HEALTH ALLIANCE PLAN
HMO SUBSCRIBER CONTRACT

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HEALTH ALLIANCE PLAN

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SECTION 1—INTRODUCTION

1.1 Your Coverage

You and your eligible Dependents are entitled to receive the benefits described in this booklet. You may also have Riders. Riders change the benefits and eligibility rules described in this booklet. You should keep this booklet and all Riders with your other important papers so that they are available for your future reference.

1.2 HMO Coverage

This Contract provides coverage through Health Alliance Plan (HAP), a nonprofit corporation licensed by the State of Michigan as a Health Maintenance Organization (HMO). Because Health Alliance Plan is an HMO, the services covered under this Contract must be provided, arranged or authorized in advance by your personal care physician (PCP). Your PCP is an Affiliated Provider that you choose who is primarily responsible for providing or arranging for health care services for you. In some cases, your PCP will also need to have services approved by us. Because your PCP is the key to receiving services under this Contract, make an appointment to see your PCP soon. It is also important to read this Contract carefully before you need services.

1.3 This Contract

This Contract is an agreement between HAP and persons who have enrolled as Members. It contains important information about your coverage. You should read this Contract carefully before you need services. By enrolling in HAP and accepting this Contract, you agree to abide by this Contract and recognize that HAP is responsible for arranging, paying or reimbursing for only those services and benefits that are Covered Services under this Contract, subject to all exclusions and limitations set forth herein.

1.4 Definitions

Throughout this Contract, Health Alliance Plan is referred to as “we”, “us”, “our” or “HAP”. The words “you”, “your”, “yours” or “Member” refer to the Subscriber and/or any Dependents covered under this Contract. There are other words and phrases used in this Contract that have meanings unique to health care. These words and phrases are defined in Section 10.

SECTION 2—ELIGIBILITY

2.1 Subscriber

You are eligible for coverage as a Subscriber under this Contract if:

(a) You meet the eligibility requirements of HAP and your Group;

(b) You live or work in HAP’s Service Area.

2.2 Dependents

The following persons are eligible for coverage as the Subscriber’s Dependents under this Contract if they meet the eligibility requirements of HAP and the Subscriber’s Group:

(a) The Subscriber’s spouse.

(b) The Subscriber’s unmarried children, by birth or legal adoption.

(c) The unmarried children of the Subscriber's spouse, by birth or legal adoption, who live with the Subscriber. An unmarried child of the Subscriber's spouse, by birth or legal adoption, who does not live with the Subscriber because he or she is attending school full time, qualifies as a Dependent.

2.3 Coverage Period for a Dependent Child

(a) Coverage for a child by legal adoption begins on the day of placement for adoption. Placement means the day on which the Subscriber or the Subscriber's spouse assumes and retains the legal obligation for total or partial support of the child in anticipation of adoption of the child.

(b) Coverage for a child who is your Dependent ends on the last day of the calendar year in which the child reaches the age of 19.

(c) Coverage for a child who is your Dependent continues without limitation if the child is diagnosed as permanently disabled due to a physical or mental condition that initially occurred and was documented before the child reached the age of 19, and the child relies on you for all or most of their support.

2.4 Effect of Medicare Eligibility

A Member who is eligible for Medicare may be eligible for coverage under this Contract only if the Group purchases the Complementary Medicare Rider. Such Member must be enrolled in Medicare Parts A and B or have the Rider that replaces the coverage provided by Medicare Parts A and/or B. Medicare-eligible Members who qualify for Medicare working aged status are not required to purchase the Complementary Medicare Rider or the Riders that replace the coverage provided by Medicare Parts A and/or B.

2.5 Initial Enrollment

You and your Dependents must enroll for coverage under this Contract within 31 days of becoming eligible or, in the case of an Open Enrollment period, within the period specified by your Group or Remitting Agent. If you fail to do so, you and/or your Dependents will not be permitted to enroll until the next Open Enrollment period.

2.6 Changes in Eligibility

You must notify your Group or Remitting Agent of events that might change the eligibility of you and your Dependents for coverage under this Contract. These events include birth, adoption, marriage, divorce, death or a mid-year loss of other health coverage. We must receive notice of these events from your Group or Remitting Agent within 31 days of the event in order to provide coverage and/or adjust Premiums. We will only cover new Dependents upon timely payment of any additional Premium due to HAP.

2.7 Notifying HAP of Important Changes

You must notify HAP as soon as possible, but at least within 31 days, of any of the following changes:

(a) A change in your name, address or telephone number.

(b) Retirement or other changes in your employment status.

(c) A change in Medicare eligibility or coverage such as entitlement to, enrollment in or disenrollment from Medicare Parts A and/or B.

(d) The addition of, or a change in, any additional health coverage to which the Member may be entitled.

2.8 Failure to Notify HAP of Changes

Failure to provide timely and complete notice of changes in eligibility or other important changes as noted above may result in a lapse in coverage. HAP is not responsible for a lapse in coverage when you, the Group or the Remitting Agent do not notify HAP of these changes.

2.9 Documentation of Coverage

Upon request by us, you must give us information, including copies of documents, which help us determine the eligibility of you or your Dependents for coverage under this Contract.

SECTION 3—PAYMENT OF PREMIUMS AND COPAYMENTS

3.1 Premium

The Premium is the rate set by HAP and paid by the Group or Remitting Agent for the right of a Member to receive Covered Services under this Contract.

3.2 Due Date of Premium

All Premiums are due and payable in advance. The first Premium must be paid before coverage becomes effective. Thereafter, we will continue coverage under this Contract for the entire period covered by the payment if we receive payment within 30 days of the date the payment was due.

3.3 Failure to Pay Premium

In the event that we do not receive payment of the Premium from the Group or Remitting Agent within 30 days after the due date, HAP may cancel your coverage under this Contract.

3.4 Agreement to Pay for Services if Premium is Not Paid

You are not entitled to Covered Services during any period for which a Premium was due but not paid by your Group or Remitting Agent. If you receive Covered Services during such a period, you are responsible for paying the provider for those services or reimbursing us in the event that we paid for such services.

3.5 Change in Premiums

HAP may change the Premiums required under this Contract upon a 30-day written notice to the Group or Remitting Agent.

3.6 Copayment

You are responsible for paying the Copayment for Covered Services established in all applicable Riders. A Copayment (or "Copay") is the fixed amount or percentage of charges you pay for certain Covered Services. Not all Covered Services have Copayments.

SECTION 4—SERVICES AND BENEFITS

The services and benefits described in this Section are Covered Services when provided in accordance with HAP's benefit, referral and practice policies by an Affiliated Provider, or as otherwise approved by HAP or its designee. Only services that are Preventive Services and/or Medically Necessary and approved by HAP or its designee are Covered Services under this Contract. These services have limitations and exclusions that are outlined in this Section and in Section 5.

4.1 Inpatient Hospital Care

HAP provides coverage for Medically Necessary inpatient hospital days and related hospital services that have been approved by HAP when you or your representative notifies HAP within 48 hours of your inpatient hospital admission, and when the services are provided by a HAP Affiliated Hospital according to HAP's benefit, referral and practice policies, including but not limited to:

(a) Semi-private room and board, including meals and special diets when Medically Necessary.

(b) Regular nursing services.

(c) Special care units, such as intensive or coronary care units.

(d) Operating, recovery and other treatment rooms.

(e) Diagnostic laboratory tests, X-rays and pathology services.

(f) Prescribed drugs and medications.

(g) Administration of blood, blood plasma and other biologicals.

(h) Medical supplies and equipment, including oxygen.

(i) Anesthetics and anesthesia services.

(j) Rehabilitation services (e.g., physical, occupational and/or speech therapy).

(k) Radiation therapy.

(l) Inhalation therapy.

4.2 Outpatient Hospital Care

HAP covers Medically Necessary outpatient hospital services provided by a HAP Affiliated Hospital, including but not limited to:

(a) Pre-surgical testing.

(b) Dressings, casts, and sterile tray services.

(c) Operating, recovery, and other treatment rooms.

(d) Diagnostic laboratory tests, X-rays and pathology services.

(e) Prescribed drugs and medications.

(f) Administration of blood, blood plasma and other biologicals.

(g) Medical supplies and equipment, including oxygen.

(h) Anesthetics and anesthesia services.

(i) Radiation therapy.

4.3 Professional Services of Physicians

HAP covers the professional services of physicians who are Affiliated Providers as follows:

(a) In the physician's office, outpatient hospital clinic or other outpatient clinic or medical center.

(b) During an inpatient hospital stay.

(c) In a skilled nursing facility.

4.4 Preventive Services

Preventive Services are those services necessary to help avoid the development of disease processes, in accordance with HAP's Health Living Guidelines. The following Preventive Services are covered according to HAP's Healthy Living Guidelines when provided by a HAP Affiliated Provider:

(a) Well baby care from birth.

(b) Periodic health evaluations, screening tests and physical examinations for children and adults.

(c) Routine adult and pediatric immunizations.

(d) Breast and pelvic exams and Pap smears for women.

(e) Breast cancer screening (mammography).

(f) Routine eye examinations.

(g) Routine hearing examinations.

4.5 Diabetic Care

The following services for diabetic Members are covered when ordered, arranged and provided by a HAP Affiliated Provider:

(a) Blood glucose monitors, insulin infusion pumps and supplies according to quantity and other limitations.

(b) Sessions with a certified diabetes educator, registered nurse, or dietitian for the purpose of working with the diabetic patient through diet and self-management training to maintain glucose control and optimize medical management of the disease.

4.6 Gynecological and Maternity Care Services

(a) Female HAP Members may receive routine OB/GYN care such as yearly pelvic exams, Pap smears and screening mammograms from any HAP Affiliated OB/GYN regardless of Physician Network or Medical Group assignment. Non-routine OB/GYN care must be provided by an Affiliated OB/GYN Provider within the Member's assigned Physician Network or Medical Group, unless otherwise authorized by HAP or its designee.

HAP recommends that a woman preparing for childbirth select an obstetrician in her assigned Physician Network or Medical Group for prenatal care. This will help ensure delivery at her Physician Network or Medical Group Affiliated Hospital.

(b) Maternity care includes prenatal, inpatient hospital and postpartum services provided to the mother by a HAP Affiliated Provider, including an Affiliated midwife.

(c) HAP provides coverage for inpatient hospital services in connection with childbirth for the mother and newborn child for up to 48 hours for a vaginal delivery and 96 hours following a delivery by cesarean section.

4.7 Weight Loss Programs and Services

If HAP's guidelines are met, the following weight loss services are covered when ordered and arranged for by a HAP Affiliated Provider and approved by HAP or its designee:

(a) Weight loss programs conducted by a HAP Affiliated Provider, limited to one program per lifetime. Programs are covered for a period not to exceed 12 months.

(b) Bariatric surgery performed at a facility approved by HAP with a $1000 Copayment. Services must be Medically Necessary according to HAP's benefit, referral and practice policies.

4.8 Emergency Services

We cover Emergency Services whether received within or outside of the HAP Service Area subject to the limitations of this Section.

(a) An Emergency Medical Condition or Emergency means a medical condition that starts suddenly and includes signs and symptoms so severe, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your 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. Emergency Services are Medically Necessary services provided to diagnose, treat and

stabilize an Emergency Medical Condition. Emergency Services end when your Emergency Medical Condition is stabilized.

(b) Inpatient hospital admission for an Emergency is covered at any hospital, Affiliated or not, only if you or your representative notifies HAP within 48 hours of your inpatient hospital admission. HAP will not cover the inpatient hospital services if the notice is not given, unless you failed to notify HAP in a timely manner because your medical condition prevented you from doing so or instructing your representative to do so. If you are conscious and able to communicate with others, you are considered to be capable of notifying HAP. In the case of a minor, the Subscriber is responsible for notifying HAP.

4.9 Services After an Emergency

(a) You should contact your PCP after an Emergency is stabilized so that your PCP may provide or arrange for any necessary follow-up care. Follow-up care received from any provider is not covered unless provided or arranged by your PCP and, if necessary, approved in advance by us.

(b) If, during or following an Emergency, you are admitted to a hospital that is not a HAP Affiliated Hospital, or to an Affiliated Hospital outside your assigned Physician Network or Medical Group, we may transfer you to a HAP Affiliated Hospital within your assigned Physician Network or Medical Group. We may transfer you when the transfer can be safely provided and would not jeopardize your medical condition, in the judgment of the attending physician and HAP or its designee. Covered Services will be extended until a transfer can be safely provided or until discharge, whichever occurs first. In the event of a transfer, the cost of appropriate transportation is a Covered Service.

(c) If you, or a representative on your behalf, refuse a transfer that HAP and the attending provider have deemed appropriate, we will not cover continued care at the initial facility; rather, you will be solely responsible for the costs of any services rendered after refusing the transfer.

4.10 Urgent Care Services

(a) Urgent Care means Medically Necessary services to treat a medical condition that is not life threatening but may require prompt attention.

(b) In the event that you need Urgent Care while you are in the Service Area, you should contact your PCP or seek services from an Affiliated urgent care center. Covered Services also include Medically Necessary services at <u>any</u> urgent care center if you are outside HAP's Service Area and are unable to return before receiving services. Coverage for Urgent Care is limited to Medically Necessary Covered Services provided by your PCP or at an urgent care facility.

(c) You must contact your PCP *after* receiving Urgent Care, so that your PCP may arrange or provide any necessary follow-up care. Follow-up care received from any provider is not covered unless provided or arranged by your PCP and, if necessary, approved in advance by us.

4.11 Mental Health Services

Treatment for acute, short-term mental health conditions or acute aggravation of an ongoing condition, not excluded under Section 5, is a Covered Service under this Contract. Covered Services are limited to the most appropriate method and scope of treatment necessary as approved by HAP or its designee. You do not need a referral from your PCP in order to receive mental health services. You must contact the HAP Coordinated Behavioral Health Management department directly at 1-800-444-5755 to receive approval and coordination of care for mental health services.

(a) **Inpatient Mental Health Services**
Coverage of inpatient care for acute mental illness is limited to 30 days per benefit period when approved by HAP or its designee. A new benefit period will begin and additional days of care will be available only when there has been a lapse of at least 60 continuous days between the last date of discharge and the next date of admission.

(1) **Mental Health Day Treatment Services**
Intensive day treatment programs may be covered in lieu of inpatient mental health services, when approved by HAP or its designee. Two days of intensive day treatment are counted as one inpatient hospital day toward the 30-day per benefit period maximum for inpatient mental health services treatment.

(2) **Electro-Convulsive Therapy (E.C.T.)**
E.C.T. is a form of treatment for severe depression, mood disorders and schizophrenia. Each outpatient E.C.T. treatment counts as one inpatient hospital day toward the 30-day per benefit period maximum for inpatient mental health services treatment.

(b) **Outpatient Mental Health Services**
Covered outpatient mental health services include psychiatric consultations and diagnosis and the use of other psychotherapeutic services as identified in a treatment plan approved by HAP or its designee, not to exceed 20 visits per Member per calendar year. Visits may include individual, family, conjoint, collateral, or group therapy sessions. These visits must be to an appropriate Affiliated Provider, such as a psychiatrist, licensed psychologist or a mental health facility that employs a psychiatric social worker or a clinical nurse specialist, as approved by HAP or its designee.
Each group therapy session or medication review visit counts as a half visit toward the 20-visit per calendar year maximum for outpatient mental health services.

4.12 Chemical Dependency Services
Coverage for chemical dependency treatment is limited to the most appropriate method and level of treatment necessary as approved by HAP or its designee. Coverage for intermediate and outpatient services for chemical dependency treatment is subject to the benefit limitations described below, but are not less than the minimum benefit established by the State of Michigan, Office of Financial and Insurance Services. You do not need a referral from your PCP in order to receive chemical dependency services. You must contact the HAP Coordinated Behavioral Health Management department directly at 1-800-444-5755 to receive approval and coordination of care for chemical dependency services.

(a) **Inpatient Chemical Dependency Services**
Coverage for inpatient chemical dependency treatment is limited to 30 days per benefit period when approved by HAP or its designee. A new benefit period will begin and additional days of care will be available only when there has been a lapse of at least 60 continuous days between the last date of discharge and the next date of admission.

Chemical Dependency Day Treatment Services
Intensive day treatment programs for chemical dependency may be covered in lieu of inpatient chemical dependency services, when approved by HAP. Two days of intensive day treatment shall be counted as one inpatient hospital day toward the 30-day per benefit period maximum for inpatient chemical dependency treatment.

(b) **Intermediate and Outpatient Chemical Dependency Services**
Intermediate and outpatient chemical dependency Covered Services may include counseling and other ancillary services, such as medical testing, diagnostic evaluation and implementation of other chemical dependency services as identified in the treatment plan approved by HAP or its designee, not to exceed 35 visits per Member per calendar year. These visits must be to an appropriate Affiliated Provider, such as a psychiatrist, licensed psychologist or a facility that employs psychiatric social workers, counselors, or clinical nurse specialists.

Each group therapy session counts as a half visit toward the 35-visit per calendar year maximum for intermediate and outpatient chemical dependency services.

4.13 Breast Cancer Screening, Diagnostic, Treatment, Rehabilitative and Mastectomy Services

(a) Covered Services for breast cancer include the following:

(1) Breast cancer screening (mammography), as medically appropriate.

(2) Breast cancer diagnostic services including mammography, surgical breast biopsy, and pathological examination and interpretation.

(3) Breast cancer treatment services including surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

(4) Breast cancer rehabilitative services including reconstructive plastic surgery, physical therapy, and psychological and support services.

(b) Covered Services for reconstruction and prosthetic services for a Member who received a mastectomy on or after October 21, 1998 include the following:

(1) Reconstruction of the affected breast.

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance.

(3) Prostheses required after mastectomy.

(4) Treatment of physical complications from all stages of mastectomy, including lymphedemas.

4.14 Home Health Care

(a) Home health care is covered when all of the following conditions are met:

(1) The services are provided for the care and treatment of an injury or illness of such severity that confinement in a hospital or other health care facility would be required without the services;

(2) The services are provided through an Affiliated home heath care agency; and

(3) The level of care is skilled as approved under HAP's guidelines.

(b) The number of visits for Medically Necessary home health care shall be approved according to HAP's benefit, referral and practice policies, and are not to exceed 60 consecutive, calendar days per illness or injury beginning with the first visit.

(c) Home health care is further limited to care needed on a part-time or intermittent basis, as defined under HAP's guidelines.

4.15 Ambulance Services

(a) An ambulance is a vehicle specially equipped and licensed for transporting wounded, injured, or sick persons and for providing limited medical services during such transport.

(b) Ambulance services provided in an Emergency are Covered Services under any of the following situations:

(1) When you receive Emergency Services, as defined in Section 4.8.

(2) When the ambulance is ordered by an employer, or a school, fire, or public safety official, and you are not in a position to refuse treatment.

4.16 Therapy Services and Rehabilitation Services

(a) Therapy and Rehabilitation services including physical, speech, and occupational therapy, and cardiac and pulmonary rehabilitation provided by an Affiliated Provider are Covered Services for a Member whose condition meets all of the following criteria:

(1) Your condition must be of such a level of complexity that the required services can be performed safely and effectively only by or under the direction of a qualified therapist;

(2) The requested therapy services must be related directly and specifically to a treatment plan as established by your HAP Affiliated Provider and the qualified therapist; and

(3) The services must be reasonable and necessary to the treatment of your diagnosis according to all of the following:

A. The treatment must be consistent with standards of medical practice and an effective treatment for your condition; and

B. It is expected that the condition will improve significantly in a reasonable (and usually predictable) period of time or the services must be necessary to the establishment of a safe and effective maintenance program as related to a specific disease state.

(b) **Physical Therapy**

Short-term physical therapy services, either in the home or outpatient clinical setting, are covered when treatment begins within 60 consecutive, calendar days following illness or injury. The number of visits for Medically Necessary physical therapy shall be approved according to HAP's benefit, referral and practice policies, and are not to exceed 60 consecutive, calendar days per illness or injury beginning with the first visit.

(c) **Speech Therapy**

(1) The therapy must be related to an organic medical condition (i.e., attributable to a physiological cause) or an immediate postoperative or convalescent state and be restorative in nature.

(2) Short-term speech therapy services, either in the home or outpatient clinical setting, are covered when treatment begins within 60 consecutive, calendar days following illness or injury. The number of visits for Medically Necessary speech therapy shall be approved according to HAP's benefit, referral and practice policies, and are not to exceed 60 consecutive, calendar days per illness or injury beginning with the first visit.

(d) **Occupational Therapy**

(1) The therapy must be concerned with improving or restoring functions to improve your ability to perform tasks required for independent functioning that have been impaired or permanently lost due to illness or injury.

(2) Short-term occupational therapy services, either in the home or outpatient clinical setting, are covered when treatment begins within 60 consecutive, calendar days following illness or injury. The number of visits for Medically Necessary occupational therapy shall be approved according to HAP's benefit, referral and practice policies, and are not to exceed 60 consecutive, calendar days per illness or injury beginning with the first visit.

(e) **Cardiac Rehabilitation**

Cardiac rehabilitation therapy is a Covered Service when the therapy is approved in advance and provided by a HAP Affiliated Provider according to HAP's benefit, referral and practice policies.

(1) Phase I of the cardiac rehabilitation program must be administered during an approved inpatient hospitalization.

(2) Phase II is a physician supervised and monitored outpatient program that includes exercise and testing. This component of the program is covered with appropriate prior approval from a HAP Affiliated Provider according to HAP's benefit, referral and practice policies.

(3) Coverage for the Phase II component is limited to 12 visits per occurrence of the condition.

(f) **Pulmonary Rehabilitation**
Pulmonary Rehabilitation is a Covered Service when the following conditions are met:

(1) The therapy is approved in advance and provided by a HAP Affiliated Provider according to HAP's benefit, referral and practice policies.

(2) Coverage for Pulmonary Rehabilitation is limited to 12 visits per lifetime.

(g) **Other Rehabilitation Services**
Other rehabilitation services, except as specifically excluded in this Contract, may be Covered Services when ordered, arranged for, and provided by a HAP Affiliated Provider according to HAP's benefit, referral and practice policies.

4.17 Reproductive Care and Family Planning Services
The following services and benefits are Covered Services, except as excluded by a Rider:

(a) History, physical examinations, laboratory tests, counseling, and medical supervision related to family planning as approved by the HAP Affiliated Provider according to HAP's benefit, referral and practice policies.

(b) Genetic testing and counseling in accordance with HAP's benefit, referral and practice policies.

(c) Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies. Following the initial sequence of diagnostic work-up and treatment, additional treatment will be undertaken only when approved by HAP or its designee according to HAP's benefit, referral and practice policies.

(d) Adult sterilization procedures are limited to vasectomy and tubal ligation procedures.

4.18 Oral and Maxillofacial Services
Oral and maxillofacial surgery and related X-rays are Covered Services with prior approval from HAP or its designee, according to HAP's benefit, referral and practice policies, for the following conditions:

(a) Prompt repair and treatment of fractures of the jaw and facial dislocation of the jaw.

(b) Emergency Services for the prompt repair of traumatic injury to sound natural teeth resulting from an injury that occurs while you are enrolled in HAP. Services provided after the Emergency are not covered.

(c) Removal of teeth for treatment of lesions, tumors, and cysts on or in the mouth when approved by HAP or its designee according to HAP's benefit, referral and practice policies.

(d) Hospital and related professional services will be covered when multiple extractions, concurrent with a hazardous medical condition, require the procedure to be performed in a hospital. These services must be arranged and approved by HAP or its designee according to HAP's benefit, referral and practice policies.

(e) Temporomandibular joint (TMJ) therapy is a covered benefit when the following conditions are met:

(1) A consultative visit with a HAP Affiliated Provider has been arranged for and approved in advance by HAP or its designee, and yields a proposed treatment plan.

(2) Only Phase I treatments, consisting of non-invasive, reversible procedures, are Covered Services under this Contract. Invasive procedures and additional services, such as occlusal bite splints, are not Covered Services.

(3) Each Phase I procedure will be approved only once per Member per lifetime.

4.19 Anti-Cancer Drugs

HAP will cover drugs approved by the Federal Food and Drug Administration (FDA) that are used in antineoplastic therapy and their administration. Coverage will be 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 FDA approval if all of the following are met:

(a) The drug is ordered by a HAP Affiliated Provider for the treatment of a specific type of neoplasm;

(b) The drug is approved by the FDA for use in antineoplastic therapy;

(c) The drug is used as part of an antineoplastic drug regimen;

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

(e) The HAP Affiliated Provider has obtained informed consent from you for the treatment regimen that includes FDA approved drugs for off-label indications.

4.20 Organ and Tissue Transplantation

(a) Organ and tissue transplants and related services are Covered Services when all of the following conditions are met:

 (1) The organ or tissue transplant is determined not to be experimental or investigational, as those terms are defined in Section 5; and

 (2) A HAP Affiliated Provider submits the initial evaluation for prior approval by HAP or its designee.

(b) When the transplant recipient is an eligible HAP Member, but the donor is not, benefits are provided for the recipient and, to the extent they are not available under any other health care coverage, for the donor. In this event the donor must have a notarized statement indicating that no other insurance is available.

(c) Donor searches and related evaluation and testing of the immediate family members only (parent, siblings, children) of the transplant recipient to establish compatibility and suitability of potential and actual donors.

(d) Donor benefits are limited to expenses incurred for all pre- and post-testing, physician services, laboratory procedures and hospitalizations needed to harvest the organ, until the donor’s discharge from the hospital immediately following the transplant.

(e) Expenses incurred in the evaluation and procurement of cadaver organs and tissue are Covered Services for Members who meet the above conditions.

4.21 Hospice Care

Hospice is a program designed to care for the special needs of the dying.

(a) Hospice care is a covered benefit when all of the following conditions are met:

 (1) The election of Hospice occurs on or after the effective date of coverage; and

 (2) A written medical certification statement of the patient’s terminal illness is presented to HAP according to HAP’s benefit, referral and practice policies.

(b) The Hospice benefit is limited to a total benefit period not to exceed 210 days per lifetime.

SECTION 5—EXCLUSIONS AND LIMITATIONS

The following are not covered under this Contract:

5.1 Non-Covered Services

(a) **Reproductive Care and Family Planning Services**

(1) Voluntary termination of pregnancy.

(2) Reversal of voluntary surgically-induced sterilization.

(3) Infertility services to persons with a history of voluntary sterilization.

(4) Services, testing and procedures, including artificial insemination and maternity care, performed in conjunction with or contemplation of surrogate motherhood.

(5) Services related to the collection or storage of sperm or eggs, including donor fees.

(6) Home uterine monitoring devices.

(7) Services or benefits furnished in connection with any Assisted Reproductive Technologies (ART) procedures that involve harvesting, storage, or manipulation of eggs and sperm. These include, but are not limited to, artificial insemination, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, embryo selection, embryo transfer, embryo freezing and drug treatment.

(b) **Sex-change Procedures**

Hospital, medical, surgical and other related services for the primary purpose of gender reassignment.

(c) **Cosmetic Services**

Services and benefits for cosmetic purposes are not covered. Cosmetic surgery is defined as surgery to reshape normal structures of the body in order to improve the patient's appearance and self-esteem, as determined by HAP or its designee. Cosmetic surgeries and services include but are not limited to:

(1) Surgery and services related to gynecomastia.

(2) Rhinoplasty.

(3) Liposuction.

(4) Face lifts.

(5) Treatment of vitiligo unless Medically Necessary.

(6) Electrolysis.

(7) Abdominal skin flap reduction (tummy tuck).

(8) Skin tag or keloid removal or modification.

(9) Breast implants, except as specified in Section 4.13.

(10) Collagen or Botox injections.

(d) **Weight Loss Programs and Services**

(1) Food or supplements used for weight loss or in conjunction with any weight loss program.

(2) Community based weight loss programs or classes.

(3) Reversals or revisions of bariatric surgery.

(4) Weight loss procedures performed for Members who do not meet established criteria according to HAP's benefit, referral and practice policies.

(e) **Experimental and Investigational Services**

Any drug, treatment, device, procedure, service or benefit that is experimental or investigational.

(1) A drug, treatment, device, procedure, service or benefit may be considered experimental or investigational by HAP if it meets any one of the following criteria:

A. It cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of its use or proposed use.

B. It is the subject of a current investigational new drug or new device application on file with the FDA.

C. It is being provided pursuant to a written protocol that describes, among its objectives, determinations of safety, effectiveness and effectiveness in comparison to conventional alternatives or toxicity.

D. It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services.

E. The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings.

F. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, efficacy or efficacy in comparison to conventional alternatives.

G. It is not investigational in itself pursuant to any of the foregoing criteria and would not be Medically Necessary but for the provision of a drug, device, treatment, or procedure that is investigational or experimental.

(2) Fees associated with the care, services, supplies, devices, or procedures that are investigational or are in conjunction with research studies.

(3) The following are considered experimental or investigational services and, therefore, are not covered:

A. Medical services that are generally regarded by the medical community to be unusual, infrequently provided, and not necessary for the protection of health.

B. Services associated with organ or tissue transplantation that are considered experimental.

(f) **Eye Care and Vision Services**

(1) Eyeglasses and contact lenses.

(2) Eye examinations for the purpose of prescribing or fitting contact lenses.

(3) Surgery to correct refractive error including but not limited to Lasik, Radial Keratotomy and Photorefractive Keratectomy.

(g) **Transportation**

Transportation to or from a health care facility or doctor's office, except for transportation by ambulance in an Emergency or for an approved transfer.

(h) **Medical Devices and Equipment, including:**

(1) Durable Medical Equipment (DME), including Medically Necessary equipment, such as crutches and wheelchairs, that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally needed or used by a person in the absence of illness or injury.

(2) Disposable medical supplies, such as dressings and support garments.

(3) Prosthetic appliances, including devices or equipment, such as prosthetic limbs, used to replace a missing or malfunctioning body part.

(4) Orthopedic devices, including rigid or semi-rigid devices, such as special shoes and custom-molded shoe inserts, used to support or immobilize a weak or injured body part.

(5) Hearing aids.

(i) **Foot Care**

(1) Routine foot care including, but not limited to, corns, calluses, or toenail clipping or removal, except for diabetic Members when approved in advance by HAP or its designee.

(2) Foot orthotics or shoe inserts.

(j) **Mental Health and Chemical Dependency**

(1) Inpatient hospitalizations for the treatment of mental illness or chemical dependency that include treatment plans or facilities in excess of the maximum benefit as described in Section 4.11 and Section 4.12.

(2) Services for mental illnesses or chemical dependency that, according to generally accepted professional standards, are not amenable to favorable modification or are determined to be a chronic condition.

(3) Care, services, supplies, devices or procedures related to involuntarily committed or deferred psychiatric admissions, that are not rendered by or at your assigned HAP Affiliated Provider except for Emergency Services to the point of stabilization subject to the limits that generally apply to your mental health benefit.

(4) Care, services, supplies, or procedures that are cognitive in nature.

(5) Care, services, supplies, devices or procedures, that are related to court-ordered services.

(k) **Nursing Services**

(1) Private duty nursing services.

(2) Residential and basic nursing services provided in a long-term care facility.

(l) **Personal Services**

(1) General housekeeping services.

(2) The costs of a private room.

(3) Exceptional medical care made necessary by your personal or religious objections to customary, appropriate and usual treatment.

(4) Custodial care, domiciliary care or basic care provided in a residential, institutional, or other setting that are primarily for the purpose of meeting your personal needs, and that could be provided by persons without professional skills or training. Examples of custodial care include, but are not limited to, assistance with the activities of daily living such as bathing, dressing, eating, walking, getting in and out of bed, and taking medication.

(5) Personal comfort and convenience items, including but not limited to, telephone and television services during an inpatient stay, and home or vehicle modifications or appliances.

(6) Lodging and/or meals necessary while receiving services either within or outside HAP's Service Area.

(m) **Custodial Inpatient Care**

Non-acute physician and other services provided while you are receiving custodial care in a residential, institutional or other setting.

(n) **Oral, Maxillofacial, and Dentistry Services**

(1) Treatment of periodontal, periapical disease, or any condition (other than malignant tumor) involving the teeth or surrounding tissue or structures.

A. Dental services, dental X-rays, dental prosthesis, oral surgery, and dental surgery in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.

B. Oral or maxillofacial surgery is not covered under this Contract unless specifically covered in Section 4.18.

C. Surgery or treatment beyond Phase I, non-invasive, reversible procedures related to TMJ dysfunction.

D. Endodontic, prosthodontic, and orthodontic treatment.

E. Orthognathic Surgery.

(o) **Drugs, Dietary Drugs, Food and Food Supplements**

(1) Outpatient prescription drugs, unless specifically covered in Section 4.19.

(2) Outpatient non-prescription (over-the-counter) drugs.

(3) Dietary drugs and food or food supplements.

(p) **Therapy and Rehabilitation Services**

(1) Services beyond the authorized visit limit as approved by HAP or its designee.

(2) Massage or aquatic therapy.

(3) Services for community-based exercise programs or health and fitness club memberships.

(4) Services related to cognitive training and/or retraining.

(5) Therapy services for diagnosis and treatment of disabilities for which another agency or entity, public or private, has responsibility.

(6) Therapy services during school vacation periods for children who would be eligible to receive services through the school system or other public agency.

(7) Therapy or rehabilitation services for educational, vocational, hobby or recreational purposes.

(8) Functional capacity evaluations and work re-integration programs.

(q) Items and services related to acupuncture or chiropractic care.

(r) Services related to biofeedback.

(s) Premarital exams, classes, or marriage counseling.

(t) Services associated with a donor search related to transplants, unless specifically covered in Section 4.20.

(u) Services, supplies, or procedures related to home delivery of infants outside a licensed medical facility.

5.2 Other Exclusions

(a) Services provided by a non-Affiliated Provider, except for an Emergency or Urgent Care or when specifically approved in advance by HAP or its designee.

(b) Non-emergent services provided in an Emergency setting are not Covered Services.

(c) Services for military-related injuries or disabilities, for which you are legally entitled to receive services, payment or reimbursement from the United States or any state or political subdivision thereof.

(d) Services rendered or expenses incurred prior to your effective date of enrollment, or after cancellation of coverage.

(e) Services or benefits that are not expressly included as Covered Services in this Contract.

(f) Fees imposed by any health provider for a missed or no-show appointment.

(g) Fees, Copayments, deductibles, coinsurance, or any other monetary requirements and obligations of the Member to any entity, other than HAP, who makes any form of payment for Covered Services.

(h) Services for treatment of illness or injuries resulting from declared or undeclared acts of war.

5.3 Services Required by a Third Party

(a) Examinations, reports, or any other services for the purpose of obtaining, or maintaining employment, licenses or insurance, or for educational or recreational purposes.

(b) Office visits, examinations, treatments and tests relating to requirements or documentation of health status for legal proceedings.

(c) Office visits, examinations, treatments, tests or immunizations relating to or required for travel purposes.

(d) Court-ordered psychiatric or chemical dependency evaluations, treatments or confinements, unless such services meet HAP's benefit, referral and practice policies and are approved by a HAP Affiliated Provider.

(e) Pre-trial or court testimony and the preparation of court-related reports or services ordered by a court for legal proceedings.

5.4 Police and Criminal Activities

(a) Services provided if you are in police custody, unless an Emergency exists or such benefits and services are provided at a HAP Affiliated Hospital by a HAP Affiliated Provider.

(b) Services for any injury, illness, or condition that results from or to which a contributing cause was your commission of or attempt to commit a crime, or engagement in illegal occupations.

SECTION 6—MEMBER RIGHTS AND RESPONSIBILITIES

You have certain rights and responsibilities. They are as follows:

6.1 Rights

(a) You have the right to contact HAP with questions or concerns regarding any aspect of your Contract. You may contact the HAP Client Services department by phone at (313) 872-8100 or 1-800-422-4641. If you are hearing impaired, you may contact our Telecommunications Device for the Deaf (TDD) at (313) 664-8000.

(b) You have the right to receive confidential and respectful care regardless of nationality, race, creed, color, age, economic status, gender or lifestyle.

(c) You have the right to be treated with respect, dignity and recognition of your right to privacy.

(d) You have the right to review your own medical records held by an Affiliated Provider by appointment.

(e) You have the right to obtain complete and current information about treatment alternatives without regard to cost or benefit coverage.

(f) You have the right to ask questions about your health problems and to participate in decision-making regarding your health care.

(g) You have the right to be provided with all the information needed to give informed consent prior to the start of any procedure or treatment. This includes an explanation of procedures, alternative treatments and any benefits and risks involved.

(h) You have the right to be informed of the HAP Affiliated Providers available to you to provide health care services. In addition, you have the right to complete and current information about HAP and its services, practitioners and providers, and the rights and responsibilities of HAP Members.

(i) You have the right to request a change to another Physician Network or Medical Group based on its availability. If you are an inpatient at the time of your request, any such change will become effective following your discharge from the facility. All changes must be approved by HAP before you may receive Covered Services at the newly selected Physician Network or Medical Group. Any services received at the newly selected Physician Network or Medical Group before HAP approves a change may not be considered by HAP to be Covered Services and, therefore, services for which you are responsible for payment.

(j) You have the right to request to change your PCP to a different PCP, either within the same Physician Network or Medical Group or a different Physician Network or Medical Group. Requests will be considered by HAP based on the current facility assignment of the PCP and the PCP's current patient load and availability.

(k) You have the right to expect HAP to respond to your requests within a reasonable timeframe.

(l) You have the right to obtain services in an Emergency without the prior approval of your PCP or HAP.

(m) You have the right to designate a patient advocate to carry out your wishes if you are unable to make decisions regarding care, custody and medical treatment.

(n) You have the right to receive a second physician's opinion from an Affiliated Provider within your assigned Physician Network or Medical Group for any diagnosis or recommended medical procedure. If no other physician practices in the same or similar area of medicine as the original physician within your assigned Physician Network or Medical Group, you have the right to receive a second physician's opinion from another Affiliated Provider practicing in the same or similar area of practice in another Physician Network or Medical Group. To obtain a second opinion, you must have a written referral, approved by HAP or its designee, from your PCP.

(o) You have the right to file a Grievance. The Grievance process provides a way for Members to seek resolution to situations where they are dissatisfied with their care or coverage. Prior to your filing a formal Grievance, HAP will attempt to resolve your complaint informally, for example, during your initial phone call voicing the complaint. You may file a formal Grievance if you are dissatisfied with an Adverse Determination, or remain dissatisfied with HAP's response to your informal complaint. Please contact HAP at (313) 872-8100 or 1-800-422-4641, or refer to Section II for more information about the Grievance process.

(p) You have the right to make recommendations regarding any revisions or additions to these Member rights and responsibilities.

6.2 Responsibilities

(a) You have a responsibility to notify HAP as soon as possible regarding any change in your name, address, or telephone number, employment status, or additional health coverage(s) to which you may be entitled. You also must notify HAP as soon as possible if you, the

Subscriber, retire, and/or you or any of your Dependents become eligible for Medicare Part A or Medicare Part B coverage.

(b) You have a responsibility to notify the Group or Remitting Agent of any events that might change the eligibility of you and your Dependents for coverage under this Contract.

(c) You have a responsibility to participate in your health care by asking questions about your health problems and developing mutually agreed upon treatment goals with your Affiliated Provider(s).

(d) You have a responsibility to follow the plans and instructions for care that you have agreed upon with those Affiliated Providers providing your health care.

(e) You have a responsibility to respect the rights of other patients, HAP Members, Affiliated Providers.

(f) You have a responsibility to review this Contract and all Riders to this Contract, the HAP Member Handbook and all relevant material provided by HAP to aid you in understanding your coverage and the provisions of this Contract.

(g) You have a responsibility to notify your PCP of any unexpected changes in your health, and to obtain follow-up care from or at the direction of your PCP after receiving Emergency Services or Urgent Care.

(h) You have a responsibility to present your HAP identification card to the providers of care when receiving Covered Services. Possession of a HAP identification card does not mean a Member has a right to benefits under this Contract. You must immediately report theft or loss of a HAP identification card to HAP.

(i) You have a responsibility to submit claims for services you have already received, or initial requests for reimbursement for services that you already paid for, within 12 months of the date services were provided. HAP will not pay any claims or requests for reimbursement that were not submitted within 12 months from the date of service.

  (1) You may submit claims to HAP at 2850 West Grand Boulevard, Detroit, MI, 48202, Attention: Claims Department.

  (2) You may submit requests for reimbursement to HAP at P.O. Box 02669, Detroit, MI, 48202, Attention: Member Reimbursement. All requests for reimbursement must include the proof of payment receipt along with the appropriate claim information.

(j) You have a responsibility at the time of enrollment to select a single Physician Network or Medical Group and a single PCP for your medical care. For selected Physician Networks or Medical Group, most Covered Services require a referral from your PCP, and most referrals from your PCP will be to Affiliated Providers within your chosen Physician Network or Medical Group.

(k) You have a responsibility to satisfy all referral, authorization and assigned network requirements described in this Contract, regardless of whether HAP pays as the primary insurer or otherwise.

(l) If HAP is not your primary insurer, you have a responsibility to ensure that claims are submitted to your primary insurance carrier before they are submitted to HAP.

(m) You have a responsibility to notify HAP of an Emergency inpatient hospital admission within 48 hours of the admission, as described in Section 4.8(b).

SECTION 7—COORDINATION OF BENEFITS, SUBROGATION AND REIMBURSEMENT

7.1 Duplicate Coverage

You may be entitled to receive services similar to Covered Services from a source other than HAP. State laws and our contracts with Groups and government programs require us to coordinate your benefits because it is a way to reduce the cost of health care. We do not duplicate benefits available from any other source. In no event will money be paid or credited to you as a result of coordinating your benefits.

(a) Coordination of benefits refers to the procedure used to establish payment responsibility for health care expenses when you are covered by any other source in addition to HAP.

(b) Subrogation and reimbursement refers to HAP's right to recover from a third party or insurance company medical expenses paid on your behalf as a result of injuries or illnesses that are caused by any act or omission of a third party, and/or complications, incident thereto, but only to the extent that HAP pays for Covered Services under this Contract.

(c) As used in this Section 7, the term "source" includes, without limitation, other health plans or insurers, automobile insurers, prepaid group practices or other prepaid coverage, employer self-insurance plans, Workers' Compensation insurers, government programs, or any other source of coverage for medical care against which a Member has or may have a claim for medical benefits, other than HAP.

(d) If we pay for Covered Services that are covered by another source, we will automatically be assigned your right to seek reimbursement and all rights of subrogation against the other source.

7.2 Your Obligation to Inform HAP of Other Coverage

You must immediately notify us of the identity of any other source of coverage, including, but not limited to, coverage under Medicare, and provide us with information requested by us. Failure to do so may result in the suspension of payment for Covered Services until you provide us with complete and accurate information regarding any other source of coverage.

7.3 How We Coordinate Benefits

(a) We coordinate your benefits under the State of Michigan coordination of benefits law, the Federal Medicare secondary payer law and other applicable law. Unless otherwise required by law, the benefits for Covered Services under this Contract shall be deemed secondary to benefits available from any other source.

(b) When you are covered by another source in addition to HAP, you must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to HAP. Except as required by law, we will not pay more as the secondary carrier than we would pay as the primary carrier.

(c) HAP pays for Covered Services only when you follow HAP's rules and procedures regarding referrals and authorizations. You are responsible for ensuring that you receive services from Affiliated Providers, regardless of whether HAP is the primary or secondary payer.

7.4 Subrogation and Reimbursement

(a) We may pursue recovery of the amounts paid for Covered Services to the extent that you have a right to recover those amounts from any other party. We are automatically assigned to all of your rights to recover the amounts paid for such Covered Services. We will not reimburse you for expenses, including, without limitation, attorney fees and costs, that you incur to recover these amounts from any other party. By accepting HAP's payment for Covered Services, you consent to the provisions contained in this Section 7,

and agree to reimburse HAP for all expenses paid for Covered Services within 30 days of obtaining a monetary recovery.

(b) If you file a claim or request for benefits or payment against any person or source related to any accident, injury, or condition for which HAP paid, or may pay in the future, you must provide written notice to HAP of such a claim or request and provide a copy of any documents submitted to the other person or source within 10 days of submitting the claim or request to the other person or source. You are required to provide us with complete and accurate information and other assistance reasonably necessary for us to enforce our rights of recovery. You cannot compromise or settle a claim or take any action that could prejudice our recovery rights unless we agree, as evidence by us in writing in a signed, duly authorized agreement. We may suspend or setoff present or future payment for Covered Services if you fail to provide us with complete and accurate information and other assistance reasonably required by us to enforce our rights of recovery.

(c) In the event that you receive or are entitled to receive payment from another person or source that is legally responsible for the injury or illness or for payment of your medical expenses, either in tort or in contract, you are obligated to reimburse HAP for all medical expenses paid for Covered Services up to the amount received or subject to recovery from the person or source who or which is legally responsible for payment. In the event that you receive or are entitled to receive payment under a settlement agreement which neither admits nor denies liability for the injury, you are obligated to reimburse HAP for all medical expenses paid for Covered Services by HAP in connection with that injury or illness.

(d) You will hold any amounts received or recovered from another person or source as a trustee for HAP until our rights under this Section 7 have been satisfied or released, as evidenced in writing by us in a signed, duly authorized agreement.

(e) You do not have the right to engage legal counsel or to act on HAP's behalf without our agreement, as evidenced in writing by us in a signed, duly authorized agreement.

(f) If you engage legal representation to pursue a claim against any person or source, you must inform your legal counsel of the rights of HAP under this Section 7.

(g) You assign us a first dollar lien (i.e., priority over other rights) against the proceeds of any recovery by you or on your behalf, regardless of whether such recovery is by way of judgment or verdict in a civil action or as a result of arbitration, mediation, settlement, or remedy provided by statute, regulation or otherwise. Such lien will extend to any and all amounts recovered by you or on your behalf regardless of the designation, categorization or allocation of amounts so recovered to losses or damages other than Covered Services and regardless of whether the amount recovered is less than, equal to or in excess of the your total losses or damages.

(h) If any recovery by you or on your behalf includes amounts for future damages or loss, you agree to hold the recovery amount in trust, subject to a continuing lien in favor of HAP, and will promptly reimburse HAP for all future Covered Services for which payment was made and which relate to the illness or injury that gave rise to the recovery.

SECTION 8—CANCELLATION

8.1 When You Wish to Cancel Coverage

You must notify your Group or Remitting Agent if you wish to cancel coverage under this Contract. We must receive written notice of cancellation from your Group or Remitting Agent. We will accept the written notice up to 30 days in advance of the cancellation date. If requested by your Group or Remitting Agent, we will cancel your coverage retroactive to the first day of the month in which the notice of cancellation is received by us.

8.2 Cancellation of Coverage by the Group

The Group may cancel coverage under this Contract with respect to any or all Member(s).

8.3 Cancellation of Coverage by HAP

We may cancel your coverage if:

(a) We do not receive the required Premium from the Group or Remitting Agent within 30 days after the due date. Such cancellation will be retroactive to the last day of the period for which a Premium was paid.

(b) Your Group's membership in an association that contracts with us on behalf of its members ceases. Such cancellation shall be effective as of the date of ineligibility.

(c) Your Group or Remitting Agent intentionally furnishes incomplete, inaccurate or false information to us or fails to follow our rules relating to Group contribution or Group participation. Such cancellation shall be effective immediately upon notice to you or your Group or the Remitting Agent.

(d) You intentionally furnish incomplete, inaccurate or false information to us, an Affiliated Provider, your Group or the Remitting Agent. Such cancellation shall be effective immediately upon notice to you.

(e) You misuse your coverage or your HAP identification card by helping an ineligible person obtain services under this Contract, using another Member's identification card or requesting payment for services you did not receive. Such cancellation shall be effective immediately upon notice to you.

(f) You fail or refuse to cooperate with us in pursuing subrogation and coordination of benefits in accordance with Section 7, including by failing to provide HAP with your entitlement and enrollment status under Medicare or other coverage. Such cancellation shall be effective upon 30 days advance written notice to you.

(g) You behave in a way that is unruly, uncooperative, disruptive or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are Members of HAP. Such cancellation shall be effective upon 30 days advance written notice to you.

8.4 Effect of Cancellation

If you become ineligible for coverage because the arrangement between HAP and the Group is canceled, the Contract ends on the effective date of cancellation. If we cancel your coverage under Section 8.3(d) through (g), we may refuse to enroll you in the future for coverage offered by HAP or its subsidiaries.

8.5 Automatic Cancellation

This Contract shall be cancelled automatically in the following circumstances:

(a) When the Subscriber ceases to be a member of the Group through which the Premium is paid.

(b) When the Member no longer meets the requirements of HAP or the Group for eligibility, including the Subscriber's spouse in the event of divorce and Dependent children who no longer qualify due to age.

(c) Upon the death of the Subscriber.

8.6 Conversion Privilege

(a) You may be eligible for conversion to an individual contract if you live or work within HAP's Service Area and one of the following applies:

(1) This Contract is cancelled in its entirety with respect to all Subscribers, unless the Group replaces the coverage provided through HAP with coverage through another health plan or insurer.

(2) Under certain circumstances, when the Subscriber ceases to be eligible for Group coverage, either through loss of employment or otherwise.

(3) You lose coverage under this Contract because of the death of the Subscriber.

(4) You lose coverage under this Contract because you are no longer an eligible Dependent. For example, the spouse of a Subscriber may be eligible for an individual conversion contract following a divorce.

(b) You must apply and pay for a conversion contract under this Section within 30 days after your coverage under this Contract is cancelled.

SECTION 9—GENERAL PROVISIONS

9.1 Contract Term

This Contract begins on the first day of the month for which Premium was paid and shall remain in effect for one month. This Contract will be renewed on a monthly basis with timely payment of the Premium.

9.2 Release of Information

You consent to the release of personal and health information by Affiliated Providers and by HAP for the administration of this Contract, including for purposes of treatment, payment and health care operations.

9.3 Amendments

Except as otherwise provided for in this Contract, no officer, agent or representative of HAP, Affiliated Provider, Group or Remitting Agent, nor any other individual or entity, is authorized to change or waive the terms and conditions of this Contract. No such change, waiver, promise or agreement will be binding upon HAP.

9.4 Your Privacy at HAP

(a) When you become a Member of HAP, we use your personal or health information to perform the business of HAP. For example, we use your personal information to enroll you, pay your claims, provide customer service, perform quality assessments and measurements, coordinate your care and as permitted by law.

(b) When you provide personal or health information to us, we may share that information with our employees, providers and contractors who need to know the information to perform services for you and as required or permitted by law. Employees, providers and contractors also have the obligation to protect your personal and health information.

(c) You have the right to access your own personal or health information held by us, or by any of our Affiliated Providers.

(c) Under certain circumstances we will obtain a special authorization from you before disclosing personal or health information, for example, for disclosure of your health information to your spouse. In the event that you are unable to give special authorization, your legal guardian or representative may do so.

For additional information on HAP's privacy practices, see Section I.

9.5 Entire Agreement

The provisions of this Contract supercede all previous Contracts between HAP and the Subscriber regarding all aspects of coverage.

9.6 Notification

Any notice required or permitted to be given by HAP will be considered to have been properly given, if in writing and deposited in the United States postal mail with postage prepaid, addressed to the Group, Remitting Agent or to the Subscriber at the last address on record at the principal office of HAP. The required notice will be considered given within three days of mailing.

9.7 Applicable Law

This Contract is made in, and will be interpreted under, the laws of the State of Michigan.

9.8 HAP Policies and Procedures

HAP may adopt reasonable policies, procedures, rules and interpretations to promote the efficient administration of this Contract and may amend such policies from time to time.

9.9 Identification Cards as HAP Property

The HAP identification card of every Member is the property of HAP and its return may be requested at any time. Possession of a HAP identification card does not mean that a Member has a right to Covered Services.

9.10 Responsibility for Care

HAP does not practice medicine or any other licensed health profession. The physician treating a Member bears sole responsibility for the care provided to the Member in accordance with medically accepted standards of care. In no circumstance shall HAP be liable for any professional acts or failures to act by any HAP Affiliated Provider or for the acts or failures to act by a third party review entity. HAP shall not be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any prescription drug or injectable insulin under this Contract.

9.11 Nonassignability of Contract

You may not assign or transfer any of your rights or responsibilities under this Contract without the prior written consent of HAP. Any attempt to make such an assignment without the required consent is void. The right to receive Covered Services under this Contract may not be assigned under any circumstances and any such assignment is void.

9.12 Coverage Determinations

HAP has the sole authority to make all determinations that are required to carry out the terms and conditions of this Contract including determinations regarding Medical Necessity and Covered Services, to make factual findings and to explain and interpret this Contract whenever necessary.

9.13 Legal Action

Legal action against HAP for breach of this Contract must be brought within 2 years from the date of the breach.

9.14 Unavailability of Certain Providers

You should join HAP because you prefer the benefits offered under the plan, not because a particular provider is an Affiliated Provider. You cannot change to another health plan or insurer because a provider leaves HAP.We cannot guarantee that any one physician, hospital or other provider will be available and/or remain Affiliated with us.

9.15 Vesting

There is no vesting of benefits under this Contract. You are entitled only to the Covered Services in effect under this Contract at the time services are received. If Covered Services are reduced or modified, then you will be entitled only to the Covered Services in effect after the effective date of the reduction or modification, even if you previously were receiving a higher level or type of Covered Services.

SECTION 10—DEFINITIONS

10.1 "Adverse Determination" – a decision by HAP or its designee that coverage for an admission, availability of care, continued stay or other health care service has been reviewed and denied, reduced or terminated. Failure by HAP or its designee to respond to a request for a decision constitutes an adverse determination.

10.2 "Affiliated" – means that a physician, hospital or other provider has signed a contract with HAP to provide Covered Services to Members.

10.3 "Affiliated Hospital" – a hospital that has signed a contract with HAP to provide Covered Services to Members.

10.4 "Affiliated Provider" – a health professional, licensed hospital, licensed pharmacy or any other institution, organization, or person having a contract with HAP to provide Covered Services to Members.

10.5 "Contract" – the document(s) defining the relationship between HAP and its Members, including: (1) this booklet, (2) any applicable Rider(s), (3) the application, questionnaires, forms and statements as completed by a Subscriber and submitted to HAP or the Remitting Agent to enroll and (4) Member identification card(s).

10.6 "Covered Services" – the Medically Necessary preventive, diagnostic and treatment services described in Section 4, when approved and provided in accordance with this Contract.

10.7 "Grievance" – a complaint by a Member (or submitted on behalf of a Member by the Member's representative) concerning any of the following:

(a) The availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to utilization review.

(b) Benefits or claims payment, handling, or reimbursement for health care services.

(c) Matters pertaining to the contractual relationship between a Member and HAP.

10.8 "Group" – the employer, association or other entity that has contracted with HAP on behalf of its employees, retirees, or members for Covered Services.

10.9 "Health Maintenance Organization" – an entity licensed by the State of Michigan that provides coverage for health care services that are Preventive Services and/or Medically Necessary, subject to the terms of a subscriber's contract, in exchange for a fixed prepaid sum or per capita prepayment.

10.10 "Medical Necessity" or "Medically Necessary"– refers to a determination, made in accordance with well-established professional medical standards as reflected in scientific and peer-reviewed medical literature, that Covered Services are:

(a) Consistent with and essential for diagnosis and treatment of the Member's condition, disease, ailment or injury;

(b) The most appropriate supply or level of service that can be provided safely;

(c) Provided for the diagnosis or direct care and treatment of the Member's condition, disease, injury or ailment;

(d) Not provided primarily for the convenience of the Member, or the Member's family, physician or other caretaker; and

(e) More likely to result in benefit than harm.

When applied to hospitalization, Medical Necessity means further that a determination has been made that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition.

10.11 **"Member" –** a Subscriber or an eligible Dependent of the Subscriber who is entitled to receive Covered Services under this Contract.

10.12 **"Open Enrollment" –** the period (usually annual) specified by the Group or Remitting Agent during which the Subscriber may select from among the health insurance and HMO programs offered by the Group.

10.13 **"Physician Network or Medical Group" –** providers who form a partnership or association and have an agreement with HAP to provide Covered Services to Members through PCPs and other health care providers within the group.

10.14 **"Personal Care Physician" or "PCP" –** the Affiliated Provider in a Physician Network or Medical Group who is primarily responsible for providing or arranging for the health care needs of a Member under this Contract. A PCP may be an Internal Medicine, Family Practice, General Practice or Pediatric physician.

10.15 **"Referral" –** the recommendation by an Affiliated Provider (usually the PCP) for a Member to receive Covered Services from another health care provider, subject to the approval of HAP or its designee.

10.16 **"Remitting Agent" –** the individual or organization authorized and designated by a Subscriber's Group to collect and remit Premiums to HAP and to receive notices from and deliver notices to the Subscriber.

10.17 **"Rider" –** a written attachment to this Contract purchased by or on behalf of a Subscriber that provides for additional, different or reduced Covered Services or that otherwise modify the terms of this Contract. In the event of a conflict between the terms and conditions stated in a Rider and the terms and conditions stated in this Contract, the terms and conditions in the Rider shall rule.

10.18 **"Service Area" –** the geographic area, approved by State of Michigan, where HAP is authorized to cover health services. HAP's current Service Area includes Genesee, Lapeer (excluding Burlington and Burnside townships), Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne counties in Southeastern Michigan. The Service Area is subject to change with the approval of the State of Michigan.

10.19 **"Subscriber" –** the individual eligible for coverage under the Group and this Contract who submitted the application for coverage through the Group.

We've Got You Covered!

	HAP COVERAGE:
PREVENTIVE SERVICES:	$15 copay per visit; $25 specialist copay
Preventive Office Visits Periodic Physical Exams Well Baby/Child Exams Immunizations Routine Eye and Hearing Exams Related Lab Tests and X-Rays Pap Smears and Mammograms	
OUTPATIENT & PHYSICIAN SERVICES:	$25 office visit copay may apply
Office Visits Allergy Testing and Injections Other Injections Lab Tests & X-Rays	
Outpatient Surgery & Related Services	$100 copay per outpatient surgery
Radiation/Chemotherapy Family Planning Services Infertility and Related Services	
Physical, Speech and Occupational Therapy	Up to 60 visits per condition lifetime
INPATIENT HOSPITAL SERVICES:	$500 copay per admission
Days of Care	Unlimited
Semi-Private Room (Specialty Care Units; when medically necessary)	Covered
Surgery and Related Services	Covered
Anesthesia	Covered
Related Lab Tests & X-Rays	Covered
Related Therapy Services	Covered
Physician/Professional Services	Covered
HOME HEALTH CARE:	
Home Health Care (by RN or LPN)	Covered
Hospice Care	Covered; 210 days lifetime
MATERNITY SERVICES:	
Outpatient Prenatal and Postnatal Care	$25 copay per visit
Labor and Delivery	$500 copay per admission
Newborn Care in Hospital	Covered

EMERGENCY/URGENT CARE:

Covered in any hospital or urgent care facility when unable to reach a HAP facility; usually billed directly to HAP

Emergency Room Services	$50 copay per visit
Urgent Care Facility Services	$15 copay per visit
Emergency Ambulance	Covered

HWK 01/07

	HAP COVERAGE:
CHEMICAL DEPENDENCY SERVICES:	
Inpatient Services	$500 copay per admission; 30 days, renewable after 60 days or state mandated annual aggregate dollar amount, whichever is greater
Outpatient Services	$25 copay per visit; 35 visits per member per calendar year or state mandated annual aggregate dollar amount, whichever is greater
MENTAL HEALTH SERVICES:	
Inpatient Services	$500 copay per admission; 30 days, renewable after 60 days
Outpatient Services	$25 copay per visit; 20 visits per member per calendar year
ADDITIONAL BENEFITS:	
Prescription Drugs, including Birth Control Pills	$10 1st Tier, $20 2nd Tier, $40 3rd Tier copay per prescription
Durable Medical Equipment (Wheelchairs, Special Beds, etc.)	Covered for authorized equipment
Prosthetic Appliances	Covered for authorized equipment
Orthotic Devices (Special Back Braces, etc.)	Covered for authorized equipment
Skilled Nursing Care in Convalescent Facility	Up to 730 days, renewable after 60 days
Assisted Reproductive Technologies	One attempt of artificial insemination per lifetime.

Health Alliance Plan of Michigan
Metro Detroit area: (313) 872-8100

Students away from school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services. This is a summary of coverages, and is subject to the terms and conditions of your actual contract. In case of conflicts between this summary and your contract, the terms and conditions of the contract govern.

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RIDER 185

OUTPATIENT SURGERY
$100 COPAYMENT RIDER

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add a $100 Copayment, or 50% of HAP's reimbursement, whichever is less, for outpatient surgery. This Rider is effective as of the date shown on the identification card issued in connection with this Rider. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

> The Copayment is $100, or 50% of HAP's reimbursement, whichever is less, for each outpatient surgery regardless of the diagnosis.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 184

OFFICE VISIT
$15 PCP/ $25 SPECIALIST COPAYMENT RIDER

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add a $15 Copayment, or 50% of HAP's reimbursement, whichever is less, per visit to your Personal Care Physician (PCP) and a $25 Copayment, or 50% of HAP's reimbursement, whichever is less, per visit to any Affiliated specialist. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

> The Copayment is $15, or 50% of HAP's reimbursement, whichever is less, per visit to your PCP for all visits regardless of the duration of visits.
>
> The Copayment is $25, or 50% of HAP's reimbursement, whichever is less, per visit to any Affiliated Provider specialist for all visits regardless of the duration of visits.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 126

ASSISTED REPRODUCTIVE TECHNOLOGIES

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add coverage for limited Assisted Reproductive Technologies to the Reproductive Care and Family Planning Services benefit. This Rider is effective as of the date shown on the identification card issued in connection with this Rider.

I. The Section entitled **Services and Benefits** is amended by the addition of the following limited Assisted Reproductive Technologies to the **Reproductive Care and Family Planning Services** benefit description:

(e) Assisted Reproductive Technologies (ART) are forms of achieving pregnancy after a diagnosis of infertility has been established. Covered ART procedures are limited to artificial insemination procedures, including intrauterine insemination (IUI) and intracervical insemination (ICI). All other forms of ART remain not covered.

(1) Covered Services include ART when ordered and provided by Affiliated Providers for female Members between the ages of 21 and 42 who have undergone infertility treatment, which has been unsuccessful in restoring fertility.

(2) Coverage for ART is limited to one attempt of artificial insemination per lifetime, including all services performed leading up to the attempt, (i.e. lab tests, ultrasounds, office visits and other procedures performed after a diagnosis of infertility has been established), even if artificial insemination does not actually take place. Sperm washing is limited to one procedure per lifetime.

II. The Section entitled **Exclusions** is amended by addition of the following limited Assisted Reproductive Technologies to the Reproductive Care and Family Planing Services benefit exclusions:

(a) Artificial insemination required due to voluntary, surgically-induced sterilization of either partner.

(b) Artificial insemination required due to the absence of a male partner.

(c) Artificial insemination for female Members 43 years of age or older or 20 years of age or younger.

(d) All tests, services, procedures, diagnostics, and attempts of artificial insemination after HAP has paid for services related to an attempt of artificial insemination.

(e) Any ART other than artificial insemination (either IUI or ICI).

III. The Section entitled **Payment of Premiums and Copayments** is amended by the addition of the following:

An additional rate for Covered Services, set forth in this Rider and in a written notice by HAP to

the Remitting Agent or the Subscriber, shall be paid in addition to the Premium for the HMO Subscriber Contract.

RIDER 124

HOME HEALTH CARE - UNLIMITED DAYS

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add coverage for unlimited Medically Necessary home health care days to the Home Health Care benefit. This Rider is effective as of the date shown on the identification card issued in connection with this Rider.

I. The Section entitled **Services and Benefits** is amended by deleting Section (b) of the Home Health Care benefit description and replacing it with the following:

Home Health Care

(b) The number of visits for Medically Necessary approved home health care shall be determined by HAP's accepted benefit, referral and practice policies.

All other terms and conditions of the Contract remain in full force and effect except as specifically amended by this Rider.

II. The Section entitled **Payment of Premiums and Copayments** is amended by the addition of the following:

An additional rate for Covered Services, set forth in this Rider and in a written notice by HAP to the Remitting Agent or the Subscriber, shall be paid in addition to the Premium for the HMO Subscriber Contract.

RIDER 123

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract with regard to the number of allowable visits for physical, speech, and occupational therapy in the **Therapy Services and Rehabilitation Services** benefit. This Rider is effective as of the date shown on the identification card issued in connection with this Rider.

I. The Section entitled **Services and Benefits** is amended by deleting Section (b) of the **Therapy Services and Rehabilitation Services** benefit description and replacing it with the following:

(b) **Physical Therapy**

Short-term physical therapy services, either in the home or outpatient clinical setting, are covered up to 60 visits per condition per lifetime. The number of visits shall be approved according to and consistent with HAP's benefit, referral and practice policies.

II. The Section entitled **Services and Benefits** is amended by deleting Section (c)(2) of the **Therapy Services and Rehabilitation Services** benefit description and replacing it with the following:

(c) **Speech Therapy**

(2) Short-term speech therapy services, either in the home or outpatient clinical setting, are covered up to 60 visits per condition per lifetime. The number of visits shall be approved according to and consistent with HAP's benefit, referral and practice policies.

III. The Section entitled **Services and Benefits** is amended by deleting Section (d)(2) of the **Therapy Services and Rehabilitation Services** benefit description and replacing it with the following:

(d) **Occupational Therapy**

(2) Short-term occupational therapy services, either in the home or outpatient clinical setting, are covered up to 60 visits per condition per lifetime. The number of visits shall be according to and consistent with HAP's benefit, referral and practice policies.

IV. The Section entitled **Payment of Premiums and Copayments** is amended by the addition of the following:

An additional rate for Covered Services, set forth in this Rider and in a written notice by HAP to the Remitting Agent or the Subscriber, shall be paid in addition to the Premium for the HMO Subscriber Contract.

RIDER 117

URGENT CARE
$15 COPAYMENT RIDER

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add a $15 Copayment or 50% of the cost of treatment, whichever is less, per visit for Urgent Care Services. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

> The Copayment is $15 or 50% of the cost of treatment, whichever is less, per visit for Urgent Care Services regardless of the duration of the visits.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 096
PRESCRIPTION DRUG
$10, $20, $40 COPAYMENT RIDER

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add prescription drug coverage with a Copayment. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

Copayments for Outpatient Prescription Drugs

Generic Drugs
Generic Drug Copayment is $10 for each prescription or refill. Generic Drugs (also called first tier drugs) are outpatient prescription drugs approved by the Food and Drug Administration to contain the same active ingredient(s) and be identical in strength or concentration to a brand drug, but priced as a generic.

Preferred Brand Drugs
Preferred Brand Drug Copayment is $20 for each prescription or refill. Preferred Brand Drugs (also called second tier drugs) are outpatient prescription drugs approved by the Food and Drug Administration and determined by HAP or its designee to meet its quality, safety and cost-effectiveness standards, consistent with HAP benefit, referral and practice policies. Generic equivalents are not available for Preferred Brand Drugs.

Non-Preferred Brand Drugs
Non-Preferred Drug Copayment is $40 for each prescription or refill. Non-Preferred Drugs (also called third tier drugs) are outpatient prescription drugs approved by the Food and Drug Administration that are not Generic or Preferred Brand Drugs.

Lifestyle Drugs
Lifestyle Drug Copayment is $40 for each prescription or refill. Lifestyle Drugs include but are not limited to outpatient prescription drugs used for weight loss, infertility, impotence or erectile dysfunction.

Members who request a Brand drug when a Generic Drug is available, will be responsible to pay the Generic Copayment plus the difference between the cost of the Generic equivalent and the Brand Drug.

The Section entitled **Services and Benefits** is amended by adding the following:

Outpatient Prescription Drugs

All outpatient prescription drugs approved by the Food and Drug Administration unless excluded.

HAP may impose quantity restrictions, prior authorization requirements, and exclusions on outpatient prescription drugs to assure quality, safety and cost-effective drug use consistent with HAP benefit, referral and practice policies.

The Section entitled **Exclusions and Limitations** is amended by deleting **Dietary and Outpatient Drugs** and replacing it with the following:

Outpatient Prescription Drugs

1. Dietary food or food supplements with or without a prescription.
2. Drugs available as non-prescription (over-the-counter) drugs.
3. Cosmetics, drugs used for cosmetic purposes, medicated soap or devices such as syringes (except for insulin), test kits, nebulizers and support garments.
4. The charge for any prescription refill in excess of the number specified by the Affiliated Provider or any refill dispensed after 1 year from the physician's order.
5. Compounded medications unless Medically Necessary and there are no commercially available alternatives.
6. Medications used for experimental purposes.
7. Coverage of investigational medications.
8. Greater than 35-day supply and/or restricted quantity.
9. Outpatient prescription drugs on HAP's maintenance drug list, as determined by HAP or its designee, may be limited to a 35-day supply or 100-unit dose, whichever is greater.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 040

HOSPITAL INPATIENT ADMISSION
$500 COPAYMENT RIDER

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add a $500 Copayment or 50% of HAP's reimbursement, whichever is less, for inpatient hospital admissions. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

> The Copayment is $500 or 50% of HAP's reimbursement, whichever is less, for each inpatient hospital admission regardless of the diagnosis.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 034

EMERGENCY SERVICES
$50 COPAYMENT RIDER

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add a $50 Copayment or 50% of HAP's reimbursement, whichever is less, for Emergency Services. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

> The Copayment is $50 or 50% of HAP's reimbursement, whichever is less, for Emergency Services rendered in an emergency room.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 016

SKILLED NURSING FACILITY RIDER
(730 Days)

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add coverage for Skilled Nursing Facility care. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Services and Benefits** is amended by adding the following:

Skilled Nursing Facility

1. Skilled nursing facility services are provided up to a maximum period of 730 days for skilled nursing care, for each continuous period of confinement or for successive periods separated by less than 60 days, of which not more than 90 days may be for care for mental illness. To be eligible for care for mental illness the confinement must immediately follow a period of acute care for mental illness at an Affiliated Hospital.
2. A new maximum service period will commence only when there has been a lapse of at least 60 days from the last date of discharge to the next date of admission.
3. The 730 day period will be reduced by 2 days for every inpatient hospital day (or successive periods of hospitalization separated by less than 60 days) prior to or during an admission to a Skilled Nursing Facility.

The Section entitled **Exclusion and Limitations** is amended by deleting **Nursing Services** and replacing it with the following:

Nursing Services

(1) Private duty nursing services.
(2) Residential and basic nursing services provided in a long-term care facility.
(3) Skilled nursing facility services for tuberculosis of any kind.
(4) Custodial care.
(5) Skilled nursing facility services for senile deterioration or mental deficiency or mental retardation.
(6) Skilled nursing facility services for mental illness, other than for short-term skilled nursing care cases in which prognosis for recovery or improvement is deemed favorable.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 012

DURABLE MEDICAL EQUIPMENT, PROSTHETIC & ORTHOTIC APPLIANCES RIDER

To the Health Alliance Plan HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to provide coverage for Durable Medical Equipment and/or Prosthetic and Orthotic Appliances. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Services and Benefits** is amended by adding the following:

"Durable Medical Equipment" ("DME") is equipment which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally needed by a person in the absence of illness or injury. The equipment must be a covered item as determined by HAP or its designee.

"Prosthetic Appliance" is an artificial device which replaces an absent part of the body or which aids the performance of a natural function of the body without replacing a missing part. The appliance must be a covered item as determined by HAP or its designee.

"Orthotic Appliance" is an external device intended to correct any defect of form or function to the human body. The appliance must be a covered item as determined by HAP or its designee.

Durable Medical Equipment ("DME")

1. All DME must be ordered by an Affiliated Provider and dispensed by an Affiliated DME Provider. Prior authorization is required.
2. Repair of DME is covered for restoration to a serviceable condition.
3. Replacement of DME is covered when:
   a. Necessitated by irreparable damage not due to misuse, intentional or nonintentional.
   b. The cost of repairs would exceed the purchase price.
   c. Due to a change in the size or condition of the patient as determined by HAP or its designee.
4. All DME must be a covered item as determined by HAP or its designee.

Prosthetic and Orthotic Appliances

1. All Prosthetic and Orthotic Appliances must be ordered by an Affiliated Provider and dispensed by an Affiliated Provider. Prior authorization is required.
2. Repair of Prosthetic and Orthotic Appliances is covered for restoration to a serviceable condition.
3. Replacement of purchased Prosthetic and Orthotic Appliances is covered when:
   a. Necessitated by irreparable damage not due to misuse, intentional or nonintentional.
   b. The cost of repairs would exceed the purchase price.

c. Due to a change in the size or condition of the patient as determined by HAP or its designee.

4. One pair of prescription lenses and one pair of frames according to HAP guidelines following a cataract operation or to replace the organic lens missing because of congenital absence are covered.
5. All Prosthetic and Orthotic Appliances must be covered items as determined by HAP or its designee.

The Section entitled **Exclusions and Limitations** is amended by deleting the **Medical Devices and Equipment** and replacing it with the following:

Medical Devices and Equipment

(1) DME, Prosthetic and Orthotic Appliances and cataract lenses ordered prior to coverage under this Contract, even if delivered after coverage.
(2) Replacement and repair of any DME or Prosthetic and Orthotic Appliances resulting from intentional or nonintentional misuse.
(3) Batteries used for any type of DME.
(4) Comfort and convenience equipment, exercise and hygiene equipment, corrective shoes and supports, dental appliances, experimental or research equipment, and self help devices not medical in nature such as sauna baths and elevators.
(5) Physician equipment such as sphygmomanometers, stethoscopes, etc.
(6) Any DME or Prosthetic and Orthotic Appliances ordered while covered but delivered more than 60 days after termination of coverage.
(7) Eyeglasses (frames and lenses) except lenses following cataract surgery.
(8) Hearing aids.
(9) Lost or stolen equipment.
(10) Home, or vehicle additions, modifications or appliances.
(11) Cost of equipment and/or devices in excess of the coverage amounts for standard equivalents.
(12) Disposable medical supplies, such as dressings and support garments.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 004

DEPENDENT CHILD CONTINUATION RIDER

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add coverage for unmarried children between 19 and 25 years of age.

The Section entitled **Eligibility** is amended by deleting (b) from **Coverage Period for a Dependent Child** and replacing it with the following:

> Coverage for a child who is your Dependent ends on the last day of the month or calendar year in which the child reaches the age as determined by your Group or Remitting Agent, but no more than 25.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER 002

SPONSORED DEPENDENT RIDER

To the Health Alliance Plan
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to add coverage for Sponsored Dependents. The Premium shall be adjusted by an amount set forth from HAP to your Group or Remitting Agent.

The Section entitled **Eligibility** is amended by adding the following to **Dependents:**

> Any person reported as a dependent on the Subscriber's most recent federal income tax return, but not persons eligible for Medicare or persons otherwise eligible for coverage under the HMO Subscriber Contract.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.