

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.
- (d) Coverage for students away at school
 - 1. If a Dependent does not live with the Subscriber because he or she is attending school full time, the following services are covered:
 - a) Emergent, urgent, or acute care.
 - b) Follow-up office visit related to an acute illness/or injury **only** with the pre-approval of Health Alliance Plan's Student Coordinator or Medical Director.
 - c) X-rays provided in the outpatient setting and related to the acute illness or acute injury.
 - d) Laboratory tests provided in the outpatient setting and related to acute illness/or injury.
 - e) Hepatitis B and Allergy injections.
 - f) Physical therapy for rehabilitation beyond the first and second follow-up appointments related to an acute illness or acute injury, only with advance approval from the Health Alliance Plan Medical Director of Designee.
 - g) Durable medical equipment related to an acute illness or acute injury, when ordered or arranged for through Health Alliance Plan. HAP reserves the right to pay maximally only the usual, customary and reasonable (fee schedule) rates within the Health Alliance Plan service area for such items and only if the Member has the additional DME/P&O Rider on their Contract.
 - h) Prescriptions related to an acute illness or acute injury are a covered benefit providing the Member has the Prescription Drug Rider on their Contract.
 - i) Conditions identified by the Personal Care Physician as requiring immediate follow-up services.
 - j) In the event of an in-patient emergency admission, HAP's Admission Department must be notified within 48 hours. HAP reserves the right to transfer a Member to an alternate facility if deemed necessary for continued care.
 - k) In the event of a leave of absence from school due to illness or injury, coverage for your Dependent shall continue for 12 months from the last date of attendance or until your Dependent no longer meets the eligibility requirements of HAP and your Group. A physician must certify to HAP in writing that the

leave of absence is Medically Necessary. We reserve the right to ask for proof of attendance to verify eligibility pursuant to this subsection.

2. The following services are not considered urgent or emergent in nature and will not be covered outside of HAP's Service area for students away at school:
 - a) Routine complete physical examinations including gynecological exams.
 - b) Outpatient non-emergent psychiatric care and substance abuse.
 - c) All elective surgery of hospitalizations.
 - d) Routine eye examinations and/or eyeglasses (optometry and optical services).
 - e) OB/GYN services for pregnancy.
 - f) Sports medicine (ie. Muscle strengthening).
 - g) Physician visits, PT, OT or other therapies or treatments that are not prior authorized by Health Alliance Plan.
 - h) Chronic dermatology including, but not limited to acne.

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 any 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 health 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, nutritional, 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.
 - (4) There is a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy.
- (b) **Physical Therapy**
Short-term physical therapy services, either in the home or outpatient clinical setting, are covered when treatment begins following illness or injury. The number of visits for Medically Necessary physical therapy is a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy.
- (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 following illness or injury. The number of visits for Medically Necessary speech therapy is a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy.
- (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 following illness or injury. The number of visits for Medically Necessary occupational therapy is a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy.
- (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 diagnoses, 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.

4.22 Drugs, Dietary Drugs, Food and Food Supplements

- (a) HAP covers all medications that are administered in an inpatient facility (inpatient facility is defined as a facility like an inpatient hospital, inpatient psychiatric hospital, inpatient Chemical Dependency facility and long term acute care facility that provides diagnostic, therapeutic, and rehabilitation services).

- (b) Outside of the inpatient setting, HAP covers medications that cannot be self administered and immunizations, according to HAP's benefit practice and referral policies that are published on HAP's website and updated on an ongoing basis.
- (c) Medications that can be self-administered are covered by HAP only when the need to treat is Urgent or is for Emergency Services.
- (d) HAP covers immunizations according to HAP's benefit, practice and referral policies.
- (e) HAP covers medication needed for transition of care.

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 for non-members 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 anatomical 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 is 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.
 - (4) Medications may be excluded from coverage by HAP when there is a similar alternative outpatient prescription drug therapy or treatment.
 - a. Medications may be excluded from coverage by HAP when the drug can be self-administered by the Member. This includes, but is not unlimited to, the select drugs and drug categories listed below:
 - 1) arthritis injections (e.g. Etanercept, Adalimumab, Anakinra)
 - 2) growth hormone injections (e.g. Somatropin)
 - 3) hepatitis B and C injections (e.g. Peginterferon Alpha-2b)
 - 4) migraine injections (e.g. Sumatriptan)
 - 5) blood cell stimulants (e.g. Darbepoetin, Epoetin Alfa, Epoetin Alfa, Filgrastim)
 - 6) multiple sclerosis injections (e.g. Interferon Beta 1-a, Interferon 1-b, Glatiramer Acetate, Interferon Beta 1-a)
 - 7) psoriasis (e.g. Etanercept, Efalizumab)
 - 8) blood thinner (e.g. Enoxaparin, Fondaparinux)
 - b. Immunizations recommended or required for travel to specific geographic locations both within and outside the U.S. are not a covered benefit.
 - c. Dietary food or food supplements with or without a prescription.
 - d. Drugs available as non-prescription (over-the-counter) drugs.
 - e. Cosmetics, drugs used for cosmetic purposes, medicated soap or devices such as syringes, test kits, and support garments.

- f. Medications used for experimental and investigational purposes according to HAP's benefit, referral and practice policies.

(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.

If you also have prescriptions drug coverage, for information on medication covered under your prescription drug plan, please refer to your prescription drug rider.

- (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 Member 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 the Member Handbook 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.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Health Alliance Plan
Notice of Privacy Practices
Effective April 14, 2003
Revised October 21, 2003**

Important Information About Privacy...

HAP works to protect the privacy of your personal and health information. We are required by law to maintain the privacy of your personal and health information and to provide individuals with notice of our legal duties and privacy practices. This notice explains how we use information about you and when we can share that information with others. It also informs you about your rights with respect to your personal and health information and how you can exercise those rights. We are required to abide by the terms of this notice.

When we use the term “member information” in this notice, we are referring to the personal and health information about you that we collect when you fill out enrollment and other forms or obtain our services. We maintain this information and use it to provide services to you and to operate HAP.

When we use the term “HAP”, “we” or “us” in this notice, we are referring to Health Alliance Plan and its subsidiaries, Alliance Health and Life Insurance Company and HAP Preferred.

Internally, we protect your oral, written and electronic information by requiring employees and others with access to such information to follow specific confidentiality and technology usage policies. Before they begin working for HAP, all employees and contractors must sign a confidentiality statement affirming that member information will be protected, and that such protection continues even after the employee or contractor leaves HAP. An employee or contractor’s use of protected information is limited to the minimum amount of information necessary to perform a legitimate job function. Employees and contractors also are required to comply with this privacy notice, and may not use or disclose your information except as described in this notice.

Using and Disclosing Member Information for Payment and Health Care Operations

HAP may use and share the member information we collect for payment and health care operations. For example, treatment, payment and health care operations includes enrollment, underwriting, care management, quality improvement, billing, claims payment, customer services, quality assurance, utilization management, licensing, credentialing and accreditation. We disclose your member information to affiliated companies as permitted by law and to non-affiliated third parties with whom we contract to help us operate HAP. The following are examples of the ways we may use or share member information about you for payment or health care operations:

- We may use member information to help pay your medical bills that have been submitted to us by doctors and hospitals for payment.
- We may share your member information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any medical records sent to us by your doctor.
- We may use or share your member information with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- We may share your information with others who help us conduct our business operations.
- We may use or share your information for certain types of public health or disaster relief efforts.
- We may use or share your information to send you a reminder if you have an appointment with your doctor.

- We may use or share your information to give you information about alternative medical treatments and programs or about health related products and services that you may be interested in. For example, we might send you information about smoking cessation or weight loss programs.
- We may use or share your information with an employee benefit plan through which you receive health benefits. Except for enrollment information or summary health information and as otherwise required by law, we will not share your information with an employer or plan sponsor, unless the employer or plan sponsor has provided us with written assurances that the information will be kept confidential and will not be used for an improper purpose.
- We may use or share your member information in limited circumstances for research purposes. For example, a research organization may wish to compare outcomes of all patients that receive a particular drug and will need to review a series of medical records. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an institutional review board or privacy board, which oversees the research, or by representations of the researchers that limit their use and disclosure.
- We may release your member information to a friend or family member who is authorized by law to act on your behalf. We may also give your member information to someone who helps pay for your care.

Using and Disclosing Member Information for Other Purposes

There are also state and federal laws that require us to release your member information to others in some of the following situations:

- We may report information to state and federal agencies that regulate us, such as the US Department of Health and Human Services and the Michigan Office of Financial and Insurance Services.
- We may share information for public health activities, such as for reporting disease, injury, birth and death, and for required public health investigations. For example, we may report information to the Food and Drug Administration if necessary to report adverse events, product defects or for product recalls.
- We may report information to public health agencies if we believe there is a serious health or safety threat.
- We may share information with a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions.)
- We may provide information to a court or administrative agency (for example, pursuant to a court order, search warrant, subpoena or discovery request).
- We may report information for law enforcement purposes.
- We may report information to a government authority regarding abuse, neglect or domestic violence.
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information to funeral directors as necessary to carry out their duties.
- We may use or share information for procurement, banking or transplantation of organs, eyes or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and protective services for the President and others.
- We may report information on job-related injuries because of requirements of your state worker compensation laws.

If one of the above reasons does not apply, we must get your written permission to use or disclose your member information. If you give us written permission and change your mind you may revoke your written permission at any time. The revocation will not apply to any information we have already disclosed. Your request to exercise any of the above member rights must be in writing and be signed by you or your representative. We may ask you to complete a form when making a request. Once you give us authorization to release your member information, we cannot guarantee that the person to whom the information is provided will not disclose the information.

Your Member Rights

The following are your rights with respect to your member information. If you would like to exercise the following rights, please contact us as described below, under “Who to Contact”.

- ***You have the right to ask us to restrict*** how we use or disclose your member information for treatment, payment, or health care operations. You also have the right to ask us to restrict member information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. *Please note that we are not required to agree to these restrictions.*
- ***You have the right to ask to receive confidential communications*** of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example in situations involving domestic disputes or violence), you can ask us to send the information by alternative means, for example, by fax or to an alternative address. We will try to accommodate reasonable requests.
- ***You have the right to inspect and obtain a copy*** of member information that we maintain about you. We may deny your request to inspect and copy your member information in certain, limited circumstances. For example, we may deny your request if review of the records could endanger you or another person. We may charge you a fee for copies. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.
- ***You have the right to ask us to amend*** member information we maintain about you. We will require that the information be accurate. *Please note that we are not required to agree to a request to amend.*
- ***You have the right to receive an accounting*** of certain disclosures of your member information made by us during the six years prior to your request. Please note that we are not required to provide you with an accounting of all disclosure we make. For example, we are not required to provide you with an accounting of member information collected prior to April 14, 2003; information disclosed or used for treatment, payment, and health care operations purposes; or information disclosed to you or pursuant to your authorization. Your first accounting in any 12-month period is free. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.
- ***You have a right to receive a copy of this notice upon request at any time.*** Your request to exercise any of the above member rights must be in writing and be signed by you or your representative. We may ask you to complete a form when making a request.

Changes to this Privacy Statement

We may from time-to-time change the contents of this notice and reserve the right to do so. If we do so the new notice will be effective for all the member information maintained by us. Once revised, we will provide the new notice to you by mail and post it on our web site.

Who to Contact

If you have any questions about this notice or about how we use or share member information, you may the HAP Privacy Officer by mail at: 2850 West Grand Blvd, Detroit, MI 48202. You may also call us at (313) 872-8100 or 1-800-422-4641 or send us an e-mail by clicking “Contact HAP ” at the top of the page on HAP’s website (www.hap.org).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Privacy Officer as noted above. You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

II HEALTH ALLIANCE PLAN GRIEVANCE POLICY

PURPOSE

To provide a mechanism by which any Health Alliance Plan (HAP) member or their representative (with the appropriate authorization) may seek resolution to those situations where the member is dissatisfied or feels aggrieved by the services, benefits, and/or policies and procedures of Health Alliance Plan or its providers. This process exists for those situations that cannot be resolved via the initial contact with a HAP provider or the Member Services Department through the Complaint/Appeal Process.

SUMMARY OF THE GRIEVANCE PROCESS

The Grievance Process acknowledges the member's right to continue to voice a dissatisfaction through a two level decision making process within HAP. This process is available for those situations when a HAP member remains dissatisfied with the solution that was proposed to him/her at the preceding pre-grievance level.

Members or their representative (with the appropriate authorization) who wish to initiate the grievance process, must submit their request *in writing* to the **Associate Vice President of Client Services, 2850 West Grand Boulevard, Detroit, MI 48202**, within two (2) years from the date of discovery or date of the initial determination, i.e., denial of service/referral, rejection of claims by HAP, etc. The member should also include any additional information; i.e., medical evaluation report, medical records or other pertinent information they feel will further support the request. The Member Services Grievance Section will send the member or their representative an acknowledgment letter confirming HAP's receipt and acceptance of the request to initiate the grievance process.

HAP's grievance policy allows for a final determination (which includes both levels) to be made within thirty (30) calendar days for both pre-service appeals (a request to change an adverse determination for care that has **not** been received) and for post-service appeals (a request to change an adverse determination for care that has already been received.) If a member approves our request for an extension of this time frame, HAP may be allowed up to ten (10) additional days for review if we have not received requested information from a health care facility or health professional required for the review. If HAP exceeds the allowable time frame, members may proceed directly to the State and exercise their right for external review. Also based on Section 502 (a) of the Employment Retirement Income Security Act (ERISA) of 1974, after exhausting both levels of HAP's internal grievance process, a member has the right to bring civil action based on an adverse benefit determination. Additionally, upon your written request, you are entitled to reasonable access to copies of documents, records and other information relevant to your grievance that is permitted by law and according to ERISA.

A 72 hour Expedited Grievance Process is also available when medically indicated, (a medical determination that the routine time frames for the internal grievance review would seriously jeopardize the life or health of a member or would jeopardize the member's ability to regain maximum function, as substantiated by a physician either orally or in writing). The eligibility of an expedited grievance will be determined by HAP based on the established criteria.

HAP's two level decision making process is as follows:

LEVEL I: ASSOCIATE VICE PRESIDENT, CLIENT SERVICES
LEVEL II: HAP GRIEVANCE COMMITTEE

If the member or their representative is dissatisfied with the response received at the first level of the process, they may continue to progress through the Grievance Process by submitting, in *writing* a grievance request for the second level. The request must be submitted within sixty (60) days from the date of the letter advising of the first level review, [Example: First level decision letter dated, March 1; second level request must be received by May 1.]

During the second and final HAP internal level, the member or their representative (with the appropriate authorization) has the option of presenting his/her grievance in person to the HAP Grievance Committee.

After the member exhausts all internal levels of the Grievance Process, (or if HAP exceeds their allowable review period for the grievance) and remains dissatisfied with HAP's final determination, he/she may further pursue an external independent review under the Patient's Right to Independent Review Act, by contacting the Michigan Insurance Commissioner at the Office of Financial and Insurance Services, Division of Insurance, Health Plans Division, 611 Ottawa, Second Floor, P.O. Box 30220, Lansing, MI 48909-7720, phone: (877) 999-6442, within sixty (60) days of the notice of the exhaustion of HAP's internal grievance process. HAP will automatically provide

members with the necessary form (**FIS 0018**) - **Health Care Request for External Review**) to request an external review. For additional information, members may contact HAP's Client Services Department at 313-872-8100 or toll free at 1-800-422-4641, or the Division of Insurance directly at the above number, or by visiting the web site of the State Insurance Division at www.cis.state.mi.us/ofis.