TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

HMO
Member Handbook

Welcome to Total Health Care USA

We are pleased to have you as a member and we look forward to serving your health care needs. Total Health Care USA will provide you and your family with the comprehensive quality health care benefits that you expect and deserve.

Your Member Handbook will serve as a quick and easy guide to help you understand your benefits. Please use the handbook as a reference; it does not modify or take the place of your Certificate of Coverage or Rider(s). Refer to your Certificate of Coverage and Rider(s) for a complete description of the specific benefits available.

If you have any questions about your plan or benefits, please contact the Customer Service Department Monday–Friday, 8:00 a.m. to 5:00 p.m.

Sincerely,

Total Health Care USA

Register today at www.THCmi.com to monitor claim status, request an ID card and to review your Explanation of Benefits.

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

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NONDISCRIMINATION NOTICE

Total Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Total Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Total Health Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  – Qualified interpreters
  – Information written in other languages

If you need these services, contact Total Health Care at (800) 826-2862, 24 hours a day, seven days a week. TTY users call 711.

If you believe that Total Health Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- Total Health Care Civil Rights Coordinator, 3011 W. Grand Blvd., Suite 1600, Detroit, MI 48202, (800) 826-2862 (TDD/TTY: 711), Fax: (800) 826-6406 or email: thc@thcmi.com.
- You can file a grievance by mail, fax or email. If you need help filing a grievance, Total Health Care Customer Service is available to help you.

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

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

(800) 368-1019, (800) 537-7697 (TDD)

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

English: ATTENTION: If you speak English, language assistance services, at no cost, are available to you. Call (800) 826-2862 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 826-2862 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم --1(رقم
هاتف الصم والبكم: (TTY: 711) 826-2862.(800)

Chinese Mandarin: 注意：如果您说中文普通话/国语，我们可为您提供免费语言援助服务。
请致电：(800) 286-2862 (TTY: 711) 。

Chinese Cantonese: 注意：如果您使用粵語，您可以免費獲得語言援助服務。請致電
(800) 826-2862 (TTY: 711) 。

Syriac:

ܫܡܘܥܝ: ܐܢ ܐܢܬ ܡܬܟܠܡ ܠܫܢ̈ܐ ܣܘܪܝܝܐ، ܐܝܟ ܐܢ ܠܐ ܐܢ ܐܝܬ ܠܟ ܫܘ̈ܬܦ̈ܐ ܕܡܬ̈ܢ ܕܥܙ̈ܪܐ ܕܠܫܢ̈ܐ ܕܡܬ̈ܢ ܕܡܬ̈ܚ̈ܐ ܠܟ ܒܠܐ ܐܓ̈ܪ̈ܐ. ܐܬܨܠ ܒ
(800) 826-2862. (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 826-2862 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (800) 826-2862 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(800) 826-2862 (TTY: 711) 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ (800) 826-2862 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 826-2862 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 826-2862 (TTY: 711)

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 826-2862 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
(800) 826-2862 (TTY: 711)まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 826-2862 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 826-2862 (TTY-711 Telefon za osobe sa oštećenim govorom ili sluhom).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 826-2862 (TTY: 711).

Customer Service

Total Health Care is available to help you over the phone, mail or internet.

TELEPHONE – The Customer Service Department is available to help you Monday–Friday, 8:00 a.m. to 5:00 p.m. at (313) 871-2000 or (800) 826-2862. During holidays, weekends and after business hours, emergency medical technicians are available to answer your calls.

INTERNET – You can access our web page at www.THCmi.com
On the web you can:

- Email your questions or concerns
- Order a replacement identification card
- Review the status of a medical claim
- Search for a provider
- Order a refill for an existing mail order prescription
- Change your primary care physician

MAIL – To correspond by mail, the address is:

Total Health Care USA
3011 W. Grand Blvd., Suite 1600
Detroit, MI 48202

Important Telephone Numbers

Total Health Care	(313) 871-2000 or (800) 826-2862
Case Management	(313) 871-6593 or (800) 826-2862 ext 6593
Coordinator of Benefits	(313) 871-6462 or (800) 826-2862 ext 6462
Grievance Coordinator	(313) 871-6583 or (800) 826-2862 ext 6583
Health Education and Wellness	(313) 871-7817 or (800) 826-2862 ext 7817
Hearing Impaired	TDD/TTY 711
Language Needs	(313) 871-2000 or (800) 826-2862
Customer Services	(313) 871-2000 or (800) 826-2862
Vision Care Services	(877) 799-0220
Behavioral Health Services	(855) 377-2416

Member Tips

As a New Member

Review your Total Health Care USA ID card(s) to verify that all of the information is correct. Please verify that an ID card has been received for every covered family member.

What to Do If Your Family Size Changes

Contact your employer's benefits office, as well as Total Health Care USA Customer Service Department, if you have had a change in the size of your family including marriage, birth, adoption, divorce or the death of a covered member. Changes must be submitted with 30 days of the event.

What to Do If You Have Other Insurance Coverage

Total Health Care USA coordinates benefits with other carriers including healthcare, auto, workers' compensation and other payers. The priority of responsibility is determined by Act No. 64 of the Public Acts of 1984.

If you have coverage through another payer, please contact the Coordination of Benefits Department.

How to Get Help and Information

For information regarding covered services, refer to your Certificate of Coverage Rider(s), and Benefit Summary or contact the Customer Service Department.

What to Do If You Get a Bill

To reduce the possibility of receiving a bill, always show your ID card to your healthcare providers. However, if you do receive a bill for a covered service, send us a copy. A Total Health Care USA representative will follow up with you after resolution. Remember to include your Total Health Care USA ID number and phone number on the bill. Mail the bill to:

Total Health Care USA
Attn: Claims Department
3011 W. Grand Blvd., Suite 1600
Detroit, MI 48202

Getting Questions Answered About Your Total Health Care USA Doctor

Before a doctor is accepted in the Total Health Care USA network, strict rules must be met. Our Customer Service Department can answer questions about a Total Health Care USA doctor, including:

- The professional qualifications of our doctors such as specialty, medical school attended, residency completed and board certification status
- General information, including name, address phone numbers and identification of doctors who are accepting new members

Incentives and Your Doctor

Total Health Care USA does not pay doctors or encourage them in any way to withhold or deny medical care or services. Decisions about your care are based on your health care benefits and medical needs. If you have questions regarding this, contact the Customer Service Department.

Explanation of Benefits

Explanation of benefits (EOB) statements are available to you online at www.THCmi.com. Log in to your account to view your EOB. The EOB statement includes the co-payment, deductible and/or co-insurance applied to the service.

Overview

Total Health Care USA offers benefit plans with varying out-of-pocket costs. Depending on your benefit plan, you may be responsible for an annual deductible, co-insurance and/or co-payments. Refer to your Certificate of Coverage, Rider(s) and Benefit Summary to determine the out-of-pocket costs for covered benefits and services. The Customer Service Department is also available to answer questions regarding your benefit plan.

Deductible: A set amount that you pay each year before Total Health Care USA makes a payment.

- The deductible applies to the out-of-pocket maximum.

Co-insurance: A percentage that you pay for certain covered benefits.

- Co-insurance amounts apply to the out-of-pocket maximum.

Co-payment: The amount a member must pay per visit or service for certain covered benefits.

- Co-payment applies to the out-of-pocket maximum.

Out-of-Pocket Maximum: The maximum combined amount of the co-payment, co-insurance and deductible that a member and/or family will have to pay during a calendar year. Once the out-of-pocket maximum is met, Total Health Care USA will pay all eligible expenses for covered services for the remainder of the calendar year.

Choosing a Primary Care Physician

When you join Total Health Care USA, you must select a Primary Care Physician (PCP) for each covered member of your family. You may want to choose your PCP based on location, hospital system, gender, or language spoken. Your PCP will help coordinate all of your medical needs. To find a PCP, refer to your Provider Directory or go online to www.THCmi.com.

The type of Primary Physician you choose may be:

- Family Practice: A doctor who cares for adults and children
- Internal Medicine: A doctor who cares for adults
- General Practice: A doctor who cares for adults and children
- Pediatrician: A doctor who cares for children

Changing Your Primary Care Physician

If for any reason you decide your Primary Care Physician is not right for you, you can change to another physician. To change, contact the Customer Service Department.

Changes made prior to the end of the month, will be effective the 1st day of the next month.

Medically Necessary Care

Covered benefits and services are for medically necessary care. Procedures intended to change the appearance of the body or body part, may not be covered. For more information on medically necessary or cosmetic care, contact the Customer Service Department.

How to Get Referrals for Specialty Care

If you need a referral to a specialist or other services, call your Primary Care Physician (PCP). This could be for in-network or out-of-network care. Your PCP's name and phone number are on your Total Health Care USA ID card.

Your PCP may want to see you before deciding what treatment is needed. If you need a specialist, your PCP will recommend one for you.

Certain treatments and specialty care require a referral from your PCP.

Benefits, Services and Other Programs

Your plan covers a wide range of benefits and services. A description of some of the benefits are listed below. Refer to your Certificate of Coverage and Rider(s) for detailed benefits, limitations and exclusions.

Adult Immunizations/Vaccinations

Coverage for adult immunizations is limited to certain vaccinations. Refer to the adult immunization schedule at www.THCmi.com or contact the Customer Service Department for more information. Vaccinations for travel are not covered.

After Hours/Urgent Care

After hours/urgent care centers are able to treat minor injuries and illnesses when your doctor's office is closed.

Examples of Conditions in Which After Hours/Urgent Care Treatment is Appropriate:

- Sore throat
- Back pain
- Headache
- Cold
- Minor injury
- Flu
- Earache
- Sprains and strains
- Frequent urination
- Minor burns

Ambulance Services

Ambulance services are covered when medically necessary.

Behavioral/Mental Health

Good mental health is important for your overall health. Total Health Care covers mental health counseling, diagnosis, inpatient and outpatient treatment. A referral from your PCP is not needed. If you think you need help or to find a provider, call (855) 377-2416.

Childhood Immunizations and Well-Child Checkups

To help keep your child healthy, it is important to get all recommended immunizations, routine health screenings and growth and developmental guidance. Well child care provides an opportunity for health professionals to promote healthy lifestyle choices, monitor children for physical and behavioral health and provide age appropriate guidance.

Diabetic Services

If you have diabetes, Total Health Care USA has diabetic services available for you. Our nurses will help you get the supplies, medications and educational classes you may need. If you or a covered family member has diabetes, please call the Health Education and Wellness Helpline.

Durable Medical Equipment

Your benefits include durable medical equipment through our exclusive provider, Binson's Medical Equipment & Supplies.

Diabetic Supplies are available through J&B Medical.

Emergency Services

You are always covered in case of a medical emergency; services are available 24 hours, 7 days a week.

- Call 911 or go to the nearest emergency room.
- If you are admitted to a hospital, you or someone on your behalf must notify Total Health Care USA as soon as possible.

A medical emergency is defined as acute symptoms of sufficient severity that may result in death, serious jeopardy to the health of a person including a pregnant woman or fetus, or serious impairment, disfigurement or dysfunction to bodily functions.

Examples of Life Threatening Emergencies Are:

- A serious accident
- Poisoning
- Uncontrolled bleeding
- Pregnancy with vaginal bleeding
- Loss of consciousness
- Heart attack
- Chest pain
- Severe shortness of breath
- Serious burn
- Stroke
- Head trauma
- Seizures

Foreign Language Services

If you do not speak English, Total Health Care USA can arrange for an interpreter for health services and/or provide written materials in your language. For assistance, contact the Customer Service Department.

Hearing Aids

Your Total Health Care USA benefits includes hearing aid evaluations and aids; refer to your Certificate of Coverage and Schedule of Out of Pocket Expenses for benefit limitations. Hearing aid evaluations and services can be provided at any contracted hearing aid provider. For assistance in locating an authorized provider, contact the Customer Service Department.

Hearing Impaired Services

If you have a hearing loss, Total Health Care USA can arrange for a sign language interpreter during health care services. For assistance, contact the Customer Service Department or the TDD/TTY line at 711.

Home Health Services

Home health services provide nursing services such as wound care, care after discharge and diabetic teaching by nursing personnel. If you think you would benefit from home health care services, contact the Case Management Department.

Hospice Services

Hospice services address the physical, psychological, social and spiritual needs of the terminally ill in a home or hospice facility. It is also designed to meet the related needs of the terminally ill member's family through the period of illness and bereavement. To obtain hospice benefits, call our Case Management Department.

Inpatient Hospital Service

Admission to the hospital can happen in several ways. You may be treated in the emergency room and need additional treatment requiring a hospital stay. Other times, it is a planned admission for elective (non-emergency) surgery, tests, or special procedures.

If you are admitted to the hospital from the emergency room, the hospital must call Total Health Care for approval. If you are admitted to a non-network hospital, Total Health Care may transfer you to a network hospital.

If you are scheduled for an elective admission, your PCP must contact Total Health Care for prior authorization 14 days prior to the admission.

Mammograms

Total Health Care USA encourages its female members to have mammograms for the screening and early detection of breast cancer. Mammogram coverage includes:

- Annual mammogram for women 40 years and older
- One (1) mammogram during a five (5) year period for women between ages 35-40 years
- All other medically indicated mammogram are covered

Mammograms for breast cancer screening do not require a referral with a participating provider.

New Technology

New treatments and new use for old treatments occur all the time. A committee at Total Health Care USA, staffed by doctors, reviews the information from the government, trials and writings by other doctors to see if members could benefit from the use of the new technology. If it is determined that it is helpful for all members or certain cases, it will be added to the benefits.

Office Visit – Primary Care Physician

Services covered in the primary care office include, but are not limited to:

- Annual physical exam
- Evaluation and treatment
- Pediatric immunizations
- Adult immunizations — limited coverage
- Therapeutic and diagnostic lab, pathology, radiology and special diagnostic services
- Treatment
- Vision and hearing screening (dependents 18 years old and under)
- Formulary drugs administered in the office

Office Visit – Specialist

Specialty office visits to a participating specialist, excluding podiatry and chiropractic care, do not require a referral from your Primary Care Physician. Services covered in a specialist office include, but are not limited to:

- Evaluation and treatment
- Therapeutic and diagnostic lab, pathology, radiology and special diagnostic services
- Formulary drugs administered in the office

Outside of the Service Area Care

If you are out of Total Health Care's service area and have a medical emergency, go to the nearest hospital or medical facility.

For a situation that requires immediate medical attention, but is not life-threatening, call your PCP. Your PCP can give you medical information and advice. If your PCP is not available, go to the nearest urgent/after hours care or emergency room, or call the Nurse Advice Line. A nurse can tell you if an appointment with your doctor, urgent/after hours care or the emergency room is the better place for treatment. To speak to a nurse at any time, call 1-866-330-9368.

Routine medical services outside of the service area are not covered, unless authorized by Total Health Care. To request approval, contact our Customer Service Department.

You do not need approval from your PCP or Total Health Care for emergency or urgent/after-hours care. Remember to:

- Show your member ID card
- Call your PCP for follow-up care

Outpatient Diagnostic and Surgical Care

With today's advanced healthcare technology, many diagnostic tests, procedures and treatments are performed in an outpatient setting. Not all services require a referral from your Primary Care Physician. Always check with your Primary Care Physician for any needed referrals before receiving services.

Pediatric Services

Total Health Care USA has many pediatric physicians as part of our network. You may choose a pediatrician for your child as his/her Primary Care Physician or you may take your child for routine services to a pediatric physician in the Total Health Care USA network without a referral.

Prenatal Services

Prenatal care is an important part of a healthy pregnancy. Preparations begin early in pregnancy and continue after the baby is born. Physician visits for prenatal care and diagnostic services are encouraged and covered for expectant others.

Prescription Drugs

Your Total Health Care USA covered benefits may include prescription drug coverage. This benefit provides prescription drugs covered on the Plan's formulary. The Plan has an authorization process for consideration of for non-formulary drugs. A formulary is a list of covered drugs. The Total Health Care USA formulary utilizes many of the generic drugs that are available. These generic drugs are of the same quality as brand-name medications, but often at a lower cost. Generic drugs contain identical active ingredients as brand name medications and must meet the same Food and Drug Administration (FDA) standards. Your physician will work with you to prescribe the right drug for you.

Your prescriptions may be filled at pharmacies within the Total Health Care USA network. Consult the Provider Directory for a listing of participating pharmacies. You must present your ID card for service.

Total Health Care USA offers a ninety (90) day supply on certain maintenance medications through our mail-order program. A maintenance drug is used to treat long-term conditions such as:

- High Blood Pressure
- Arthritis
- Gastric Reflux
- Depression
- Diabetes
- High Cholesterol
- Thyroid Conditions
- Seasonal Allergies

Home delivery order forms are available on the web site at www.THCmi.com or by calling the Pharmacy Department. Pharmacy benefit and drug information is also available at www.envisionrx.com.

Online services include:

- Pharmacy co-payment information
- Ordering a refill for an existing mail order prescription
- Locating a participating pharmacy
- Information on drug interactions
- Information on common side effects and risks of a drug
- Information on generic alternatives

Prosthetics & Orthotics (P&O)

Your benefits include prosthetic & orthotic equipment. For assistance in locating an authorized provider, contact the Customer Service Department.

Reconstructive Breast Surgery Following Mastectomy

Total Health Care USA covers reconstructive breast surgery, mastectomy and mastectomy related services as the result of treatment for cancer. Benefits include:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications, all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Rehabilitative Services

Up to forty-five (45) combined visits for physical, occupational and speech therapy services are covered a calendar year, when it is expected to improve a condition within a two (2) month period.

Skilled Nursing Facility

Your Total Health Care USA covered benefits may include skilled nursing care in a nursing home or extended care facility; refer to your Certificate of Coverage and Rider for applicable coverage. This benefit provides skilled nursing care services in an affiliated facility certified to provide skilled nursing care.

Substance Abuse Services

Substance abuse is a serious problem. It involves the excessive consumption or misuse of alcohol or drugs for non-therapeutic effects on the mind or body, especially drugs or alcohol. The toll of substance abuse can be dramatically reduced with prevention, early intervention and treatment. If you think you or a covered dependent are at risk or need help with a substance abuse problem, contact Behavioral Health Services.

Transplant Services

Total Health Care USA Case Management Department is available to help you coordinate the care needed for transplant services. Candidates for transplants must be enrolled in Case Management. For assistance, contact the Case Management Department.

Vision Care Services

Your Total Health Care USA covered benefits may include vision care coverage. Vision care services can be provided at any of the vision providers in the Directory or on the website at www.THCmi.com. Refer to your Certificate of Coverage and Rider for the specifics of the benefit. Vision care does not require authorization from your PCP. For an eyecare provider in your area or questions, please contact Vision Care Services.

Well Women Services

Total Health Care USA encourages its female members to have a well woman examination every year. A well woman exam includes but is not limited to, preventive health screening such as, breast examination and Pap testing. These services may detect breast and cervical cancer. Well women exams do not require a referral when rendered by a participating provider.

Wellness Programs

Total Health Care USA has wellness services to help improve your health. For information about health and wellness programs, call the Health Education and Wellness Helpline. Health and wellness programs include:

- Healthy Children
- Project Women
- Smoking Cessation
- Weight Management
- Asthma Disease Management
- Diabetes Disease Management
- Heart Disease Management
- Chronic Obstructive Pulmonary Disease (COPD) Management
- High Blood Pressure Disease Management

Members Rights and Responsibilities

You Have the Right…

- To get information about Total Health Care, its services, its providers, and member rights and responsibilities.
- To make recommendations regarding Total Health Care's member rights and responsibilities policy.
- To be treated with respect and dignity by others.
- To have privacy while you receive care.
- To take part with your doctors in decision-making about your health care, including the right to refuse treatment.
- To talk openly about your treatment options regardless of cost or benefit coverage. You have a right to get these explained to you in words that you understand.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To be free to exercise your rights without adversely affecting the way Total Health Care or our providers treat you.
- To be free from other discriminations prohibited by State and Federal regulations.
- To receive health care services consistent with your contract, and with State and Federal regulations.
- To voice your complaints or grievance/appeals about Total Health Care or the care provided.

You Have the Responsibility…

- To receive all your health care services through Total Health Care.
- To understand your health care benefits.
- To provide Total Health Care and its providers with the information needed to care for you.
- To help your doctor decide what treatment will work best for you.
- To follow the plans and instructions for care that you have agreed to with your doctor.
- To respect the rights of other patients, doctors and staff of Total Health Care.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

* Total Health Care's staff and providers will comply with all regulations concerning your rights.

Member Complaint Process

Your satisfaction is our priority. If you have a problem or complaint, our Customer Service Department is available to help resolve the issue. The department is available Monday–Friday, 8:00 a.m. to 5:00 p.m. at (313) 871-2000 or toll-free at (800) 826-2862.

Customer Service will make every effort to resolve your issue immediately. If we are unable to solve the problem within twenty-four (24) hours, you have the right to file a complaint. If at anytime you do not agree with the resolution, you have the right to file a grievance.

The Customer Service representative will explain your rights and how to file a complaint. If you need help filing the complaint, the department will assist you.

When filing a complaint another person can act as your authorized representative. The person may be a family member, friend, or a physician. If you decide to use an authorized representative, you must send written notification to Total Health Care authorizing the person to act on your behalf.

We will contact you by mail within three (3) business days to tell you that the Grievance Coordinator has received your complaint. The Grievance Coordinator will send you a resolution within thirty-five (35) calendar days. If you do not agree with the resolution, you or your authorized representative may file a grievance by mail, email or fax. You can also call (313) 871-2000 or toll free at (800) 826-2862 to file a grievance. The grievance information is included with your resolution letter.

Member Grievance and Appeal Process

A grievance is the process we use to handle your dissatisfaction. A grievance may be due to a denial of payment (to your provider) or an adverse determination. A grievance involving denial of payment, such as lack of authorization or the provider being out of THC's network, is called an administrative grievance.

You have the right to have your benefits continue pending resolution of the grievance. There may be conditions under which you will be required to pay for services provided while your benefits are continued. You also have the right to authorize someone to act as your authorized representative in the grievance. An authorized representative must have your written permission to represent you. You have the right to send additional documentation with the grievance. The member grievance process includes two steps. The first step is to file the grievance and the second step is to appeal the resolution.

As part of your grievance rights, you can request Total Health Care USA to arrange a meeting with the Appeals Review Committee. You can discuss your grievance with the committee. You or

your authorized representative may attend the meeting in person or by telephone. A person not involved in the first decision will review your grievance. No one who reports to the person involved in the initial decision can review your grievance. The person who reviews your grievance will be of a similar specialty.

A medical grievance/appeal will be completed within fifteen (15) calendar days for pre-service and thirty (30) calendar days for a post-service grievance after it is received. You will be notified in writing of the final decision. If the decision upholds the denial, an external appeal can be filed. The final letter tells you of your external appeal rights and how to file the appeal.

Expedited Grievance

In some urgent cases, a time delay may increase the risk of harm to your health or life. A grievance is considered expedited (quick), when a physician notifies us verbally or in writing that waiting the 30 days would cause you to have severe pain or put your life at risk. The physician must be able to support the attestation. Total Health Care USA will not punish a provider who requests or supports an expedited grievance on your behalf.

The grievance must be received within ten (10) days of your denial. If we deny your request for an expedited grievance it is changed to a thirty (30) day grievance. You can request an extension of the decision time. Your extension request moves the grievance to a thirty (30) day grievance.

A decision about an expedited grievance is made no later than seventy-two (72) hours after it is received. Total Health Care USA will notify you of the decision by phone. We will also mail the decision to you within two (2) business days.

After filing an expedited internal grievance with Total Health Care USA, you may file an appeal and request an expedited external review with the Department of Insurance and Financial Services (DIFS).

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

External Appeal Rights

You or your authorized representative has the right to request an external review from DIFS. The request should be made after Total Health Care USA notifies you of the final decision. Notification of the final decision completes the Total Health Care USA internal appeal process.

You or your representative must file the DIFS Health Care Request for External Review Form to be given an external review. A copy of the Health Care Request for External Review Form will be included with the final decision letter. You may also call DIFS at (877) 999-6442 to have a form sent to you. The form should be filed no later than sixty (60) days after you receive the final decision letter.

When appropriate, DIFS obtains the recommendations of an independent review organization as designated by the Patients Right to an Independent Review Act. The independent review organization is not a part of Total Health Care. The Commissioner of DIFS will issue a final order.

To ask questions about the external review process, contact Total Health Care.

To request an independent review, write or fax:

Department of Insurance and Financial Services
Health Plan Division
P.O. Box 30220
Lansing, Michigan 48909-7720
Fax: (517) 241-4168

Fraud and Abuse

If you have any information about fraud and abuse or think that someone may have used your I.D. card to receive benefits, please contact the Fraud and Abuse Coordinator. You can report fraud and abuse anonymously by writing or calling:

Total Health Care USA
Attn: Fraud and Abuse
3011 W. Grand Blvd., Suite 1600
Detroit, MI 48202

Phone: (313) 871-2000 or toll free (800) 826-2862
Fax: (313) 871-0196
Email: ELIMINATEFWA@THCMI.COM

Notice of Privacy Practices – Total Health Care USA

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

Total Health Care USA provides your health care benefits. We are required by law to maintain the privacy of your health information and to give you this notice of our legal duty and how we protect the privacy of your written, spoken and electronic health information. We are generally required to notify you if your health information is not secured and is used or released in a way that is not permitted by this notice or privacy laws. We will follow the requirements of this notice while it is in effect. This notice is effective September 23, 2013, and will remain in effect until we change it.

How we may use and release your health information without your permission

Only people who have both a need and a legal right may see your health information. Unless you give us written permission, we will only use and release your health information for the following purposes:

To You or Your Personal Representative. We may release your health information to you or your personal representative (someone who has the legal right to act for you).

For Treatment. We may use and release your health information to help you get health care. For example, we may notify your doctor about care you get in an emergency room.

For Payment. We may use and release your health information so that your health care is correctly paid. For example, we may ask an emergency room for details about your health care before we pay the bill.

For Healthcare Operations. We may use and release your health information for our business operations. For example, we may use your information to review the quality of care you get or to talk to you about your health benefits.

To Others Involved in Your Care. Unless you tell us not to, we may release your health information to a member of your family, a close friend, or any other person you request, if they are involved in your health care or payment for your health care.

To Business Associates. We may release your health information to the companies we hire to help us in our business. Before these companies can get your information, they must agree in writing that they will follow our privacy rules.

To Group Health Plans and Plan Sponsors. If you participate in an employee benefit plan that we insure, we may share certain health information with the employer that sponsors the plan under certain conditions required by law.

Other Permitted Uses and Releases of Your Information. Although certain rules apply, we may use or release your health information as required by law; for public health activities; to a health oversight agency for activities authorized by law, such as inspections of our offices by the government; to a governmental authority if we reasonably believe that you have been a victim of abuse, neglect or domestic violence; as required by the Food and Drug Administration; in the course of judicial or administrative proceedings (for example, in response to an order of a court); in response to certain law enforcement requests; to coroners, medical examiners, and funeral directors; for organ, eye or tissue donation purposes; for workers' compensation purposes; for special government functions, including national security and intelligence activities; and to avert a serious and immediate threat to the health or safety of a person or the public. We may disclose your health information to researchers in limited circumstances, if the researchers use privacy protections required by law. We must also release your information when required by the Department of Health and Human Services to investigate our compliance with the privacy laws.

Health Related Benefits. We may use or release your health information to send you our newsletters or to tell you more about the benefits we offer.

Written Permission. We may use your information for other purposes not described in this notice if you give us permission in writing. We generally need your permission to use or release your health information if it relates to psychotherapy notes, relates to marketing, or relates to the sale of your health information. You have the right to change your mind and revoke your written permission. You must revoke your written permission in writing. We cannot take back any uses or releases made before you revoke your permission.

If we use or release your health information for underwriting purposes, we are prohibited from using or releasing your health information that is genetic information for underwriting purposes.

Generally, federal privacy laws regulate how we may use and release your health information. In some circumstances state law also regulates how we may use and release your health information. In such situations, we will comply with the law that is most protective of your health information and/or gives you additional rights.

Your Rights

You have the following rights regarding your health information:

Right to Inspect and Copy. In most cases, you have the right to look at or get copies of your records upon written request. You may be charged a fee for the cost of copying your records. If we deny your request, you may ask to have our decision reviewed.

Right to Amend. Upon written request, you may ask us to change your records if you feel that the record is incorrect or incomplete. We may deny your request for certain reasons, but we must give you a written reason for our denial.

Right to a List of Releases. Upon written request, you have the right to receive a list of releases of your health information made by us during the six year period before the request. This list will not include information that was released for treatment, payment or health care operations, or as permitted as described above. This list will not include information provided directly to you or your family, or information that was released based upon your written permission.

Right to Request Restrictions on Our Use or Releases of Your Information. Upon written request, you have the right to ask for limits on how your health information is used or released. We are not required to agree to such requests.

Right to Request Confidential Communications. You have the right to ask that we share information with you in a certain way or in a certain place. Your request must be in writing. For example, you may ask us to send information to your work address instead of your home address.

How to Use Your Rights Under This Notice. If you want to use your rights under this notice, you may write to us at the address listed below. We will help you prepare your written request, if you wish.

Changes to This Notice

We reserve the right to change this notice. A revised notice will be effective for health information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. If the changes are important, the new notice will be mailed to you before it takes effect.

Complaints

Complaints to the Federal Government. If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:

Office of Civil Rights Dept. of Health and Human Services
200 Independence Avenue, S.W., Washington, D.C. 20201
Phone: (877) 696-6775 TTY: (886) 788-4989
or go to www.hhs.gov/ocr/privacy/hipaa/complaints/

You will not be penalized for filing a complaint with the federal government.

Complaints and Communications to Us. If you want to exercise your rights under this notice, communicate with us about privacy issues, or if you wish to file a complaint about us, you can call or write to us at:

3011 W. Grand Blvd., Suite 1600, Detroit, MI 48202
Phone: (313) 871-2000 or (800) 826-2862

You will not be penalized for filing a complaint.

Copies of This Notice

You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. Please call or write to us to request a copy.

TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

3011 West Grand Blvd.
Suite 1600
Detroit, MI 48202
(313) 871-2000
www.THCmi.com

HEALTH PLAN NCQA ACCREDITATION ACCREDITED

HMO LOB06_MH 122016

TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

HMO Certificate of Coverage

Non-Grandfathered
2019

ARTICLE I. TOTAL HEALTH CARE USA, INC.

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

ARTICLE II. DEFINITIONS

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

2.01 "Adverse Benefit Determination'' means any of the following: a denial, reduction, termination or 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, 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.

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

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

2.04 "Affiliated Pharmacy" means a Pharmacy that contracts with the pharmacy benefit manager as designated by Total Health Care USA, Inc. to provide Covered Services to Members. Plan's network includes Pharmacies within the Plan's service areas as well as a national network of Pharmacies for out-of-area services. Names of Participating Pharmacies can be found in the Provider Directory or on online at www.THCmi.com.

2.05 "Affiliated Physician/PCP" means a primary care provider licensed to practice medicine (family practitioner, general practitioner, internist, pediatrician, nurse practitioner or a physician assistant) who has contracted with the Plan.

2.06 "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 (1) or more health maintenance services to Members. Affiliated Providers make up the "In Total Health Care USA Network."

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

2. 08 "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).

2.09 "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.

2.10 "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 necessarily limited to, USPTF, HRSA guidelines and the CDC.

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

2.12 "Certificate" means this Certificate of Coverage Agreement and applicable Riders.

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

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

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

2.15 "Contract Year" means the twelve (12) month period from the date that coverage was initially effective under this Certificate. It also refers to each twelve (12) month period thereafter unless otherwise stated and agreed upon.

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

2.17 "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.

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

2.19 "Enrollment Application" means the form approved by the Plan by which the Subscriber seeks to enroll one or more Members in the Plan.

2.20 " 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.

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

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

2.23 "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 (ID) card constitutes the contract between the Plan, the Group, and the Member.

2.24 "Habilitative Services" mean health care services that help a person retain, 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 are for people with disabilities in a variety of inpatient and or outpatient settings.

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

2.26 "Hospice" means a licensed health care program to provide a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

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

2.28 "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. .

2.29 "Maximum Out-of-Pocket Expense" means the highest or total amount a Member is required to pay towards the cost of health care in a Plan Year. Co-pays, Coinsurance and Deductibles all are applied to Maximum Out-of-Pocket Expense for services rendered through Affiliated Physicians, Provider and Psychiatrists. Other than Emergency Medical Services, costs incurred outside of the Affiliated network do not apply toward the Out-of-Pocket Maximum.The Out of Pocket Maximum does not include any of the following and once the Maximum Out of Pocket Expense has been reached, you still will be required to pay any charges for non-covered health services and charges that exceed eligible expenses.

2.30 "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.

2.31 "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.

2.32 "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.

2.33 "Non-Participating Provider means those physicians, health professionals, hospitals and other facilities that have not contracted with the Plan. Non-Participating Providers are not listed in the Provider Directory. Services from a Non-Participating Provider are not Covered unless Prior Authorized by the Plan.

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

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

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

2.38 "Preferred Brand Name Drug" means a prescription drug approved by the Food and Drug Administration (FDA). It is protected by a patent, made by a single company and sold under the brand name.

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

2.43 "Preventive Benefits" means Covered Services that are meant to prevent disease while it is more easily treatable. These are defined by the US Preventive Services Task Force A and B recommendations.

2.44 "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 a Treating Physician, Affiliated Physician, or Referral Physician when admission is authorized by the Plan's Medical Director or his/her designee.

2.51 "Referral Physician: means a physician other than a Treating Physician who is licensed to practice medicine and who delivers medical care to a Member on the referring order of a Treating Physician.

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

2.47 "Semi-private Room" means Hospital accommodations where there are two (2) or more beds to a room.

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

2.49 "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.

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

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

2.52 "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) For whom Premiums have been received.

2.53 "Treating Physician" means an individual licensed to practice medicine or osteopathy and is responsible for a Member's care with regards to a particular diagnosis or treatment.

2.54 "Urgent Condition" means a medical condition manifesting in an urgent, but not life-threatening condition, such that the absence of medical attention within a 24 hour period from the onset of symptoms could reasonably be expected to result in further complication of the patient's conditions,
or deterioration of the patient's condition. Such conditions may include:

(1) High fever.
(2) Uncontrolled vomiting and/or diarrhea.
(3) Ear ache.
(4) Minor wounds.

2.55 "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 2.43.

2.56 "Non Elective Abortion" means any of the following: (1) The intentional use of an instrument, drug, or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert her death; (2) Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy.

ARTICLE III. ENROLLMENT; EFFECTIVE DATE OF COVERAGE; PREMIUMS

3.01 Enrollment

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

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

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

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

3.02 Effective Date of Coverage

(1) Except as limited in subsection (3) below, the effective date of coverage for Members who enroll during an Open Enrollment Period will be the date agreed upon in the Group Operating Agreement, provided that the signed Enrollment Application and appropriate Premium have been received by the Plan.

(2) Except as limited in subsection (3) below, and unless otherwise provided in the Group Operating Agreement, the effective date of coverage for newly eligible Members who enroll between Open Enrollment Periods shall be the first day of the month following the month of the Plan's receipt of the signed Enrollment Application and Premium.

(3) The effective dates of coverage set out above will be deferred for persons not already Members of the Plan who are confined to any prison on the effective date until the day after the person is released from the prison facility.

3.03 Premiums

Premiums shall be paid to the Plan at the rate established by the Plan for coverage under this Certificate as set forth in a written notice by the Plan to the Remitting Agent. All Premiums are to be remitted on a monthly basis on or before the first day of each month unless otherwise agreed upon in writing by the Plan and Remitting Agent. If the Group pays the Premium to the Plan during the thirty (30) day Grace period, there will be no lapse in coverage.

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

3.04 Renewability. Coverage at the end of the Contract Year is guaranteed to be renewed except for the following reasons:

(a) Non-payment of Premium.
(b) Fraud.
(c) Member moves outside of the Plan Service Area.
(d) The Plan withdraws from the market.

3.05 Health Factors. The Plan attests that it does not limit benefits based on genetic testing when Medically Necessary. It does not use information obtained from genetic testing to limit coverage, adjust premiums based upon such information. It does not request or require such testing or collect such information from an individual at any time for underwriting purposes. The Plan also attests it does not limit benefits based upon health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability or disability.

ARTICLE IV. GENERAL CONDITIONS

4.01 This policy, including the applicable riders and endorsements; the application for coverage if specified by the insurer; the identification card if specified by the insurer; and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved by an executive officer of the insurer and unless

the approval is endorsed on this policy or attached to this policy. An insurance producer does not have authority to change this policy or to waive any of its provisions.

4.02 **Primary Care Provider**. In completing the Enrollment Application, each Subscriber must select any available Affiliated Physician/PCP. That physician may be a general practitioner, family practitioner, internist, pediatrician, nurse practitioner or physician assistant. Each Member agrees that all Authorized Benefits and Services must be provided by or authorized through this selected Affiliated Physician/PCP, except in the event of a Medical Emergency or Accidental Injury. When necessary, your Affiliated Physician/PCP will work with other Affiliated Providers and Specialty Physicians to ensure you receive the care you need. For help with the selected Affiliated Physician/PCP or for more information, the Member should call the Plan's Customer Service Department at (800) 826-2862. You may change your PCP at any time.

4.03 Members do not need approval from the Affiliated Physician/PCP to see most participating Specialty Physicians or Affiliated Providers (see 5.05). All Covered Services must be received by participating providers unless Prior Approved by the Plan. If you do not receive an approval from the Plan prior to seeking Covered Services from a Non-Participating Provider, you will be responsible for payment. A referral from your Affiliated Physician/PCP is not enough for the services to be covered. If the Plan gives prior approval for the referral to a Non-Participating Provider, your PCP or the ordering provider will be notified.

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

4.05 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.

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

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

4.08 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, MI 48202.

4.09 The Plan shall not be liable for any delay or failure of an Treating Physician, 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.

4.10 Complaint, Grievance and Appeal Process

Grievances/Appeals

The Plan will provide each Member with a written explanation of the procedure upon enrollment in the Plan and/or at any time upon request. A Member can call the Plan or write to the Plan to file a written grievance at:

Total Health Care USA
Attention: Grievance Coordinator
3011 W. Grand Blvd., Suite 1600
Detroit, Ml 48202
Phone: (313) 871-7889
Fax: (313) 871-0196
e-mail: results@thc-online.com

A grievance (also known as appeal) may be filed due to a denial of payment, an adverse determination, or other dissatisfaction with the Plan. An adverse determination means health care services have been reviewed and denied, reduced or terminated. An untimely response to a request becomes an adverse determination. The Member or authorized representative has one hundred and eighty (180) days from the date of the adverse determination letter to file a grievance/appeal. An authorized representative must have written permission to represent the Member. This consent must be included with the grievance/appeal.

The member grievance process includes two steps. The first step is to file the grievance and the second step is to appeal the resolution. A Member can file the grievance telephonically or in writing. Once the grievance has been file, the Member can request the Plan to arrange a meeting with the Appeal Review Committee. The Member can discuss the grievance/appeal with the committee. The Member or authorized representative may attend a meeting in person or by telephone. A person not involved in the first decision will review the grievance/appeal. No one who reports to the person involved in the initial decision can review the grievance/ appeal. The person who reviews the grievance/appeal will be of similar specialty.
A Member has the right to have benefits continue pending resolution of the grievance/ appeal. The Member may also authorize a representative to act on their behalf in the grievance/appeal process. The Member has the right to send additional documentation with the grievance/appeal.

A pre-service grievance/appeal takes at most 15 days and a pre-service appeal also takes at most 15 days. The whole process will be completed within 30 days. Similarly, a post-service grievance takes at most 30 days and a post-service appeal also takes at most 30 days. The whole process will be completed within 60 days. The time frame may be extended up to ten (10) business days if the Member requests an extension or if the Plan can show that there is need for additional information and can demonstrate that the delay is in the Member's best interest. If the Plan utilizes the extension, the Member will receive written notice of the reason for the delay.

The Member will be notified in writing of the final decision. If the decision upholds the denial, an external appeal can be filed. The final letter informs the Member of the external appeal rights and how to file the appeal.

Expedited Grievance

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

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

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

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

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

External Appeal Rights

A Member or authorized representative has the right to request an external review from DIFS. The request should be made after receiving Total Health Care's final decision. Notification of the final decision completes the Total Health Care internal appeal process.

A Member or authorized representative must file the DIFS, Health Care-Request for External Review Form to be given an external review. A copy of the Health Care-Request for External Review Form will be included with the final decision letter. Members may also call DIFS at 1-877-999-6442 to have a form mailed. The form should be filed no later than one hundred twenty seven (127) days after receipt of the final decision letter.

When appropriate, DIFS will request a recommendation by an independent review organization. The independent review organization is not a part of Total Health Care. The Director of DIFS will issue a final order. To ask questions about the external review process, contact the Total Health Care Grievance Coordinator at (313) 871-7889 or 1-800-826-2862 x889. To request an independent review write to:

Department of Insurance and Financial Services
Healthcare Appeals Section, Office of General Counsel
P.O. Box 30220
Lansing, MI 48909-7720
Or call: (877) 999-6442
Or fax: (517) 284-8848
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

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

4.12 The Plan may adopt reasonable policies, procedures, and rules to promote orderly and efficient administration of this Certificate. Direct questions about such policies in writing, to:

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

4.13 The Member identification (ID) card is the property of the Plan. Each Member understands and agrees to return the Member identification card upon request of the Plan.

4.14 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.

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

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

1. Information Concerning Affiliated Providers. The Member Provider Directory includes the names of Plan Affiliated Providers, specialty or type of practice, practice location, and information concerning accessibility/availability. Requests may be made for the following additional information:

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

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

2. Financial Relationships with Affiliated Providers. Information concerning 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 Benefits 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 information concerning disciplinary action and open formal complaints filed against a health professional or Affiliated Provider is available through the Department of Licensing and Regulatory Affairs at http://www.michigan.gov/lara/. You may also request a copy by emailing LARAFOIAInfo@michigan.gov or fax to 517-335-4037.

4. Benefits. This Certificate of Coverage, together with any Riders, and the Member Handbook provided to Members, contains a description of the benefits available to Plan Members, including rules regarding accessing benefits such as prior authorization requirements, Member's financial participation including Co-Payments, Deductibles, and Coinsurance, drug formulary requirements, if any, and exclusions and limitations applicable to the specific categories of benefits provided. If you require clarification with respect to any of this information, please contact the Member Services Department.

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

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

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

4.17 Autopsy. The Plan, at its own expense, shall have the right and opportunity to examine a Member when and as often as it may reasonably require during the pendency of a claim to make an autopsy in case of death where it is not forbidden by law.

4.18 Claims Provisions.

(a) When a Member receives Authorized Benefits and Services from an Affiliated Provider, Member will not be required to pay any amounts except for 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 /PCP and the Plan, or they were the result of 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

(b) **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 the 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 (800) 826-2862.

(c) **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 unable 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 may be limited by state or federal law. Send itemized medical bills promptly to:

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

(d) **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 BENEFITS AND SERVICES

The following services are covered with no Deductible, Coinsurance or Co-pay.

(1) Preventive Health Services (See Section 5.01)
(2) Prenatal and Postnatal Care, including maternity classes without a referral or authorization
(3) Weight Loss Services

5.01 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.
- Fluoride Chemoprevention supplements – children without fluoride in their water source.
- Gonorrhea preventive medication – all newborns.

(c) Screening an d 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 and physical activity counseling – adults at higher risk for chronic disease.
- Hepatitis B & C for high risk adults
- HIV – all adults at higher risk and pregnant women.
- 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.
- Tuberculosis

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

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

(e) Assessments and Screenings for Children

- Alcohol and Drug Use Assessments – adolescents.
- Autism Screening – children at 18 and 24 months
- Behavioral Assessments – children of all ages.
- Cervical Dysplasia Screening – sexually active females.
- Congenital Hypothyroidism Screening – Newborns.
- Developmental Screening – adolescents aged 12 to 18 years.
- Hearing Screening – all newborns.
- Hemoglobinopathies or Sickle Cell Screening – all newborns.

- Hepatitis B - high risk adolescents.
- HIV Screening – adolescents at higher risk.
- Obesity Screening and Counseling – children of all ages.
- Phenylketonuria (PDU) Genetic Disorder Screening – all newborns.
- Sexually Transmitted Infection (STI) Prevention Counseling – adolescents at higher risk.
  - Skin cancer behavioral counseling
  - Tobacco use interventions.
  - Vision Screening – all children.

(f) In compliance with the consumer protections of the Patient Protection and Affordable Care Act, this "non-grandfathered health plan" includes preventive health care services that address health needs specific to women:

- Well-women visits
- Screening for gestational diabetes
- Human papilloma virus testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immune-deficiency virus
- Women's prescribed contraceptive methods (including women's sterilization procedures) and counseling*
- Breastfeeding support, prescribed supplies and counseling
- Screening and counseling for interpersonal and domestic violence

*Additional information and limitations regarding women's contraceptive methods and counseling:

- Women's contraceptive methods (including women's sterilization procedures) and counseling are not Covered under this Certificate or under and prescription drug Rider to the Certificate for Members of a plan established or maintained by a Religious employer certified as exempt from providing such Coverage under the Patient Protection and Affordable Care Act.
- Women's contraceptive methods (including women's sterilization procedures) and counseling are not Covered under this Certificate under any prescription drug Rider to the Certificate for Members of plans certified under the temporary enforcement safe harbor provisions of the Patient Protection of the Affordable Care Act.
- Brand name oral and injectable contraceptive drugs are only Covered under preventive health care services if approved by the Plan as Medically Necessary. If your plan includes a prescription drug Rider and services are provided by a Participation Pharmacy, brand name oral and injectable contraceptive drugs are Covered at the Preferred Brand Name Copayment or Non- Preferred Brand Name Copayment described in your prescription drug Rider unless otherwise approved by the Plan. If you elect to receive a Brand Name Drug when an equivalent Generic Drug is reasonably available, you may also be responsible for the difference in cost between the Brand Name Drug and the Generic Drug.

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 Inpatient Hospital Care

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

(a) A semi-private room, including general nursing services, meals, and special diets.
(b) Use of intensive care units, operating rooms, delivery rooms, recovery rooms, and other special treatment rooms.
(c) Anesthesia services.
(d) Laboratory examinations, including typing of blood donors and other diagnostic and pathological services.
(e) All necessary medical and surgical supplies.
(f) Use of X-ray and other diagnostic and therapeutic services
(g) Drugs, biologicals and related preparations as prescribed by the attending physician.
(h) Maternity and nursery care of at least forty-eight (48) hours following vaginal delivery; ninety-six (96) hour minimum stay in the case of a cesarean section delivery.
(i) Radiation and inhalation therapy.
(j) Medical rehabilitative services and physical therapy, which can be expected to result in significant improvement of the Member's condition.
(k) Other inpatient services medically necessary for admission, diagnosis, and treatment of the Member.

5.03 Organ and Tissue Transplants

Organ or body tissue transplant is covered when:

(1) Evaluations for transplants and transplants of the following organs at a facility approved by the Plan, but only when we have approved the transplant as Medically Necessary and non-experimental:
    (a) Bone marrow or stem cell.
    (b) Cornea.
    (c) Heart.
    (d) Kidney.
    (e) Liver.
    (f) Lung.
    (g) Pancreas.
    (h) Small bowel.
    (i) Related Services:
(2) Member is enrolled in Total Health Care USA's Case Management Program during the evaluation, pre and post-transplant care; and
(3) The approved transplant is performed in a Total Health Care USA authorized facility.
(4) Expenses related to Computer organ bank searches and any subsequent testing necessary after a potential donor is identified, unless covered by another health plan.
(5) Typing or screening of a potential donor only if the person proposed to receive the transplant is a Member.
(6) 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.
(7) One comprehensive evaluation per transplant except as permitted by our medical policies.
(8) Transplants also include the necessary hospital, surgical, lab, and X-ray services for a non-member donor, unless the Member donor has coverage for such service.

Non-Covered Services include:

(a) Community wide searches for a donor.

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

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

5.04 Outpatient Services

(1) Outpatient surgical care, including routine surgical procedures that do not require the use of inpatient hospital facilities and can be performed on an outpatient basis at a Hospital, ambulatory surgical center or physician office. Such services include surgical scopic procedures including but not limited to arthroscopy, hysteroscopy, laparoscopy.

(2) Therapeutic and diagnostic laboratory, pathology, radiology and special diagnostic services which are medically necessary for the diagnosis or treatment of a disease, injury, or medical condition and which are provided by an Affiliated Provider.

(3) Medical and surgical supplies.

(4) Pre-hospital admission screening procedures which have been authorized by a Treating Physician and/or the admitting physician.

5.05 Professional Services

Services listed in Article V (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 when approved in advance by the Plan if required, including services necessary to treat a Medical Emergency or Urgent Care situation. Affiliated Physician/PCPs 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 Care. Professional Services include:

(1) Office visits at the Member's Primary Care Physician, including annual physical examinations.
(2) Specialty physician care.
(3) Drugs administered at the primary care office, including Allergy shots.
(4) The following Drugs are excluded from the Prescription Drug Benefit and are covered under the Medical Benefit portion of Member's Certificate of Coverage. These include
    (a) Injectable and infusible drugs administered in an inpatient or emergency setting.
    (b) Injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility.
(5) Therapeutic and diagnostic laboratory, pathology, radiology, and special diagnostic services which are medically necessary for the diagnosis or treatment of a disease, injury, or medical condition.
(6) Prenatal and Postnatal care including services from a nurse mid-wife.
(7) Nutritional counseling and health education services.
(8) Pre-hospital admission screening procedures which have been authorized by a Treating Physician and/or the admitting physician.

(9) Vision and hearing screening examinations for Dependents through the completion of the calendar year in which they attain the age of eighteen (18) years, to determine the need for vision and/or hearing corrections.

(10) Infertility counseling , testing and treatment for the underlying cause of infertility.

5.06 Rehabilitative and Habilitative Medicine Services

(1) Short-term medical Rehabilitative Services, for conditions which Treating Physician expects will result in significant improvement of a Member's condition within a period of two (2) months, including:

(a) Physical, Occupational, Chiropractic and Osteopathic Manipulations for a combined 30 visits per calendar year

(b) Speech therapy for a maximum of 30 visits per calendar year

(c) Cardiac and pulmonary rehabilitation for a combined 30 visits per calendar year

(2) Habilitative Services, including but not limited to all therapies for developmental delays and cognitive disorders, including:

(a) Physical, Occupational, Chiropractic and Osteopathic Manipulations for a combined 30 visits per calendar year

(b) Speech therapy for a maximum of 30 visits per calendar year

(c) Sensory integration therapy

(d) Cognitive rehabilitative therapy (neurological training or retraining)

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

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

(3) Habilitative and Rehabilitative Devices

Short-term Rehabilitative Medicine Services are covered if:

(1) Treatment is provided for an illness, injury or congenital defect and

(2) Services are provided in an outpatient setting or in the home; and

(3) You cannot receive these services from any federal or State agency, or any local political subdivision, including school districts; and

(4) Services result in meaningful improvement within 90 days in your ability to do important day-to-day activities that are necessary in your life roles.

Non-Covered Professional Rehabilitative and Habilitative Services include:

(1) 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.

(2) Craniosacral therapy.

(3) Prolotherapy.

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

(5) Relational, educational and sleep therapy and any related diagnostic testing. This exclusion does not apply to therapy or testing provided as part of Affiliated Hospital or Affiliated Facility services outside the scope of practice of the servicing provider.

(6) Services outside the scope of practice of the servicing Provider.

(7) Strength training and exercise programs.

(8) Visual training and sensory integration therapy.

(9) 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.

(10) Extra-spinal manipulation and related services performed by a chiropractor are not covered.

5.07 Plastic Surgery, Medically Necessary

(1) All services defined as Medically Necessary Plastic Surgery require Prior Authorization/approval by the Plan's Medical Director.

Covered Services:

(a) Blepharoplasty of upper lids.
(b) Breast Reduction.
(c) Panniculectomy.
(d) Surgical Treatment of Male Gynecomastia.
(e) Surgery to correct Sleep Apnea
(f) Rhinoplasty.
(g) Septorhinoplasty.

Non-Covered Services:

(1) Any procedures deemed for cosmetic purposes, primarily to improve the way the body looks. Coverage is excluded for, but not limited to:

(a) Blepharoplasty of lower lids.
(b) Breast augmentation except when provided as part of post-mastectomy reconstructive services.
(c) Chemical peel for acne.
(d) Collagen implants.
(e) Diastasis recti repair.
(f) Excision or repair of excess or sagging skin, however, a panniculectomy is covered according to Plan medical policies.
(g) Fat grafts, unless an integral part of another Authorized Benefit and Service.
(h) Hair transplants or repair of any congenital or acquired hair loss, including hair analysis.
(i) Liposuction, unless an integral part of another Authorized Benefit and Service.
(j) Orthodontic treatment, even when provided along with reconstructive surgery.
(k) Removal for excessive hair growth by any method, even if caused by an underlying medical condition.
(l) Rhytidectomy (wrinkle removal).
(m) Rhinophyma treatment.
(n) Salabrasion.
(o) Spider vein removal.
(p) Tattoo removal.

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

(a) 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

(b) there is reasonably expectation that the surgery will correct the condition, and

(c) 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.

(d) 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.

Gender Transition / Gender Dysphoria

Covered Services

- Medically Necessary hospitalizations, prescription drug, medical, surgical and behavioral health services as stated in other areas of this policy and subject to prior approval, as noted elsewhere in this Certificate, related to gender transition or gender dysphoria.

5.08 Home Health Care

When prescribed by a Treating Physician, home health care visits are covered when the 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 or physical, speech, occupational therapy or infusion therapy.

5.09 Breast Cancer Screening, Diagnostic Treatment, and Rehabilitative Services

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

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

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

(4) Other Breast Services and Treatment Following a Mastectomy:

(a) Reconstruction of the breast on which the mastectomy has been performed.
(b) Surgery and reconstruction on the breast to produce a symmetrical appearance.
(c) Prosthesis (breast implant); and
(d) Treatment for physical complications of the mastectomy, including lymphedema
(e) Any other procedure intended to improve the results or ameloiorate the debilitating consequences of treatment of breast cancer, including psychological and social support services.

5.10 Diabetic Services

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

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

5.11 Antineoplastic Drug Coverage (Chemotherapy) and Clinical Trials

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

(1) The drug is ordered by a physician for the treatment of a specific type of neoplasm.
(2) The drug is approved by the Federal Food and Drug Administration for use in antineoplastic therapy.
(3) The drug is used as part of an antineoplastic drug regimen.
(4) Current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment.
(5) The physician has obtained informed consent from the patient for the treatment regimen that includes Federal Food and Drug Administration-approved drugs for off-label indications.

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.

Coverage Limitations:

- Routine patient costs in connection with Certain Phase II and Phase II cancer clinical trials may be Covered if approved in advance by the Plan Medical Director.

5.12 Behavioral Health Services, Substance Use Services

Covered Services:
This plan Covers evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for both acute and chronic behavioral 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.

Behavioral health services are available in a variety of settings and except for outpatient services, require Prior Approval from our Behavioral Health Provider. 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) 344-2416 to be directed to behavioral health experts who can answer your questions.
Covered treatment settings include:

- 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.
- Residential Behavioral Health Rehabilitation. Treatment Services are provided to individuals who require 24-hour treatment and supervision in a safe therapeutic environment. Residential treatment is a 24 hour a day/7 day a week facility-based level of care which provides individuals with significant and persistent Behavioral Health disorders therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. Prior Approval from our Behavioral Health Provider is required for Residential Services.

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. 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.
- Autistic Disorder, including Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, are Covered for initial evaluation and follow-up psychiatric medication management.
- Intellectual Disabilities 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:
        a) transitional living centers,
        b) non-licensed programs, or
        c) therapeutic boarding schools.
    - the costs for care that is:
        a) Custodial,
        b) designed to keep you from continuing unhealthy activities, or
        c) typically provided by community behavioral health services program.
        d) provided via telephone, e-mail or Internet .
- Counseling and other services for:
    - caffeine abuse or addiction,
    - sexual/gender identity issues, including sex therapy,
    - antisocial personality,
    - insomnia and other non-medical sleep disorders,
    - adoption adjustment issues, including treatment for reactive attachment disorder,
    - marital and relationship enhancement, and
    - religious oriented counseling provided by a religious counselor who is not an Affiliated Provider.
    - experimental/investigational or unproven treatments and services.
    - scholastic/educational testing. Intelligence and learning disability testing and evaluations should be requested and conducted by the child's school district.

Substance Use Services

Covered Services:

- Substance use services, 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

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

Covered treatment settings include:

- 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.
- Residential Substance Use Rehabilitation Treatment Services are provided to individuals who require 24-hour treatment and supervision in a safe therapeutic environment. Residential treatment is a 24 hour a day/7 day a week facility-based level of care which provides individuals with significant and persistent substance use disorders therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. Prior Approval from our Behavioral Health Provider is required for Residential Services.

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.

5.13 Autism Services

Definitions:

- "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. ABA involves evidence-based behavioral modification techniques under supervision of a psychiatrist, psychologist or licensed Health Professional specializing in autism treatments in which positive or negative reinforcement is used to encourage or reduce certain behaviors. The treatment is

delivered in a highly structured and intensive program with one-to-one instruction by a trained therapist, typically 15-30 hours per week over the duration of one to two years.

- "Autism diagnostic observation schedule" means the protocol available through western psychological services for diagnosing and assessing autism spectrum disorders.
- "Autism spectrum disorders" means any of the following pervasive developmental disorders as defined by the diagnostic and statistical manual:
    - Autistic disorder.
    - Asperger's disorder.
    - Pervasive developmental disorder not otherwise specified.
- "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.
- "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 when provided by a board certified Health Professional who has the appropriate credentials.
- Evidence-based behavioral health outpatient therapy for the treatment of Autism Spectrum Disorder.
- Evidence-based physical therapy, occupational therapy and speech therapy services for the treatment of Autism Spectrum Disorder.
- Prescription Drugs.

Coverage Limitations:

- Coverage is available for children through age 18.
- Coverage must be Medically Necessary as determined in accordance with Plan medical policies and will be considered when performed by an approved Plan facility or agency along with other criteria set forth in Plan medical policies and is limited to specific treatments outlined in those medical policies.
- Covered services for Applied Behavioral Analysis treatment are limited to $50,000 benefit maximum per Contract Year as allowed by the State of Michigan.
- Coverage for Autism Spectrum Disorder services are subject to the same Deductible (if any), Copayments and Coinsurance that apply to the corresponding benefit categories shown on your Schedule of Out-of-Pocket Expenses. Examples of Autism Spectrum Disorder service benefit categories include Physician Office visits, outpatient behavioral health services, physical, occupational, speech therapies. Any day or visit limitations under these benefit categories do not apply to Autism Spectrum Disorder services. All other terms and limitations apply.

Non Covered Services:

- This Certificate of Coverage 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.

- Autism treatment not approved in advance by the Plan.
- Treatments or services provided by a Non-Participating Provider unless otherwise approved in advance by the Plan.
- Treatments for Autism Spectrum Disorder that are in conflict with the Plan's medical policies, including non-evidence based services for the treatment of Autism Spectrum Disorder.

5.15 Dental Services

(1) Dental services are not covered. Accidental Dental Surgery is covered under Oral Surgery as noted below:
(2) Oral Surgery

(a) Facility, ancillary and anesthesia services for limited dental services may be Covered for pediatric Members when:
   i. a child under age seven (7) needs multiple extractions or restorations,
   ii. a total of six or more teeth are extracted in various quadrants,
   iii. there are dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy
   iv. extensive oral-facial and/or dental trauma has occurred causing treatment under local anesthesia to be ineffective or compromised,
   v. a patient has a serious medical condition that may interfere with routine dental work,
   vi. medical services are required in connection with a dental accident.

(b) Removal of sound natural teeth required in preparation for other medical procedures that are Covered under this Certificate.
(c) Care of fractures of facial bones.
(d) 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.
(e) 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.
(f) Medical and surgical services required to correct accidental Injuries, including emergency care to stabilize dental structures following Injury to sound natural teeth.
(g) Treatment for oral and/or facial cancer.
(h) Treatment for conditions affecting the mouth other than the teeth.
(i) Facility and ancillary services relating to dental services for adults require Prior Authorization by the Plan.

Non-Covered Services:

(a) Routine Dental exams, cleanings and restorative services except as mentioned above.
(b) Dental x-rays.
(c) Dental surgery such as root canals and tooth extractions.
(d) Orthodontia and orthodontic x-rays.
(e) Orthognathic surgery unless specifically Covered by this Certificate.
(f) Dental prostheses, including implants and dentures and preparation of the bone to receive implants or dentures.

(g) Bite splints used for dental purposes.
(h) Treatment of congential dental defects, such as missing or abnormally developed teeth.
(i) Treatment, services and supplies related to periodontal/inflammatory gum disease.
(j) Dental services required due to accidents.
(k) Rebuilding or repair for cosmetic purposes.
(l) Orthodontic treatment, even when provided along with oral surgery.
(m) 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.

(3) 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:

(a) Referral care for evaluation and orthognathic treatment only when prior authorized by the Plan
(b) Cephalometric study and x-rays.
(c) Orthognathic surgery and post-operative care, including hospitalization, if Medically Necessary.

Coverage Limits:

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

5.16 Temporomandibular Joint Syndrome Treatment

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

(2) When deemed Medically Necessary and provided or authorized by a Treating Physician, and approved by the Medical Director, the following services and treatment for Temporomandibular Joint Syndrome are Authorized Benefits and Services:

(a) Office visits for medical evaluation and treatment.
(b) Specialty referral for medical evaluation and treatment.
(c) X-rays of the temporomandibular joint including contrast studies, but not dental X-rays.
(d) Palliative therapy including TENS therapy and intraoral fixation.
(e) Myofunctional therapy.
(f) Surgery to the temporomandibular joint including, such as condylectomy, meniscectomy, arthrotomy and arthrocentesis.

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

5.17 Hospice

(1) Eligibility. A Member is eligible for Hospice coverage when the individual is suffering from a disease or condition with a terminal prognosis. A Member shall be considered to have a disease or condition with a terminal

prognosis if, in the opinion of a Treating Physician, the Member's death is anticipated within six (6) months after the date of admission to Hospice. The fact that a Member lives beyond the 6-month or less prognosis shall not disqualify the person from continued Hospice care. In order to be eligible for Hospice coverage, a Member must have knowledge of the illness and the life expectancy, and elect to receive Hospice services rather than active treatment for the illness.

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

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

5.18 Medical Emergency or Urgent Care

(1) Urgent Care. When you have an Illness or Injury that needs immediate attention, such as cuts or sprains, but it is not as serious as a Medical Emergency, call your Affiliated Physician/PCP before you seek any services. If it is after hours, your PCP or another Affiliated Physician acting on his/her behalf must be available 24 hours a day, 7 days a week to help you determine the best place to go for care. If you are out of the Service Area at that time, your Affiliated Physician/PCP 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/PCP's office and your Illness or Injury needs Urgent Care, go to an Urgent Care Center or Hospital emergency room. Present your ID card and be prepared to pay the required 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/PCP'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-Participating Provider must be Prior Approved by the Plan in order to be covered.

(2) 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, the Plan's in-network rates or Medicare rates whichever is greater. However, this means if the provider does not accept the Plan's payment as payment in full, you may be responsible for additional costs up to charges.

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/PCP and the Plan as 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/PCP can provide or arrange all follow-up care with Affiliated Providers. Follow-up care with Non-Participating Providers will be Covered only if you receive Prior Approval from the Plan.

(3) 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. . The Plan will pay for emergency transportation based on reasonable and customary charges, the Plan's in-network rates or Medicare rates, whichever is greater. This means that if the provider does not accept the Plan's reimbursement as payment in full, you may be responsible for additional costs up to charges for services, including air ambulance.

5.19 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:

- Emergency room services shortly after you left a facility against medical advice;
- A Hospital stay to treat complications caused by leaving a facility against medical advice.
- A Hospital stay to treat complications caused by not taking prescribed medications such as insulin or blood pressure medication.

5.20 Out -of-Area Coverage

Out-of-Area benefits shall be limited to inpatient and outpatient care for Medical Emergencies or Accidental Injuries only. Out-of-Area services are covered if it would be a danger to the member's health to wait to until care could be provided by a provider within the Service area.

Out-of-Area services will not be covered if the member traveled outside of the Service area to obtain these services. If a service cannot be obtained within the Service area, the Plan's Medical Director or designee may authorize the service.

(1) In order to be covered for services under this Section 5.16, the Member must notify the Plan within twenty-four (24) hours after admission to a hospital or as soon as medically possible after admission where the Member is incapable of calling the Plan.

(2) Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered by the Member's Affiliated Physician/PCP only, unless specifically authorized in writing by the Plan's Medical Director or designee.

(3) Consult Rider for application Co-pay.

5.21 Language Services

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

5.21 Pain Management

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

5.23 Hearing Aid

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

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

LIMITATIONS
Hearing Aid benefits are limited to one Hearing Aid per ear every three (3) years up to $600 per hearing aid; Hearing Aids are limited to Affiliated Providers in the Total Health Care USA Network only.

5.24 Vision Care Services

(1) One vision screening, performed as part of a physical exam, during each Plan Year to determine vision loss.
(2) 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.
(3) 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

5.25 Durable Medical Equipment, Prosthetics & Orthotics

(1) Durable Medical Equipment (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 is covered exclusively from the Plan's DME provider.

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. The Plan 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 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 tthe 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 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.
- Certain outpatient medical supplies that are consumable or disposable, including but not limited to gloves, diapers, adhesive bandages, elastic bandages and gauze.
- Durable Medical Equipment excludes any deluxe equipment and features as attachments to such equipment which are not medically necessary.

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

(2) Prosthetic and Orthotic Equipment and Devices (P&O) are covered when prescribed by an Affiliated Physician/PCP or by a Referral Physician (if approved by an Affiliated Physician/PCP), authorized by the Plan's Medical Director or his/her designee. Adjustments and replacements of P&O are covered in the following cases:

(a) Wear and tear,
(b) Changes in member's condition, or
(c) Change in size needed.

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 Necessary according to the criteria set forth in our medical policies or for the convenience of the Member or caregivers.
- Clothing necessary for prosthesis, other than the approved initial purchase, is excluded.

(2) Food, Supplements and Formula

(a) 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.
(b) 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:

(c) 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.

5.26 Skilled Nursing

Skilled nursing care, including therapy and room and board in semi-private accommodations at a skilled nursing, sub-acute or inpatient rehabilitation facility will be provided when deemed medically necessary and/or appropriate by an Affiliated Physician/PCP or by a Referral Physician (if approved by an Affiliated Physician/PCP when authorized by the Plan's Medical Director or his/her designee and under an approved treatment plan in advance. Skilled Nursing Care is limited to forty-five (45) days per calendar year.

Non-covered services include:

(1) 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.

(2) Care provided in a facility required to protect you against self-injurious behavior.

(3) Custodial Care, even if you receive Skilled Nursing Services or therapies along with Custodial Care.

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

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

(6) 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.

5.27 Tobacco Cessation Treatment

(1) Smoking Cessation services provided by the Plan's Behavioral Health Provider.
(2) Tobacco Cessation prescription drug treatments are Covered according to the Approved Drug List.

5.28 Weight Loss Services for Morbid Obesity

Covered Services:

- Weight loss management programs pre-approved by the Plan and provided exclusively within the Total Health Care Network. 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 Necessary according to Total Health Care's clinical criteria and prior authorized.

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, diet supplements.

ARTICLE VI. EXCLUSIONS AND LIMITATIONS

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

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

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

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

6.05 Infertility treatment is not covered.

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

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

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

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

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

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

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

6.13 Services that are deemed not Medically Necessary. Unless stated below, the Plan's Medical Director or designee will make the final determination of medical necessity.

(1) Services and supplies that the Plan determines are not Medically 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.

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

(3) 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;

(4) 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;

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

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

(7) NOTE: If we exclude Coverage because a service or supply is not Medically 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, 4.07.

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

6.15 Services of private duty nurses are not covered unless they are authorized by the Plan's Medical Director or designee before the services are rendered.

6.16 Custodial care, domiciliary care, or basic care in a residential, institutional, or other setting that is primarily for the purpose of meeting the Member's personal needs and which could be provided by persons without professional skills or training is not covered. Examples of custodial care include: assistance in bathing, dressing, eating, walking, getting in and out of bed, and taking medicine.

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

6.18 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 insurance policy.

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

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

6.21 Unless included in a Rider, elective abortions are not covered.

6.22 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.

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 the 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:

(1) All inpatient services, with the exception of:
   (a) Inpatient admissions as the result of a Medical Emergency

(b) Inpatient Hospital admissions for a mother and her newborn up to forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean delivery

(2) Behavioral Health and Substance Use Disorder inpatient and partial hospitalizations.
(3) Outpatient services as outlined on our website, including but not limited to outpatient surgeries.
(4) Referrals to Non-Affiliated Physicians and Providers.
(5) Prosthetic and orthotic charges over $200 and all shoe inserts.
(6) Implant Devices / Stimulators.
(7) Genetic Testing
(8) Home Health Care
(9) Hospice
(10) Diagnostic Imaging Examinations, including but not limited to:
    (a) PET Scans (positron-emission tomography)
    (b) MRI (Magnetic Resonance Imaging)
    (c) CT Scans (computed tomography)
    (d) Nuclear Cardiology Studies
(11) Certain Injectible Drugs and Specialty Drugs (under the Medical Benefits)
(12) Transplants and evaluations for Transplants
(13) Clinical trials for cancer care or other life-threatening conditions or disease
(14) Sterilization – Female or Male. Vasectomy is covered only when performed in a physician office or when performed in connection with another covered inpatient or outpatient surgery.
(15) Additional items as outlined on our website.

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, the Plan may ask for additional information or additional time in which to make a determination. Based on Plan 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 send a letter to both the Member and the Affiliated Provider who ordered the services in the event that the service is denied coverage.

If you obtain services that the Plan says are not covered or services in excess of what the Plan says is covered, you are responsible for payment for those services. If you want the Plan decision to be reconsidered, 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 re-evaluate 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 Necessary and provided by an Affiliated Provider, the care will be covered. If we determine that the care received was Medically Necessary and provided by a Non-Affiliated Provider or not your assigned Affiliated Physician/PCP, the care may be covered only if the necessary care was unavailable from an Affiliated Provider. If we determine that the care received was not Medically Necessary or

the care was provided by a Non-Affiliated Provider or a PCP other than your assigned PCP when it could have been provided by an Affiliated Provider or your assigned PCP, the services will not be covered.

ARTICLE VII. 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 of insurance 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.

ARTICLE IX. COORDINATION OF BENEFITS

9.01 The coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. A Plan includes group and non-group insurance contracts, health maintenance contracts (HMO) or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, medical benefits under group or individualized automobile contracts; and Medicare of any other federal governmental plan, as permitted by law. 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:

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

(2) Except as otherwise provided in subsection (3), if two (2) policies or certificates cover a person on whose expenses the claim is based as a Dependent, the benefits of the policy or certificate of the person whose birthday anniversary occurs earlier in the calendar year shall be determined before the benefits of the policy or certificate of the person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the benefits of a policy or certificate that has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate that has covered the person for the shorter period of time. However, if

either policy or certificate is lawfully issued in another state and does not have the coordination of benefits procedure regarding Dependents based on birthday anniversaries as provided in this subsection, and as a result each policy or certificate determines its benefits after the other, the coordination of benefits procedure set forth in the policy or certificate that does not have the coordination of benefits procedure based on birthday anniversaries shall determine the order of benefits.

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

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

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

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

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

(1) The benefits of a policy or certificate covering the person on whose expenses the claim is based as a laid-off or retired employee or a Dependent of a laid-off or retired employee shall be determined after the benefits of any other policy or certificate covering the person other than as a laid-off or retired employee or Dependent of a laid-off or retired employee.

(2) Subsection (1) shall not apply if either policy or certificate is lawfully issued in another state and does not have a provision regarding laid-off or retired employees and, as a result, each policy or certificate determines its benefits after the other.

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 insurance 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 must notify the Plan in writing within thirty (30) days of any changes in the status of each Member such as a death, birth, legal adoption, changes in legal residence of children, change of telephone number, and/or entrance into or return from military service.

ARTICLE XI. TERMINATION OF GROUP 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 XII) as follows:

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

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

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

(4) Coverage shall terminate at the end of the month in which a Dependent attains the age of twenty-six (26) unless said Dependent is an unmarried child who is incapable of self-support due to developmental disability or physical disability, and who is dependent upon the Subscriber for support and maintenance. Subscriber must submit satisfactory proof of the Dependent's incapacity to the Plan not later than 31 days after the attainment of age of 26.

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

12.03 The Plan may rescind a Member's coverage under this Certificate for intentional misrepresentation of a material fact on the Enrollment Application.

12.04 The Plan may terminate a Member's coverage for providing false or misleading information or withholding material information on any required plan form or in applying for or seeking any health care under the terms of this Certificate. Termination of coverage is effective ten (10) 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 immediately.

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, by giving written notice to the Plan and the Remitting Agent.

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 date of termination.

ARTICLE XIII. CONTINUATION COVERAGE AND CONVERSION

13.01 CONTINUATION OF GROUP COVERAGE OPTION

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

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

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

13.02 CONVERSION OPTION

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

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

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

ARTICLE XIV. Member Rights & Responsibilities

As a Total Health Care USA Member, you have the right to:

- Receive prompt medical care appropriate for your condition, including emergency care if necessary;
- Discuss all treatment options available to you regardless of Coverage limitations; • Receive information about the Plan, our services, our Providers and your rights and responsibilities;
- Colllaborate with Physicians and Health Professionals to make informed decisions about the care that you receive;
- Be treated with respect;
- Have your privacy protected;
- Have your medical and financial records maintained by the Plan kept confidential, whether in electronic or written form. We will not disclose information about your medical records without your consent, except as allowed by Law or in accordance with our Notice of Privacy;
- Be notified in a timely manner if we release information about you in response to a court order;
- Inspect your medical records and those of your minor dependents as allowed by state of federal law;
- Contact us to discuss concerns about the quality of care you have received from an Affiliated Provider;
- Register a complaint or file a Grievance with us or the Director of the Department of Insurance and Financial Services (DIFS) without retaliation, if you experience a problem that remains unresolved; • Initiate a legal

proceeding without retaliation if you experience a problem with the Plan or our Affiliated Providers after you have exhausted the Grievance Process.

As a Total Health Care USA Member, you have the responsibility to:

- Read the Certificate of Coverage and accompanying Member materials;
- Understand and comply with the terms and conditions of your health benefits contined within this Certificate;
- Coordinate all medical services through your Affiliated Physician/PCP, except in the case of a Medical Emergency;
- Obtain Prior Authorization form the Plan as specified in this Certificate except in the case of a Medical Emergency;
- Comply with the limits of any approval of services;
- Use Participating Providers for all services and supplies not requiring Prior Approval;
- Pay Copayments, Deductibles and Coinsurance as appropriate and at the time of service;
- Present your ID Card to the Provider before receiving a service;
- Notify the Plan promptly if your ID card is stolen and cooperate with the Plan to prevent the unauthorized use of your ID card;
- Follow instructions concerning your treatment plans and collaborate with Physicians and Health Professionals to make informed decisions about your care.

ARTICLE XV. PRESCRIPTION DRUG RIDER

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.

Coverage provided is based on the Plan Approved Drug List with required dispensing from an Affiliated Pharmacy or Plan Mail Order Pharmacy.

The Pharmacy & Therapeutics Management Committee (P&T) authorizes tier placement changes. The P&T makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the P&T reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please refer to the Approved Drug Lists available at www.THCmi.com or call Customer Service for the most up-to-date information.

The Plan requires that you use an Affiliated Pharmacy for prescription drugs, including but not limited to Specialty Prescription Drugs and mail orders to obtain benefits within the THC Network.

Benefits for drugs on the Approved Drug List are available when the drug meets the definition of Authorized Benefits and Services (see Definition 2.14) or the Member is part of an Approved Clinical Trial (see Definition 2.10). Exceptions for drugs not found on the formulary for circumstances when a non-formulary alternative is medically necessary and appropriate are considered under prior authorization.

Upon purchase of a rider, members will receive a specific Schedule of Out of Pocket Expenses related to pharmacy co-pays, coinsurance and deductibles.

TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

3011 West Grand Blvd. Suite 1600
Detroit, MI 48202
www.THCmi.com

$20.00 OFFICE VISIT CO-PAYMENT RIDER

This Rider is issued in conjunction with the Group's Certificate of Coverage Agreement.

All definitions, terms, conditions, exclusions and limitations in the Basic Certificate of Coverage Agreement shall remain unchanged except as provided in this Rider.

I. LIMITATIONS

Co-payment: The Member will be charged a $20.00 co-payment per office visit.

PRESCRIPTION DRUG RIDER

$5.00 GENERIC/$20 BRAND NAME/$45 BRAND NAME NON FORMULARY

This Rider is issued in conjunction with the Certificate of Coverage Agreement.

All definitions, terms, conditions, exclusions, and limitations in the Certificate of Coverage Agreement shall remain unchanged except as provided in this Rider.

The following additional definitions, terms, conditions, exclusions, and limitations are applicable to the additional Authorized Benefits and Services provided by this Rider.

I. DEFINTIONS

1.01 "Affiliated Pharmacy" means a licensed pharmacist or mail order pharmacy who has a contract with the Plan to provide services to Members.

1.02 "Prescription Drug" means:

a) All prescription drugs, biologics, and compound medications, including birth control pills, which are listed in the Plan's formulary, as it may be amended from time to time, and

b) Injectible insulin and hypodermic needles and syringes used for the administration of insulin.

1.03 "Maintenance Medications" means, most extended use medications for the treatment medical conditions such as high blood pressure, arthritis, gastric reflux, depression, high cholesterol, thyroid conditions and seasonal allergies.

II. AUTHORIZED BENEFITS AND SERVICES

2.01 The Plan will cover Prescription Drugs:

a) When the prescription is filled by an Affiliated Pharmacy for a 30-day supply or Affiliated mail order pharmacy for a 90-day supply of certain Maintenance Medications; and

b) When the Prescription Drug was prescribed by an Affiliated Physician or prescribed by a Referral Physician and approved by an Affiliated Physician.

c) When a prescription is filled at a non-Affiliated Pharmacy outside the Plan's Service Area, the Plan will pay for a 30-day supply when the Member presents to the Plan a receipt showing payment for a Prescription Drug itemizing the Prescription Drug purchased; and

i. the member was outside the Plan's Service Area for a period of not less than thirty (30) consecutive days; or

ii. The Prescription Drug was not prescribed or approved by a Physician within the Plan's Service Area, but was ordered in the course of treating a Medical Emergency or Accidental Injury.

III. LIMITATIONS

3.01 **Co-payment at an Affiliated Pharmacy**: When a prescription is filled in accordance with Section II, Authorized Benefits and Services, member shall pay the pharmacy a co-payment of $5.00 for generic drugs, $20.00 for brand-name drugs and $45 for brand non- Plan formulary drugs.

3.02 **Co-payment at an Affiliated Mail Order Pharmacy**: When a Maintenance Medication is filled in accordance with Section II, Authorized Benefits and Services, member shall pay the pharmacy a co-payment of $10.00 for a 90 day supply of generic drugs, and $40.00 for a 90 day supply of brand-name drugs. **Brand-name non-formulary drugs are excluded from mail order.**