



TOTALLY THERE FOR YOU.

# HMO

# Certificate of Coverage



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## ARTICLE I. TOTAL HEALTH CARE USA

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

## ARTICLE II. DEFINITIONS

- 2.01 When used in this Certificate of Coverage Agreement, Riders, the Group Operating Agreement, the Enrollment Application signed by the Subscriber and the identification card issued to Members, the definitions in Sections 2.02 to 2.35 apply.
- 2.02 “Affiliated Facility” means any legally qualified and state-licensed intermediate care or skilled nursing facility or Hospice, which has a contract with the Plan to provide services for Members.
- 2.03 “Affiliated Hospital” means any Hospital that has a contract with the Plan to provide hospital services to Members.
- 2.04 “Affiliated Physician” means an individual licensed to practice medicine or osteopathy and who has a contract with the Plan or an IPA to provide services to Members.
- 2.05 “Affiliated Provider” means a health professional, a Hospital, licensed pharmacy or any other institution, organization or person who has a contract with the Plan or an IPA to render one (1) or more health maintenance services to Members.
- 2.06 “Affiliated Psychiatrist” means an individual licensed to practice psychiatry and who has a contract with the Plan to provide services to Members.
- 2.07 “Authorized Benefits and Services” are those health care benefits and services available to Members under this Certificate when provided by health care providers authorized to provide such care under this Certificate.
- 2.08 “Breast Cancer Rehabilitative Services” means a procedure intended to improve the results of, or ameliorate the debilitating consequences of the treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to, reconstructive plastic surgery, physical therapy, and psychological and social support services.
- 2.09 “Calendar Year” means a 12 month period of benefit coverage that begins on January 1st. Deductible amounts are reset at the beginning of each calendar year.
- 2.10 “Certificate” means this Certificate of Coverage Agreement and applicable Riders.
- 2.11 “Contract Year” means, the twelve (12) month period from the date that coverage was initially effective under this Certificate and each 12-month period thereafter, unless otherwise stated and agreed upon.
- 2.12 “Co-Payment” means, when expressed as a percentage (%) or dollar sum (\$), the amount each Member must pay per visit to a treating provider in connection with Authorized Benefits and

Services. Co-pay, when expressed as a percentage (%), means the portion of contracted payment that each Member must pay per visit to a treating Provider for Authorized Benefits. Such percentage co-pays shall not exceed 50% of T-USA's contracted reimbursement to the provider for providing that service to a Member.

- 2.13 "Deductible" means, the amount of money each member is responsible to pay for Covered Services during a calendar year before the Total Health Care USA payment begins.
- 2.14 "Dependent" means any of the following, unless otherwise excluded by the Group Operating Agreement:
- (1) The Spouse of a Subscriber;
  - (2) Unmarried children of the Subscriber or the Spouse by birth, legal adoption or legal guardianship, who meet all of the following criteria:
    - a. are dependent upon the Subscriber or Spouse for support as defined by the Internal Revenue Code; and
    - b. are nineteen (19) years of age or younger.
  - (3) Unmarried children of the Subscriber or the Spouse by birth, legal adoption or legal guardianship, who meet all of the following criteria:
    - a. are dependent upon the Subscriber or Spouse for support as defined by the Internal Revenue Code; and
    - b. are totally and permanently disabled prior to or at the age of 19 due to physical or mental conditions and are now over the age of 19.
  - (4) Unmarried children of the Subscriber or Spouse by birth, legal adoption or legal guardianship, who do not reside with the Subscriber but meet all of the following criteria:
    - a. are the Subscriber's or Spouse's legal responsibility pursuant to court order; and
    - b. are dependent upon the Subscriber or Spouse for support as defined by the Internal Revenue Code; and
    - c. are 19 years of age or younger or were totally and permanently disabled before age 19 and are now older than 19.
  - (5) Unmarried children of the Subscriber or Spouse by birth or legal adoption who do not reside with the Subscriber but:
    - a. for whom a court has ordered the Subscriber or Spouse to provide health care coverage;
    - b. are 19 years of age or younger or were totally and permanently disabled before age 19 and are now older than 19.

A child need not be claimed as a Dependent on the federal income tax return of the Subscriber to qualify as a Dependent.

- 2.15 "Enrollment Application" means the form approved by the Plan by which an individual seeks to enroll one or more Members in the Plan.
- 2.16 "Grace Period" means the thirty (30) day period allowed for payment of the Premium immediately following the due date for the Premium.
- 2.17 "Group" means an employer group or organization that has executed the Group Operating Agreement on behalf of its employees or members.

- 2.18 “Group Operating Agreement” means the agreement entered into between the Plan and the Group through its authorized representative, which outlines the criteria of eligibility of persons to be Members of the Group, and which together with any agreement regarding new and rehired group employees, the Certificate, the Enrollment Application and the Member identification card constitutes the contract between the Plan, the Group and the Member.
- 2.19 “Health Center” means a health care facility that is operated by an Individual Practice Association.
- 2.20 "Hospice" means a licensed health care program that has a contract with the Plan to provide a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.
- 2.21 “Hospital” means a state-licensed acute care facility that provides inpatient, outpatient and emergency medical, surgical or psychiatric diagnosis, treatment and care of injured or acutely sick persons, by or under the supervision of a staff of physicians and that continuously provides twenty-four (24) hour-a-day nursing service by registered nurses, and which is not, other than incidentally, a place for the treatment of pulmonary tuberculosis, a place for the treatment of drug abuse, a place for the treatment of alcoholism, nor a nursing home.
- 2.22 “Individual Practice Association” or “IPA” means a partnership, corporation, association or other entity that has a contract with the Plan to provide and arrange for services to Members, has as its primary objective the delivery, or arrangement for the delivery, of health care services, and employs or has entered into written service agreements with health professionals, a majority of whom are physicians.
- 2.23 “Medical Emergency or Accidental Injury”:
- (1) “Medical Emergency” means a medical condition manifested by severe symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life if not treated immediately.
  - (2) “Accidental Injury” means a traumatic bodily injury that, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a Member’s health or result in loss of life.
  - (3) Heart attacks, hemorrhaging, poisoning, loss of consciousness or respiration, trauma and convulsions are some examples of Medical Emergencies or Accidental Injuries.
- 2.24 “Member” means a Subscriber or Dependent eligible to receive services under this Certificate and the Group Operating Agreement, and who has enrolled in the Plan.
- 2.25 “Open Enrollment Period” means that limited period of time during which eligible persons are given the opportunity to enroll in the Plan.
- 2.26 “Plan” means Total Health Care USA.
- 2.27 “Premium” means the amount of money prepaid monthly by a Group, including Subscriber contributions, if any, on behalf of the Members.

- 2.28 “Breast Rehabilitative Services” means a procedure intended to improve the results of, or ameliorate the debilitating consequences of treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to, reconstructive plastic surgery, physical therapy, and psychological and social support services.
- 2.29 “Referral Facility” means any legally qualified and state-licensed intermediate care facility, skilled nursing facility, Hospice or Hospital that provides services to Members under the orders of an Affiliated Physician or Referral Physician when admission is authorized by the Affiliated Physician and the Plan’s Medical Director or his/her designee.
- 2.30 “Referral Physician” means a physician other than an Affiliated Physician who is licensed to practice medicine or osteopathy and who delivers medical or osteopathic care to a Member on the referring order of an Affiliated Physician.
- 2.31 “Remitting Agent” means the Group or the person designated by the Group who is responsible for the payment of the monthly premiums.
- 2.32 “Semi-private Room” means Hospital accommodations where there are two (2) or more beds to a room.
- 2.33 “Service Area” means the geographic area where the Plan is available and readily accessible to Members and where the Plan has been approved by the State of Michigan to market its services.
- 2.34 “Spouse” means the legally married husband or wife of a Subscriber.
- 2.35 “Subscriber” means an individual who enters into an HMO contract, or on whose behalf an HMO contract is entered into, with an HMO that has received a certificate of authority from the State of Michigan and to whom an HMO contract is issued:
- (1) Who meets all eligibility criteria established by the Group Operating Agreement and this Certificate; and
  - (2) Who has completed an Enrollment Application which has been received by the Plan; and
  - (3) Who resides within the Service Area at the time of application; and
  - (4) For whom Premiums have been received.

### ARTICLE III. ENROLLMENT; EFFECTIVE DATE OF COVERAGE; PREMIUMS

- 3.01 Enrollment
- (1) Persons meeting the Group’s and Plan’s eligibility requirements during an Open Enrollment Period may enroll in the Plan only during that Open Enrollment Period. In order to enroll, an Enrollment Application must be completed and received by the Group during the Open Enrollment Period. A person who is an eligible person at the time of an Open Enrollment Period and not already a Subscriber who fails to enroll during such Open Enrollment Period shall not be entitled to enroll at a later date except during a subsequent Open Enrollment Period.
  - (2) Persons who join the Group between Open Enrollment Periods, or otherwise become eligible to enroll in the Plan for the first time may do so by completing an Enrollment Application within thirty (30) days of attaining eligibility pursuant to the Group Operating Agreement.

In the event that such a newly eligible person fails to complete and submit an Enrollment Application within this 30-day time period, the person shall be entitled to enroll in the Plan only during a subsequent Open Enrollment Period.

3.02 Effective Date of Coverage

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

3.03 Premiums

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

If the Premium is paid by the Group to the Plan during the 30-day Grace Period, there will be no lapse in coverage.

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

## ARTICLE IV. GENERAL CONDITIONS

- 4.01 In completing the Enrollment Application, each Subscriber selects a Primary Care Physician. Each Member agrees and understands that all Authorized Benefits and Services must be provided by or authorized and arranged through this designated Primary Care Physician, except in the event of a Medical Emergency or Accidental Injury. If a Member cannot recall the Primary Care Physician selected or needs further information, the Member should contact the Plan's Member Services Department at (313) 871-2000.
- 4.02 Inability, failure, neglect and/or refusal of an IPA to provide Authorized Benefits and Services, shall give the Plan the right to transfer Members covered from one Primary Care Physician to another Primary Care Physician during such inability, failure, neglect and/or refusal. The Plan's right to transfer Members will be exercised in the best interests of the Members' health care needs and within the legal limitations dealing with termination of medical care to patients. In the event of such a transfer, the Plan does not guarantee that transferred Members will return to the former Primary Care Physician in the future.
- 4.03 Nothing contained within this Certificate shall interfere with the professional relationship between the Member and the physician providing care. Each Member shall have the right to choose, to the

- extent feasible and appropriate, the Affiliated Physician and other health care professionals responsible for his/her primary care, subject to the provisions in Section 11.09. Each IPA maintains medical records at the designated Primary Care Physician for each Member receiving services. The medical records are available for inspection and review during regular business hours upon request by the Member.
- 4.04 No officer, agent or representative of the Plan except the Executive Director is authorized to vary the terms or conditions of this Certificate in any way or to make any promises or agreements supplemental to this Certificate. Any supplemental agreements or variances to the terms or conditions of this Certificate must be in writing signed by the Executive Director of the Plan.
- 4.05 The Authorized Benefits and Services provided under this Certificate are solely for the individual benefit of the Members and cannot be transferred or assigned. If any Member aids, attempts to aid or knowingly permits any other person not a Member of the Plan to obtain benefits or services from or through the Plan, that Member's coverage under this Certificate shall be terminated immediately, and the Member shall be responsible for payment for any services rendered to such other person. The theft or wrongful use, delivery or circulation of a Member identification card may constitute a felony under Michigan law.
- 4.06 If a Member's identification card is lost or stolen, the Member must contact the Plan's Member Services Department at (313) 871 -2000 by the close of the business day following discovery of theft or loss. Failure to notify of the loss or theft of a Member identification card within that time period shall result in the termination of coverage under this Certificate.
- 4.07 When a Member enrolls in the Plan, s/he shall be deemed to have agreed to use Affiliated or Referral Physicians and Affiliated or Referral Facilities and other Providers for all services and supplies, except in case of a Medical Emergency or Accidental Injury.
- 4.08 This Certificate supercedes all previous contracts or certificates between the Plan, the Group and the Members.
- 4.09 Any notice required to be given by the Plan, the Group or a Member, shall be deemed to have been duly given if in writing and personally delivered, or deposited in the United States mail with postage prepaid, addressed, as applicable, to the Remitting Agent, to the Member at the last address on record at the Plan's principal office, or to the Plan at 3011 W. Grand Blvd., Suite 1600, Detroit, Michigan 48202.
- 4.10 The Plan shall not be liable for any delay or failure of an Affiliated Provider, Referral Physician or Referral Facility to provide services due to lack of available facilities or personnel, if the lack is a result of circumstances beyond the Plan's control. In the event of circumstances beyond the Plan's control, the Plan shall attempt to arrange Authorized Benefits and Services, insofar as practical, according to its best judgment and within the limitations of facilities and personnel then available. Circumstances beyond the Plan's control include, but are not limited to, complete or partial disruption of facilities, war, riot, civil insurrection, epidemic, labor disputes, unavailability of supplies, disability of a significant part of an Affiliated Provider's personnel or similar causes.

#### 4.11 **GRIEVANCE/APPEAL**

A grievance/appeal may be due to a denial of payment or an adverse determination. An adverse determination means health care services have been reviewed and denied, reduced or terminated. An untimely response to a request becomes an adverse determination. A Member or authorized representative has one hundred and eighty days (180) days from the date of the adverse determination letter to file a grievance.

A Member has the right to have benefits continue pending resolution of the grievance. There may be conditions under which a Member will be required to pay for services provided while benefits are continued. A Member also has the right to authorize someone to act as an authorized representative in the grievance. An authorized representative must have the Member's written consent to represent the Member. The Member also has the right to send additional documentation with the grievance.

At the Member's request, as a part of the grievance/appeal rights, Total Health Care USA will arrange a meeting with the Appeal Review Committee. The Member can discuss the grievance with the committee. The Member or authorized representative may attend the meeting in person or by telephone. A person not involved in the first decision will review the grievance. No one who reports to the person involved in the initial decision can review the grievance. The person who reviews the grievance will be of similar specialty.

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

##### **Expedited Grievance**

In some urgent cases, a time delay may increase the risk of harm to the Member's health or life. A grievance is considered expedited (quick), when a physician notifies the Plan verbally or in writing that waiting the 30 days would cause the Member to have severe pain or put their life at risk. The physician must have knowledge of the Member's medical condition and be able to support the attestation. Total Health Care USA will not punish a provider who requests or supports an expedited grievance on the Member's behalf. The grievance must be received within ten (10) days of the denial.

If Total Health Care USA denies the request for an expedited grievance, it is changed to a thirty (30) day grievance. After filing an expedited internal grievance with Total Health Care USA, the Member may file an appeal to request an expedited external review with the Office of Financial and Insurance Regulation (OFIR).

A decision about an expedited grievance is made no later than seventy-two (72) hours after it is received. Total Health Care USA will notify the Member of the decision by phone. The Plan will also mail the decision within two (2) business days. The Member can request an extension of the decision time. The request moves the grievance to a thirty (30) day grievance.

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

### **External Appeal Rights**

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

The Member or authorized representative must file the OFIR, Health Care-Request for External Review Form to be given an external review. A copy of the Health Care-Request for External Review Form will be included with the final decision letter. The Member may also call OFIR at 1-877-999-6442 to have a form mailed. The form should be filed no later than sixty (60) days after receipt of the final decision letter.

When appropriate OFIR will request a recommendation by an independent review organization. The independent review organization is not a part of Total Health Care USA. The Commissioner of OFIR will issue a final order.

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

To request an independent review write to:

Appeals Section  
Office of Financial and Insurance Regulation  
P.O. Box 30220  
Lansing, Michigan 48909-7720  
1 (877) 999-6442  
Or fax to (517) 241-4168

- 4.12 All Member protected health information (“PHI”) is maintained in a manner that assures confidentiality consistent with applicable law. PHI includes such information as a Member’s name, address, phone number, Social Security Number, demographic information and any information related to his/her health condition or diagnosis. The Plan will not use or disclose PHI concerning Members and/or their medical treatment other than for purposes of treatment, payment or healthcare operations except upon written authorization of the Member or as otherwise required by law. Any such disclosure of PHI will be limited to that which is minimally necessary.
- 4.13 The Plan may adopt reasonable policies, procedures and rules to promote orderly and efficient administration of this Certificate. Questions about such policies should be directed, in writing, to:

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

- 4.14 The Member identification card is the property of the Plan. Each Member understands and agrees to return the Member identification card upon request of the Plan.
- 4.15 As a Member of the Plan, the Plan will provide you, upon your request, with a description of any of the following. To request this information, please contact the Member Services Department by telephone at (313) 871-2000, or mail your request to the Member Services Department at:

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

Be sure to include your Member ID number on your request.

- A. **Information Concerning Affiliated Providers.** The Directory includes the names of Plan Affiliated Providers, specialty or type of practice, practice location, and information concerning accessibility/availability. You may request from the Member Services Department, and the Plan will provide you with:
- Clarification with respect to the information contained in the Directory
  - Information concerning which Affiliated Providers are not accepting new Plan Members
  - Information concerning the professional credentials of Affiliated Providers that are health professionals, including professionals certified in the specialty of pain medicine, evaluation and management. The type of information available includes, but is not necessarily limited to, professional degrees held, dates of certification by professional boards and other professional bodies, affiliation status with Affiliated Providers that are facilities, such as hospitals.
- B. **Financial Relationships with Affiliated Providers.** You may request from the Member Services Department, and the Plan will provide, information indicating the nature of financial relationships between the Plan and its Affiliated Providers. The Plan will provide you with a description of its financial relationships with Affiliated Providers including:
- Whether a fee-for-service arrangement exists, under which the Affiliated Provider is paid a specific amount for each Covered Service rendered to a Member
  - Whether a capitation arrangement exists, under which a fixed amount is paid to the Affiliated Provider for all, or a specified set, of Covered Services that are or may be rendered to the Member, or all persons in the Member's family covered by the Plan
  - Whether payments to Affiliated Providers are based on standards relating to cost, quality and/or patient satisfaction.
- C. **Licensure Verification.** You can verify the license of Affiliated Providers that are health professionals through the Michigan Department of Labor and Economic Growth. You can verify a license electronically at the following websites: <http://www.cis.state.mi.us/verify.htm> and <http://www.cis.state.mi.us/free/default.asp>. You also can verify a license, and request information concerning disciplinary action and open formal complaints filed against a health professional, by calling the Michigan Department of Labor and Economic Growth at 517-241-9427.
- D. **Benefits.** This Certificate of Coverage Agreement, together with any riders, and the Member Handbook provided to Members contains a description of the benefits available to Plan Members, including rules regarding accessing benefits such as prior authorization requirements for specialist services, Referral Physicians, Referral Facilities and other

services, drug formulary requirements, if any, and exclusions and limitations applicable to the specific categories of benefits provided. If you require clarification with respect to any of this information, please contact the Member Services Department.

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

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

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

## ARTICLE V. COVERED BENEFITS AND SERVICES

### 5.01 Inpatient Hospital Care

#### (1) Physician Services:

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

#### (2) Hospital Services:

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

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

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

**Deductible may apply, consult your riders.**

5.02 Outpatient Services

- a. Outpatient surgical care, including routine surgical procedures that do not require the use of inpatient hospital facilities.
- b. Therapeutic and diagnostic laboratory, pathology, radiology and special diagnostic services which are medically necessary for the diagnosis or treatment of a disease, injury or medical condition.
- c. Medical and surgical supplies.
- d. Pre-hospital admission screening procedures which have been authorized by an Affiliated Physician and/or the admitting physician.

**Deductible may apply, consult your riders.**

5.03 Professional Services

- (1) The following Authorized Benefits and Services are available for preventive, diagnostic, therapeutic and rehabilitative care when provided by an Affiliated Physician, health care personnel employed by or having written service agreements with an IPA, personnel employed by the Plan, or by a Referral Physician when authorized by an Affiliated Physician:
  - a. Annual physical examinations.
  - b. Office visits at the Member's designated Primary Care Physician.
  - c. Pediatric immunizations (influenza vaccination covered from six (6) months - five (5) years of age).
  - d. Formulary drugs administered at the primary care office.
  - e. Outpatient surgical procedures performed in physician's office.
  - f. Medical and surgical supplies.
  - g. Therapeutic and diagnostic laboratory, pathology, radiology and special diagnostic services which are medically necessary for the diagnosis or treatment of a disease, injury or medical condition when authorized by an Affiliated Physician.
  - h. Prenatal and postnatal care.
  - i. Nutrition counseling and health education services.
  - j. Short-term medical rehabilitative services and physical therapy for up to forty-five (45) days per calendar year, for conditions which an Affiliated Physician expects will result in significant improvement of a Member's condition within a period of two (2) months.
  - k. Vision and hearing screening examinations for Dependents through the completion of the calendar year that they attain the age of eighteen (18), to determine the need for vision and/or hearing corrections.
  - l. Visits for mental health consultation, diagnosis and treatment including crisis intervention, group therapy and testing by a psychiatrist, psychiatric social worker or a counseling or clinical psychologist. Coverage is limited to twenty (20) visits per calendar year for such mental health care and is provided through an Affiliated Psychiatrist.
  - m. Pre-hospital admission screening procedures which have been authorized by an Affiliated Physician and/or the admitting physician.

**Co-payment may apply, consult your riders.**

(2) Home Health Care Aides

When prescribed by an Affiliated Physician, home health care visits by nursing personnel will be provided up to 100 visits per calendar year.

5.04 Breast Cancer Diagnostic Services and Breast Cancer Screening

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

**Covered in full.**

Breast cancer diagnostic services means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammography, surgical breast biopsy, and pathological examination and interpretation.

**Deductible may apply, consult your riders.**

5.05 Breast Cancer Treatment

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

**Deductible may apply, consult your riders.**

5.06 Other Breast Services and Treatment Following a Mastectomy includes:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction on the breast to produce a symmetrical appearance
- Prosthesis (breast implant); and
- Treatment for physical complications of the mastectomy, including lymphedema

**Deductible may apply, consult your riders.**

5.07 Diabetic Services

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

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

5.08 Antineoplastic Drug Coverage (Chemotherapy)

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

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

5.09 Intermediate and Outpatient Care for Substance Abuse

Intermediate and outpatient care for substance abuse will be provided as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs when prescribed by the Psychiatrist. The coverage shall comply with Section 500.3425 of the Michigan Insurance Code which establishes minimum coverage. The current minimum (\$3,774.00) shall be adjusted annually on March 31, 2009 and each year thereafter in accordance with the U.S. Consumer Price Index for the twelve (12) month period ending the preceding December 31, and shall be effective for one (1) year commencing April 1. For information regarding the amount of coverage, please call Member Services at 1-800-826-2862.

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

- (i) Chemotherapy.
- (ii) Counseling.
- (iii) Detoxification services.
- (iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

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

- (i) Chemotherapy.
- (ii) Counseling.
- (iii) Detoxification services.
- (iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

**Deductible may apply for Intermediate Care, consult your riders.**

#### 5.10 Behavioral Health

- (1) Visits for behavioral health consultation, diagnosis and treatment including crisis intervention, group therapy and testing by a psychiatrist, psychiatric social worker or a counseling or clinical psychologist. Coverage is limited to twenty (20) visits per calendar year.
- (2) Inpatient Psychiatric Care shall be covered when authorized by the Plan's Medical Director and/or his designee. Inpatient Psychiatric Care shall be limited to forty-five (45) days per Member for each continuous period of hospitalization, or for successive periods of Hospital care separated by less than sixty (60) days. A new benefit period will begin only when there has been a lapse of at least sixty days from the last date of discharge to the next date of admission.

**Outpatient Behavioral Health: Covered:**

**Deductible may apply for Inpatient Psychiatric Care, consult your riders.**

#### 5.11 Emergency Care

- (1) Emergency medical care coverage is provided for the treatment and stabilization of Medical Emergencies and Accidental Injuries as defined in Article 2.22. Emergency medical care is available twenty-four (24) hours a day. Call 9-1-1 or go to the nearest Emergency Room.
- (2) Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered in the Member's designated Primary Care Physician office only, unless specifically authorized in writing by the Plan's Medical Director or designee.

**Co-payment:** The Member will be responsible for \$40 co-payment per visit or as defined by rider for covered emergency services. However, if the emergency results in the admission to a Hospital, this co-payment will not be assessed.

#### 5.12 Ambulance Service

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

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

5.13 Temporomandibular Joint Treatment

- (1) Temporomandibular Joint Syndrome (TMJ) is defined as muscle tension and spasms of musculature related to the temporomandibular joint, facial and cervical muscles, causing pain, loss of function, neurological and personality dysfunctions.
- (2) When deemed medically necessary and provided or authorized by an Affiliated Physician, and approved by the Medical Director, the following services and treatment for Temporomandibular Joint Syndrome are Authorized Benefits and Services:
  - a. Office visits for medical evaluation and treatment.
  - b. Specialty referral for medical evaluation and treatment.
  - c. X-rays of the temporomandibular joint including contrast studies, but not dental X-rays.
  - d. Palliative therapy including TENS therapy and intraoral fixation.
  - e. Myofunctional therapy.
  - f. Surgery to the temporomandibular joint including but not limited to condylectomy, meniscectomy, arthrotomy and arthrocentesis.
- (3) Dental and orthodontic services, treatment, prosthesis and appliances for or related to treatment for temporomandibular syndrome are not covered.

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

5.14 Emergency Inpatient Admission In Non-Affiliated Hospitals In the Service Area

- (1) If, in case of a Medical Emergency or Accidental Injury, a Member seeks emergency services at a non-affiliated Hospital and is admitted to the non-affiliated Hospital, the Plan will cover inpatient care at the admitting Hospital. Coverage will be limited to one (1) day of care, unless transferring the Member to an Affiliated Hospital or Referral Facility would jeopardize the Member's medical condition in the opinion of the Plan's Medical Director or designee. When a transfer would jeopardize a Member's medical condition, benefits will be extended until a transfer is practical or until discharge. In the event of a transfer, the cost of medically necessary and appropriate transportation is covered in full by the Plan. A transfer to an Affiliated Hospital or Referral Facility will be made under the supervision of the Plan. When a Member of his/her family refuses a transfer to an Affiliated or Referral Facility, continued care shall thereafter be the financial responsibility of the Member.
- (2) Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered at the Member's designated Health Center only, unless specifically authorized in writing by the Plan's Medical Director or designee.

**Deductible may apply, consult your riders.**

5.15 Out-of-Area Coverage

- (1) Out-of-Area coverage is provided only when a Member is outside the Service Area for a period no greater than three (3) consecutive months or when a Member is nineteen (19) years or younger and is attending an accredited college or university outside of the Service Area. Out-of-area benefits shall be limited to inpatient and outpatient care for Medical Emergencies or Accidental Injuries only. Members traveling outside the Service Area are not covered for out-of-area obstetrical services and related Hospital care within four (4) weeks of the estimated date of delivery, as determined by the Affiliated Physician, whether or not the obstetrical services and related Hospital care were required as a result of a Medical Emergency or Accidental Injury.

- (2) In order to be covered for services under this Section 5.15, the Member must notify the Plan within twenty-four (24) hours after admission to a Hospital or as soon as medically possible after admission if the Member is incapable of calling the Plan.
- (3) Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered at the Member's Designated Health Center only, unless specifically authorized in writing by the Plan's Medical Director or designee.

**Co-payment:** The Member will be responsible for \$40 co-payment per visit or as defined by rider for covered emergency services. However, if the emergency results in the admission to a Hospital, this co-payment will not be assessed.

**Deductible may apply for Inpatient admission, consult your riders.**

#### 5.16 Hospice

##### (1) Eligibility

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

##### (2) Settings

The majority of hospice care is provided in the Member's home. If the Member is eligible for hospice services but does not have a family member or friend to provide the care necessary to allow the Member to remain in the home, an Affiliated Physician in conjunction with the Plan shall arrange for hospice care in an Affiliated Facility.

##### (3) Hospice Services

Hospice care shall be under the direction of an Affiliated Physician and address the physical, psychological, social and spiritual needs of the terminally ill Member and shall be designed to meet the related needs of the terminally ill Member's family through the periods of illness and bereavement.

**Covered in full.**

#### 5.17 Language Services

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

#### 5.18 After Hours Care

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

**Covered in full.**

## ARTICLE VI. EXCLUSIONS AND LIMITATIONS

- 6.01 All benefits and services not specifically described as Authorized Benefits and Services in this Certificate are excluded from coverage under this Certificate.
- 6.02 Medical, surgical, Hospital and similar services (except for an Emergency) obtained by a Member from providers other than Affiliated Providers, are not covered unless they are authorized in writing by the Plan's Medical Director or designee before their services are rendered.
- 6.03 Services which are not medically necessary are not covered. The final determination of medical necessity is made by the Plan's Medical Director or designee.
- 6.04 Services for disabilities associated with military service to which the Member is legally entitled and for which facilities are reasonably available to the Member are not covered.
- 6.05 Services for an occupational injury or disease for which services, payment or reimbursement is available under any workers compensation or employer's liability law are not covered.
- 6.06 Care for conditions that federal, state or local laws require be treated in a public health facility are not covered.
- 6.07 Infertility treatment is not covered.
- 6.08 Services ordered by a court of competent jurisdiction are not covered, unless they are otherwise Authorized Benefits and Services.
- 6.09 Services provided during police custody are not covered, unless they are otherwise Authorized Benefits and Services.
- 6.10 Services for mental illnesses, disorders and disabilities that, according to generally accepted professional standards, are not amenable to treatment are not covered.
- 6.11 Services for chronic substance abuse (including alcohol) are not covered beyond the limits set forth in Section 5.09.
- 6.12 Unless included in a rider, outpatient prescription or nonprescription drugs, prosthetic appliances, orthotic equipment, eyeglasses, vision exams, audiometric exams, hearing aids, durable medical equipment, skilled nursing care and diet supplements are not covered.
- 6.13 Surgery and other services for cosmetic purposes, as determined by the Plan's Medical Director or his/her designee, are not covered.
- 6.14 Dental services and/or surgeries are not covered except in cases of multiple extractions or removal of unerupted teeth under general anesthesia where a concurrent medical condition exists.
- 6.15 Medical, surgical and other health care procedures determined by the Plan's Medical Director to be experimental (including research studies) are not covered. Health services which are unusual, infrequently provided and not necessary for the protection of individual health are not covered.

- 6.16 Reversal of voluntary, surgically induced sterilization is not covered.
- 6.17 Services of private duty nurses are not covered unless they are authorized by the Plan's Medical Director or designee before the services are rendered.
- 6.18 Custodial care, domiciliary care or basic care in a residential, institutional or other setting that is primarily for the purpose of meeting the Member's personal needs and which could be provided by persons without professional skills or training is not covered. Examples of custodial care include: assistance in bathing, dressing, eating, walking, getting in and out of bed and taking medicine.
- 6.19 General housekeeping services and personal convenience items, including, but not limited to, television and telephone services are not covered.
- 6.20 Health care benefits and services rendered as a result of a motor vehicle accident are not covered to the extent there is coverage under any policy.
- 6.21 Services that constitute vocational rehabilitation or employment counseling, or that are in connection with examinations for insurance employment screening are not covered, except as they may be incidental to an annual health examination.
- 6.22 If a Member requests inpatient accommodations that are more expensive than those provided in this Certificate, the Member must pay the Hospital the difference between those charges incurred and those allowable and payable by the Plan.
- 6.23 Hospital, medical and surgical services for the primary purpose of sex transformation are not covered.

## ARTICLE VII. SUBROGATION

- 7.01 Subrogation means that the Plan will have the same right as a Member to recover expenses for treatment of an injury or illness for which another person or organization is legally liable. To the extent the Plan provides services in such situations, the Plan will be subrogated to the Member's right of recovery against any responsible person or organization, including any other health plan or insurers on policies including those issued to and in the name of the Member.
- 7.02 By acceptance of an identification card from the Plan, the Member agrees as a condition to receiving Authorized Benefits and Services under this Certificate, that the Member will make a good faith effort to pursue recovery from any liable person or organization and upon collection of any recoveries for any Authorized Benefits and Services provided by the Plan will reimburse the Plan. The Plan shall have a lien for any Authorized Benefits and Services rendered on any such recoveries whether by judgment, settlement, compromise or reimbursement.
- 7.03 Members shall take such action, furnish such information and assistance and execute such assignments and other instruments as the Plan may request to facilitate enforcement of the rights of the Plan hereunder.

- 7.04 A Member shall not compromise or settle a claim or take any action that would prejudice the rights and interests of the Plan without the Plan's prior written consent.
- 7.05 Refusal or failure of a Member, without good cause, to cooperate with the Plan under this Article, shall be grounds for termination of membership in the Plan and for recovery by the Plan from the Member for the value of services and benefits provided by the Plan.

## ARTICLE VIII. COORDINATION OF BENEFITS

- 8.01 Benefits under this Certificate will be coordinated with all group health policies and/or other HMO benefits available to the Member under any policy or certificate that also has a coordination of benefits provision. The priority of responsibility under the coordinating policies or certificates will be determined in the following manner as prescribed under Act No. 64 of the Public Acts of 1984:
- (1) The benefits of a policy or certificate that covers the person on whose expense the claim is based other than as a Dependent, shall be determined before the benefits of a policy or certificate which covers the person as a Dependent.
  - (2) Except as otherwise provided in subsection (3), if two (2) policies or certificates cover a person on whose expenses the claim is based as a Dependent, the benefits of the policy or certificate of the person whose birthday anniversary occurs earlier in the calendar year shall be determined before the benefits of the policy or certificate of the person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the benefits of a policy or certificate that has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate that has covered the person for the shorter period of time. However, if either policy or certificate is lawfully issued in another state and does not have the coordination of benefits procedure regarding Dependents based on birthday anniversaries as provided in this subsection, and as a result each policy or certificate determines its benefits after the other, the coordination of benefits procedure set forth in the policy or certificate that does not have the coordination of benefits procedure based on birthday anniversaries shall determine the order of benefits.
  - (3) In the case of a person for whom claim is made as a Dependent minor child, benefits shall be determined according to the following:
    - a. Except as provided in paragraph c. below, if the parents of the minor child are legally separated or divorced, and the parent with custody of the child has not remarried, the benefits of the policy or certificate that covers the minor child as a Dependent or the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the non-custodial parent.
    - b. Except as provided in paragraph c. below, if the parents of the minor child are divorced, and the parent with custody has remarried, the benefits of a policy or certificate that covers the minor child as a Dependent of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the spouse of the custodial parent, and the benefits of a policy or certificate that covers the minor child as a Dependent of the spouse of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the non-custodial parent.

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

- 8.02 If Section 8.01 (1), (2) and (3) above do not establish an order of benefit determination, the benefits of a policy or certificate in connection with a group disability benefit plan that group disability plan has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate that has covered the person for the shorter period of time, subject to the following:
- (1) The benefits of a policy or certificate covering the person on whose expenses the claim is based as a laid-off or retired employee or a Dependent of a laid-off or retired employee shall be determined after the benefits of any other policy or certificate covering the person other than as a laid-off or retired employee or Dependent of a laid-off or retired employee.
  - (2) Subsection (1) shall not apply if either policy or certificate is lawfully issued in another state and does not have a provision regarding laid-off or retired employees and, as a result, each policy or certificate determines its benefits after the other.
- 8.03 Benefits under this Certificate shall not be reduced or otherwise limited because of the existence of another non-group contract that is issued as a hospital indemnity, surgical indemnity, specified disease or other policy of disability insurance as defined in Section 3400 of the Insurance Code of 1956, Act 218 of the Public Acts of 1956, being Section 500.3400 of the Michigan Compiled Laws.
- 8.04 Health care benefits and services rendered as a result of a motor vehicle accident are not covered to the extent there is coverage under any other policy.
- 8.05 The Plan is not required to pay claims or coordinate benefits for services that are not provided or authorized by the Plan and that are not Authorized Benefits and Services under this Certificate.

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

- 9.01 The Plan will not make adjustments in the rate(s) used to determine Premiums, nor in the terms and/or conditions of this Certificate with less than thirty (30) days written notice to the Remitting Agent.
- 9.02 The Subscriber must notify the Plan and the Remitting Agent in writing within thirty (30) days of any changes in the status of each Member as a result of marriage, divorce, disability, death, birth, legal adoption, dependency or changes in legal residence of children, changes in address, change of telephone number, entrance into or return from military service.

#### ARTICLE X. TERMINATION OF GROUP COVERAGE

- 10.01 The Certificate and the Group Operating Agreement shall continue in effect for one (1) year from the effective date and from year to year thereafter. The Plan may terminate this Certificate and the

Group Operating Agreement without notice if the Group fails to pay the Premium within the Grace Period. In the event the Premium is not paid within the Grace Period, this Certificate terminates and all Authorized Benefits and Services cease retroactively as of 11:59 p.m. on the due date, unless otherwise expressly agreed upon by the Plan in writing. In the event of termination, the Plan reserves the right to recover from the Group the costs of services rendered to the Members during the period following the due date and to reject claims submitted by providers for services rendered during the period following the due date.

## ARTICLE XI. TERMINATION OF A MEMBER'S COVERAGE

- 11.01 If this Certificate is terminated pursuant to Article X, the Member's coverage shall terminate at the time specified in Article X without further action of the Plan.
- 11.02 If a Member ceases to meet the eligibility requirements of the Group Operating Agreement and this Certificate, coverage shall terminate (subject to the conversion rights under Article XII) as follows:
- (1) If the Subscriber ceases to be a member of the Group, Authorized Benefits and Services for the Subscriber and enrolled Dependents will be continued only until the end of the month for which Premiums have been paid without any further action by the Plan.
  - (2) Upon the death of the Subscriber, all Authorized Benefits and Services will be continued for enrolled Dependents only until the end of the month for which Premiums have been paid without any further action by the Plan.
  - (3) In the event of divorce or legal separation of Subscriber and Spouse, all Authorized Benefits and Services will be continued for the Spouse only until the end of the month for which Premiums have been paid without any further action by the Plan.
  - (4) In the event a Member becomes a member of the Armed Services of the United States, all Authorized Benefits and Services shall terminate as to such Member as of that date without any further action by the Plan.
  - (5) Without any further action by the Plan, all Authorized Benefits and Services will be continued only until the end of the month in which the event occurs if an enrolled unmarried dependent child:
    - a. marries; or
    - b. establishes a residence separate from the Subscriber's household, except as provided in Section 2.13, (3) and (4); or
    - c. ceases being dependent upon a Subscriber or Spouse as defined by the Internal Revenue Code.
  - (6) Coverage shall terminate at the end of the calendar year in which a Dependent attains the age of nineteen (19) except as provided in Section 2.13, (3), (4), and (5).
  - (7) In the event a Member transfers residence outside the Service Area, Authorized Benefits and Services may be continued or may be terminated at the Plan's discretion.
- 11.03 The Plan may rescind a Member's coverage under this Certificate for intentional misrepresentation of a material fact on the Enrollment Application.
- 11.04 The Plan may terminate a Member's coverage for providing false or misleading information or withholding material information on any required plan form or in applying for or seeking any

- health care under the terms of this Certificate. Termination of coverage is effective ten (10) days after notice of termination is given by the Plan.
- 11.05 The Plan may terminate a Member's coverage if that Member fails to report theft or loss of a Member identification card within the time required by Section 4.06. Termination of coverage is effective immediately.
- 11.06 The Plan may terminate a Member's coverage if that Member knowingly fails or refuses to furnish information requested by the Plan. Termination of coverage is effective ten (10) days after notice of termination is given by the Plan.
- 11.07 The Plan may terminate a Member's coverage if the Member aids, attempts to aid or knowingly permits any other person not a Member to obtain benefits or services from or through the Plan. Termination of coverage is effective immediately.
- 11.08 The Plan may terminate a Member's coverage if the Member refuses or fails, without good cause, to cooperate with the Plan pursuant to Article VII.
- 11.09 The Plan may terminate the enrollment of a Member for the inability of the Member to establish a satisfactory relationship between the Member and an Affiliated Physician, including failure to comply with a prescribed treatment regimen, after reasonable attempts at establishing a satisfactory relationship with not less than two (2) Affiliated Physicians have proven unsuccessful, subject to the Member's rights under the Plan's grievance procedure to determine whether such a situation exists. Termination is effective thirty (30) days after notice of termination is given by the Plan.
- 11.10 Members may elect to terminate their coverage during Group Open Enrollment that occurs once a year, or in the event that the member ceases to meet the eligibility requirements as defined in this document or the Group Operating Agreement, by giving written notice to the Plan and the Remitting Agent.
- 11.11 Benefits for any authorized inpatient admission to a Hospital or skilled nursing facility that began prior to the effective date of termination will be provided only until the last day of coverage.

## ARTICLE XII. CONTINUATION COVERAGE AND CONVERSION

- 12.01 CONTINUATION OF GROUP COVERAGE OPTION
- (1) A Member may be entitled under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue his/her coverage under this Certificate by making periodic payments directly to his/her Group. Subject to its terms and conditions, and timely payment, this Certificate shall be continued for such members for a maximum of eighteen (18) months from the date of termination of employment or thirty-six (36) months from the date of death, divorce or loss of Dependent status, or until the continuation of Coverage is no longer available through the Group.
- (2) Upon election to continue coverage for 18 months or 36 months, payment shall be made by the member to the Remitting Agent who shall pay the Plan in advance at the rate and in accordance with the frequency schedule established by the Plan, unless otherwise agreed to by the Plan in writing. If the Premium is not received within thirty-one (31) days of the due

date, this Certificate may terminate without notice. If this Certificate is terminated, the Plan reserves the right to recover from the Group the cost of services rendered during the period following the due date.

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

#### 12.02 CONVERSION OPTION

- (1) A member who loses eligibility for Coverage under this Certificate as a Group member, for other than his/her violation of this Certificate, is entitled to convert this Certificate to an individual Contract by making Application within thirty (30) days of receiving notification of the event which made the Member ineligible for Group coverage. Evidence of good health will not be required by the Plan in order exercise this conversion option.
- (2) Individual Coverage will be of the type currently being offered by Total Health Care USA, and may not be identical to the health care benefits provided by this Group Certificate.
- (3) If a Member fails to make timely payment to the Plan, the Member's coverage under the Individual Contract will be subject to termination in accordance with the terms of the Contract.

NOTES:

NOTES:



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