means a Hospital long-term care unit, nursing home, county medical care facility, or a distinct part thereof, which is certified by the Michigan Department of Community Health to provide skilled nursing care and which has a contract with the Plan to provide services to Members.

<table>
<thead>
<tr>
<th></th>
<th>PPN NETWORK</th>
<th>THC USA NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill Amount</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Allowable/contracted rate</td>
<td>$1,160</td>
<td>$1,600</td>
</tr>
<tr>
<td>Deductible Paid by Member</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance Paid by Member</td>
<td>$0</td>
<td>$200</td>
</tr>
<tr>
<td>Amount THC pays (allowable less Deductible and Coinsurance)</td>
<td>$860</td>
<td>$800</td>
</tr>
<tr>
<td>TOTAL AMOUNT YOU PAY</td>
<td>$300</td>
<td>$800</td>
</tr>
</tbody>
</table>
2.09 “Audiologist” means a person who is qualified in the State of Michigan to conduct Audiometric Examinations and Hearing Aid Evaluation Tests and who possesses:

   (1) a Master’s or Doctorate Degree in Audiology or Speech Pathology from an accredited university; or
   
   (2) a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association.

2.10 “Audiometric Examination” means a procedure for measuring hearing acuity that includes tests relating to air conduction, bone conduction, speech reception threshold, and speech discrimination.

2.11 “Authorized Benefits and Services” are those health care benefits and services available to Members under this Certificate when provided by health care providers authorized to provide such care under this Certificate.

2.12 “Breast Cancer Rehabilitative Services” means a procedure intended to improve the results of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including, but not limited to, reconstructive plastic surgery, physical therapy, and psychological and social support services.

2.13 “Calendar Year” means a twelve (12) month period of benefit coverage that begins on January 1. Deductible amounts are reset at the beginning of each calendar year.

2.14 “Certificate” means this Certificate of Coverage Agreement and applicable Riders.

2.15 “Contact Lenses” means ophthalmic corrective lenses as prescribed by an Affiliated Optometrist or an Ophthalmologist to be fitted directly to a Member’s eyes.

2.16 “Contract Year” means the twelve (12) month period from the date that coverage was initially effective under this Certificate and each twelve (12) month period thereafter, unless otherwise stated and agreed upon.

2.17 “Coinsurance” means the percentage of contracted payment that each Member must pay per visit to a treating Provider for Authorized Benefits.

2.18 “Cofinity Network” means facility and professional providers who have signed an agreement with Cofinity. Cofinity is not an Affiliated Provider within the “In Total Health Care USA Network.”

2.19 “Co-Payment” means the dollar amount each Member must pay per visit to a treating provider in connection with Authorized Benefits and Services.

2.20 “Deductible” means the amount of money a Member must pay for Covered Services before the Plan becomes responsible for payment. The Deductible is applied annually and is based upon the Contract Year. Each Contract Year begins a new Deductible period.

2.21 “Dependent” means any of the following, unless otherwise excluded by the Group Operating Agreement:
(1) The Spouse of a Subscriber;
(2) Child of the Spouse or Subscriber by birth, legal adoption, or legal guardianship who has not attained the age of twenty-six (26). A child need not be claimed as a Dependent on the federal income tax return of the Subscriber to qualify as a Dependent.

2.22 "Durable Medical Equipment" (DME) means items which primarily and customarily are used to serve a medical purpose for which they are prescribed, generally have no other use other than the treatment of the ill or injured, are able to withstand repeated or continual use or are used more than once (as opposed to being disposable or expendable), and are appropriate for home use.

2.23 "Ear Mold" means a device of soft rubber, plastic, or a non-allergenic material which may be vented or non-vented and is individually fitted to the external auditory canal and pinna of the patient.

2.24 "Enrollment Application" means the form approved by the Plan by which an individual seeks to enroll one or more Members in the Plan.

2.25 "Frames" means standard eyeglass frames into which two (2) Lenses are fitted.

2.26 "Grace Period" means the thirty (30) day period allowed for payment of the Premium immediately following the due date for the Premium.

2.27 "Group" means an employer group or organization that has executed the Group Operating Agreement on behalf of its employees or members.

2.28 "Group Operating Agreement" means the agreement entered into between the Plan and the Group through its authorized representative, which outlines the criteria of eligibility of persons to be Members of the Group, and which together with any agreement regarding new and rehired group employees, the Certificate, the Enrollment Application, and the Member identification card constitutes the contract between the Plan, the Group, and the Member.

2.29 "Health Center" means a health care facility that is operated by an Individual Practice Association.

2.30 "Hearing Aid" means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if necessary.

2.31 "Hearing Aid Dealer" means any person or organization who is contracted with the Plan to provide services and supplies, including Hearing Aids to Members prescribed by an Affiliated Physician, Referral Physician, or Audiologist, and approved by an Affiliated Physician and the Medical Director or his/her designee, and operates in compliance with state laws or regulations governing such issues.

2.32 "Hearing Aid Evaluation Test" means a series of subjective and objective tests by which a physician or Audiologist determines which make and model of Hearing Aid will best compensate for loss of hearing acuity and which make and model will therefore be prescribed.
2.33 “Hospice” means a licensed health care program to provide a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

2.34 “Hospital” means a state-licensed acute care facility that provides inpatient, outpatient, and emergency medical, surgical, or psychiatric diagnosis, treatment, and care of injured or acutely sick persons, by or under the supervision of a staff of physicians and that continuously provides twenty-four (24) hour-a-day nursing service by registered nurses, and which is not, other than incidentally, a place for the treatment of pulmonary tuberculosis, a place for the treatment of drug abuse, a place for the treatment of alcoholism, nor a nursing home.

2.35 “Individual Practice Association” or “IPA” means a partnership, corporation, association, or other entity that has a contract with a Plan to provide and arrange for services to Members, has as its primary objective the delivery, or arrangement for the delivery, of health care services, and employs or has entered into written service agreements with health professionals, a majority of whom are physicians.

2.36 “In Total Health Care USA Network” means all Affiliated Providers as defined in Articles 2.02, 2.03, 2.04, 2.05, 2.06, 2.07, and 2.08 above.

2.37 “Lenses” means the transparent refracting medium made of glass or plastic used to correct vision deficiencies.

2.38 “Medical Emergency or Accidental Injury”:

   (1) “Medical Emergency” means a medical condition manifested by severe symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life if not treated immediately.

   (2) “Accidental Injury” means a traumatic bodily injury that, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a Member’s health or result in loss of life.

   (3) Heart attacks, hemorrhaging, poisoning, loss of consciousness or respiration, trauma, and convulsions are some examples of Medical Emergencies or Accidental Injuries.

2.39 “Member” means a Subscriber or Dependent eligible to receive services under this Certificate and the Group Operating Agreement, and who has enrolled in the Plan.

2.40 “Non-Elective Abortion” means any of the following:

   (1) 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.

   (2) Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy.

2.41 “Orthotic Shoe” means any shoe attached to a leg brace.
2.42 “Orthotic Equipment and Devices” means those rigid/semi-rigid devices which are designed to correct or assist in the prevention of a body defect, either of form or function, or to support a weak or deformed body part by restricting or eliminating motion.

2.43 “Out-of Network” means facility and professional providers who are not contracted with neither the Plan nor the Cofinity Network.

2.44 “Open Enrollment Period” means that limited period of time during which eligible persons are given the opportunity to enroll in the Plan.

2.45 “Plan” means Total Health Care USA.

2.46 “Physician Preferred Network” means a group of PCPs designated as Preferred Providers and indicated in a Physician Directory as Physician Preferred Network Providers.

2.47 “Premium” means the amount of money prepaid monthly by a Group, including Subscriber contributions, if any, on behalf of the Members.

2.48 “Prosthetic Appliances” means devices which replace a missing part of the body.

2.49 “Referral Facility” means any legally qualified and state-licensed intermediate care facility, skilled nursing facility, Hospice, or Hospital that provides services to Members under the orders of an Affiliated Physician or Referral Physician when admission is authorized by the Affiliated Physician and the Plan’s Medical Director or his/her designee.

2.50 “Referral Physician” means a physician other than an Affiliated Physician who is licensed to practice medicine or osteopathy and who delivers medical or osteopathic care to a Member on the referring order of an Affiliated Physician.

2.51 “Rehabilitative Services” means various treatments aimed to increase functional independence, prevent further loss of function, and maintain or improve quality of life for individuals living with physical illnesses or conditions. Rehabilitation Services include, but are not limited to, occupational, physical, speech, pulmonary, and cardiac therapies.

2.52 “Remitting Agent” means the Group or the person designated by the Group who is responsible for the payment of the monthly Premiums.

2.53 “Semi-Private Room” means Hospital accommodations where there are two (2) or more beds to a room.

2.54 “Service Area” means the geographic area where the Plan is available and readily accessible to Members and where the Plan has been approved by the State of Michigan to market its services.

2.55 “Spouse” means the legally married husband or wife of a Subscriber.

2.56 “Subscriber” means an individual who enters into an HMO contract, or on whose behalf an HMO contract is entered into, with an HMO that has received a certificate of authority from the State of Michigan and to whom an HMO contract is issued:
(1) Who meets all eligibility criteria established by the Group Operating Agreement and this Certificate; and

(2) Who has completed an Enrollment Application which has been received by the Plan; and

(3) Who resides within the Service Area at the time of application; and

(4) For whom Premiums have been received.

2.57 “Treating Physician” means an individual licensed to practice medicine or osteopathy and is responsible for a Member’s care with regards to a particular diagnosis or treatment.

2.58 “Urgent Condition” means:

A medical condition manifesting in an urgent, but not life-threatening condition, such that the absence of medical attention within a twenty-four (24) hour period from the onset of symptoms could reasonably be expected to result in further complication of the patient’s conditions, or deterioration of the patient’s condition. Such conditions may include:

(1) High fever.

(2) Uncontrolled vomiting and/or diarrhea.

(3) Ear ache.

(4) Minor wounds.

ARTICLE III. ENROLLMENT; EFFECTIVE DATE OF COVERAGE; PREMIUMS

3.01 Enrollment

(1) Persons meeting the Group and Plan’s eligibility requirements during an Open Enrollment Period may enroll in the Plan only during that Open Enrollment Period. In order to enroll, an Enrollment Application must be completed and received by the Group during the Open Enrollment Period.

A person who is an eligible person at the time of an Open Enrollment Period and not already a Subscriber who fails to enroll during such Open Enrollment Period shall not be entitled to enroll at a later date except during a subsequent Open Enrollment Period.

(2) Persons who join the Group between Open Enrollment Periods, or otherwise become eligible to enroll in the Plan for the first time may do so by completing an Enrollment Application within thirty (30) days of attaining eligibility pursuant to the Group Operating Agreement. In the event that such a newly eligible person fails to complete and submit an Enrollment Application within this thirty (30) day time period, the person shall be entitled to enroll in the Plan only during a subsequent Open Enrollment Period.

3.02 Effective Date of Coverage

(1) Except as limited in subsection (3) below, the effective date of coverage for Members who enroll during an Open Enrollment Period will be the date agreed upon in the Group Operating Agreement, provided that the signed Enrollment Application and appropriate Premium have been received by the Plan.
(2) Except as limited in subsection (3) below, and unless otherwise provided in the Group Operating Agreement, the effective date of coverage for newly eligible Members who enroll between Open Enrollment Periods shall be the first day of the month following the month of the Plan's receipt of the signed Enrollment Application and Premium.

(3) All newborn coverage starts at birth. To be covered, a Member must enroll the newborn and pay any Premium within thirty-one (31) days of birth.

3.03 Premiums

Premiums shall be paid to the Plan at the rate established by the Plan for coverage under this Certificate as set forth in a written notice by the Plan to the Remitting Agent. All Premiums are to be remitted on a monthly basis on or before the first day of each month unless otherwise agreed upon in writing by the Plan and Remitting Agent.

If the Group pays the Premium to the Plan during the thirty (30) day Grace Period, there will be no lapse in coverage.

If the Premium is not received within the Grace Period, the Plan may terminate the Group Operating Agreement and this Certificate in accordance with Article X. In the event of termination, the Plan reserves the right to recover from the Group the cost of services rendered during the period following the due date, and to reject claims submitted by providers for services rendered during the period following the due date. Termination shall be effective retroactively to the due date of said Premium.

ARTICLE IV. GENERAL CONDITIONS

4.01 Nothing contained within this Certificate shall interfere with the professional relationship between the Member and the physician providing care. Each Member shall have the right to choose, to the extent feasible and appropriate, the Affiliated Physician or other health care professionals responsible for his/her primary care.

4.02 No officer, agent, or representative of the Plan except the Executive Director is authorized to vary the terms or conditions of this Certificate in any way or to make any promises or agreements supplemental to this Certificate. Any supplemental agreements or variances to the terms or conditions of this Certificate must be in writing signed by the Executive Director of the Plan.

4.03 The Authorized Benefits and Services provided under this Certificate are solely for the individual benefit of the Members and cannot be transferred or assigned. If any Member aids, attempts to aid, or knowingly permits any other person not a Member of the Plan to obtain benefits or services from or through the Plan, that Member's coverage under this Certificate shall be terminated automatically, and the Member shall be responsible for payment for any services rendered to such other person. The theft or wrongful use, delivery, or circulation of a Member identification card may constitute a felony under Michigan law.
4.04 This Certificate supersedes all previous contracts or certificates between the Plan, the Group, and the Members.

4.05 Any notice required to be given by the Plan, the Group, or a Member, shall be deemed to have been duly given if in writing and personally delivered, or deposited in the United States mail with postage prepaid, addressed, as applicable, to the Remitting Agent, to the Member at the last address on record at the Plan's principal office, or to the Plan at 3011 W. Grand Blvd., Suite 1600, Detroit, Michigan 48202.

4.06 The Plan shall not be liable for any delay or failure of an Affiliated Provider, Referral Physician, Referral Facility, or Cofinity Network to provide services due to lack of available facilities or personnel, if the lack is a result of circumstances beyond the Plan's control. In the event of circumstances beyond the Plan's control, the Plan shall attempt to arrange Authorized Benefits and Services, insofar as practical, according to its best judgment and within the limitations of facilities and personnel then available. Circumstances beyond the Plan's control include, but are not limited to, complete or partial disruption of facilities, war, riot, civil insurrection, epidemic, labor disputes, unavailability of supplies, disability of a significant part of an Affiliated Provider's personnel, or similar causes.

4.07 Complaint, Grievance, and Appeal Process:

The Plan has a procedure to assist any Member who has a complaint or appeal regarding any aspect of the Plan's services. The Plan will provide each Member with a written explanation of the procedure upon enrollment in the Plan and/or at any time upon request. A Member can call the Plan to voice a complaint, or write to the Plan to file a written complaint/grievance. The complaint/grievance should be directed to:

Total Health Care USA  
Attention: Grievance Coordinator  
3011 W. Grand Blvd., Suite 1600  
Detroit, MI 48202

Phone: (313) 871-7889  
Fax: (313) 871-0196  
e-mail: results@thc-online.com

When filing a complaint, another person can act as the Member's authorized representative. To use an authorized representative, written notification must be submitted to Total Health Care authorizing the person to act on behalf of the Member.

Grievance

A grievance is the process used to handle a complaint. A grievance may be due to a denial of payment or an adverse determination. An adverse determination means health care services have been reviewed and denied, reduced, or terminated. An untimely response to a request
becomes an adverse determination. Members or their authorized representative have one hundred and eighty days (180) from the date of the notification letter to file a grievance.

Covered benefits continue pending resolution of the grievance. Members have the right to authorize someone to act as an authorized representative in the grievance. An authorized representative must have the Member’s written permission to represent them. Members have the right to send additional documentation with the grievance.

Members have the right to ask Total Health Care to arrange a meeting with the Appeal Review Committee. Members or an authorized representative may attend the meeting in person or by telephone. A person not involved in the first decision will review the grievance. No one who reports to the person involved in the initial decision can review the grievance. The person who reviews the grievance will be of similar specialty.

Medical grievance will be completed within thirty (30) calendar days after receipt. Administrative or denial of payment grievance will be completed within thirty-five (35) calendar days after it is received. Members will be notified in writing of the final decision. If the decision upholds the denial, an external appeal can be filed. The final letter explains external appeal rights and how to file the appeal.

**Expedited Grievance**

An expedited review of a grievance will be made when a physician notifies us verbally or in writing that waiting the thirty (30) days would cause the Member to have severe pain or put their life at risk. The physician must be able to support the attestation. The grievance must be received within ten (10) days of the denial.

After filing an expedited internal grievance with Total Health Care, an appeal and request may be filed for an expedited external review with the Department of Insurance and Financial Service (DIFS). If a request for an expedited grievance is denied, it is changed to a thirty (30) day grievance.

A decision about an expedited grievance is made no later than seventy-two (72) hours after it is received. A request for an extension of the decision time moves the grievance to a thirty (30) day grievance.

Total Health Care will notify the Member of the decision by phone. The decision will also be mailed to the Member within two (2) business days.

If the decision upholds the denial, the specific reasons for the final denial will be provided. The notification letter will include the benefit provision, guideline, protocol, or other criteria used. Upon request, access to and copies of all papers related to the grievance are provided.

**External Appeal Rights**

A Member or authorized representative has the right to request an external review from DIFS. The request should be made after receiving Total Health Care’s final decision. Notification of the final decision completes the Total Health Care internal appeal process.
A Member or authorized representative must file the DIFS, Health Care-Request for External Review Form to be given an external review. A copy of the Health Care-Request for External Review Form will be included with the final decision letter. Members may also call DIFS at 1-877-999-6442 to have a form mailed. The form should be filed no later than sixty (60) days after receipt of the final decision letter.

When appropriate, DIFS will request a recommendation by an independent review organization. The independent review organization is not a part of Total Health Care. The Director of DIFS will issue a final order.

To ask questions about the external review process, contact the Total Health Care Grievance Coordinator at (313) 871-7889 or 1-800-826-2862 x889.

To request an independent review, write to:

Department of Insurance and Financial Services
General Counsel- Appeals Section
P.O. Box 30220
Lansing, Michigan 48909-7720

Or call: (877) 999-6442
Or fax: (517) 241-4168

4.08 All Member protected health information (PHI) is maintained in a manner that assures confidentiality consistent with applicable law. PHI includes electronic, written, and spoken information, such as a Member’s name, address, phone number, Social Security Number, demographic information, and any information related to his/her health condition or diagnosis. The Member has the right to inspect and review their medical records. The Plan will not use or disclose PHI concerning Members and/or their medical treatment other than for purposes of treatment, payment, or health care operations, except upon written authorization of the Member or as otherwise required by law. Any such disclosure of PHI will be limited to that which is minimally necessary.

4.09 The Plan may adopt reasonable policies, procedures, and rules to promote orderly and efficient administration of this Certificate. Questions about such policies should be directed, in writing, to:

Total Health Care USA
3011 W. Grand Boulevard, Suite 1600
Detroit, MI 48202
Attn: Marketing Dept.

4.10 The Member identification card is the property of the Plan. Each Member understands and agrees to return the Member identification card upon request of the Plan.

4.11 As a Member of the Plan, the Plan will provide you, upon your request, with a description of any of the following. To request this information, please contact the Member Services Department by telephone at (313) 871-2000, or mail your request to the Member Services Department at:
Be sure to include your Member ID number on your request.

A. **Information Concerning Affiliated Providers.** The Member Provider Directory includes the names of Plan Affiliated Providers, specialty or type of practice, practice location, and information concerning accessibility/availability. You may request from the Member Services Department, and the Plan will provide you with:

1. Clarification with respect to the information contained in the Provider Directory.
2. Information concerning which Affiliated Providers are not accepting new Plan Members.
3. Information concerning the professional credentials of Affiliated Providers that are health professionals, including professionals certified in the specialty of pain medicine, evaluation and management. The type of information available includes, but is not necessarily limited to, professional degrees held, dates of certification by professional boards and other professional bodies, affiliation status with Affiliated Providers that are facilities, such as hospitals.

B. **Financial Relationships with Affiliated Providers.** You may request from the Member Services Department, and the Plan will provide, information indicating the nature of financial relationships between the Plan and its Affiliated Providers. The Plan will provide you with a description of its financial relationships with Affiliated Providers including:

1. Whether a fee-for-service arrangement exists, under which the Affiliated Provider is paid a specific amount for each Covered Service rendered to a Member.
2. Whether a capitation arrangement exists, under which a fixed amount is paid to the Affiliated Provider for all, or a specified set, of Covered Services that are or may be rendered to the Member, or all person in the Members family covered by the Plan.
3. Whether payments to Affiliated Providers are based on standards relating to cost, quality and/or patient satisfaction.

C. **Licensure Verification.** You can verify the license of Affiliated Providers that are health professionals through the Michigan Department of Labor and Economic Growth. You can verify a license electronically at the following websites: http://www.cis.state.mi.us/verify.htm and http://www.cis.state.mi.us/free/default.asp. You also can verify a license, request information concerning disciplinary action, and open formal complaints filed against a health professional, by calling the Michigan Department of Labor and Economic Growth at (517) 241-9427.
D. **Benefits.** This Group Health Maintenance Contract, together with any Riders, and the Member Handbook provided to Members contain a description of the benefits available to Plan Members, including rules regarding accessing benefits such as prior authorization requirements for specialist services, Referral Physicians, Referral Facilities and other services, drug formulary requirements, if any, and exclusions and limitations applicable to the specific categories of benefits provided. If you require clarification with respect to any of this information, please contact the Member Services Department.

E. **Affiliated Provider Termination.** In the event of termination, Members in an ongoing course of treatment with an Affiliated Physician or Referral Physician shall be permitted to continue such treatment with Plan authorization as follows:

1. For a period of ninety (90) days from the date the Member is notified of the termination;
2. If the Member is in the second or third trimester of pregnancy, treatment shall continue through post-partum care; or
3. If it is determined that the Member is terminally ill as defined in Section 5653 of the public health code, treatment will continue for the remainder of the Member’s life for care directly related to the treatment of terminal illness.

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

4.13 A deductible carry-over from the prior carrier applies for eligible expenses incurred within ninety (90) days of the Group’s effective date with Total Health Care USA. The Member must provide documentation of the expense within sixty (60) days of the initial Total Health Care USA effective date. The deductible carry-over does not accumulate toward the Out-of-Pocket Maximum.

**ARTICLE V. COVERED BENEFITS AND SERVICES**

**Physician Preferred Network Plan**

**Calendar Year Deductible:**
- In Physician Preferred Network/Total Health Care USA Network: $300 per Person, $600 per Family
- In Cofinity Network: $600 per Person, $1,200 per Family

**Out-of-Pocket Maximum (inclusive of the Deductible):**
- Medical Maximum Out-of-Pocket: $2,000 per Member
- Maximum Out-of-Pocket: $4,000 per Family
Pharmacy
Pharmacy Co-Payment and Deductibles:

- **Annual Deductible:** $0 per Member
- **Maximum Out-of-Pocket:** $4,350 per Member
- **Maximum Out-of-Pocket:** $8,700 per Family

**Combined Out-of-Pocket Maximum:**
- **Maximum Out-of-Pocket:** $6,350 per Member
- **Maximum Out-of-Pocket:** $12,700

Co-Payments, Coinsurance, and Deductibles are applied to Out-of-Pocket Maximums

5.01 Inpatient Hospital Care

(1) Physician Services:

All Physician services which are deemed necessary for the medical, surgical, obstetrical, and related diagnosis and treatment of a Member and are Authorized Benefits and Services.

(2) Hospital Services:

When a Member is admitted to an Affiliated Hospital or any other Hospital upon authorization of a Treating Physician and the Plan's Medical Director or his/her designee or through an emergency admission, the Member is entitled to the following Authorized Benefits and Services when deemed necessary for the medical, surgical, obstetrical, and related diagnosis and treatment of the Member:

a. A semi-private room, including general nursing services, meals, and special diets.

b. Use of intensive care units, operating rooms, delivery rooms, recovery rooms, and other special treatment rooms.

c. Anesthesia services.

d. Laboratory examinations, including typing of blood donors and other diagnostic and pathological services.

e. All necessary medical and surgical supplies.

f. Use of X-ray and other diagnostic and therapeutic services.

g. Drugs, biologicals, and related preparations as prescribed by the attending physician.

h. Maternity and nursery care of at least forty-eight (48) hours following childbirth; ninety-six (96) hour minimum stay in the case of a cesarean section.

i. Radiation and inhalation therapy.

j. Medical rehabilitative services and physical therapy which can be expected to result in significant improvement of the Member's condition.

k. Other inpatient services medically necessary for admission, diagnosis, and treatment of the Member.

l. Non-Elective Abortions.
**Coinsurance after Deductible:**
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Coinsurance not applicable, Covered in full

**Within the Cofinity Network:** Member pays 20% of Cofinity rate

### 5.02 Organ and Tissue Transplants

Organ or body tissue transplant is covered when:

1. Transplant is considered non-experimental in accordance with generally accepted medical practice; and
2. It is medically necessary; and
3. Member is enrolled in Total Health Care USA's Case Management Program during the evaluation, pre-transplant, transplant, and post-transplant care; and
4. The approved transplant is performed in a Total Health Care USA authorized facility.

Transplants also include the necessary Hospital, surgical, lab, and X-ray services for a non-Member donor, unless the Member donor has coverage for such service.

**Coinsurance:**
At a Total Health Care USA authorized facility: Coinsurance not applicable, Covered in full
Within the Cofinity Network: NOT COVERED

### 5.03 Outpatient Services

1. Outpatient surgical care, including routine surgical procedures that do not require the use of inpatient Hospital facilities.
2. Therapeutic and diagnostic laboratory, pathology, radiology, and special diagnostic services which are medically necessary for the diagnosis or treatment of a disease, injury, or medical condition.
3. Medical and surgical supplies.
4. Pre-Hospital admission screening procedures which have been authorized by a Treating Physician and/or the admitting physician.
5. Non-Elective Abortions.

**Coinsurance after Deductible:**
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Coinsurance not applicable, Covered in full
Within the Cofinity Network: Member pays 20% of Cofinity rate

### 5.04 Professional Services

1. The following Authorized Benefits and Services are available for preventive, diagnostic, therapeutic, and rehabilitative care (does not apply to chemotherapy; see Section 5.09 for benefit details).
a. Office visits at the Member’s Primary Care Physician.

b. Specially physician care.

c. Formulary drugs administered at the primary care office.

d. Therapeutic and diagnostic laboratory, pathology, radiology, and special diagnostic services which are medically necessary for the diagnosis or treatment of a disease, injury, or medical condition.

e. Short-term medical Rehabilitative Services for up to forty-five (45) days per calendar year, for conditions which Treating Physician expects will result in significant improvement of a Member’s condition within a period of two (2) months.

f. Pre-Hospital admission screening procedures which have been authorized by a Treating Physician and/or the admitting physician.

h. Chiropractic care (limited to twenty (20) visits per calendar year).

Office Visit Co-Payment (Co-Payment does not apply to d and f):

Within the Physician Preferred Network: Member pays $10 per office visit

Within Total Health Care USA Network: Member pays $25 per office visit

Within the Cofinity Network: Member pays $40 per office visit

Coinsurance after Deductible for Therapeutic and Diagnostic Services as described in d and f above:

For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Covered in full

Within the Cofinity Network: Member pays 20% of Cofinity rate

### 5.05 Clinical Preventive Service Benefits

The following Authorized Benefits and Services are available for preventive care when authorized by an Affiliated Physician, health care personal employed by or having written service agreements with an IPA, or employed by the plan or a Referral Physician when authorized by an Affiliated Physician:

1. Immunizations (doses, recommended ages and recommended populations vary based on recommendations from the Advisory Committee on Immunization Practices [CDC]):
   a. Certain vaccines – children from birth to age eighteen (18).
   b. Certain vaccines – all adults.

2. Certain Drugs
   b. Folic Acid supplements – women who may become pregnant.
   c. Fluoride Chemoprevention supplements – children without fluoride in their water source.
   d. Gonorrhea preventive medication – all newborns.
   e. Iron supplements – children ages six (6) to twelve (12) months at risk for anemia

3. Screening and Counseling Services for Adults
   a. Abdominal Aortic Aneurysm – men of specified ages who have ever smoked (one time only).
   b. Alcohol Misuse – all adults.
d. Cholesterol – adults of certain ages or adults at higher risk.
e. Colorectal Cancer – adults over fifty (50).
f. Depression – all adults.
g. Type 2 Diabetes – adults with high blood pressure.
h. Diet counseling – adults at higher risk for chronic disease.
i. HIV – all adults at higher risk.
j. Obesity – all adults.
k. Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk.
l. Tobacco Use – all adults (includes cessation interventions for tobacco users).
m. Syphilis – all adults at higher risk.

(4) Screening and Counseling Services for Women (Including Pregnant Women)
a. Anemia – on a routine basis for pregnant women.
b. Bacteriuria (urinary tract or other infection screening) – pregnant women.
c. BRCA (counseling about genetic testing) – women at higher risk.
d. Breast Cancer Mammography – every one (1) to two (2) years for women over forty (40).
e. Breast Cancer Chemoprevention – women at higher risk.
f. Breast Feeding – interventions to support and promote breastfeeding.
g. Cervical Cancer – sexually active women.
h. Chlamydia Infection – younger women and other women at higher risk.
i. Gonorrhea – all women at higher risk.
j. Hepatitis B – pregnant women at their first prenatal visit.
k. Osteoporosis – women over age sixty (60) depending on risk factors.
l. Rh Incompatibility – all pregnant women and follow-up testing for women at higher risk.
m. Tobacco Use – all women, and expanded counseling for pregnant tobacco users.
n. Syphilis – all pregnant women or other women at increased risk.

(5) Assessments and Screenings for Children
a. Alcohol and Drug Use Assessments – adolescents.
b. Autism Screening – children at eighteen (18) and twenty-four (24) months.
c. Behavioral Assessments – children of all ages.
d. Cervical Dysplasia Screening – sexually active females.
e. Congenital Hypothyroidism Screening – newborns.
f. Developmental Screening – children under age three (3), and surveillance throughout childhood.
g. Dyslipidemia Screening – children at higher risk of lipid disorders.
h. Hearing Screening – all newborns.
i. Height, Weight and Body Mass Index Measurements – children of all ages.
j. Hematocrit or Hemoglobin Screening – children of all ages.
k. Hemoglobinopathies or Sickle Cell Screening – all newborns.
l. HIV Screening – adolescents at higher risk.
m. Lead Screening – children at risk of exposure.
n. Medical History – all children throughout development.
o. Obesity Screening and Counseling – children of all ages.
q. Phenylketonuria (PKU) Genetic Disorder Screening – all newborns.
r. Sexually Transmitted Infection (STI) Prevention Counseling – adolescents at higher risk.
s. Tuberculin Testing – children at higher risk of tuberculosis.
t. Vision Screening – all children.
The benefits in this Section are subject to change based on provisions of the Affordable Care Act. Visit the CMS website at www.healthcare.gov/prevention for the most up-to-date services.

**Within the Physician Preferred Network**: Member pays $0 per office visit
**Within Total Health Care USA Network**: Member pays $0 per office visit
**Within the Cofinity Network**: Member pays $40 per office visit

5.06 Home Health Care

When prescribed by a Treating Physician, home health care visits by nursing personnel will be provided (limited to one hundred (100) visits per calendar year).

**Co-Payment:**
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Covered in full
**Within the Cofinity Network**: NOT COVERED

5.07 Breast Cancer Screening, Diagnostic, Treatment, and Rehabilitative Services

(1) Breast cancer screening mammography services are covered by the Plan and subject to applicable Co-Payments or Coinsurance. Coverage is for one (1) mammography screening every year for women forty (40) years and older, and one (1) mammography during a five (5) year period for women between the ages of thirty-five (35) and forty (40) years. Any other medically indicated mammography is covered.

**Co-Payment:**
**Within the Physician Preferred Network**: Covered in full
**Within Total Health Care USA Network**: Covered in full
**Within the Cofinity Network**: Member pays $40 per office visit

(2) Breast cancer diagnostic services include procedures intended to aid in the diagnosis of breast cancer, including, but not limited to, surgical breast biopsy, pathologic examination, and interpretation.

**Coinsurance after Deductible:**
**Within the Physician Preferred Network**: Coinsurance not applicable, covered in full
**Within Total Health Care USA Network**: Coinsurance not applicable, covered in full
**Within the Cofinity Network**: Member pays $20 of Cofinity rate

(3) Breast cancer treatment delivered on an inpatient or outpatient basis including, but not limited to, surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

**Coinsurance after Deductible:**
**Within the Physician Preferred Network**: Coinsurance not applicable, covered in full
**Within Total Health Care USA Network**: Coinsurance not applicable, covered in full
**Within the Cofinity Network**: Member pays $20 of Cofinity rate
(4) Other Breast Services and Treatment Following a Mastectomy.
   a. Reconstruction of the breast on which the mastectomy has been performed.
   b. Surgery and reconstruction on the breast to produce a symmetrical appearance.
   c. Prosthesis (breast implant); and
   d. Treatment for physical complications of the mastectomy, including lymphedema.

Coinsurance after Deductible:

Within the Physician Preferred Network: Coinsurance not applicable, covered in full
Within Total Health Care USA Network: Coinsurance not applicable, covered in full
Within the Cofinity Network: Member pays $20 of Cofinity rate

5.08 Diabetic Services

The Plan shall provide coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary, meets established criteria, and is prescribed by a licensed allopathic or osteopathic physician:

(1) Blood glucose monitors.
(2) Blood glucose monitors for the legally blind.
(3) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
(4) Syringes.
(5) Insulin pumps and medical supplies required for the use of the insulin pump.
(6) Diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management and treatment of the diabetic condition.
(7) Insulin and other medications for the treatment of diabetes and associated conditions, if the Member subscribes to the prescription rider (refer to rider for Co-Payment details).

Co-Payment:
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Covered in full
Within the Cofinity Network: NOT COVERED

5.09 Antineoplastic Drug Coverage (Chemotherapy)

The Plan covers drugs used in antineoplastic therapy and the reasonable cost of its administration. Coverage for antineoplastic drugs is provided, regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the Federal Food and Drug Administration, if all of the following conditions are met:

(1) The drug is ordered by a physician for the treatment of a specific type of neoplasm.
(2) The drug is approved by the Federal Food and Drug Administration for use in antineoplastic therapy.

(3) The drug is used as part of an antineoplastic drug regimen.

(4) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(5) The physician has obtained informed consent from the patient for the treatment regimen that includes Federal Food and Drug Administration-approved drugs for off-label indications.

Coinsurance after Deductible:
Within the Physician Preferred Network: Coinsurance not applicable, covered in full
Within Total Health Care USA Network: Coinsurance not applicable, covered in full
Within the Cofinity Network: Member pays $20 of Cofinity rate

5.10 Intermediate and Outpatient Care for Substance Abuse

Intermediate and outpatient care for substance abuse will be provided as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs when prescribed by the Psychiatrist.

"Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(1) Chemotherapy.
(2) Counseling.
(3) Detoxification services.
(4) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

"Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(1) Chemotherapy.
(2) Counseling.
(3) Detoxification services
(4) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

Intermediate Care: Coinsurance after Deductible:
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Coinsurance not applicable, subject to Deductible.
Within the Cofinity Network: 20% Coinsurance

Outpatient Care: Co-Payment:
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: $10 per office visit
Within the Cofinity Network: $40 per office visit

5.11 Behavioral Health

(1) Visits for behavioral health consultation, diagnosis, and treatment including crisis intervention, group therapy, and testing by a psychiatrist, psychiatric social worker, or a counseling or clinical psychologist.

(2) Inpatient Psychiatric Care shall be covered when authorized by the Plan’s Medical Director and/or his/her designee.

Outpatient Behavioral Health: Co-Payment:
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: $25 per office visit
Within the Cofinity Network: $40 per office visit

Inpatient Psychiatric Care: Coinsurance after Deductible:
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Coinsurance not applicable, covered in full
Within the Cofinity Network: Member pays 20% of Cofinity rate

5.12 Emergency Care

Emergency medical care coverage is provided for the treatment and stabilization of Medical Emergencies and Accidental Injuries as defined in Article II, 2.38 above. Emergency medical care is available twenty-four (24) hours a day. Call 9-1-1 or go to the nearest Emergency Room

Co-Payment:
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Member pays $125
Within the Cofinity Network: Member pays $125
Note: Co-Payment is waived if emergency visit results in a hospital admission

5.13 Ambulance Service

(1) Ambulance service will be provided only when deemed medically necessary, as determined by the Plan’s Medical Director or designee according to the following criteria:
   a. If the Member is admitted as an inpatient to the Hospital immediately following emergency room treatment; or
   b. When necessary for management of shock, trauma, unconsciousness, heart attack, or other condition requiring active medical management prior to availability of Hospital care; or
   c. When an ambulance is ordered by an employer, school, fire or public safety official, and the Member is not in a position to refuse.
Any medically necessary and appropriate transportation ordered by an Affiliated Hospital is covered in full by the Plan.

**Co-Payment:** Except as provided in subsection (2) above, the Member will be responsible for $75, not to exceed 50% of the Plan's reimbursement for ambulance services.

## 5.14 Temporomandibular Joint Treatment

(1) Temporomandibular Joint Syndrome (TMJ) is defined as muscle tension and spasms of musculature related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function, neurological, and personality dysfunctions.

(2) When deemed medically necessary and provided or authorized by a Treating Physician, and approved by the Medical Director, the following services and treatment for Temporomandibular Joint Syndrome are Authorized Benefits and Services:
   c. X-rays of the temporomandibular joint including contrast studies, but not dental X-rays.
   d. Palliative therapy including TENS therapy and intraoral fixation.
   e. Myofunctional therapy.
   f. Surgery to the temporomandibular joint including, but not limited to, condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

(3) Dental and orthodontic services, treatment, prosthesis, and appliances for or related to treatment for temporomandibular syndrome are not covered.

**Coinsurance:** The Member will be responsible for an amount not to exceed 50% of the Plan's reimbursement to the facility and to Affiliate Providers.

## 5.15 Out-of-Area Coverage

(1) Out-of-Area coverage is provided only when a Member is outside the Service Area for a period no greater that three (3) consecutive months or when a Member is twenty-six (26) years or younger and is attending an accredited college or university outside of the Service Area. Out-of-area benefits shall be limited to inpatient and outpatient care for Medical Emergencies or Accidental Injuries only. Members traveling outside the Service Area are not covered for out-of-area obstetrical services and related Hospital care within four (4) weeks of the estimated date of delivery, as determined by the Affiliated Physician, whether or not the obstetrical services and related Hospital care were required as a result of a Medical Emergency or Accidental Injury.

(2) In order to be covered for services under this Section 5.15, the Member must notify the Plan within twenty-four (24) hours after admission to a Hospital or as soon as medically possible after admission where the Member is incapable of calling the Plan.

(3) Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered only within the Plan's Service area by Affiliated Providers or within the Cofinity Network unless specifically authorized in writing by the Plan's Medical Director or designee.
**Emergency Care Out-of-Network:** Member pays $125 Co-Payment

**Note:** Co-Payment is waived if emergency visit results in a hospital admission

5.16 Hospice

1) **Eligibility**
A Member is eligible for Hospice coverage when the individual is suffering from a disease or condition with a terminal prognosis. A Member shall be considered to have a disease or condition with a terminal prognosis if, in the opinion of a Treating Physician in conjunction with the Plan, the Member’s death is anticipated within six (6) months after the date of admission to Hospice. The fact that a Member lives beyond the six (6) month or less prognosis shall not disqualify the person from continued Hospice care. In order to be eligible for Hospice coverage, a Member must have knowledge of the illness and the life expectancy and elect to receive Hospice services rather than active treatment for the illness.

2) **Settings**
The majority of Hospice care is provided in the Member’s home. If the Member is eligible for Hospice services but does not have a family member or friend to provide the care necessary to allow the Member to remain in the home, a Treating Physician shall arrange for Hospice care in a Hospice Facility.

3) **Hospice Services**
Hospice care shall address the physical, psychological, social, and spiritual needs of the terminally ill Member and shall be designed to meet the related needs of the terminally ill Member’s family through the periods of illness and bereavement.

**Coinsurance after Deductible:**
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Coinsurance not applicable, covered in full
Within the Cofinity Network: Member pays 20% of Cofinity rate

5.17 Urgent Care

Urgent Care is defined as medically necessary care for non-life threatening conditions such as colds, flu, sore throats, fever, diarrhea, upper respiratory symptoms, earache, minor burns, allergic reactions, sprains, strains, and similar conditions when such services are delivered when your doctor’s office is closed and are inappropriate for a Hospital emergency room.

**Co-Payment:**
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Member pays $25 per office visit
Within the Cofinity Network: Member pays $50 per office visit
5.18 Language Services

The Plan provides an interpreter if the Member does not speak English and a sign language interpreter if the Member has a hearing impairment. For assistance, the Member must call the Plan’s hotline at (313) 871-2000 or 1-800-826-2862 or the TDD/TTY line at 1-800-647-3777.

Covered in full

5.19 Hearing Aids

(1) An Audiometric Examination is covered when performed by an Audiologist or Referral Physician who has been authorized by the Plan to perform such an examination. This examination may also include a Hearing Aid Evaluation test if deemed medically necessary by the Affiliated Physician or Audiologist or Referral Physician (when approved by the Plan).

(2) Hearing Aids, including Ear Molds, are covered when prescribed by an Affiliated Physician, Audiologist, or Referral Physician and approved by the Plan. Hearing aids of the following functional types are covered: in-the-ear, behind-the-ear (including air conduction and bone conduction types), and on-the-body. Replacement parts, repair, and battery replacement are covered only when authorized by the Medical Director or his/her designee.

Limitations: Hearing Aid benefits are limited to one Hearing Aid per ear every three (3) years and covers $600 per hearing aid.

5.20 Durable Medical Equipment, Orthotics, and Prosthetics

(1) Durable Medical Equipment is covered when prescribed by an Affiliated Physician or by a Referral Physician (if approved by an Affiliated Physician), and when authorized by the Plan’s Medical Director and his/her designee. Such equipment must be deemed reasonable and necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body member. Medical supplies which the Plan deems medically necessary for the proper functioning of the Durable Medical Equipment are covered when authorized by an Affiliated Physician (if approved by an Affiliated Physician), and when authorized by the Plan’s Medical Director or his/her designee for their rental, lease, or purchase, the Member must secure a purchase order from the Plan.

(2) Orthotic Equipment and Devices are covered when prescribed by an Affiliated Physician or by a Referral Physician (if approved by an Affiliated Physician), and when authorized by the Plan’s Medical Director or his/her designee. Adjustments and replacements of Orthotic Equipment and Devices are covered in the following cases:
   a. Wear and tear,
   b. Changes in member’s condition, or
   c. Change in size needed.

(3) Prosthetic Appliances are covered when prescribed by an Affiliated Physician or by a Referral Physician (if approved by an Affiliated Physician), and when authorized by the Plan’s Medical Director or his/her designee. Adjustments and replacement of Prosthetic Appliances are covered in the following cases:
a. Wear and tear,
b. Changes in member’s condition, or
c. Change in size needed.

**LIMITATIONS**

(1) Durable Medical Equipment is limited to the following categories:
   a. Hospital beds and related equipment
   b. Equipment used to increase mobility, such as, but not limited to wheelchairs, walkers, canes and crutches
   c. Commodes and urinals
   d. Oxygen equipment
   e. Therapeutic equipment
   f. Diagnostic equipment
   g. Certain power chairs and seat lifts

(2) Benefits hereunder are provided for the use of Durable Medical Equipment for home use outside of a Hospital, Skilled Nursing Care Facility, or upon discharge from such facility.

(3) Medical supplies are limited to those supplies deemed medically necessary for the proper functioning of Durable Medical Equipment.

(4) Orthopedic Shoes are limited to the situations when such shoes are a necessary part of an orthotic leg brace.

**Within Total Health Care USA Network:** Covered in full  
**Within the Cofinity Network:** Not covered

5.21 Skilled Nursing Care

Skilled nursing care will be provided in an Affiliated Skilled Nursing Facility when deemed medically necessary and/or appropriate by an Affiliated Physician or by a Referral Physician (if approved by an Affiliated Physician), and when authorized by the Plan’s Medical Director or his/her designee. Skilled Nursing Care is limited to forty-five (45) days per calendar year.

**Coinsurance after Deductible:**
**Within Total Health Care USA Network:** Coinsurance not applicable, covered in full  
**Within the Cofinity Network:** NOT COVERED

5.22 Well Vision Care

A. (1) The Plan will cover vision care when the services are performed by an Affiliated Optometrist and when the Member is referred to the Affiliated Optometrist by an Affiliated Physician.

(2) Eyeglasses supplied by an Ophthalmologist must be obtained by the Affiliated Optometrist and are subject to the limitations set forth in sections B1 below.
LIMITATIONS

B.

(1) Eye examinations are limited to one (1) per Member per contract year.

Eyeglasses:

a. Eyeglasses (Frames and Lenses) are provided once every two (2) contract years. Eyeglasses may be issued more frequently if there is a radical change in the prescription and/or if deemed medically necessary by an Affiliated Optometrist or an Affiliated Physician.

b. When eyeglasses are prescribed by an Affiliated Optometrist, Members will be allowed to choose Frames from a pre-designated selection as outlined in the Plan’s Optometric Contract. If a Member elects to choose designer, over-sized, or other Frames which are more expensive than the pre-designated selection, the Member understands that he/she is responsible for the difference in costs.

c. Members may select either standard size glass or clear plastic Lenses with any prescription except myodisc, cataract, and other highly specialized prescriptions. If a Member elects to choose tinted photosensitive, anti-reflective, over-sized, designer, or other Lenses which are more expensive than the standard Lenses, the Member understands that he/she is responsible for the difference in costs.

d. The Plan will provide bi-focal or tri-focal Lenses as medically necessary.

e. Eye examinations by an Ophthalmologist will be covered if it is deemed medically necessary by the Affiliated Optometrist and the Affiliated Physician.

f. Members eligible for eyeglasses have the option of applying the amount of money allowed for eyeglasses towards the purchase of Contact Lenses. Members requesting this option understand that:

I. The dollar amount which exceeds the standard Lenses and Frames allowance is their financial responsibility;

II. By electing to use the Lenses and Frames allowance for Contact Lenses, Members have exhausted the benefit as described in Section B. above.

For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: No Co-Payment or Deductible

Within the Cofinity Network: NOT COVERED

5.23 Weight Loss Services for Morbid Obesity

Covered Services:

(1) Weight loss programs pre-approved by the Plan. Contact Customer Service at 313-871-2000 for more information.

(2) Certain surgical treatments and bariatric surgery when co-morbid health conditions exist and all reasonable non-surgical options have been tried. Surgical treatment for weight loss must be prior approved by the Plan’s Medical Director.
Coinsurance after Deductible:
For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: Coinsurance not applicable, covered in full
Within the Cofinity Network: Member pays 20% of Cofinity rate

5.24 Child and Adolescent Health Center (CAHC)

Members may choose to obtain services from a Child and Adolescent Health Center (CAHC) without prior authorization from the Plan.

5.25 Women's Routine Preventive Health Services, Routine Obstetrical/Gynecological Services
Female members may obtain routine and preventive health services from in-plan women's health specialists without prior authorization from the Plan or PCP.

5.26 Autism Services

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

(2) “Autism diagnostic observation schedule” means 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 Finance Services (DIFS), if the Director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

(3) “Autism spectrum disorders” means any of the following pervasive developmental disorders as defined by the diagnostic and statistical manual:
   a. Autistic disorder.
   b. Asperger’s disorder.
   c. Pervasive developmental disorder not otherwise specified.

(4) “Behavioral health treatment” means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:
   a. Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
   b. Are provided or supervised by a board-certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist’s formal university training and supervised experience.

(5) “Diagnosis of autism spectrum disorders” means assessments, evaluations, or tests, including the autism diagnostic observation schedule, performed by a licensed physician or a licensed psychologist to diagnose whether an individual has one of the autism spectrum disorders.
(6) “Diagnostic and statistical manual” or “DSM” means the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association or other manual that contains common language and standard criteria for the classification of mental disorders and that is approved by the Department of Insurance and Financial Services (DIFS), if DIFS determines that the manual is recognized by the health care industry and the classification of mental disorders is at least as comprehensive as the manual published by the American Psychiatric Association on the effective date of this section.

(7) “Pharmacy care” means medications prescribed by a licensed physician and related services performed by a licensed pharmacist and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

(8) “Psychiatric care” means evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(9) “Psychological care” means evidence-based direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(10) “Therapeutic care” means evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

(11) “Treatment of autism spectrum disorders” means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:
   b. Pharmacy care.
   c. Psychiatric care.
   d. Psychological care.
   e. Therapeutic care.

(12) “Treatment plan” means a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board-certified or licensed 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.

**Covered Services:**

(1) Diagnosis of Autism Spectrum Disorder including, but not limited to, assessments, evaluations, or tests, including the autism diagnostic observation schedule, performed by a licensed physician or a licensed psychologist.

(2) Applied Behavioral Analysis including, but not limited to, Therapeutic behavioral services, skills and training development, home care training for both Member and Member’s family, mental health service plan development, and insight-oriented, behavior-modifying, or supportive psychotherapy.
(3) Behavioral health treatment including, but not limited to, individual and group psychotherapy and behavioral modification.

(4) Pharmacy care.

(5) Psychiatric care.

(6) Psychological care.

(7) Habilitative Services including, but not limited to, physical therapy, occupational therapy and speech therapy. Physical therapy, occupational therapy, and speech therapy visits do not count toward the limits established in Section 5.04e.

Coverage Limitations:

(1) Co-Pays, Deductibles, and/or Coinsurance may apply. Consult your Schedule of Out-of-Pocket Expense.

(2) Behavioral health treatment, evidence-based counseling, and treatment programs including ABA that meet the following requirements:
   a. Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functions of an individual.
   b. Are provided or supervised by a board-certified behavior analyst or licensed psychologist with formal university training and supervised experience.

Non-Covered Services:

(1) This Amendment does not require the Plan to provide coverage for autism spectrum disorders to a Member under more than one Certificate of Coverage. If a Member has more than one policy, certificate, or contract that covers autism spectrum disorders, the benefits provided are subject to the limits of this Amendment when coordinating benefits.

(2) There is no coverage for a Member who has attained the age of nineteen (19).

Terms and Conditions:

(1) If a Member has been receiving treatment for an autism spectrum disorder, as a condition to receiving the coverage under this section, the Plan may do all of the following:
   a. Require a review of that treatment consistent with current protocols and may require a treatment plan. If requested by the Plan, the cost of treatment review shall be borne by the Plan.
   b. Request the results of the autism diagnostic observation schedule that has been used in the diagnosis of an autism spectrum disorder for that Member.
   c. Request that the autism diagnostic observation schedule be performed on that Member not more frequently than once every three (3) years.
   d. Request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to the Plan.

For this benefit, the Physician Preferred Network and Total Health Care USA Network are considered to be the Total Health Care USA Network: $10 per office visit

Within the Cofinity Network: $40 per office visit
ARTICLE VI. EXCLUSIONS AND LIMITATIONS

6.01 All benefits and services not specifically described as Authorized Benefits and Services in this Certificate, unless benefits and services are allowed under State or Federal law, are excluded from coverage under this Certificate.

6.02 Services, which are not medically necessary, are not covered. The final determination of medical necessity is made by the Plan's Medical Director or designee.

6.03 Services for disabilities associated with military service to which the Member is legally entitled and for which facilities are reasonably available to the Member are not covered.

6.04 Services for an occupational injury or disease for which services, payment or reimbursement is available under any workers compensation or employer's liability law are not covered.

6.05 Care for conditions that federal, state, or local laws require be treated in a public health facility is not covered.

6.06 Infertility treatment is not covered.

6.07 Services ordered by a court of competent jurisdiction are not covered, unless they are otherwise Authorized Benefits and Services.

6.08 Services provided during police custody are not covered, unless they are otherwise Authorized Benefits and Services.

6.09 Services for mental illnesses, disorders, and disabilities that, according to generally accepted professional standards, are not amenable to treatment are not covered.

6.10 Unless included in a Rider, outpatient prescription and nonprescription drugs and diet supplements are not covered.

6.11 Surgery and other services for cosmetic purposes, as determined by the Plan's Medical Director or his/her designee, are not covered.

6.12 Dental services and/or surgeries are not covered except in cases of multiple extractions or removal of unerupted teeth under general anesthesia where a concurrent medical condition exists.

6.13 Medical, surgical, and other health care procedures determined by the Plan's Medical Director to be experimental (including research studies) are not covered. Health services that are unusual, infrequently provided, and not necessary for the protection of individual health are not covered.

6.14 Reversal of voluntary, surgically induced sterilization is not covered.

6.15 Services of private duty nurses are not covered unless they are authorized by the Plan's Medical Director or designee before the services are rendered.
6.16 Custodial care, domiciliary care, or basic care in a residential, institutional, or other setting that is primarily for the purpose of meeting the Member's personal needs and which could be provided by persons without professional skills or training is not covered. Examples of custodial care include: assistance in bathing, dressing, eating, walking, getting in and out of bed, and taking medicine.

6.17 General housekeeping services and personal convenience items, including, but not limited to, television and telephone services are not covered.

6.18 Hospital, medical and surgical services for the primary purpose of sex transformation are not covered.

6.19 Health care benefits and services rendered as a result of a motor vehicle accident are not covered to the extent there is coverage under any policy.

6.20 Services that constitute vocational rehabilitation or employment counseling, or that are in connection with examinations for employment screening are not covered, except as they may be incidental to an annual health examination.

6.21 If a Member requests inpatient accommodations that are more expensive than those provided in this Certificate, the Member must pay the Hospital the difference between those charges incurred and those allowable and payable by the Plan.

6.22 Durable Medical Equipment excludes any deluxe equipment and features as attachments to such equipment which are not medically necessary.

6.23 Any medical supplies not medically necessary for the operation of Durable Medical Equipment are excluded.

6.24 Clothing necessary for prosthesis, other than the approved initial purchase, is excluded.

6.25 The following are not covered unless deemed therapeutically or medically necessary by the Affiliated Optometrist and approved by the Medical Director or his designee:

1. Contact Lenses;
2. Tinted, photo-sensitive, or anti-reflective Lenses;
3. Over-sized Lenses and Frames. Designer Lenses or Frames are not covered. The Member is responsible for the difference in cost between standard Lenses and Frames and designer Lenses and Frames as provided in Section 5.24.
4. Replacement of Lenses and Frames and Contact Lenses due to theft or loss are not covered.
5. Repairs are not covered.
6. Safety glasses, whether or not required in the performance of a job, are not covered.
7. Lenses and Frames, Contact Lenses, and eye examination are not covered when ordered:
   a. From a non-affiliated provider;
   b. Before the effective date of coverage of this Rider; or
   c. After termination of coverage.
   d. Lenses and Frames and Contact Lenses ordered for the Member while covered hereunder, but delivered more than sixty (60) days after termination of coverage are not covered.
Surgical treatment of obesity is limited to once per lifetime unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.

6.27 Unless included in a Rider, elective abortions are not covered

ARTICLE VII. SUBROGATION

7.01 Subrogation means that the Plan will have the same right as a Member to recover expenses for treatment of an injury or illness for which another person or organization is legally liable. To the extent the Plan provides services in such situations, the Plan will be subrogated to the Member’s right of recovery against any responsible person or organization, including any other health plan or insurers on policies including those issued to and in the name of the Member.

7.02 By acceptance of an identification card from the Plan, the Member agrees as a condition to receiving Authorized Benefits and Services under this Certificate, that the Member will make a good faith effort to pursue recovery from any liable person or organization and upon collection of any recoveries for any Authorized Benefits and Services provided by the Plan will reimburse the Plan. The Plan shall have a lien for any Authorized Benefits and Services rendered on any such recoveries whether by judgment, settlement, compromise, or reimbursement.

7.03 Members shall take such action, furnish such information and assistance, and execute such assignments and other instruments as the Plan may request to facilitate enforcement of the rights of the Plan hereunder.

7.04 A Member shall not compromise or settle a claim or take any action that would prejudice the rights and interests of the Plan without the Plan’s prior written consent.

7.05 Refusal or failure of a Member, without good cause, to cooperate with the Plan under this Article, shall be grounds for termination of membership in the Plan and for recovery by the Plan from the Member for the value of services and benefits provided by the Plan.

ARTICLE VIII. COORDINATION OF BENEFITS

8.01 Benefits under this Certificate will be coordinated with all group health policies and/or other HMO benefits available to the Member under any policy or certificate that also has a coordination of benefits provision. The priority of responsibility under the coordinating policies or certificates will be determined in the following manner as prescribed under Act No. 64 of the Public Acts of 1984:

1. The benefits of a policy or certificate that covers the person on whose expense the claim is based other than as a Dependent, shall be determined before the benefits of a policy or certificate which covers the person as a Dependent.

2. Except as otherwise provided in subsection (3), if two (2) policies or certificates cover a person on whose expenses the claim is based as a Dependent, the benefits of the policy...
or certificate of the person whose birthday anniversary occurs earlier in the calendar year shall be determined before the benefits of the policy or certificate of the person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the benefits of a policy or certificate that has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate that has covered the person for the shorter period of time. However, if either policy or certificate is lawfully issued in another state and does not have the coordination of benefits procedure regarding Dependents based on birthday anniversaries as provided in this subsection, and as a result each policy or certificate determines its benefits after the other, the coordination of benefits procedure set forth in the policy or certificate that does not have the coordination of benefits procedure based on birthday anniversaries shall determine the order of benefits.

(3) In the case of a person for whom claim is made as a Dependent minor child, benefits shall be determined according to the following:

a. Except as provided in paragraph c. below, if the parents of the minor child are legally separated or divorced, and the parent with custody of the child has not remarried, the benefits of the policy or certificate that covers the minor child as a Dependent or the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the non-custodial parent.

b. Except as provided in paragraph c. below, if the parents of the minor child are divorced, and the parent with custody has remarried, the benefits of a policy or certificate that covers the minor child as a Dependent of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the Spouse of the custodial parent, and the benefits of a policy or certificate that covers the minor child as a Dependent of the Spouse of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the non-custodial parent.

c. If the parents of the minor child are divorced, and the decree of divorce places financial responsibility for the medical, dental, or other health care expenses of the minor child upon either the custodial or the non-custodial parent, the benefits of the policy or certificate that covers the minor child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy or certificate that covers the minor child as a Dependent.

8.02 If Section 8.01 (1), (2) and (3) above do not establish an order of benefit determination, the benefits of a policy or certificate in connection with a group disability benefit plan that group disability plan has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate that has covered the person for the shorter period of time, subject to the following:

(1) The benefits of a policy or certificate covering the person on whose expenses the claim is based as a laid-off or retired employee or a Dependent of a laid-off or retired employee shall be determined after the benefits of any other policy or certificate covering the person other than as a laid-off or retired employee or Dependent of a laid-off or retired employee.
(2) Subsection (1) shall not apply if either policy or certificate is lawfully issued in another state and does not have a provision regarding laid-off or retired employees and, as a result, each policy or certificate determines its benefits after the other.

8.03 Benefits under this Certificate shall not be reduced or otherwise limited because of the existence of another non-group contract that is issued as a Hospital indemnity, surgical indemnity, specified disease, or other policy of disability benefits as defined in Section 3400 of the Insurance Code of 1956, Act 218 of the Public Acts of 1956, being Section 500.3400 of the Michigan Compiled Laws.

8.04 Health care benefits and services rendered as a result of a motor vehicle accident are not covered to the extent there is coverage under any other policy.

8.05 The Plan is not required to pay claims or coordinate benefits for services that are not provided or authorized by the Plan and that are not Authorized Benefits and Services under this Certificate.

ARTICLE IX. CHANGES IN RATES, CERTIFICATE, OR STATUS OF MEMBERS

9.01 The Plan will not make adjustments in the rate(s) used to determine Premiums, nor in the terms and/or conditions of this Certificate with less than thirty (30) days written notice to the Remitting Agent.

9.02 The Subscriber must notify the Plan and the Remitting Agent in writing within thirty (30) days of any changes in the status of each Member as a result of marriage, divorce, disability, death, birth, legal adoption, dependence, or changes in employment of children, changes in address, change of telephone number, or entrance into or return from military service.

ARTICLE X. TERMINATION OF GROUP COVERAGE

10.01 The Certificate and the Group Operating Agreement shall continue in effect for one (1) year from the effective date and from year to year thereafter. The Plan may terminate this Certificate and the Group Operating Agreement without notice if the Group fails to pay the Premium within the Grace Period. In the event the Premium is not paid within the Grace Period, this Certificate terminates and all Authorized Benefits and Services cease retroactively as of 11:59 p.m. on the due date, unless otherwise expressly agreed upon by the Plan in writing. In the event of termination, the Plan reserves the right to recover from the Group the costs of services rendered to the Members during the period following the due date and to reject claims submitted by providers for services rendered during the period following the due date.
ARTICLE XI. TERMINATION OF A MEMBER’S COVERAGE

11.01 If this Certificate is terminated pursuant to Article X, the Member’s coverage shall terminate at the time specified in Article X without further action of the Plan.

11.02 If a Member ceases to meet the eligibility requirements of the Group Operating Agreement and this Certificate, coverage shall terminate (subject to the conversion rights under Article XII) as follows:

1. If the Subscriber ceases to be a member of the Group, Authorized Benefits and Services for the Subscriber and enrolled Dependents will be continued only until the end of the month for which Premiums have been paid without any further action by the Plan.

2. Upon the death of the Subscriber, all Authorized Benefits and Services will be continued for enrolled Dependents only until the end of the month for which Premiums have been paid without any further action by the Plan.

3. In the event of divorce or legal separation of Subscriber and Spouse, all Authorized Benefits and Services will be continued for the Spouse only until the end of the month for which Premiums have been paid without any further action by the Plan.

4. In the event a Member becomes a member of the Armed Services of the United States, all Authorized Benefits and Services shall terminate as to such Member as of that date without any further action by the Plan.

5. Coverage shall terminate at the end of the month in which a Dependent Child attains the age of twenty-six (26).

6. In the event a Member transfers residence outside the Service Area, Authorized Benefits and Services may be terminated.

11.03 The Plan may rescind a Member’s coverage with thirty (30) days written notice under this Certificate for intentional misrepresentation of a material fact on the Enrollment Application. Member may use the Plan’s internal grievance policy described in Section 4.07 to appeal the Plan’s decision.

11.04 The Plan may terminate a Member’s coverage for providing false or misleading information or withholding material information on any required plan form or in applying for or seeking any health care under the terms of this Certificate. Termination of coverage is effective thirty (30) days after notice of termination is given by the Plan.

11.05 The Plan may terminate a Member’s coverage if that Member knowingly fails or refuses to furnish information requested by the Plan. Termination of coverage is effective thirty (30) days after notice of termination is given by the Plan.

11.06 The Plan may terminate a Member’s coverage if the Member aids, attempts to aid or knowingly permits any other person not a Member to obtain benefits or services from or through the Plan. Termination of coverage is effective thirty (30) days after notice is given by the Plan.

11.07 The Plan may terminate a Member’s coverage if the Member refuses or fails, without good cause, to cooperate with the Plan pursuant to Article VII.
11.08 Members may elect to terminate their coverage during Group Open Enrollment that occurs once a year, or in the event that the Member ceases to meet the eligibility requirements as defined in this document or the Group Operating Agreement, by giving written notice to the Plan and the Remitting Agent.

11.09 Benefits for any authorized inpatient admission to a Hospital or skilled nursing facility that began prior to the effective date of termination will be provided only until the last day of coverage.

11.10 Benefits for any authorized inpatient admission to a Hospital or skilled nursing facility that began prior to the effective date of termination will be provided only until the date of termination or until the last day of coverage.

ARTICLE XII. CONTINUATION COVERAGE AND CONVERSION

12.01 CONTINUATION OF GROUP COVERAGE OPTION

1. A Member may be entitled under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue his/her coverage under this Certificate by making periodic payments directly to his/her Group. Subject to its terms and conditions, and timely payment, this Certificate shall be continued for such Members for a maximum of eighteen (18) months from the date of termination of employment or thirty-six (36) months from the date of death, divorce, or loss of Dependent status, or until the continuation of Coverage is no longer available through the Group.

2. Upon election to continue coverage for eighteen (18) months or thirty-six (36) months, payment shall be made by the Member to the Remitting Agent who shall pay the Plan in advance at the rate and in accordance with the frequency schedule established by the Plan, unless otherwise agreed to by the Plan in writing. If the Premium is not received within thirty (30) days of the due date, this Certificate may terminate without notice. If this Certificate is terminated, the Plan reserves the right to recover from the Group the cost of services rendered during the period following the due date.

3. A Member who elects to receive continuing coverage for a maximum of eighteen (18) months or thirty-six (36) months, as applicable, may convert to an individual contract at the end of the eighteen (18) month or thirty-six (36) month period.

12.02 CONVERSION OPTION

1. A Member who loses eligibility for Coverage under this Certificate as a Group Member, for other than his/her violation of this Certificate, is entitled to convert this Certificate to an Individual Contract by making Application within thirty (30) days of receiving notification of the event which made the Member ineligible for Group coverage. Evidence of good health will not be required by the Plan in order exercise this conversion option.

2. Individual Coverage will be of the type currently being offered by Total Health Care USA, and may not be identical to the health care benefits provided by this Group Certificate.

3. If a Member fails to make timely payment to the Plan, the Member’s coverage under the Individual Contract will be subject to termination in accordance with the terms of the Contract.