TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

Total Health Care USA is a Qualified Health Plan issuer in the Health Insurance Marketplace.

HMO
Certificate of Coverage

ARTICLE I. TOTAL HEALTH CARE USA, INC.

Total Health Care USA, Inc. is a non-profit corporation 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

When used in this Certificate of Coverage, the Group Operating Agreement, the Enrollment Application signed by the Subscriber, and the identification card issued to Member, the following definitions apply.

2.01 "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 to Members.

2.01 "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 to Members.

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

2.03 "Affiliated Physician" means a primary care physician legally qualified and licensed to practice medicine or osteopathy and who has a contract with the Plan or an IPA to provide services to Members.

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

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

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

2.07 "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, and which follow evidence-based guidelines of, but not necessary limited to, USPTF, HRSA guidelines and the CDC.

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

2.09 "Certificate" means this Certificate of Coverage and Schedule of Out-of-Pocket Expense.

2.10 "Coinsurance" means the balance of the allowable amount that each Member must pay after the Plan has paid its percentage towards the allowed amount.

2.11 "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.

2.12 "Co-Pay" means a service-specific fixed-dollar amount each Member must pay at the time and place Authorized Benefits and Services are rendered.

2.13 "Deductible" means the dollar amount a Member must satisfy in a Plan Year for Authorized Benefits and Services before being eligible for certain benefits to be payable by the Plan. The Deductible is applied annually and is based upon the Plan Year. Each Plan Year begins a new Deductible period.

2.14 "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); and (3) Who is not offered any health coverage by their employer. A child need not be claimed as a Dependent on the federal income tax return of the Subscriber to qualify as a Dependent nor is he/she required to be a student.

2.15 "Effective Date" means the date the Member is eligible to receive services under this Certificate of Coverage.

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

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

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

2.19 "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.

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

2.21 "Hospice" means a licensed health care program that has a contract with the Plan 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.

2.22 "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 nursing service by registered nurses, and which is not, other than incidentally, a place for the treatment of pulmonary tuberculosis, drug abuse, alcoholism nor a nursing home.

2.23 "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.

2.24 "Medical Emergency or Accidental Injury" means an emergent situation such as the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. Active labor is included if a time at which (a) delivery is imminent; (b) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (c) a transfer may pose a threat to the health and safety of the patient or the unborn child and such other acute conditions.

2.25 "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.

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

2.27 "Plan" means Total Health Care USA, Inc.

2.28 "Plan Year" means a twelve (12) month period of benefit coverage that begins on January 1st. Deductible amounts are reset to zero at the beginning of each Plan Year.

2.29 "Premium" means the amount of money due on the first of every month and prepaid monthly by a Group, including Subscriber contributions, if any, on behalf of the Members.

2.30 "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 designee.

2.31 "Specialty 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.

2.32 "Remitting Agent" means the Group or the person designated by the Group who is responsible for the payment of the monthly premiums.

2.33 "Semi-Private Room" means hospital accommodations where there are two (2) or more beds to a room.

2.34 "Service Area" means the geographic area where the Plan is authorized by the Department of Insurance and Financial Services to provide health care services to Members and is available and readily accessible to Members.

2.35 "Spouse" means the legally married husband or wife of a Subscriber.

2.36 "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.

2.37 "Preventive Benefits" means covered services that are intended to prevent disease while it is more easily treatable as defined by the US Preventive Services Task Force A and B recommendations.

2.38 "Adverse Benefit Determination'' means any of the following: a denial, reduction, or termination or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction or termination or failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

2.39 "Approved Drug List" means a list of both Generic and Preferred Brand Name Drugs, including Specialty Drugs, approved by Total Health Care, USA Pharmacy and Therapeutics Committee for use by our Members. Preferred Brand Name Drugs are usually Brand Name Drugs that have been on the market for a while or are commonly prescribed and have been selected based on their clinical effectiveness and safety. Non-preferred Brand Name Drugs are usually the highest cost drugs in a given category that have lower-cost alternatives with equal or better clinical effectiveness.

2.40 "Preferred Brand Name Drug" means a prescription drug approved by the Food and Drug Administration (FDA) that is protected by a patent, supplied by a single company and marketed under the manufacturer's brand name.

2.41 "Generic Drug" means a prescription drug approved by the Food and Drug Administration (FDA) that is produced and distributed without patent protection and contains the same active ingredient as the Brand Name Drug.

2.42 "Affiliated Pharmacy" means a Pharmacy that contracts with the pharmacy benefit manager as designated by Total Health Care, USA to provide Authorized Benefits and Services to Members. Plan's network includes Pharmacies within our Service Area as well as a national network of Pharmacies for out-of-area services. Names of Affiliated Pharmacies can be found in the Provider Directory or online at www.THCmi.com.

2.43 "Pharmacy" an establishment where prescription drugs are legally dispensed.

2.44 "Specialty Drugs" means drugs listed on the Approved Drug List meeting certain criteria, such as:

(1) Drugs or drug classes whose cost on a per- month or per-dose basis exceeds the threshold established by the Centers for Medicare and Medicaid Services; or
(2) Drugs that require special handling or administration; or
(3) Drugs that have limited distribution; or
(4) Drugs in selected therapeutic categories.

Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.

2.45 "Specialty Pharmacy" means a Pharmacy that specializes in the handling, distribution, and patient management of Specialty Drugs.

2.46 "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) Earache
(4) Minor wounds

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

2.48 "USPTF" means the United States Preventative Task Force available online at http://www.uspreventiveservicestaskforce.org, which is an independent panel of non-Federal experts in prevention and evidence-based medicine and is composed of primary care providers (such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists). The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. Preventive Services in the Certificate are based on these recommendations, as noted in 2.37.

2.49 "Clean Claim" means a claim that is completed in the format specified by the Plan and may be processed without obtaining additional information from the provider of service or from a third party. All claims must be computer generated or typed. In addition a "clean claim" is one that does all of the following:

(a) Identifies the health professional or facility that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers;
(b) Sufficiently identifies the patient and Subscriber;
(c) Lists the date and place of service;
(d) Is a claim for Covered Services provided to a Member
(e) If necessary, substantiates the medical necessity and appropriateness of the service provided;
(f) If prior authorization is required, contains information sufficient to establish that prior authorization was obtained;
(g) Identifies the service rendered using a generally accepted system of procedure or service coding; and
(h) Includes additional documentation based on services rendered as reasonably required by Plan.
(i) Is billed within one year of the date of service.

2.50 "Medically Necessary" means health care services provided by the Plan which adhere to nationally recognized and scientific evidence-based standards, appropriate in terms of type, amount, frequency, level, setting and duration for the Member's diagnosis or condition.

2.51 "Approved Clinical Trial" means a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in the Patient Protection and Affordable Care Act [PPACA] such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trial exempt from having an investigational new drug application).

ARTICLE III. ELIGIBILITY, RENEWABILITY AND GENETIC TESTING

3.01 **Eligibility.** Members are not excluded from coverage for pre-existing conditions. Coverage is not limited for members meeting the definition of the term Dependent.

(1) Persons meeting the eligibility requirements of the Group, Plan or the Health Insurance Marketplace, if applicable, 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 or appropriate enrollment procedure must be followed when applying through the Health Insurance Marketplace, if applicable. 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 or enrollment procedure 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) Newborn coverage starts at birth. To be covered, a Member must enroll the newborn as noted above and pay any premium within thirty-one (31) days of birth.

(4) Coverage for Dependent does not vary based on age of Dependent child.

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 Subscriber 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.

3.03 **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 Premium is paid by the Group to the Plan during the thirty-one (31) 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.

3.04 **Renewability.** Coverage at the end of the Contract Year is guaranteed renewable except for the following reasons:

(1) Non-payment of Premium.
(2) Fraud.
(3) Member moves outside of the Plan Service Area.
(4) The Plan withdraws from the market.

3.05 **Genetic Testing.** The Plan attests that it does not limit genetic testing when Medically Necessary, use information obtained from genetic testing to limit coverage, adjust premiums based upon genetic information, request or require genetic testing or collect genetic information from an individual at any time for underwriting purposes.

ARTICLE IV. GENERAL CONDITIONS

4.01 In completing the Enrollment Application, each Subscriber must select any available Affiliated Physician. That physician may be a general practitioner, family practitioner, internist, or a pediatrician in the case of a child. Each Member agrees and understands that all Authorized Benefits and Services must be provided by or authorized and arranged through this designated Affiliated Physician, except in the event of a Medical Emergency or Accidental Injury. For assistance with the selected Affiliated Physician or for further information, the Member should contact the Plan's Customer Service Department at (313) 871-2000.

4.02 Inability, failure, neglect, and/or refusal of an IPA to provide Authorized Benefits and Services shall give the Plan the right to transfer Members from a Health Center to another Health Center during such inability, failure, neglect, and/or refusal. The Plan's right to transfer Members will be exercised in the best interest of the Members' health care needs and within the legal limitations dealing with termination of medical care to patients. In the event of such a transfer, the Plan does not guarantee that transferred Members will return to the former Health Center in the future.

4.03 Nothing contained within this Certificate shall interfere with the professional relationship between the Member and the Affiliated Physician or Affiliated Provider. Each Member shall have the right to choose, to the extent feasible and appropriate, the Affiliated Physician responsible for his/her primary care. Each IPA maintains medical records at the designated Health Center for each Member receiving services. The medical records are available for inspection and review during regular business hours upon request by the Member.

4.04 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.

4.05 The Authorized Benefits and Services provided under this Certificate are solely for the individual benefit of the Member 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 immediately, 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.

4.06 If a Member's identification card is lost or stolen, the Member must contact the Plan's Customer Service Department at (313) 871-2000 by the close of the business day following discovery of theft or loss. Failure to notify of the loss or theft of a Member identification card within that time period shall result in the termination of coverage under this Certificate.

4.07 When a Member enrolls in the Plan, he shall be deemed to have agreed to use Affiliated or Specialty Physicians, Providers and Facilities for all services and supplies, except in case of a Medical Emergency or Accidental Injury.

4.08 This Certificate supersedes all previous contracts or certificates between the Plan, the Group, and the Members.

4.09 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.

4.10 The Plan shall not be liable for any delay or failure of an Affiliated Provider, Referral Physician, or Referral Facility 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.

4.11 The Member shall notify the Plan of any change of address within thirty (30) days of the change.

4.12 **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 Grievance procedure upon enrollment in the Plan and/or at any time upon request. The criteria used by the Plan to make an Adverse Benefit Determine will be made available to a Member upon written request to the Plan. A Member has the right to call the Plan to voice a complaint or write to the Plan to file a written complaint or to obtain information on any of the following:

(a) Benefits (including services determined to be experimental or investigational or not Medically/Clinically Necessary),
(b) Eligibility,
(c) Rescission of your Coverage,
(d) Payment of claims (in whole or in part),
(e) Delivery, coordination and/or quality of health care services,
(f) Contracts with our Providers,
(g) Availability of care or Providers,
(h) An Adverse Benefit Determination, including services which upon review by the Plan have either been denied, reduced or terminated. It also may include a slow response to a request for a decision.

The complaint / inquiry should be directed to:
Total Health Care USA, Inc.
Attention: Grievance Coordinator
3011 W. Grand Blvd., Suite 1600,
Detroit, MI 48202
Phone: (313) 571-6583
Fax: (313) 871-3104
e-mail: results@THCmi.com

When filing a complaint, another person can act as the Member's authorized representative. Written notification must be submitted to Total Health Care, USA, Inc authorizing the person to act on behalf of the Member concerning the appeal.

Grievance. A grievance is the process used to handle a complaint for any of the circumstances listed above. Members or their authorized representative have one hundred and eighty (180) days from receipt of the adverse benefit determination or written notice from the Plan concerning their complaint in which to file an appeal and enter into the Grievance process. The Grievance process allows for two levels of appeal – internal and external.

Internal Appeal. Members have the right to request a meeting with the Total Health Care, USA Appeal Review Committee. Members or an authorized representative may attend the meeting in person or by telephone. The person(s) reviewing the appeal will not be the same person(s) involved in the original decision nor will they be subordinates of the original reviewer(s). The person who reviews the appeal will consult with a medical expert within the appropriate medical specialty. Medical appeals will be completed within thirty (30) calendar days after receipt. Administrative appeals will be completed within thirty-five (35) calendar days after receipt. Members will be notified in writing of the final decision. If the decision upholds the denial, a second level external appeal may be filed. The final letter explains external appeal rights and how to file the appeal.

Expedited Appeal. An expedited review of an appeal is allowed when applying the standard timeframes for appeal could, in the opinion of a Physician with knowledge of the medical condition, seriously jeopardize the Member's life or health or ability to regain maximum function or cause severe pain that cannot be adequately managed without treatment, service or procedures. If a Physician with knowledge of the Member's medical condition determinates that an expedited review of the appeal is necessary and so informs the Plan, either verbally or in writing, the Plan will consider the internal appeal in the expedited fashion and make its determination within seventy-two (72) hours upon receipt of the appeal. The Plan will notify the Member of the decision by phone and also mail a copy of the decision to the Member within two (2) business days. If denied, a second level expedited appeal may be filed with the Department of Insurance and Financial Services (DIFS) and must be received within ten (10) days of the first level internal appeal denial. If a request for an expedited appeal is denied, it then reverts to a thirty (30) day grievance.

If the first level internal appeal decision upholds the original denial, the specific reasons for the appeal decision will be provided. The notification letter will include the benefit provision, guideline, protocol, or other criterion used in the determination. Upon request, access to and copies of all papers related to the determination are provided.

External Appeal. A Member or authorized representative has the right to request a second level external appeal from DIFS within sixty (60) days of receipt of the decision from the first level internal appeal. The Member or authorized representative initiates the external appeal request by filing the DIFS Health Care Request for External Review Form within sixty (60) days. A copy of the Health Care Request for External Review Form will be included with the final decision letter from the first level internal appeal. Members may also call DIFS at (877) 999-6442 to receive the form via US mail.

When appropriate, DIFS will request a recommendation by an independent review organization. The independent review organization is not a part of the Plan. The Commissioner of DIFS will issue a final order which then exhausts the Member's appeal right. To ask questions about the external review process, contact the Total Health Care, USA Grievance Coordinator at (313) 571-6583 or (800) 826-2862 x822 or write:

Department of Insurance and Financial Services
Healthcare Appeals Section, Office of General Counsel
P.O. Box 30220
Lansing, Michigan 48909-7720
Or call: (877) 999-6442
Or fax: (517) 241-4168

4.13 **Protected Health Information (PHI).** All Member protected health information 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 Member's health condition or diagnosis. The Member has the right to inspect and review his medical records. The Plan will not use or disclose PHI concerning Member other than for purposes of treatment, payment, or health care operations except upon written authorization/approval of the Member or as otherwise required by law. Any such disclosure of PHI will be limited to that which is minimally necessary.

4.14 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 Department

4.15 **Identification Card.** 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.

4.16 **Written Documents.** As a Member of the Plan, request for the following information can be made either verbally by calling the Customer Service Department at (313) 871-2000 or in writing via US mail to:

Total Health Care, USA Inc
3011 W. Grand Boulevard, Suite 1600
Detroit, MI 48202
ATTN: Customer Service Department

(1) **Information concerning Affiliated Providers.** The Provider Directory includes the name, specialty type, practice location and availability / accessibility of the Affiliated Providers. Requests may be made for the following additional information:

(a) Clarification with respect to the information contained in the Provider Directory.

(b) Professional credentials including, but not limited to, professional degrees, dates of certification by professional boards and other professional bodies and affiliation status of Affiliated Physicians, Providers, Affiliated Facilities and Affiliated Hospitals.

(2) **Financial Relationships with Affiliated Providers.** Information indicating the nature of financial relationships between the Plan and its Affiliated Providers can include:

(a) 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;

(b) Whether a capitation arrangement exists, under which a fixed amount is paid to the Affiliated Provider for all or a specified set of Authorized Benefit and Services that are or may be rendered to the Member;

(c) Whether payments to Affiliated Providers are based on standards relating to cost, quality, and/or patient satisfaction.

(3) **Licensure Verification** including information concerning disciplinary action and open formal complaints filed against a health professional or Affiliated Provider is available through the Michigan Department of Labor and Economic Growth by calling (517) 241-9427 or electronically online at http://www.cis.state.mi.us/verify.htm.

(4) **Certification of Coverage, Schedule of Out-of-Pocket Expense, Member Handbook.** Clarification regarding the rules to access benefits such as prior authorization requirements, formulary restrictions, if any, and exclusions and limitations applicable to the specific categories of benefits.

(5) **Termination of Affiliated Provider.** Clarification regarding access to care for a Member in an ongoing course of treatment with a terminated Affiliated Physician, Specialty Physician or Provider, which shall be permitted with Plan authorization as follows:

(a) For a period of ninety (90) days from the date the Member is notified of the termination;

(b) For a Member in her second or third trimester of pregnancy through post-partum care;

(c) For the remainder of the Member's life for care directly related to the treatment of the terminal illness, if it is determined that the Member is terminally ill as defined in Section 5653 of the public health care.

4.17 **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.

4.18 **Claims Provisions.** When a Member receives Authorized Benefits and Services from an Affiliated Provider, Member will not be required to pay any amounts except for applicable Co-Pays, Deductibles and Coinsurance. Member will not be required to submit any claim forms for Authorized Benefits and Services received from Affiliated Providers. Member is responsible for the cost of any services received from non-Affiliated Providers or Physicians unless those services were arranged for and approved in advance by your Affiliated Physician and the Plan, or unless they were the result of treatment for a Medical Emergency. Members will receive an Explanation

of Benefits from the Plan and the Provider of Services will receive an Explanation of Payment upon filing a Clean Claim with the Plan. Plan pays Clean Claims that are submitted within one year from the date of service within forty-five (45) days of receipt.

Member Self Pay. If a Member is required to pay for an Authorized Benefit and Services (other than for applicable Deductible, Coinsurance or Co-Pay), a written request for reimbursement can be made to the Plan. The request must include a bill that shows exactly what services were received, including applicable diagnosis and CPT codes, the date, place of service and rendering provider. A statement that shows only the amount owed is not sufficient. Reimbursement will be made less any applicable Co-pay, Coinsurance and Deductible. If you have questions about what is required, call Total Health Care, USA Customer Service Department at (313) 871-2000.

Reimbursement Request Time Limit. Request for reimbursement for a self-pay Authorized Benefit and Service must be made within sixty (60) days of the date in which the services were obtained. Requests for reimbursement beyond the sixty (60) days can be limited or refused by the Plan, unless it is not reasonably possible to provide proof of payment in the required time. The required information must be made available as soon as reasonably possible. Upon review of the request for reimbursement, the Plan may require additional information to process a reimbursement request. Unless Member is legally incapacitated and, therefore, unable to respond, the Plan will not be liable for a claim or reimbursement request if additional information is not received within sixty (60) days of the request. The Plan's right to that information or documentation may be limited by state or federal law.

The Plan will be liable for a claim or reimbursement request only if it is received within one year after the date of service, unless the Member is legally incapacitated. Send itemized medical bills promptly to:

Total Health Care USA, Inc.
Claims Department
3011 W. Grand Boulevard, Suite 1600
Detroit, MI 48202

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

ARTICLE V. COVERED AND NON COVERED SERVICES

5.01 **Professional Services**

Preventive Health Care Services – available without Co-Pays, Coinsurance or Deductibles

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

(b) Certain Drugs

- Aspirin – men and women of certain ages
- Folic Acid supplements – women who may become pregnant
- Flouride Chemoprevention supplements – children without fluoride in their water source
- Gonorrhea prevention medication – all newborns
- Iron supplements – children ages 6 to 12 months at risk for anemia

(c) Screening and Counseling Services for Adults

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

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

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

(e) Assessments and Screenings for Children

- Alcohol and Drug Use Assessments – adolescents
- Autism Screening – children at 18 and 24 months

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

The benefits in this Section are subject to change based on provisions of the Affordable Care Act. Visit the CMS web site at www.healthcare.gov/prevention for the most up-to-date services.

5.02 **Other Services Provided by Health Professionals.** Services listed in this Section 5.02 (other than those designated as Non-Covered) are covered when provided by an Affiliated Provider during an office, home or Hospital visit for the diagnosis and treatment of an Authorized Benefit and Service and approved in advance by the Plan if required, including:

(a) Services necessary to treat a Medical Emergency or Urgent Care situation, and
(b) Services and supplies received from an Affiliated obstetrician/gynecologist for an annual well-woman examination or routine pregnancy services (no prior authorization, approval or referral required).

Allergy Testing and Treatments

Covered Services:

- Allergy testing, evaluations and injections, including serum costs.

Non-Covered Services:

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

Clinical Ecology and Environmental Medicine

Non-Covered Services:

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

Diabetic Services, Supplies, and Medications

Covered Services:

- Blood glucose monitors and diabetes test strips.
- Syringes and lancets.
- Diabetes educational classes to ensure that persons with diabetes are trained as to proper self-management and treatment of their diabetes.
- Certain diabetic supplies, such as syringes, needles, lancets, and blood glucose test strips, may be purchased from the Plan's Diabetic Supply Provider.
- Insulin pumps.
- Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.
- Specialty shoes prescribed for a person with diabetes.

Non-Covered Services:

- Alcohol and gauze pads.
- Services and supplies for the convenience of the Member of caregiver.

Dialysis Services

Covered Services:

- Outpatient Dialysis Services.

Dietitian Services

Covered Services:

- Consultations with an affiliated dietitian, upon referral from an Affiliated Physician up to a maximum of six (6) visits per Contract Year.

Educational Services

Covered Services:

- Classes when conducted by an Affiliated Provider for the purpose of managing chronic disease states such as diabetes or asthma.
- Maternity classes conducted by Affiliated Providers.

Non-Covered Services:

- Services for remedial education, including school-based services.
- Services, treatment or diagnostic testing related to learning disabilities, cognitive disorders and developmental delays.
- Education testing or training, including intelligence testing.
- Classes covering such subjects as stress management, parenting and lifestyle changes.

Eye Care

Covered Services:

- Treatment of medical conditions and diseases of the eye.

Coverage Limitations:

- Vision care services (described later in this Section V).

Foot Care

Coverage Limitations:

- Covered when referred by an Affiliated Provider

Non-Covered Services:

- Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care.
- Cleaning, soaking, and skin cream application for the feet.
- Shoes unless attached to a brace or prescribed for a person with diabetes.

Home Health Care

Covered Services:

When Member is:

- Confined to the home,
- Under the care of a Physician,
- Receiving services under a Plan of Care established and periodically reviewed by a Physician, and
- In need of intermittent skilled nursing care of physical, speech or occupational therapy.

Coverage Limitations:

- Up to forty-five (45) visits per Plan Year when referred by an Affiliated Physician and authorized by the Plan.

Non-Covered Services:

- Custodial Care, even in the event the Member receives Authorized Benefits and Services for Home Health Care or Skilled Nursing Services concurrent with Custodial Care.

Homeopathic and Holistic Services

Non-Covered Services:

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

Chiropractic Care

Coverage Limitations:

- Up to thirty (30) visits per Plan Year when referred by the Affiliated Physician. Visits are combined with physical and occupational therapy.

Pain Management

Covered Services:

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

Plastic Surgery, Medically Necessary

All services defined as Medically Necessary Plastic Surgery require Prior Authorization by the Plan's Medical Director.

Covered Services:

- Blepharoplasty of upper lids
- Breast Reduction
- Surgical Treatment of Male Gynecomastia
- Surgery to correct Sleep Apnea
    - Panniculectomy
    - Rhinoplasty
    - Septorhinoplasty

Non Covered Services:

- Any procedures deemed for cosmetic purposes, primarily to improve the way the body looks. Coverage is excluded for, but not limited to:
    - Blepharoplasty of lower lids.
    - Breast augmentation except when provided as part of post-mastectomy reconstructive services.
    - Chemical peel for acne.
    - Collagen implants.
    - Diastasis recti repair.
    - Excision or repair of excess or sagging skin, however, a panniculectomy is covered according to our medical policies.
    - Fat grafts, unless an integral part of another Authorized Benefit and Service.
    - Hair transplants or repair of any congenital or acquired hair loss, including hair analysis.
    - Liposuction, unless an integral part of another Authorized Benefit Service.
    - Orthodontic treatment, even when provided along with reconstructive surgery.
    - Removal for excessive hair growth by any method, even if caused by an underlying medical condition.

- Rhytidectomy (wrinkle removal).
- Rhinophyma treatment.
- Salabrasion.
- Spider vein removal.
- Tattoo removal.

Reconstructive Surgery

Covered Services:

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

- The defects and/or effects of Illness or Injury cause clinical functional impairment. "Clinical functional impairment" exists when the defects and/or effects of Illness or Injury:
    i. causes significant disability or major psychological trauma (psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the Illness or Injury for which the reconstructive surgery is requested),
    ii. interfere with employment or regular attendance at school,
    iii. require surgery that is a component of a program of reconstructive surgery for a congenital deformity or trauma, or
    iv. contribute to a major health problem, and
- There is reasonable expectation that the surgery will correct the condition, and
- The services are approved in advance by the Plan and you receive them within two years of the event that caused the impairment, unless either of the following applies:
    i. the impairment caused by Illness or Injury was not recognized at the time of the event. In that case, treatment must begin within two years of the time that the problem is identified, or
    ii. your treatment needs to be delayed because of developmental reasons.
- The Plan will cover treatment to correct the functional impairment even if the treatment needs to be performed in stages as long as that treatment begins within two years of the event causing the impairment and as long as you remain a Member.
- **Reconstructive Surgery Following a Mastectomy**
- In compliance with the Women's Health and Cancer Rights Act of 1998, the Plan will consult with your Affiliated Physician or other Affiliated Provider to determine coverage for these services:
    i. Reconstruction of the breast on which a mastectomy was performed;
    ii. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    iii. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

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

Coverage Limitations:

- Refer to the Schedule of Out-of-Pocket Expense for additional information about limitations on certain procedures, treatments and reconstructive surgeries.

Breast Cancer Rehabilitative Services

Covered Services:

- Any procedure intended to improve the results of or ameliorate the debilitating consequences of treatment of breast cancer, delivered inpatient or outpatient, including but not limited to, reconstructive plastic surgery, physical therapy and psychological and social support services.

Rehabilitative Medicine Services

Covered Services:

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

- Cardiac and Pulmonary Rehabilitation
- Physical and Occupational Therapy
- Speech Therapy for treatment of medical diagnoses
- Biofeedback for treatment of medical diagnoses when Medically/Clinically Necessary, as determined according to our medical policies.

Short-term Rehabilitative Medicine Services are covered if:

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

Coverage Limitations:

- Cardiac and Pulmonary Rehabilitation is limited to thirty (30) visits per contract year
- Physical and Occupational therapy combined with Chiropractic spinal manipulations and manipulations by an osteopathic Physician are limited to thirty (30) visits per contract year
- Speech therapy for treatment of medical diagnoses is limited to thirty (30) visits per contract year

Non-Covered Services:

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

- All therapies for developmental delays and cognitive disorders, including physical, occupational, speech, cognitive and sensory integration therapy.
- Cognitive rehabilitative therapy (neurological training or retraining).
- Craniosacral therapy.
- Prolotherapy.
- Rehabilitation services obtained from non-Health Professionals, including massage therapists.
- Relational, educational and sleep therapy and any related diagnostic testing. This exclusion does not apply to therapy or testing provided as part of Covered Hospital Inpatient or Outpatient Care.
- Services outside the scope of practice of the servicing provider.
- Strength training and exercise programs.
- Summer programs meant to maintain physical condition or developmental status during periods when school programs are unavailable.
- Therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition including, but not limited to, cerebral palsy and developmental delays.
- Therapy to correct an impairment, when the impairment is not due to Illness, Injury or a congenital defect for which you have received corrective surgery.
- Visual training and sensory integration therapy.
    - Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluation and all return to work programs , employment counseling or those that are in connection with examinations for insurance or employment screening, except as they may be incidental to an annual health exam.
- Extra-spinal manipulation and related services performed by a chiropractor are not covered.

Sex Change or Transformation

Non-Covered Services:

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

Tobacco Cessation Treatment

Covered Services:

- Smoking cessation services provided by the Plan's Behavioral Health Provider.
- Tobacco cessation prescription drug treatments are covered according to the formulary.

Non-Covered Services:

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

Transplants

Covered Services:

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

- Bone marrow or stem cell.
- Cornea.
- Heart.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Small bowel.
- Related Services:
    - Expenses related to Computer organ bank searches and any subsequent testing necessary after a potential donor is identified, unless covered by another health plan.
    - Typing or screening of a potential donor only if the person proposed to receive the transplant is a Member.
    - Donor's medical expenses directly related to or as a result of a donation surgery if the person receiving the transplant is a Member and the donor's expenses are not covered by another health benefit plan.
    - One comprehensive evaluation per transplant except as permitted by our medical policies.

Non-Covered Services:

- Community wide searches for a donor.
- All donor expenses, even those of Members, for transplant recipients who are not Members.
- Transplants of organs when the transplant is considered experimental or investigational.

Weight Loss Services for Morbid Obesity

Covered Services:

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

Coverage Limitations:

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

Non-Covered Services:

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

Affiliated Physician, Affiliated Provider and Health Professional Services

- Evaluation and Management Services, Surgical Services and any other related professional services within a Hospital, both Inpatient and Outpatient, Ambulatory Surgical Center, Office, Skilled Nursing Facility, Rehabilitation Facility other any other approved facility and the Patient's Home.
    - Affiliated Physicians are not required to provide referrals to Affiliated Specialty Physicians for office-based services, including Ob/Gyn care, with the exception of Chiropractic and Podiatry.

5.03 **Prescription Drugs and Supplies**

Prescription Drugs Received while Inpatient

Covered Services:

- Drugs and supplies that are prescribed and received during a covered inpatient stay.

Cancer Drug Therapy/Antineoplastic Drug Therapy and Clinical Trials

Covered Services:

- As required by state law, drugs for cancer therapy (Antineoplastic Drug Therapy) and the reasonable cost of administering them are covered. Coverage for cancer/neoplastic 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 (FDA), and regardless of the type of neoplasm, if all of the following conditions are met:
    - The drug is ordered by a physician for the treatment of a specific type of neoplasm. The ordering physician is not required to be an Affiliated Provider, and the drug / treatment is approved by the Plan's Medical Director.
    - The drug is used as part of an antineoplastic drug regimen.
    - Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
    - The physician has obtained informed consent from the patient for the treating regimen that includes federal FDA approved drugs for off-label indications.

- Routine patient costs associated with a clinical trial, defined as all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial.

Non-Covered Services:

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

Injectable Drugs

Covered Services:

- Growth Hormone, when self-injected and obtained through Plan's Specialty Pharmacy with Prior Approval.

Coverage Limitations:

- Selected Specialty Drugs are available exclusively through our Specialty Pharmacy with Prior Approval.
- The following drugs are excluded from the Prescription Drug Benefit and are covered under the Medical Benefit portion of your Certificate. Exceptions are outlined in the Plan medical policies:
    - Injectable and infusible drugs administered in an inpatient or emergency setting.
    - Injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility.

Outpatient Prescription Drugs

Coverage provided is based on the Plan Approved Drug List with required dispensing from an Affiliated Pharmacy or Plan Mail Order Pharmacy. Drugs may be added or removed from the Approved Drug List throughout the Plan Year. With a prescription order, written by a prescriber, the Plan will cover:

Covered Services:

- Drugs that are intended to be and can be self-administered, regardless of the setting. Exceptions to this rule are outlined in our medical policies.
- Outpatient prescription drugs that require a prescription and are listed in our Approved Drug List, or
- Drugs listed in Section 5.01 under Preventive Health Care Guidelines.
- Outpatient prescription drugs dispensed by a non-Affiliated Pharmacy during a Medical Emergency or Urgent Care situation, as defined in Section 5 of the Certificate.

5.04 Hospitals, Diagnostic Tests and Other Facilities Services

Ambulatory Surgical Services and Supplies

Covered Services:

- Outpatient services and supplies furnished by a surgery center along with a covered surgical procedure on the day of the procedure, including breast cancer treatment.

Hospice Care

Covered Services:

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

- Inpatient Hospice Care. Short-term inpatient care in a licensed hospice facility when Skilled Nursing Services are required and cannot be provided in other settings. Prior Approval of inpatient Hospice Care is required.
- Outpatient Hospice Care when intermittent Skilled Nursing Services by a registered nurse or a licensed practical nurse are required or when medical social services under the direction of a Physician are required. Outpatient Hospice Care is any care provided in a setting other than a licensed hospice facility. Hospice Care provided while you are in a Hospital or skilled nursing facility is considered outpatient Hospice Care.
- Respite Care in a facility setting as outlined in our medical policies.

Coverage Limitation:

- Coverage limited to 45 days per Contract Year.

Non Covered Services:

- Custodial Care even if you receive inpatient or outpatient Hospice Care along with Custodial Care.

Hospital and Long-term Acute Care

Covered Services:

- Hospital Inpatient Care. Hospital and long term acute inpatient services and supplies including services performed by Physicians and Health Professionals, room and board, general nursing care, Surgery, non-experimental Antineoplastic Surgical Drugs or other drugs administered while you are confined as an inpatient, and related services and supplies. Non-emergency inpatient Hospital stays must be approved in advance, with the exception of Inpatient Hospital stays for a mother and her newborn up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.
- Hospital Outpatient Care. Hospital services and supplies listed under Hospital Inpatient Care above that you receive on an outpatient basis. Hospital Observation Care received after an emergency room visit is considered Hospital Outpatient Care.

Coverage Limitations:

- See your Schedule of Out-of-Pocket Expense for additional information about limitations on certain procedures, treatments and surgeries.

Non-Covered Services:

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

Private Duty Nursing

Non-Covered Services:

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

Diagnostic Imaging and Testing and Laboratory Procedures

Covered Services:

- Diagnostic and therapeutic radiology services, including radiation therapy, high-tech radiology procedures such as PET, MRI, CT Scans, and laboratory tests not excluded elsewhere in this Section. See Article VII for Prior Approval requirements.
- All non-emergency laboratory tests, including high-tech radiology examinations, must be performed at an Affiliated laboratory or facility.
- Except for preventive health care services and maternity care, radiology services and laboratory tests may be subject to a Deductible even if ordered and performed in a Provider's office.
- Radiology services and laboratory tests performed in a Hospital, either while you are an inpatient or an outpatient, are subject to the same Coinsurance and Deductible as Hospital services even if the service or test is ordered and partially performed in a Provider's office.

5.05 **Skilled Nursing Services, Sub-acute, and Inpatient Rehabilitation Facility Care**

Covered Services:

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

Coverage Limitations:

- Coverage limited to 45 days per Contract Year.

Non-Covered Services:

- Admission to a skilled nursing, sub-acute or inpatient rehabilitation facility if the necessary care or therapies can be provided safely in a less intensive setting, including the home or an Affiliated Provider's office.
- Care provided in a facility required to protect you against self-injurious behavior.

- Custodial Care, even if you receive Skilled Nursing Services or therapies along with Custodial Care.
- Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.
- Residential Facility or Assisted Living Facility Care. Non-skilled care received in a residential facility or assisted living facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.
- Room charges that exceed the cost of a semi-private room when the room upgrade is requested by the Member and a semi-private room is available. The Member must pay the facility those charges that exceed the cost of a semi-private room payable by the Plan.

5.06 **Durable Medical Equipment (DME) and Supplies, Prosthetics and Orthotics**

Durable Medical Equipment (DME)

DME is equipment intended for repeated use in order to serve a medical need, is generally not useful to a person in the absence of Illness or Injury, and is appropriate for use in the home. Examples of covered DME are manual wheelchairs, CPAP machines and glucose monitoring devices. DME must be supplied by the Plan's DME provider.

Covered Services:

- DME prescribed by your by a Physician or Health Professional.
- Repair or replacement, fitting and adjustment of covered DME needed as the result of normal use, body growth or body change.
- Training or education on the use of DME.
- Disposable supplies necessary for the proper functioning or application of the DME.
- Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.
- Specialty shoes according to the criteria specified in our medical policies.

Coverage Limitations:

- *NOTE: Inhaler assist devices and some diabetic supplies, such as syringes, needles, lancets and blood glucose test stripes may be covered as a prescription drug benefit depending on where you obtain the supplies.*
- Coverage is for standard DME only. Equipment must be appropriate for home use.
- Coverage is limited to one piece of same-use equipment. We may substitute one type or brand of DME for another when the items are comparable for meeting your medical needs. Wheelchair Coverage is generally limited to a manually operated, standard wheelchair unless another model is Prior Approved by us according to our medical policies.
- DME may be rented, purchased or repaired. The decision to rent, purchase, repair or replace DME is made by the Plan. We may limit replacement of DME to the expected life of the equipment.

Non-Covered Services:

- Equipment that is not conventionally used for the medical need for which it was prescribed.
- Equipment and devices solely for the convenience of you or your caregiver.
- The purchase or rental of personal comfort items, convenience items, or household equipment that have customary non-medical purposes, such as protective beds, chair lifts, air purifiers, water purifiers, exercise equipment, non-allergenic pillows, mattresses or waterbeds, spas, tanning equipment, and other similar equipment even if they are Medically/Clinically Necessary.
- Modifications to your home, living area, or motorized vehicles. This includes equipment and the cost of installation of equipment, such as central or unit air conditioners, escalators, elevators, swimming pools, and car seats.
- Items designed for self-assistance, safety, communication assistance and other adaptive aids. This includes, but is not limited to, reachers, feeding, dressing and bathroom aids, augmentive communication devices, car seats, and protective beds.
- Non-standard DME unless we approve the non-standard equipment in advance.
- All repairs and maintenance that result from misuse or abuse.
- Replacement of lost or stolen DME.

Food, Supplements and Formula

Covered Services:

- Supplemental feedings administered via tube, known as enteral feeding, along with formulas intended for this type of feeding, supplies, equipment and accessories needed to administer this type of nutrition therapy.
- Supplemental feedings administered via an IV, known as parenteral nutrition, along with associated nutrients, supplies, and equipment needed to administer this type of nutrition.

Non-Covered Services:

- All other food, formula and nutritional supplements except those intended for tube feeding and nutrients necessary for IV feeding. This includes, but is not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the FDA.

Medical Supplies

Covered Services:

- Medical supplies received while an inpatient or in connection with a home health visit are covered at your Hospital benefit level.
- Some medical supplies are covered under your Durable Medical Equipment (DME) benefit, including such supplies as catheters, syringes, ostomy supplies, feeding tubes, and lancets.

Non-Covered Services:

- Certain outpatient medical supplies that are consumable or disposable, including but not limited to, gloves, diapers, adhesive bandages, elastic bandages, and gauze.

Prosthetic and Orthotics

Covered Services:

- Surgically implanted prosthetic devices, such as a replacement hip or heart pacemaker.
- Externally worn prosthetic devices.
- Purchased, repaired or replaced prosthetics and orthotics.
- Repairs or replacement, fitting and adjustment of covered prosthetic and orthotic devices that are needed as the result of normal use, body growth or change.

Non-Covered Services:

- All repairs and maintenance that result from misuse or abuse.
- Appliances that have been lost or stolen.
- Prosthetic or orthotic devices that are not conventional, not Medically/Clinically Necessary according to the criteria set forth in our medical policies or are for the convenience of the Member or caregivers.

5.07 **Behavioral Health Services, Mental Health Services**

PARITY: The Certificate of Coverage provides for like and equal benefits for Behavioral Health and Medical Benefits, including Co-Pays, Coinsurance, Deductibles and visits.

Covered Services:

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

(a) provided by licensed behavioral Health Professionals;
(b) provided in licensed behavioral health treatment facilities; and
(c) clinically-proven to work for your condition.

Mental health services are available in a variety of settings. You may be treated as an inpatient or as an outpatient or in the emergency room, depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know where to go for treatment, call our Customer Service Department at (313) 871-2000 or the Plan's behavioral health provider at (855) 377-2416 to be directed to behavioral health experts who can answer your questions.

Covered Services:

- Outpatient mental health services do not require a referral from your Affiliated Physician or the Plan. Inpatient mental health services (including partial hospitalization) require Prior Approval from our Behavioral Health Provider, except in a Medical Emergency.

- Acute Inpatient Hospitalization. This is the most intensive level of care. Prior Approval from our Behavioral Health Provider is required for inpatient services except in a Medical Emergency. Upon discharge, you will be referred to a less intensive level of care.
- Partial Hospitalization. This is a non-residential level of service that is similar in intensity to acute inpatient hospitalization. You are generally in treatment for more than four hours but less than eight hours daily. Prior Approval from our Behavioral Health Provider is required for partial hospitalization services.
- Intensive Outpatient Treatment. This is outpatient treatment that is provided with more frequency and intensity than routine outpatient treatment. You are generally in treatment for up to four hours per day, and up to five days per week. You may be treated individually, as a family or in a group.
- Outpatient Treatment. This is the least intensive, and most common, type of service. It is provided in an office setting, generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day by a licensed behavioral Health Professional.

Coverage Limitations:

- Treatment for medical complications related to certain behavioral health conditions, including but not limited to neuropsychological testing, when appropriate, is covered under your medical benefits.
- Eating disorders and feeding disorders of infancy or childhood, are covered at all levels of care described above based on our medical policies.
- Attention deficit hyperactivity disorders are covered for initial evaluation, and follow-up psychiatric medication management. Outpatient behavioral therapy is covered for children age 12 and under.
- Personality disorders are covered only for specific psychological testing to clarify the diagnosis.
- Organic brain disorders are covered for initial evaluation to clarify the diagnosis and for follow-up psychiatric medication management. Inpatient services for Members with organic brain disorders, such as closed head Injuries, Alzheimer's and other forms of dementia, are covered based on our medical policies.
- Pervasive developmental disorders, including but not limited to autism spectrum disorder, are covered for initial evaluation and follow-up psychiatric medication management.

Non-Covered Services:

Care provided in a home, residential or institutional facility, or other facility on a temporary or permanent basis, including:

- The costs of living and being cared for in:
    - Transitional living centers,
    - Non-licensed programs, or
    - Therapeutic boarding schools.

- The costs for care that is:
    - Custodial,
    - Designed to keep you from continuing unhealthy activities, or
    - Typically provided by community mental health services program.
- Provided via telephone, e-mail or Internet .
- Counseling and other services for:
    i. caffeine abuse or addiction,
    ii. sexual/gender identity issues, including sex therapy,
    iii. antisocial personality,
    iv. insomnia and other non-medical sleep disorders,
    v. adoption adjustment issues, including treatment for reactive attachment disorder,
    vi. marital and relationship enhancement, and
    vii. religious oriented counseling provided by a religious counselor who is not a Affiliated Provider.
    viii. experimental/investigational or unproven treatments and services.
    ix. scholastic/educational testing is not Covered. Intelligence and learning disability testing and evaluations should be requested and conducted by the child's school district.
    x. Mental illness disorders and disabilities that according to generally accepted professional standards are not amenable to treatment.

Substance Use Disorder

Covered Services:

- Substance use disorder, including counseling, medical testing, diagnostic evaluation and detoxification in a variety of settings. You may be treated in an inpatient or outpatient setting or emergency room, depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know what the most appropriate treatment setting is for your condition, call our Customer Service Department for assistance. The Plan follows the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.
- Outpatient substance use disorder services do not require a referral from your Affiliated Physician or the Plan. Inpatient substance use disorder services (including partial hospitalization) require Prior Approval from our Behavioral Health Provider, except in a Medical Emergency.
- Inpatient Detoxification. These are detoxification services that are provided while you are an inpatient in a Hospital or sub-acute unit. When provided in a medical setting, services are managed by the Plan.
- Medically Monitored Intensive Inpatient Treatment. Following full or partial recovery from acute detoxification symptoms, this type of care is provided at an inpatient facility or sub-acute unit.

- Partial Hospitalization. This is an intensive, non-residential level of service provided in a structured setting, similar in intensity to inpatient treatment. You are generally in treatment for more than four hours but generally less than eight hours daily.
- Intensive Outpatient Programs. These are outpatient services provided by a variety of Health Professionals at a frequency of up to four hours daily, and up to five days per week.
- Outpatient Treatment. This is the least intensive level of service. It is provided in an office setting generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.
- Outpatient/Ambulatory Detoxification. These detoxification services may be provided on an outpatient basis within a structured program when the consequences of withdrawal are non-life-threatening. These services are covered under your medical benefits.

Non-Covered Services:

- The costs of residential treatment programs without medical monitoring, institutional care, non-licensed programs, half-way houses or assisted living settings.
- Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.
- Services for caffeine abuse or addiction.
- Experimental/investigational or unproven treatments and services.

5.08 **Autism Services**

Definitions:

(a) "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.

(b) "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 Commissioner of the Department of Insurance and Finance Services (DIFS), if the Commissioner determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

(c) "Autism spectrum disorders" means any of the following pervasive developmental disorders as defined by the diagnostic and statistical manual:

i. Autistic disorder.

ii. Asperger's disorder.

iii. Pervasive developmental disorder not otherwise specified.

(d) "Behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

i. Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

ii. 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.

(e) "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.

(f) "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.ESB 414

(g) "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.

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

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

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

(k) "Treatment of autism spectrum disorders" means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

i. Behavioral health treatment.

ii. Pharmacy care.

iii. Psychiatric care.

iv. Psychological care.

v. Therapeutic care.

(l) "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:

- 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
- 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 insight oriented, behavior modifying or supportive psychotherapy.
- Behavioral health treatment including but not limited to individual and group psychotherapy and behavioral modification.
- Pharmacy care.
- Psychiatric care.
- Psychological care.
- Habilitative Services including but not limited physical therapy, occupational therapy and speech therapy.

Coverage Limitations:

- Co-Pays, Deductibles, Coinsurance may apply. Consult your Schedule of Out-of-Pocket Expense.
- Behavioral health treatment- evidence based counseling and treatment programs, including ABA, that meeting the following requirements:
    - Are necessary to develop, maintain, or restore to the maximum extent practicable, the functions of an individual
    - Are provided or supervised by a board certified behavior analyst or licensed psychologist with formal university training and supervised experience

Non Covered Services:

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

Terms and Conditions:

- 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:
    i. 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.
    ii. Request the results of the autism diagnostic observation schedule that has been used in the diagnosis of an autism spectrum disorder for that Member.

iii. Request that the autism diagnostic observation schedule be performed on that member not more frequently than once every 3 years.
iv. Request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to the Plan.

5.09 **Family Planning and Maternity Care Services**

Abortions

Non-Covered Services:

- All services and supplies relating to elective abortions.

Contraceptive Medications and Devices

Covered Services:

- Contraceptive medications and devices.

Maternity and Newborn Care

Covered Services:

- Hospital and Provider care. Services and supplies furnished by a Hospital or Provider for prenatal care, including genetic testing, postnatal care, Hospital delivery, and care for the complications of pregnancy.
- Hospital confinement for the mother and newborn of no less than 48 hours following a normal vaginal delivery or no less than 96 hours following a cesarean section with no prior authorization/approval. If the mother and her attending Physician agree, the mother and the newborn may be discharged from the Hospital sooner. If the birth occurred outside of the hospital, the length of stay will be determined by the admission date and time.
- Newborn child care including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, for the first 31 days from birth. If newborn coverage is to continue beyond the first 31-day period, Member must notify the Plan or the health insurance marketplace, if applicable, and complete the necessary enrollment procedure.
- Home care services. Telephone assessment and home visits by a registered nurse shortly after the date of the mother's discharge for evaluation of the mother, newborn and family if medically necessary as identified by an Affiliated Provider.
- Maternity education programs.

Coverage Limitations:

- Maternity education is limited to approved programs.
- Care extending beyond the 48 hours for a vaginal delivery and 96 hours for a cesarean delivery must be Prior Authorized by the Plan.

Non-Covered Services:

- All maternity care within four (4) weeks of the estimated date of delivery as determined by the Affiliated Physician, including prenatal services, delivery services and postpartum care, provided while you are outside of the Service Area. A routine delivery is not considered to be a Medical Emergency.

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

Reproductive Services

Covered Services:

- Diagnostic counseling and planning services for treatment of the underlying cause of infertility. Examples of covered Services are sperm count, endometrial biopsy, hysterosalpingography, diagnostic laparoscopy and infertility drugs.
- Advice on contraception and family planning, including childbirth education.
- Certain genetic counseling, testing and screening services when approved in advance by the Plan.
- Sterilization procedures such as tubal ligations, tubal obstructive procedures and vasectomy.

Coverage Limitations:

- Reproductive services may be excluded or limited as shown in the Schedule of Out-of-Pocket Expense.
- Vasectomy is covered only when performed in a Physician's office or when performed in connection with another covered inpatient or outpatient surgery.

Non-Covered Services:

- Services to reverse voluntary surgical sterilization.
- Condoms, contraceptive foams, and contraceptive jellies and ointments.

5.10 **Dental, Vision and Hearing Services**

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.

Oral Surgery

Covered Services:

- Treatment of fractures of facial bones.
- Biopsy and removal of tumors or cysts of the jaw, other facial bones, soft tissues of the mouth, lip, tongue, accessory sinuses, and salivary glands and ducts.
- Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury. This includes treatment for abnormalities such as cleft lip or cleft palate.
- Medical and surgical services required to correct accidental Injuries, including emergency care to stabilize dental structures following Injury to sound natural teeth.
- Treatment for oral and/or facial cancer.
- Treatment for conditions affecting the mouth other than the teeth.

Non-Covered Services:

- Rebuilding or repair for cosmetic purposes.
- Orthodontic treatment, even when provided along with oral surgery.
- Dental surgery in preparation for implants or dentures, including preparation of the bone, or dental surgery done in connection with any of the Covered Services listed above.
- Routine Dental exams, cleanings and restorative except as mentioned above.

Dental and Pediatric Dental Coverage may be obtained through the Health Insurance Market Place.

Orthognathic Surgery

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

Covered Services:

- Referral care for evaluation and orthognathic treatment only when prior authorized by the Plan.
- Cephalometric study and x-rays.
- Orthognathic surgery and post-operative care, including hospitalization, if necessary.

Coverage Limitations:

- See the Orthognathic Surgery category of your Schedule of Out-of-Pocket Expense for specific limitations to this benefit.

Non-Covered Services:

- Orthodontic treatment, even when provided along with orthognathic surgery.

Temporomandibular Joint Dysfunction or Syndrome

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

Covered Services:

- Medical care or services to treat dysfunction or TMJS resulting from a medical cause or Injury.
- Office visits for medical evaluation and treatment.
- X-rays of the temporomandibular joint including contrast studies, but not dental x-rays.
- Myofunctional therapy.
- Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

Coverage Limitations:

- See the Temporomandibular Joint Dysfunction or Syndrome category of your Schedule of Out-of-Pocket Expense for specific limitations to this benefit.

Non-Covered Services:

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

Vision Care Services

Covered Services:

- One vision screening, performed as part of a physical exam, during each Plan Year to determine vision loss.
- Eyeglasses, eyeglass frames, (all types of contact lenses if Medically Necessary) or corrective lenses every two (2) years for adults and yearly for children up to the age of 18 years.
- Refractions.

Coverage Limitations:

- Refractions are limited to one time per Plan Year.
- Eyeglass frames are limited to a specific selection.
- Contact lenses are covered for Medically Necessary reasons only.

Non-Covered Services:

- Eye exercises, visual training, orthoptics, sensory integration therapy.
- Radial keratotomy, laser surgeries and other refractive keratoplasty.
- All other vision care services and supplies.

Hearing Care Services

Covered Services:

- One hearing screening, performed as part of a physical exam, during each Plan Year to determine hearing loss.
- Services and supplies related to hearing care, including ear plugs, external BAHA devices, hearing aids and adjustments
- Examinations for hearing aids

Coverage Limitations:

- Hearing aids will be limited to one hearing aid per ear every three years, up to $600.

5.11 **Non-Emergent Care After Regular Office Hours.** If you become Ill or are Injured after regular office hours, call your Affiliated Physician's office and tell them you are a Member of Total Health Care, USA. Your Affiliated Physician or another Affiliated Provider acting on his or her behalf must be available 24 hours a day, 7 days a week to help you determine the best place to go for care.

5.12 **Medical Emergency or Urgent Care**

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

Urgent Care services received from a Non-Affiliated Provider who is located in our Service Area are not covered. Urgent Care services received from a Non-Affiliated Provider who is located outside of our Service Area are covered.

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

Medical Emergency.

If you have a Medical Emergency, seek help immediately (no prior authorization/approval is required; Co-Pays may apply and do not vary based on Affiliated/Non-Affiliated Status of the Provider). Payment for emergency services will be based on reasonable and customary charges, median in-network rates or Medicare rates whichever is greater. All medically necessary care required to treat a Medical Emergency, including care by non-Affiliated Providers is covered.

If you are confined in a Hospital as an inpatient after a Medical Emergency, you (or someone on your behalf) must notify your Affiliated Physician and the Plan soon as it is reasonably possible about your confinement. Once your inpatient stay is no longer a Medical Emergency and you have received care to the point of stabilization, the Plan must approve your continued inpatient stay at any Non-Affiliated Hospital in order for it to be covered. Once your condition has stabilized, the Plan may require you to be transferred to an Affiliated Facility to continue to be covered.

- Following a Medical Emergency, your Affiliated Physician can provide or arrange all follow-up care with Affiliated Providers. Follow-up care with Non-Affiliated Providers will only be covered if you receive Prior Approval from the Plan.

Emergency Transportation/Ambulance Services. In a Medical Emergency, the Plan will cover EMT and ambulance service to the nearest medical facility that can provide Medical Emergency care. The Plan will cover ambulance transfers between facilities when prior approved. All other non-emergent transportation is not covered unless prior approved by the Plan.

5.13 **Against Medical Advice/Noncompliance.** Members who elect to leave an Affiliated or non-Affiliated Facility or Hospital against medical advice or who are noncompliant with a medically necessary course of medical treatment and subsequently require services as a result of this noncompliance forfeit coverage of those related services. Services that are needed because you left a facility against medical advice or because you are noncompliant with treatment are not covered. Examples of services that may not be covered include, but are not limited to:

(a) Emergency room services shortly after you left a facility against medical advice;
(b) A Hospital stay to treat complications caused by leaving a facility against medical advice.

5.14 **Court Ordered Services**

Covered Services:

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

Non-Covered Services:

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

Domestic Violence

Covered Services:

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

Experimental, Investigational or Unproven Services

The Plan uses the following criteria when evaluating new technologies, procedures and drugs:

(a) Evidence of clear therapeutic effectiveness when used in the general population as demonstrated in peer-reviewed clinical trials.
(b) Evidence of patient safety when used in the general population.
(c) Evidence that the medical community in general accepts the safety and effectiveness of the service outside of investigational setting.
(d) Evidence of clinical meaningful outcomes.
(e) Evidence that clinically meaningful outcomes can be attained at a reasonable cost.

Covered Services:

- Coverage is available for routine patient costs in connection with approved clinical trials. For information about which trials are covered, your Affiliated Provider should contact the Plan's Utilization Management Department.
- Treatment that is experimental, investigational, or unproven may be covered if the condition being treated is either

i. A terminal disease and there are no reasonable alternative treatments, or
ii. A chronic, life threatening, severely disabling disease that is causing serious clinical deterioration

An individual case review will be conducted to determine if care or treatment that is investigational, yet promising for the conditions described will be covered.

Non-Covered Services:

- Any drug, device, treatment or procedure that is experimental, investigational or unproven. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:
  - An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy.
  - The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy.

Not Medically/Clinically Necessary

Non-Covered Services:

- Services and supplies that the Plan determines are not Medically/Clinically Necessary according to medical and behavioral health policies established by the Plan with the input of Physicians not employed by the Plan or according to criteria developed by reputable external sources and adopted by the Plan.
- Those services rendered by a Health Professional that do not require the technical skills of such a Provider;
- Those services and supplies furnished mainly for the personal comfort or convenience of you, anyone who cares for you, or anyone who is part of your family;
- Those services and supplies furnished to you as an inpatient on any day on which your physical or mental condition could safely and adequately be diagnosed or treated as an outpatient;
- Any service or supply beyond those services sufficient to safely and adequately diagnose or treat your physical or mental condition; and
- Additional or repeated services or treatments of no demonstrated additional benefit.
- *NOTE: If we exclude Coverage because a service or supply is not Medically/ Clinically Necessary, that decision is a determination about benefits and not a medical treatment determination or recommendation. You, with a Physician, may choose to go ahead with the planned treatment at your own expense. You have the option to Appeal our denial of your claim for Coverage as described in Section IV, 4.12.*

Other Non-Covered Services

Non-Covered Services:

- **Illegal Acts.** The Plan shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation. The Plan reserves the right to recover the cost of services and supplies that were initially covered by us and later determined to be excluded as described in this Illegal Acts section.
- **No Legal Obligation to Pay.** Service or supplies are not covered if you would not be required to pay for them if you did not have this coverage. That includes, among other things, service and supplies performed or provided by a family member.
- **No Show Charges.** Any missed appointment fee charged by a Provider because you failed to show up at an appointment.
- **Third Party Requirements.** Services required or recommended by third parties, such as courts, schools, employers, or accrediting/licensing agencies, related to getting or keeping a job, getting or keeping any license issued by a governmental body, getting insurance coverage, foreign travel, adopting children, obtaining or maintaining child custody, school admission or attendance and participation in athletics. Non-Covered Services include but are not limited to:

    - Physical examinations performed in excess of one per Plan year by your Affiliated Physician or other Health Professional,
    - Diagnostic services; and
    - Immunizations.

- **Unauthorized Services and Supplies**, including:
    - Services and supplies that are not performed, prescribed, or arranged according to the guidelines of this Certificate; and
    - Services and supplies that are provided without any required Prior Approval by the Plan.
- **Services and supplies not directly related to your care**, such as guest meals and accommodations, telephone charges, travel expenses, take-home supplies and similar costs.
- **Items or Services Furnished, Ordered or Prescribed by any Provider included on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities or the Systems for Award Management.** These lists are available on the OIG website at www.hhs.gov/oig or sam.gov.
- **Services and supplies received from Non-Affiliated Providers** except in the case of a Medical Emergency or if approved by the Plan prior to obtaining the services and supplies. See Section 5.D for the requirements and the steps of the Prior Approval process, including how to confirm coverage before receiving services.
- **Treatment by a Federal, State, or Governmental Provider.** The following are excluded to the extent permitted by law:
    i. Services and supplies provided in a Non-Affiliated Hospital owned or operated by any federal, state, or other governmental entity.

ii. Services and supplies provided for conditions relating to military service, if you are legally entitled to the services and supplies and if you have reasonable access to the services and supplies at a governmental facility.
iii. Services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment.

- **Providers Barred from Reimbursement.** Services and supplies received from Providers who have either been terminated from our Provider Network for failing to meet the Plan's credentialing criteria or identified as being noncompliant with the Plan's quality standards and programs.

ARTICLE VI. EXCLUSIONS AND LIMITATIONS

All benefits and services not specifically described as Authorized Benefits and Services in this Certificate are excluded for coverage under this Certificate. **There is no limitation of either annual or lifetime dollar limits for essential health benefits, as listed in Section 5.01 of this Certificate.**

The following criteria must apply for a Member to receive Authorized Benefits and Services from a non-Affiliated Provider:

(a) An Affiliated Provider has referred you for Medically Necessary care; and
(b) The service is an Authorized Benefit and Service but unavailable from an Affiliated Provider; and
(c) The services have been Prior Authorized by the Plan; or
(d) The services are received as the result of a Medical Emergency.

Absent the circumstances above, the services will not be covered, and you will have to pay the entire cost. See Section VII for requirements and the steps of the Prior Approval process. You also must pay for services you receive in excess of services approved.

A referral from an Affiliated Physician or Provider does not guarantee coverage. Sometimes an Affiliated Provider may refer you for or suggest a service that the Plan does not cover under its Certificate. If you receive services that are not listed in your Certificate of Coverage, you must pay for those services.

6.01 **Benefit Maximums.** Some of the Authorized Benefits and Services described in this Certificate are covered for a limited number of days or visits per Contract Year. This is known as a benefit maximum. The Schedule of Out-of-Pocket Expense attached to this Certificate lists the maximums that apply to certain benefits. Once you have reached a maximum for a Covered Service, you will be responsible for the cost of additional services received during that Contract Year even when continued care is Medically/Clinically Necessary.

6.02 **Out-of-Pocket Maximums.** Co-Pays, Deductible and Coinsurance accrue towards your Out-of-Pocket Maximums for the Contract Year. There may be a limit to the total amount of Co-pays that you have to pay for Covered Services in a Contract Year. This limit is called an Out-of-Pocket Maximum. The Schedule of Out-of-Pocket Expense provides more information about Out-of-Pocket Maximums that may apply to you.

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

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

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

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

ARTICLE VII. PRIOR APPROVAL/AUTHORIZATION REQUIREMENTS

Some services and supplies require Prior Approval by the Plan in order to be covered under this plan. The complete and detailed list of these services is available by calling your Customer Service Department at (313) 871-2000 or online at www. THCmi.com. This list may change throughout the Contract Year as new technology and standards of care emerge. Below are the general categories of services and supplies that require Prior Approval by the Plan:

- **All inpatient services**, with the exception of:
    i. Inpatient admissions as the result of a Medical Emergency
    ii. Inpatient Hospital admissions for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean delivery.
- Behavioral Health and Substance Use Disorder inpatient and partial hospitalizations.
- Outpatient services as outlined on our Web site.

- Referrals to Non-Affiliated Physicians and Providers.
- Prosthetics and orthotics charges over $200.00 and all shoe inserts.
- Implant Devices / Stimulators.
- Diagnostic Imaging examinations, including but not limited to:
    - PET Scans (positron-emission tomography).
    - MRI (magnetic resonance imaging).
    - CT Scans (computed tomography).
    - Nuclear Cardiology Studies.
- Certain Injectable Drugs and Specialty drugs.
- Home Health Care, including home infusion services and intermittent skilled services.
- Transplants and evaluations for transplants.
- Genetic testing.
- Clinical trials for cancer care or other life-threatening condition or disease described in PPACA.
- Additional items as outlined on our Web site.

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

Urgent Requests. For urgent requests, the Plan must respond within seventy-two (72) hours. A request is considered urgent if delaying treatment would put your life in serious danger, interfere with your full recovery or delay treatment for severe pain. The Plan will receive a letter to both the Member and the Affiliated Provider who ordered the services in the event the service is denied coverage.

If you obtain services that we say are not covered or services in excess of what we say is covered, you are responsible for payment for those services. If you want our decision to be reviewed, you may contact us. Refer to Section IV as to your right for Appeal.

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

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

ARTICLE VIII. SUBROGATION

8.01 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.

8.02 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.

8.03 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.

8.04 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.

8.05 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 IX. COORDINATION OF BENEFITS

9.01 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 insurance policies or certificates will be determined in the following manner as prescribed under Act No. 64 of the Public Acts of 1984:

(a) 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.

(b) Except as otherwise provided in subsection (c), 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.

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

i. Except as provided in paragraph iii. 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 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.

ii. Except as provided in paragraph iii. 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.

iii. 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.

9.02 If Section 9.01 (a), (b) and (c) 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:

(a) 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.

(b) Subsection (a) 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.

9.03 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 policies 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.

9.04 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.

9.05 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 X. CHANGES IN RATES, CERTIFICATE, OR STATUS OF MEMBERS

10.01 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.

10.02 The Subscriber or Member may terminate this Certificate by giving written notice of no greater than fourteen (14) days to the Plan and Health Insurance Marketplace.

10.03 The Subscriber must notify the Plan in writing within thirty (30) days of any changes in the status of each Member as a result of divorce, death, birth, legal adoption, changes in legal residence of children, changes in address, change of telephone number, entrance into or return from military service, or when a Dependent has been employed by a company offering health benefits.

ARTICLE XI. TERMINATION OF A MEMBER'S COVERAGE

11.01 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 XII. TERMINATION OF A MEMBER'S COVERAGE

12.01 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.

12.02 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 XIII) only for the reasons outlined as follows:

(a) If the Subscriber or Plan is no longer eligible for coverage through the Health Insurance Marketplace, if applicable.
(b) Coverage shall terminate at the end of the month in which a Dependent child attains the age of twenty-six (26).
(c) In the event a Member transfers residence outside the Service Area, Authorized Benefits, and Services may be terminated.
(d) Coverage shall terminate for the Dependent child if the Dependent child becomes eligible for coverage from their employer.
(e) Member changes Products on the Health Insurance Marketplace.
(f) Member is no longer part of the Group.

12.03 The Plan may rescind a Member's coverage under this Certificate for intentional misrepresentation of a material fact on the Enrollment Application. Member will be given thirty (30) days advanced written notice of rescission of coverage.

12.04 The Plan may terminate a Member's coverage for intentionally or fraudulently 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.

12.05 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 upon thirty (30) days advanced written notice. Reason for termination will be stated in the letter.

12.06 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, or within the period of no greater than fourteen (14) days, by giving written notice to the Plan and the Remitting Agent and Health Insurance Marketplace, if applicable.

12.07 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.

ARTICLE XIII. CONVERSION AND CONTINUATION

13.01 Conversion Option

(a) 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 contacting the Health Insurance Marketplace or by making Application to the Plan 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.

(b) 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.

(c) 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.

13.02 If Members covered under this Certificate cease to be eligible to continue membership by reason of death of the Subscriber, divorce from the Subscriber or loss of Dependent status, such Members shall be eligible to convert to their own Individual Certificate of Coverage.

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