HealthChoice Program Handbook and Subscriber Certificate

Effective January 1, 2011

Dear Member:

Thank you for choosing HealthChoice of Michigan, also referred to as HealthChoice; the right choice for your health care coverage. HealthChoice is committed to making affordable health coverage a reality.

HealthChoice is incorporated under the Michigan Municipal Health Facilities Corporation Act. This booklet contains both the HealthChoice Program Handbook and the HealthChoice Subscriber Certificate of Eligibility. While the Program Handbook and Subscriber Certificate are two separate documents, they have been combined in one booklet for your convenience.

The Program Handbook makes up the first half of this booklet. We have designed the Program Handbook to give you a better understanding of how you access care, various legal rights, and Program administrative matters. When properly completed by your employer, it also serves as a Summary Plan Description under ERISA, if required.

The second half of this booklet contains the Subscriber Certificate of Eligibility, which is your new contract. The Subscriber Certificate details covered health care services ("Covered Services") provided for persons who are eligible and have enrolled as HealthChoice Members. By enrolling in HealthChoice, a Group and its Members agree to abide by the contract and recognize that, upon receipt of the premium payment, HealthChoice is responsible for arranging for only those services and benefits that are Basic Covered Services or, if selected for you, Supplemental Covered Services under your contract, subject to all exclusions and limitations set forth herein.

If after reading the Program Handbook and Subscriber Certificate you have further questions, please contact 1-800-WELL-NOW or 1-866-896-3450 and our staff will be happy to assist you.

ABOUT YOUR PROGRAM HANDBOOK AND SUBSCRIBER CERTIFICATE

The Program Handbook is designed to help you access HealthChoice's covered benefits, referred to as "Covered Services". The Program Handbook is **not** a legal contract. The Subscriber Certificate of Eligibility and any amendments and riders thereto, along with your Subscriber Application Form and the Group Operating Agreement, which are attached as appendices to the Handbook, contain the specific provisions and limitations of your coverage and constitute your contract with HealthChoice of Michigan.

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I.

SUMMARY INFORMATION
(to be completed by employer)

A. PROGRAM INFORMATION:

Name of Program:	________________________________ (Employer Name Group Health Care Program)
Common Names of Program:	**The Program** **HealthChoice**
Address of Program:	________________________________ (Employer Street Address) ________________________________ (Employer Street Address) ________________________________ (Employer City, State, Zip)
Program Number:	________________________________
Type of Program:	**Group Health Care Program**

B. Parties Involved:

ERISA Plan Administrator: (If Group is subject to ERISA)	________________________________ (Employer Name) ________________________________ (Taxpayer ID Number) ________________________________ (Employer Street Address) ________________________________ (Employer Street Address) ________________________________ (Employer City, State, Zip) ________________________________ (Employer Telephone Number)

Managed Care Provider:	___________________________________ (Provider Name) ___________________________________ (Provider Address) ___________________________________ (Provider City, State, Zip)
Municipal Health Facilities Corporation Program Coordinator:	**HealthChoice of Michigan** **640 Temple, Suite 370** **Detroit, MI 48201**
Service of Process:	___________________________________ (Employer Human Resources Director's Name) ___________________________________ (Employer Street Address) ___________________________________ (Employer Street Address) ___________________________________ (Employer City, State, Zip)
The Only Employer Sponsoring This ERISA Plan Is:	___________________________________ (Employer Name)

C. Participation and Benefits:

Participation Requirements:	See Subscriber Certificate requirements, including but not limited to working a minimum of twenty (20) hours per week for at least twelve consecutive weeks and not being covered by any other health care coverage.
Benefits Requirements:	Continued employment of a minimum of twenty (20) hours per week and payment of premium.
Circumstances That May Result in Disqualification, Ineligibility, Denial of	Termination of employment; Reduction of hours to less than twenty (20) hours per week; Failure to pay premium by employee or employer or

Benefits or Loss of Benefits:	HealthChoice; Late payment of premium by employee or employer; Eligibility for other employer-sponsored coverage. Please refer to Subscriber Certificate for a complete list.
Circumstances That May Result In Discontinuation of Subsidy	Employer fails to maintain principal place of business in Wayne County; Hourly rate of pay increases to $14.51 or higher.
Summary of Benefits:	See Subscriber Certificate. A detailed schedule of benefits is available without cost.
Amendment of Benefits:	Benefits may be amended upon thirty (30) days' written notice by HealthChoice.
Elimination of Benefits:	Benefits may be eliminated upon thirty (30) days' written notice by the employer or HealthChoice.

D. **Program Finances:**

Source of Contributions:	Employee contribution (premium) Employer contribution If eligible, HealthChoice subsidy
Organization Through Which Benefits Are Provided:	Managed Care Provider
Method of Calculation:	Contribution amounts are determined by the HealthChoice Board of Trustees and are subject to the availability of subsidy funds.
Cost Sharing Provisions:	See Subscriber Certificate. You are financially responsible for deductibles, co-insurance and co-payment amounts.
Annual or Lifetime Caps:	See Subscriber Certificate.
Preventive Services:	See Subscriber Certificate.
Drug Coverage:	See Subscriber Certificate.
Medical Expense Coverage:	See Subscriber Certificate.
Managed Care Provider Network	See Subscriber Certificate.

Services Outside of Managed Care Provider Network:	See Subscriber Certificate.
Selection of Primary Care Provider:	See Subscriber Certificate.
Emergency Medical Care:	See Subscriber Certificate.
Preauthorization Conditions:	See Subscriber Certificate.
Participating Providers:	See Subscriber Certificate.
Non-Participating Providers:	See Subscriber Certificate.
Urgent Care Facility Services	See Subscriber Certificate.

E. **Termination of Program:**

Amendment:	The program may be amended upon thirty (30) days' written notice by HealthChoice.
Termination:	The program may be terminated upon thirty (30) days' written notice by the Employer or HealthChoice.
Benefits:	Benefits end on effective date of termination.
Rights:	Your rights to benefits for Covered Services continue only for Covered Services provided before the Program termination date.
Obligations:	You are responsible for all co-pays and non-covered medical expenses incurred before termination. Your obligation to pay health care premiums ends on the effective date of termination.

Continued Coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

This section on COBRA does not apply to small Employers (with fewer than 20 employees), government employers, and church plans.

Carrying out the requirements of COBRA is the direct responsibility of the plan administrator, which is your Employer. HealthChoice does not assume any of the obligations assigned by COBRA to your employer or any other employer.

COBRA Rights:	Upon termination of employment, you may have rights to continue your health care coverage in most circumstances. Your Employer is responsible for determining your eligibility for COBRA coverage and sending out all required COBRA notifications, including notifying HealthChoice of your enrollment for COBRA coverage.
COBRA Obligations:	In order to continue your health care coverage under COBRA, you must complete a COBRA enrollment form, timely deliver the form to your employer, and timely deliver your premium payment which must clear your financial institution without any reason for return.
Qualifying Events:	Death of covered employee; Termination of employment; Reduction of hours of employment; Divorce or legal separation; Disability; Dependent child ceasing to be a dependent; Employee enrollment in Medicare.
Qualified Beneficiaries:	Spouse of covered employee. Dependent child of employee.
Premiums:	Employee pays 100% of Premium.
Notice Requirements:	Notice of the COBRA Election Form is to be given to Qualified Beneficiaries by the Employer.
Election Requirements:	Election must be made within sixty (60) days of receipt of the COBRA Election Form.

Election Procedures:	Submit the Application/Change Form and all premium payments in a timely manner.
Duration of Coverage:	Up to 18 months for employee. Up to 29 months for disability. Up to 36 months for eligible dependent.

Administration of Plan:

Program Year Ends On:	December 31st
Program Records Are Kept On:	A Calendar year basis
Type of Administration:	Third Party Contract Administration and Program Administration

Claims Procedure:

Payment of Claims:	The Managed Care Provider is responsible for payment of covered claims.

Required ERISA Plan Statements:

1. A complete list of the employers and employee organizations sponsoring the ERISA Plan may be obtained upon written request to the ERISA Plan Administrator and is available for examination.

2. You may receive from the ERISA Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the ERISA Plan and, if the employer or employee organization is a plan sponsor, the employer is the primary plan administrator contact.

3. Service of legal process may be made upon the ERISA Plan Administrator at:

   HealthChoice of Michigan
   640 Temple, Suite 370
   Detroit, Michigan 48201

4. You may receive from the ERISA Plan Administrator, upon written request, a copy of the procedures governing qualified medical child support order (QMCSO) determinations.

5. Provider network lists are furnished automatically, without charge, as a separate document.

II.

IDENTIFICATION CARD

Your Identification Card is your key to receiving quality health care and must be presented by the Member to the Participating Provider when covered services are requested. Other photo identification may also be required. Eligible dependent children will not receive an identification card; and will be required to present the identification card of the subscriber or spouse of the subscriber when covered services are requested.

The Identification Card shows:

NAME	The name of the Subscriber/Member eligible for health care benefits.
MEMBER NUMBER	The number that identifies the Member in the Managed Care Provider network.
GROUP NUMBER	Identifies your employer group.
SEX	Indicates the gender (male or female) of the Member.
DATE OF BIRTH	The date of birth (Month/Day/Year) of the Member.
BENEFIT CODE	Indicates your Covered Services including any Supplemental Covered Services.
EFFECTIVE DATE	The date your coverage will begin.
REPLACEMENT CARDS	If your card is lost or stolen, you must call the HealthChoice Customer Service Office immediately at 1-800-WELL-NOW. Failure to notify HealthChoice of a lost or stolen card could result in your termination from the program.

A new card will be sent to you automatically when you inform HealthChoice that you have changed your name.

PREVENTING FRAUD

HealthChoice tries to prevent fraudulent use of your Identification Card. Only the Member listed on your Identification Card and your eligible dependent children are covered for services.

A participating provider of medical services may ask for identification in addition to your HealthChoice Identification Card, such as a passport, driver's license or state identification card. Checking the identification of the cardholder is one way of preventing unauthorized use of your Identification Card.

ASSIGNMENT OR TRANSFER

Assignment or transfer of Identification Card is prohibited.

If you think someone is using your Identification Card illegally, or that you are being billed for services you did not receive, call our Customer Service Number at 1-800-WELL-NOW. *Your call is strictly confidential.* Or, you may write:

HealthChoice of Michigan
640 Temple, Suite 370
Detroit, Michigan 48201

Remember to include your Group and Subscriber numbers in all correspondence.

III.

MEMBER CHANGES

ADDITION OF NEW DEPENDENTS

In order for your new dependents to be covered by HealthChoice you must notify your employer and complete a Subscriber Application/Change Form, obtained from your employer, upon the occurrence of any event which may increase the number of your dependents. You must enroll your new dependents for HealthChoice coverage in the thirty (30) days after the person became qualified to be enrolled as an eligible dependent (i.e., within thirty (30) days of the "qualifying event") or you will be required to wait until the next open enrollment period, which will impact the effective date of coverage. You will be required to show that dependent children under the age of 18 have applied for enrollment in the State of Michigan's MIChild program before enrolling them for HealthChoice coverage. If your dependent child(ren) are eligible and enrolled in MIChild, HealthChoice will pay the monthly MIChild premium upon receipt of the invoices from you. HealthChoice reserves the right to discontinue payment of MIChild premiums at any time, for any reason.

Your monthly premium charges will change with this action. (See Subscriber Certificate of Eligibility).

DELETION OF DEPENDENTS

If you decide to remove a dependent from HealthChoice coverage or if a person you have had covered as a dependent no longer qualifies as an eligible dependent, you must notify your employer and fill out a Subscriber Application/Change Form.* A copy of the Subscriber Application/Change form is included in the Administrative Forms section of this Program Handbook.

Once a dependent child reaches age 26, you must notify your employer promptly to remove that dependent. When deleting a spouse or child who no

longer meets applicable eligibility requirements, the effective coverage disenrollment date (assuming no rights to extend under COBRA) will be the first day of the month following the last day you were required to notify your employer of this change in status.

Ineligibility may occur due to divorce or legal separation, marriage of a child or death of a dependent. (See Subscriber Certificate of Eligibility).

*You are required to inform your employer within 30 days of any change in status of a person who had previously been qualified to enroll with HealthChoice as your eligible dependent. If HealthChoice is notified more than 30 days after the date of the event, the change to your contract cannot be made and must be submitted at the next open enrollment period. Please remember to report any membership changes to your employer promptly so these changes can be reflected on your records. If you fail to notify HealthChoice within 30 days of any change in status, you will be liable for any payments made by HealthChoice on behalf of your dependents for medical services that have been provided subsequent to the date of the event.

ADDRESS AND OTHER CHANGES

If you change your address, or if your address is incorrect, please notify your employer and fill out a Subscriber Application/Change Form promptly. This will ensure that you will continue to receive correspondence from HealthChoice.

IV.

SUBSCRIBER/MEMBER RIGHTS AND RESPONSIBILITIES

A) It is the Subscriber's responsibility to notify the Employer of any changes in principal residence by submission of a Subscriber/Application Change form.

B) It is the Subscriber/Member's responsibility to present his/her Identification Card (and any other requested identification) to Participating Providers when receiving covered services by their Provider.

C) It is the Subscriber/Member's responsibility to immediately report theft or loss of any Identification Card.

D) It is the Subscriber/Member's responsibility to follow HealthChoice rules and regulations as noted in this Program Handbook and Subscriber Certificate of Eligibility.

E) It is the Subscriber/Member's responsibility to provide HealthChoice with accurate and timely information concerning changes to his/her eligibility and the eligibility of any enrolled dependent.

F) The Subscriber/Member may not assign any of his/her rights or responsibilities under their Subscriber Certificate of Eligibility, including but not limited to the right to receive covered services.

V.

EMPLOYER/GROUP RESPONSIBILITIES

A) It is the Employer/Group's responsibility to timely pay premiums to HealthChoice.

B) It is the Employer/Group's responsibility to comply with the requirements of COBRA. The Program does not assume any of the obligations assigned by COBRA to the Employer/Group or any other employer.

C) The Employer/Group shall notify the Program of any change in the status of the Group affecting the Group's ability to have its employees enroll as Subscribers and of any change in the status of the Subscriber affecting such Subscriber's eligibility to participate in the HealthChoice Program, including but not limited to the number of Subscribers, location of the Group's principal place of business, Subscriber residency changes, and a Subscriber's reduction in hours to less than 20 hours a week.

VI.

COVERAGE WHEN TRAVELING

Remember to carry your HealthChoice Identification Card with you at all times. In case of emergency, please follow the instructions on the back of your Identification Card. Emergency Medical Care is **not** fully covered if provided by a Non-Participating Provider, and different coverage rates apply depending on whether the services are provided by a Non-Participating Provider inside or outside of Wayne, Oakland, Macomb, Washtenaw or Monroe Counties. See Subscriber Certificate for Emergency Medical Care coverage. A Member's coverage does not include emergency services for obstetrical care outside of Wayne, Oakland, Macomb, Washtenaw or Monroe Counties within 4 weeks of the Member's due date.

VII.

CLAIMS PROCESSING

Your assigned Managed Care Provider will pay approved claims for Covered Services to participating physicians, hospitals and other providers at an amount determined by agreement between the Managed Care Provider and each participating physician, hospital and other providers.

Participating providers have agreed to accept the approved amount as payment in full. You are responsible for any deductibles or co-payments that may apply as outlined in your Subscriber Certificate of Eligibility.

You do not need to complete any claim forms. All claims are processed by the Managed Care Provider. Should you receive any billings, please call your Managed Care Provider for further instructions.

If a claim for payment of a medical bill is rejected and you disagree with the rejection, follow these procedures:

1) Immediately contact your Managed Care Provider to discuss your medical claim with one of their representatives. Generally, a satisfactory resolution can be achieved in this manner. If the issue cannot be resolved informally, you may submit an appeal to your Managed Care Provider within 60 days after receipt of the denial. Any appeals submitted later than 60 days after receipt of the denial will be denied as untimely and you will be responsible for the cost of the care.

2) Within 45 days after receipt of a denial from your Managed Care Provider, you may appeal in writing to the Executive Director of HealthChoice. Any appeals submitted to the Executive Director later than 45 days after receipt of the denial will be denied as untimely and you will be responsible for the cost of the care.

3) If your questions are not resolved, and your claim is denied, you may appeal to HealthChoice Board of Trustees within 30 days of receipt of the denial from the Executive Director of HealthChoice. You will be notified of the Board's decision within 15 days of the next Board meeting. The decision of the HealthChoice Board of Trustees is final. Any appeals submitted to the HealthChoice Board of Trustees later than 30 days after receipt of denial from the Executive Director of HealthChoice will be denied as untimely and you will be responsible for the cost of the care.

All claims must be presented for payment within one year of the date of services. Otherwise, you will be responsible for the cost of such care.

VIII.

SUBSCRIBER'S FINANCIAL RESPONSIBILITY

It is your responsibility to verify that the Provider of services is a HealthChoice Participating Provider before using the Provider's services. When you use the services of a Participating Provider, you will be charged only for deductibles or co-payments (where required by your contract) and for services and supplies that are not covered by your contract. Refer to your Subscriber Certificate of Eligibility for more specific information.

If you use the services of a non-participating provider without obtaining prior written authorization from your Managed Care Provider, you may be responsible for charges related to the services. You may be responsible for additional charges related to emergency care from nonparticipating physicians, hospitals and other providers located outside of Wayne, Oakland, Macomb, Washtenaw or Monroe Counties. If you receive non-emergency care or services from a nonparticipating provider without prior approval of your Managed Care Provider, you will be responsible for the cost of that care.

IX.

CUSTOMER SERVICE

You may phone or write HealthChoice.

TO PHONE: HealthChoice Customer Service
lines are open for calls between the hours of
8:00 a.m. and 5:00 p.m., Monday thru Friday.

Please have your Identification Card with
your Group and Member numbers ready
when you call:
1-800-WELL-NOW

TO WRITE: Send your inquiries to the following:
HealthChoice of Michigan
640 Temple, Suite 370
Detroit, Michigan 48201

Always include your Group and Member numbers in your correspondence. It is also helpful if you include a daytime telephone number.

We hope that this Program Handbook has helped you understand the details of your health care coverage.

HealthChoice will do everything possible to provide you with the best health care and personal satisfaction.

Please refer to the Subscriber Certificate of Eligibility, Section XI, for details regarding HealthChoice term of contract, member rights and responsibilities, basic covered services and definitions, supplemental covered services, co-payment information, exclusions from coverage, and coordination of benefits.

X.

NOTICES

ERISA Notice

As a participant in ________________________ Group Health Care Plan you are entitled to
(Employer Name)
certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your continuation of coverage rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Reduction or elimination of exclusionary period of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Model COBRA Continuation Coverage Election Notice

(For use by Single-Employer Group Health Plans)

______________[*Enter date of notice*]

Dear ______________________[*Identify the qualified beneficiary(ies), by name or status*]:

This notice contains important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan). Please read the information contained in this notice very carefully. If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact ____________________ [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us at the address shown on the Election Form. The completed Election Form must be post-marked [or received by if submitted by other means].

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [*enter date*] due to [*check appropriate box*]:

[ ] End of employment
[ ] Death of employee
[ ] Entitlement to Medicare
[ ] Reduction in hours of employment
[ ] Divorce or legal separation
[ ] Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [*enter* 18 *or* 36*, as appropriate and check appropriate box or boxes; names may be added*]:

[ ] Employee or former employee
[ ] Spouse or former spouse
[ ] Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
[ ] Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on ___________[*enter date*] and can last until ____________[*enter date*]. [*Add, if appropriate:* You may elect any of the following options for COBRA continuation coverage: [*list available coverage options*].

COBRA continuation coverage will cost: ___________[*enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.*] You do not have to send any payment with the Election Form.

Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [*Enter Name and Address*]

The Election Form must be completed and return by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

I (We) elect COBRA continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	Social Security No. (or other identifier)	Coverage Option Elected
a.________	________	________	________	________
b.________	________	________	________	________
c.________	________	________	________	________
d.________	________	________	________	________

________________________________ ________________________________
Signature Date

________________________________ ________________________________
Print Name Relationship to individual(s) listed above

____

________________________________ ________________________________
Print Address Telephone number

If you do not submit a completed election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [*add if applicable:* open enrollment and] special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[*If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:*]

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.*] Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First,

you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

[*If employees might be eligible for trade adjustment assistance, the following information may be added*: The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full within those 45 days, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact [*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the [*enter due day for each monthly payment*] for that coverage period. [*If Plan offers other payment schedules, enter with appropriate dates:* You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [*select one:* will *or* will not] send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period [*or enter longer period permitted by Plan*] to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. [*If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:* However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[*enter appropriate payment address*]

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights Under the Women's Health and Cancer Rights Act of 1998

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for--

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

As of January 31, 2011, Michigan does not offer a premium assistance program. To see if Michigan has added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

HEALTHCARE REFORM NOTICES

Important Notices. Please Read.

The newly enacted federal health reform laws provided under the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act, require HealthChoice of Michigan to provide you with certain notices. These important notices are found below.

Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in HealthChoice. Individuals may request enrollment for such children for thirty (30) days from the date of notice or through the end of the annual open enrollment period, whichever comes later. Enrollment will be effective on January 1, 2011. For more information contact HealthChoice at 1-800-935-5669.

Right to Choose a Primary Care Provider

HealthChoice generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network of the Managed Care Provider you select during open enrollment (CCA, Midwest or ProCare) and who is available to accept you or your family members. Until you make this designation, your Managed Care Provider designates a primary care provider for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, refer to the HealthChoice Subscriber Certificate or contact your Managed Care Provider: CCA, 1-866-323-3224, Midwest, 1-888-654-3300, or ProCare, 1-866-776-0891.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from HealthChoice or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your Managed Care Provider's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Managed Care Provider.

Grandfathered Health Plan

HealthChoice believes its plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for

example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to HealthChoice, 1-800-935-5669. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTICE OF PRIVACY PRACTICES

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.

This notice is required under the Health Insurance Portability and Accountability Act ("HIPAA"). This is your Notice of Privacy Practices from HealthChoice of Michigan. You have received this notice because of your medical benefits from HealthChoice. This notice describes how we protect the individually identifiable health information we have about you ("Protected Health Information") and how we may use and disclose this information. Protected Health Information includes information that relates to your past, present, or future health, treatment, or payment for health care services. This notice also describes your rights with respect to the Protected Health Information and how you can exercise those rights.

We are required by law to:

- Maintain the privacy of your Protected Health Information;
- Provide you this notice of our legal duties and privacy practices with respect to your Protected Health Information; and
- Follow the terms of this notice.

We protect your Protected Health Information from inappropriate use or disclosure. Our employees, and those companies that help us service your Medical Benefits, are required to protect the confidentiality of your Protected Health Information.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

In some circumstances, the law allows us to use or disclose your Protected Health Information without asking for your authorization in advance or giving you an opportunity to object. These circumstances include:

- **For Payment:** We may use and disclose Protected Health Information to pay for benefits under your medical plan. For example, we may review Protected Health Information contained on claims to reimburse providers for services rendered.
- **For Treatment:** We may use and disclose Protected Health Information to health care workers who are part of your medical care. For example, we may disclose Protected Health Information to create and carry out a treatment plan.

- **For Health Care Operations:** We may also use and disclose Protected Health Information for our Medical plan operations. These purposes include evaluating a request for medical plan products or services, administering those products or services, and processing transactions requested by you.

- **As Required by Law:** We will disclose Protected Health Information about you when required to so by federal, state, or local law. These include (i) for judicial and administrative proceedings pursuant to legal authority; (ii) to report information related to victims of abuse, neglect or domestic violence; and (iii) to assist law enforcement officials in their law enforcement duties.

- **Public Health Risks:** We may disclose Protected Health Information about you for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability.

- **Health Oversight Activities:** We may disclose Protected Health Information about you for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability.

- **Medical Examiners and Funeral Directors:** We may release Protected Health Information to a funeral director or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

- **To Avert a Serious Threat to Health or Safety:** We may disclose Protected Health Information to avert a serious threat to your health and safety or the health and safety of the public or another person pursuant to law.

- **For Health-Related Benefits or Services:** We may use Protected Health Information to provide you with information about benefits available to you under your current Medical Benefits Plan and about health-related products or services that may be of interest to you.

- **Specific Government Functions:** We may use and disclose Protected Health Information for specialized government functions such as protection of public officials or reporting to various branches of the armed services. We may disclose Protected Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Individuals Involved in Your Care or Payment for Your Care:** We will disclose relevant Protected Health Information to family members and close personal friends who are involved in your care or the payment for your care, if you have agreed to the disclosure, have been given an opportunity to object and have not objected, or under circumstances in which we determine in the exercise of professional judgment that the disclosure is in your best interest. The Protected Health Information disclosed should be only that which is directly relevant to the friend or family member's involvement in your health care.

- **Organ and Tissue Donation:** If you are an organ donor, we may release Protected Health Information about you to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes or tissues.

- **Workers' Compensation:** We may disclose Protected Health Information to workers' compensation insurers, State administrators, employers, and other persons or entities involved in the workers' compensation system: (1) to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness; (2) to the extent disclosure is required by State or other law; and/or (3) for purposes of obtaining payment for any health care provided for work-related injuries or illness.

- **Inmates:** We may disclose Protected Health Information about you to the correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of a law enforcement official.

- **To the Federal Department of Health and Human Services ("DHHS"):** Under the privacy standards, we must disclose Protected Health Information to the Secretary of DHHS as necessary for them to determine our compliance with those standards.

- **To Our Business Associates:** We may disclose Protected Health Information with our Business Associates. Business associates are third parties under contract to perform services for us. We will have an agreement with that third party to protect the privacy and security of your Protected Health Information. For example, we may share your Protected Health Information with business associates who process claims for us.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of Protected Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If you or your legal representative authorize us to use or disclose Protected Health Information about you, you or your legal representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Medical Benefits. You should understand that we would not be able to take back any disclosures we have already made with the authorization. To revoke your authorization, you or your legal representative must send a written revocation to the HIPAA Privacy Officer at the address listed below.

YOUR RIGHTS REGARDING THE PROTECTED HEALTH INFORMATION WE MAINTAIN ABOUT YOU

The following are your various rights as a consumer under HIPAA concerning your protected Health Information. Should you have questions about a specific right, please write to the HIPAA Privacy Officer at the address listed below.

- **Right to Inspect and Copy Your Protected Health Information:** In most cases, you may inspect and obtain a copy of the Protected Health Information that we maintain about you. If your Protected Health Information is maintained in an electronic health record, you have the right to receive a copy of that Protected Health Information in electronic format. To arrange for access or a copy of your Protected Health Information, you should submit a request in writing to the Privacy Officer identified on below. Certain types of Protected Health Information will not be made available for inspection and copying. This includes psychotherapy notes; Protected Health Information collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding; information subject to the Clinical Laboratory Improvements Amendments of 1988 to the extent giving you access is prohibited by law; and information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information. If we deny you access, we will explain why and what your rights are, including whether review of the decision is available and how to seek review. We will comply with the outcome of a review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.

- **Right to Amend/Correct Your Protected Health Information:** If you believe that your Protected Health Information is incorrect or that an important part of it is missing, you have the right to request that we amend your Protected Health Information kept in our records. You must provide your request and your reason for the request in writing, and submit it to the HIPAA Privacy Officer identified below. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Protected Health Information that:

    - is accurate and complete;
    - was not created by us, unless the person or entity that created the Protected Health Information is no longer available to make the amendment;
    - is not part of the Protected Health Information kept by or for us; or
    - is not part of the Protected Health Information which you would be permitted to inspect and copy.

  If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

- **Right to an Accounting of Disclosures:** You may request a list providing an accounting of the disclosures we have made of Protected Health Information about you. This list will only include certain disclosures. For example, it will not include disclosures made for treatment, payment, or health care operations, for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. If your Protected Health Information is maintained in an electronic format, disclosures made for treatment, payment and health care operations that were made via that electronic health record will be included. However, the time frame for such an accounting is three years. To request this list, you must submit your request in writing to the HIPAA Privacy Officer identified below. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than 6 years and may not include dates before April 13, 2003. Your request should indicate in what form you want the list (example, on paper or electronically). The list must be provided to you within 60 days of receipt of your request. The first list you request within a 12 month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You may request a restriction or limitation on Protected Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. Health care operations consist of activities necessary to carry out our Medical Plan operations. While we will consider your request, we are not required to agree to it. We must approve requested restrictions on disclosures of Protected Health Information about an individual if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for treatment purposes), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved was paid out of pocket in full. If we do agree to it, we will comply with your request until you request otherwise or we give your advance notice. To request a restriction, you must make your request in writing to the HIPAA Privacy Office identified below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Protected Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications:** You may request us to communicate with you regarding your Protected Health Information in a certain way or at a certain location, if you tell us that the disclosure of all or part of that information could endanger you. We will accommodate reasonable requests that you make.

- **Right to Receive a Paper Copy of this Notice upon Request:** You have the right to obtain a paper copy of this notice, and may do so by contacting the HIPAA Privacy Officer listed at the end of this notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the DHHS. To file a complaint with us, please contact the HIPAA Privacy Officer at the address provided below. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

RIGHT TO CHANGE OUR PRIVACY PRACTICES

We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Protected Health Information we already have about you as well as any Protected Health Information we receive in the future. You can locate the effective date of this and any revised notice on the first page in the top right hand corner. If we make a material change to this notice you will receive a copy of the revised notice from us within 60 days of the revision.

CONTACTING US ABOUT DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Please direct all inquires, requests for records, requests to revoke a previously signed authorization, requests for copies of our Notice of Privacy Practices, complaints, or concerns to the individual(s) identified below. Bear in mind that any complaint of a violation of your rights under the HIPAA Privacy Rules must be sent in writing to the HIPAA Privacy Officer identified below.

HIPAA Privacy Officer
640 Temple, Suite 370
Detroit, MI 48201
(313) 833-4780

You may file a complaint with the Federal Government at the U.S. Office of Civil Rights:

Medical Privacy, Complain Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington D.C. 20201
(866) 627-7748

Email: OCRMail@hhs.gov

WEBSITES PROVIDING ADDITIONAL INFORMATION

HEALTHCARE REFORM:	
Consumer Information on Health Plans	http://www.dol.gov/ebsa/consumer_info_health.html
Your HealthCare Explained	http://www.healthcare.gov/?gclid=CK7vhfe286UCFcbsKgodqUrLnw
ERISA:	
Workers' Right to Health Plan Information	http://www.dol.gov/ebsa/newsroom/fserisa.html
HIPAA:	
"Your Health Plan and HIPAA ... Making The Law Work For You"	http://www.dol.gov/ebsa/publications/yhphipaa.html
Medical Privacy - National Standards to Protect the Privacy of Personal Health Information (general website)	http://www.hhs.gov/ocr/hipaa/
Fact Sheet	http://www.dol.gov/ebsa/newsroom/fshipaa.html

COBRA:

"An Employer's Guide to Group Health Continuation Coverage Under COBRA - The Consolidated Omnibus Reconciliation Act of 1986"	http://www.dol.gov/ebsa/pdf/cobraemployer.pdf
Fact Sheet	http://www.dol.gov/ebsa/newsroom/fscobra.html

The Newborns And Mother's Health Protection Act Of 1996:

Protections for Newborns, Adopted Children, New Parents	http://www.dol.gov/ebsa/publications/newborns.html
Fact Sheet	http://www.dol.gov/ebsa/newsroom/fsnmhafs.html

Women's Health and Cancer Rights Act:

"Your Rights After a Mastectomy . . . Women's Health and Cancer Rights Act of 1998"	http://www.dol.gov/ebsa/publications/whcra.html
Fact Sheet	http://www.dol.gov/ebsa/newsroom/fswhcra.html

XI.

ADMINISTRATIVE FORMS

1. Subscriber Application /Change Form
2. Group Operating Agreement – Medical (Form GAO-2)
3. Group Operating Agreement – Dental and Vision Rider
4. COBRA Continuation Coverage Election Form
5. Request For Certificate of Health Insurance
6. Certificate of Group Health Plan Coverage (with statement of HIPAA Portability Rights)

Wayne County's
HEALTHCHOICE
640 Temple #370
Detroit, MI 48201
1-800-935-5669
HEALTHCHOICE OF MICHIGAN

CHECK ONE:
Original Subscriber Application ❑
Change Form ❑
Term ❑

PRINT ONLY

SUBSCRIBER APPLICATION /CHANGE FORM

SOCIAL SECURITY #	BIRTH DATE	SEX MALE ❑ FEMALE ❑	AREA CODE	HOME PHONE#
LAST NAME	FIRST NAME	MIDDLE INITIAL	AREA CODE	BUSINESS PHONE#
ADDRESS	APT#	CITY	COUNTY	STATE	ZIP CODE

DO YOU HAVE OTHER MEDICAL COVERAGE? YES❑ NO❑	COVERAGE /INSURANCE NAME	POLICY CONTRACT #
DOES YOUR DEPENDENT(S) HAVE MEDICAL COVERAGE? YES❑ NO❑	COVERAGE /INSURANCE NAME	POLICY CONTRACT #

MARITAL STATUS: SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑

DATE OF HIRE

PLEASE LIST THE NAMES OF ELIGIBLE DEPENDENTS TO BE COVERED (SEE REVERSE SIDE FOR DEPENDENT CRITERIA)

#						
1.	LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTH DATE	
	SOCIAL SECURITY #	SEX	RELATION	AGE	MARITAL STATUS	FULL-TIME STUDENT
2.	LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTH DATE	
	SOCIAL SECURITY #	SEX	RELATION	AGE	MARITAL STATUS	FULL-TIME STUDENT
3.	LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTH DATE	
	SOCIAL SECURITY #	SEX	RELATION	AGE	MARITAL STATUS	FULL-TIME STUDENT
4.	LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTH DATE	
	SOCIAL SECURITY #	SEX	RELATION	AGE	MARITAL STATUS	FULL-TIME STUDENT

ADDITIONAL ELIGIBLE DEPENDENTS LISTED ON SEPARATE SHEET YES❑ NO❑

FOR CHANGE FORM PURPOSES ONLY

DEPENDENT
ADDITION (Date of Event)________________________ MARRIAGE ❑ NEWBORN ❑ PRINCIPLE SUPPORT ❑ ADOPTION / LEGAL GUARDIANSHIP ❑

DELETION (Date of Event)________________________ DIVORCE ❑ DEATH ❑ OTHER ❑

DO YOU OR ANY OF YOUR DEPENDENTS HAVE A PRE-EXISTING CONDITION(S) LISTED ON THE BACK? YES❑ NO❑
WHO?____
LIST PRE-EXISTING CONDITIONS ____
PLEASE ATTACH CERTIFICATE OF CREDITABLE COVERAGE FROM PRIOR PLAN OR DEMONSTRATE CREDITABLE COVERAGE (SEE SUBSCRIBER CERTIFICATE FOR EXPLANATION)

BY SIGNING BELOW, I ACKNOWLEDGE THAT: (1) I HAVE BEEN PROVIDED WITH A COPY OF THIS TWO PAGE FORM; (2) I HAVE READ, UNDERSTAND, AND AGREE TO THE CONDITIONS ON THE REVERSE SIDE OF THIS FORM; AND (3) I HAVE ATTACHED MY MOST RECENT PAY STUB.

APPLICANT S SIGNATURE ____ **DATE** ________________________

EMPLOYER APPLICATION

COMPANY NAME				FEDERAL ID#		
ADDRESS	CITY	STATE	ZIP CODE		AREA CODE	BUSINESS PHONE #
EMPLOYMENT STATUS ACTIVE ❑ COBRA ❑ IF COBRA, WAS ELIGIBILITY VERIFIED AND NOTICE PROVIDED TO EMPLOYEE? YES❑ NO❑						EMPLOYEE HOURS OF WORK PER WEEK
PROVIDER SELECTED COMMUNITY CARE ASSOCIATES ❑ MIDWEST ❑ PROCARE ❑						
GOLDEN DENTAL ❑					HERITAGE VISION ❑	

THE UNDERSIGNED REPRESENTS AND WARRANTS THAT: (1) HE /SHE HAS BEEN AUTHORIZED TO EXECUTE THIS SUBSCRIBER APPLICATION AND MAKE THE FOREGOING CERTIFICATIONS ON BEHALF OF THE EMPLOYER; (2) HE /SHE HAS BEEN PROVIDED WITH A COPY OF THIS TWO PAGE FORM; AND (3) HE /SHE HAS READ, UNDERSTANDS, AND AGREES TO THE CONDITIONS ON THE REVERSE SIDE OF THIS FORM.

EMPLOYER S SIGNATURE____ **DATE**________________________

FOR OFFICIAL USE ONLY **ID#**________________ **GROUP #**________________ **EFFECTIVE DATE**________________

SUBSCRIBER CERTIFICATION OF ELIGIBILITY

By submission of this Subscriber Application, I am applying for Basic Services specified in my Subscriber Certificate of Eligibility with HealthChoice of Michigan and any amendments thereto (hereinafter

collectively referred to as "Subscriber Certificate") and for the selected Supplemental Services (also known as "riders"), as defined in my Subscriber Certificate of Eligibility with HealthChoice of Michigan.

I understand that all Supplemental Services elected have been elected for myself and all eligible dependents as defined in the Subscriber Certificate, and that I am responsible for paying the premium for the Supplemental Services in addition to the premium for Basic Services.

By submission of the Subscriber Application, I hereby certify that, to the best of my knowledge, I qualify as a Subscriber under the terms of the Subscriber Certificate by meeting all of the following criteria:
A) I am an employee of a qualified employer and have an anticipated work future of more than five (5) months.
B) I am currently without health care benefits and am not eligible, without regard to the availability of coverage, for Medicare, Medicaid or other employer sponsored health care coverage.
C) I am currently working at least 20 hours per week. I agree to notify HealthChoice if my hours are reduced to less than 20 hours per week for any reason at any time after enrollment.
D) My employer has not offered or contributed to health care benefits of employees in the same or similar job classification in which I am employed in the 65 day period immediately preceding the effective date of the Group Operating Agreement between my employer and HealthChoice of Michigan.
E) I am a resident of the State of Michigan as defined in the Subscriber Certificate, and I have accurately listed the County of my residence on the reverse side.
F) I have completed and signed this Subscriber Application for enrollment.

By submission of this Subscriber Application for an eligible dependent as defined in the Subscriber Certificate, I hereby certify that, to the best of my knowledge, each eligible dependent listed on this application qualifies as an eligible dependent under the terms of the Subscriber Certificate by meeting all of the following criteria:
(a)Be the spouse of the Subscriber who:
1. Qualifies for coverage, subject to verification of family income;
2. Is not serving in the Armed Forces of the United States;
3. Is without health care benefits at time of enrollment; and
4. Is not eligible, without regard to the scope of coverage, for Medicare, Medicaid or other employer-sponsored health benefit plan or program.
Or
(b) As defined as in Internal Revenue Code § 152 (f)(1), be a child of the Subscriber, which is defined as a son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the Subscriber until the child reaches the age of 26. An eligible foster child is an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adopted child includes both a legally adopted child of the Subscriber and a child who is lawfully placed with the Subscriber for legal adoption by the Subscriber. An adult child age 19 and over is not eligible for coverage if the adult child has another offer of employer-sponsored coverage.

By submission of this Subscriber Application to my employer, I hereby authorize my employer to deduct from my wages, as a payroll deduction, an amount not to exceed that portion of the monthly advance premium and any Supplemental Services selected for myself and eligible dependents that my employer may charge to me under the terms of the Subscriber Certificate of Eligibility.

I further certify that I have received and read the Subscriber Certificate, and I acknowledge that I have been advised that the Subscriber Certificate of Eligibility is available online at www.waynecountyhealthchoice.org. I understand that the Subscriber Certificate, any riders thereto and this Subscriber Application Form contain the specific provisions and limitations of my coverage and are my contract with HealthChoice of Michigan.

I appoint my employer as my agent to handle all matters of HealthChoice of Michigan coverage. I am responsible for giving notices of changes in my status and that of my family members, which affect coverage, to my employer. I authorize HealthChoice of Michigan to obtain hospital and medical records relating to me and my family from providers of service.

I have reviewed the Explanation of Pre-Existing Condition Limitations and have disclosed all pre-existing conditions for myself and my eligible dependents on the reverse side of this form. I understand that if I or my eligible dependents have been treated for an injury or illness within six (6) months prior to becoming eligible for benefits under the Subscriber Certificate, then all health care services incurred as a result of such injury or illness will not be considered as Covered Services until expiration of the maximum period authorized by state or federal law for a pre-existing condition limitation (as reduced by any period of creditable service or by other reductions required by law).

HealthChoice or its Managed Care Providers may require any person to verify their ineligibility for Medicaid or Medicare by completion and submission of an application for Medicaid or Medicare benefits as a part of the Subscriber Application for the person or at any time during the period a person is a Member. Refusal by a Member of request by the Program or its Managed Care Providers to complete and submit an application for Medicaid or Medicare benefits may result in termination of this Subscriber Certificate for the Member.

I represent and warrant that the information provided by me on this Subscriber Application is true, correct, and complete. I understand that if I falsify or withhold information requested by HealthChoice on the Subscriber Application, or as required under the Subscriber Certificate, including a refusal of a request by HealthChoice or its Managed Care Providers, I will be terminated from the Program immediately and coverage for myself and my eligible dependents will end as of the effective date of termination.

EMPLOYER CERTIFICATION
By execution of and submission of this Subscriber Application, the undersigned certifies, on behalf of the employer, that to the best of the employer's knowledge, the applicant qualifies as a Subscriber under the terms of the Subscriber Certificate, that all eligible dependents for whom coverage is sought by the Subscriber qualify as eligible dependents under the terms of the Subscriber Certificate and that the employer qualifies as a Group whose employees may enroll as Subscribers under the terms of the Subscriber Certificate by meeting the following criteria unless waived in writing by HealthChoice:
A) Have their principle place of business for global operations located in Wayne County.
B) At the time the Group enters into the Group Operating Agreement, the Group has two (2) or more employees who are otherwise eligible to enroll as Subscribers.
C) Including this Subscriber Application, the employer has submitted two (2) or more complete Subscriber Applications for employees who otherwise qualify as Subscribers and will have two (2) or more employees enrolled in the program.
D) At the time the Group enters into the Group Operating Agreement, not less than 50% of all employees have an hourly wage of fourteen dollars and fifty cents ($14.50) or less.
E) The employer has entered into a Group Operating Agreement with HealthChoice of Michigan.
If this form is being submitted for purposes of a Subscriber Change Form relating to COBRA coverage, employer certifies that it is responsible for determining employee's eligibility for COBRA coverage and sending out all required COBRA notifications. Employer agrees to indemnify and hold harmless HealthChoice of Michigan for all claims related to COBRA eligibility, notification and coverage.

GROUP OPERATING AGREEMENT BETWEEN
____(THE “GROUP”), #___________
HEALTHCHOICE OF MICHIGAN (THE “PROGRAM”) AND MANAGED CARE PROVIDER/CPE

The intent of this Agreement is to establish between the parties hereto the terms under which the Program will offer health care coverage to Eligible Employees of the Group (“Subscribers”) and their Eligible Dependents (collectively referred to as “Members”) by reference to the Program’s Subscriber Certificate of Eligibility, any amendments thereto, and any applicable riders (hereinafter collectively referred to as the “Subscriber Certificate”), and the underwriting and administrative requirements under which the Group is to operate.

The Group, the Program and the selected Managed Care Provider/CPE hereby agree:

1. This Agreement is effective only when a fully-executed copy of this Agreement that is approved by the Program’s Executive Director is returned to the Group. This Agreement is subject to and the Group agrees to comply with the terms of the Subscriber Certificate, the provisions of which are incorporated herein. The Group acknowledges that the Program has provided a copy of the Subscriber Certificate to the Group and all Subscribers.

2. Subject to the terms of the Subscriber Certificate, the Program will provide Covered Services to all Members as provided for in the Subscriber Certificate, including Covered Services to any individual who is required to be provided with and elects continuation coverage pursuant to the Comprehensive Omnibus Budget Reconciliation Act (COBRA).

3. The Group is at all times acting as agent for individuals who are enrolled as Members. Notification received from, or given to, such agent by the Program will fulfill all notice requirements of the Subscriber Certificate. The Group, at its own expense, agrees to provide any notification received from the Program to all of its Subscribers.

4. The Group agrees to prepay, on or before the Premium Payment Deadline, the monthly advance premiums calculated on the basis of and pursuant to the terms of the current Premium Rate Schedule for all Members, including Members entitled to continued services pursuant to Part XIII of the Subscriber Certificate. In its sole discretion, the Program may reduce or eliminate the credit provided to the Group by this Paragraph and agrees to notify the Group before the 15th day of each month if the credit is reduced or eliminated.

5. Covered Services described in the Subscriber Certificate will be offered by the Group to all individuals eligible under the terms of the Subscriber Certificate. The following Supplemental Covered Services are selected by the Group for all employees of the Group who enroll as Subscribers and their Eligible Dependents who are enrolled by the employee:

Physical Therapy (R/1) ________________ Inpatient Drug & Alcohol Rehabilitation (R/4) ____________

Durable Medical Equipment (R/2) _______ Additional Ten (10) Inpatient Hospital Days (R/6) _________

6. The Group agrees to the operating procedures as described in this Agreement, the HealthChoice Program Handbook and Subscriber Certificate, as furnished and amended by the Program from time to time, and the Subscriber Application/Change Form. Upon initiating coverage for its employees, the Group represents and warrants that it complies with the criteria set forth in the Subscriber Certificate to be qualified as a Group. The Group agrees to furnish upon request, but not less than annually, to the Program such information as may be required for its underwriting review and to permit a membership and payroll audit by the Program or its representatives.

7. This Agreement may be canceled or amended by the Program or the Group upon 30 days’ written notice, except as otherwise provided pursuant to the terms of the Subscriber Certificate. Termination will be effective the first day of the month immediately following the month for which premiums for the Member have been paid, unless the Subscriber Certificate provides for a different termination date.

8. The Group agrees to comply with all requirements under COBRA/ERISA as documented in the HealthChoice Program Handbook and Subscriber Certificate.

9. The Group understands and acknowledges that HealthChoice is a Michigan Municipal Health Facilities Corporation, the Covered Services provided are provided pursuant to the HealthChoice Program, and that HealthChoice and the Managed Care Provider/CPE are not licensed or regulated by the Michigan Office of Financial and Insurance Regulation.

10. The Managed Care Provider/CPE selected by the Group accepts the selection and agrees to deliver health care services to Members in a manner and to the extent identified in its contract with HealthChoice of Michigan in return for the monthly HealthChoice subsidy and premiums paid by the Group and Subscribers referenced in its HealthChoice contract. The Managed Care Provider/CPE is not liable for the provision or payment of Dental or Vision Services.

THIS AGREEMENT IS NOT EFFECTIVE UNLESS AND UNTIL SIGNED BY THE EXECUTIVE DIRECTOR OF THE PROGRAM.

HEALTHCHOICE OF MICHIGAN

By: ______________________________ Dated: _____________

Title: Executive Director

MANAGED CARE PROVIDER/CPE

By: ________________________________ Dated: _____________

GROUP

By: ______________________________ Dated: _____________

Title: ____

Address: ____

Phone: ___________________ Federal I.D. # __________________

White – HealthChoice *Canary* – Provider *Pink* – Employer Rev. 7/2009

DENTAL AND VISION RIDER
GROUP OPERATING AGREEMENT
BETWEEN
____ (THE "GROUP"), #__________
HEALTHCHOICE OF MICHIGAN (THE "PROGRAM") AND CPE/TPA

The intent of this Agreement is to establish, between the parties hereto, the terms under which the Program will offer vision and/or dental care coverage to Eligible Employees of the Group ("Subscribers") and their Eligible Dependents (collectively referred to as "Members") by reference to the Program's Subscriber Certificate of Eligibility, any amendments thereto, and the selected Dental and/or Vision Riders (hereinafter collectively referred to as the "Subscriber Certificate"), and the underwriting and administrative requirements under which the Group is to operate.

The Group, the Program, and the CPE/TPA hereby agree:

1. The following Riders are selected by the Group for all employees of the Group who enroll as Subscribers and their Eligible Dependents who are enrolled by the Subscriber:

Vision Exams & Glasses (R/3) ____________ Dental (R/7) _____________

2. This Agreement is effective only when a fully-executed copy of this Agreement that is approved by the Program's Executive Director is returned to the Group. This Agreement is subject to and the Group agrees to comply with the terms of the Subscriber Certificate and the selected Rider(s), the provisions of which are incorporated herein. The Group acknowledges that the Program has provided a copy of the Subscriber Certificate to the Group and all Subscribers.

3. Subject to the terms of the Subscriber Certificate and the selection made in paragraph 1 above, the Program will provide Dental and/or Vision Services to all Subscribers and their Eligible Dependents as provided for in the Subscriber Certificate and the selected Rider(s).

4. The Group is at all times acting as agent for individuals who are enrolled as Members. Notification received from, or given to, such agent by the Program will fulfill all notice requirements of the Subscriber Certificate related to Dental and/or Vision Care Coverage. The Group, at its own expense, agrees to provide any notification received from the Program to all of its Subscribers.

5. The Group agrees to prepay, on or before the Premium Payment Deadline, the monthly advance premiums for the selected Rider(s) calculated on the basis of and pursuant to the terms of the current Premium Rate Schedule for all Members, including Members entitled to continued services pursuant to Part XIII of the Subscriber Certificate. In its sole discretion, the Program may reduce or eliminate the credit provided to the Group by this Paragraph and agrees to notify the Group before the 15th day of each month if the credit is reduced or eliminated.

6. Dental and/or Vision Services described in the selected Rider(s) will be offered by the Group to all individuals eligible under the terms of the Subscriber Certificate and the selected Rider(s). The Group agrees to notify the Program each month of the names of the Subscribers and their Eligible Dependents for whom a Premium Payment for Dental and/or Vision Services has been made to the Program.

7. The Group agrees to the operating procedures as described in this Agreement, the HealthChoice Program Handbook and Subscriber Certificate furnished and amended by the Program from time to time, and the Subscriber Application/Change Form. The Group agrees to furnish upon request, but not less than annually, to the Program such information as may be required for its underwriting review and to permit a membership and payroll audit by the Program or its representatives.

8. This Agreement may be canceled or amended by the Program or the Group upon 30 days' written notice, except as otherwise provided pursuant to the terms of the Subscriber Certificate and Dental and/or Vision Rider. Termination will be effective the first day of the month immediately following the month for which premiums for the Member have been paid, unless the Subscriber Certificate provides for a different termination date.

9. The Group understands and acknowledges that HealthChoice is a Michigan Municipal Health Facilities Corporation, the Dental and/or Vision Services provided are provided pursuant to the HealthChoice Program, and that HealthChoice and the CPE/TPA are not licensed or regulated by the Michigan Office of Financial and Insurance Regulation.

10. The CPE/TPA selected by the Group accepts the selection and agrees to deliver Dental or Vision Services to Members in a manner and to the extent identified in its contract with HealthChoice of Michigan in return for the monthly HealthChoice subsidy and premiums paid by the Group and Subscribers referenced in its HealthChoice contract. The TPA/CPE is not liable for the provision or payment of health care services or Supplemental Covered Services not required by its contract with HealthChoice.

THIS AGREEMENT IS NOT EFFECTIVE UNLESS AND UNTIL SIGNED BY THE EXECUTIVE DIRECTOR OF THE PROGRAM.

HEALTHCHOICE OF MICHIGAN

By: __________________________________ Dated: _____________

Title: Executive Director

TPA/CPE

By (R/3): ______________________________ Dated: _____________

By (R/7):_______________________________ Dated: _____________

GROUP

By: __________________________________ Dated: ______________

Title: ____

Address: ____

Phone: ______________________ Federal I.D. # ____________________

White – HealthChoice *Canary* – Provider *Pink* – Employer
Rev. 7/2009

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [*Enter Name and Address*]

The Election Form must be completed and return by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

I (We) elect COBRA continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	Social Security No. (or other identifier)	Coverage Option Elected
a.______________	________	______________	____________	__________
b.______________	________	______________	____________	__________
c.______________	________	______________	____________	__________
d.______________	________	______________	____________	__________

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Print Name Relationship to individual(s) listed above

____

______________________________ ______________________________
Print Address Telephone number

If you do not submit a completed election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights which are included in the "Statement of HIPAA Portability Rights" on pages 48-49.

The certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

****

REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Name of Participant: _____________________________ Date: ______________________

Address: ____

Telephone Number: _____________________________

Name and relationship of any dependents for who certificates are requested (and their address if different from above):

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of this certificate: ____

2. Name of group health plan: ____

3. Name of participant: ____

4. Identification number of participant: ____________________________________

5. Name of individuals to whom this certificate applies: ______________________

   ____

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: ____

   ____

7. For further information, call: ____

8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10: _______

9. Date waiting period or affiliation period (if any) began: _____________________

10. Date coverage began: ____

11. Date coverage ended (or if coverage has not ended, enter "continuing"): ____________

Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws, or http://www.cms.hhs.gov/hipaa1.

XII.

SUBSCRIBER CERTIFICATE

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HEALTHCHOICE OF MICHIGAN
SUBSCRIBER CERTIFICATE OF ELIGIBILITY

This Subscriber Certificate of Eligibility and any amendments (the "Subscriber Certificate"), by and between HealthChoice of Michigan, a Michigan municipal health facilities corporation (the "Program"), located at 640 Temple, Suite 370 Detroit, Michigan 48201, and the Subscriber named in the Subscriber Application, describes the Covered Services to which the Subscriber and his or her Eligible Dependents are entitled upon payment of the Premium and subject to the terms and conditions set forth herein.

PART I. DEFINITIONS

As used in this Subscriber Certificate, the Subscriber Application, the Identification Card, and any Rider, the following capitalized terms shall have the following meanings:

1.01 **"BASIC COVERED SERVICES"** means those services listed in Appendix A hereto, subject to the exclusions of Appendix B and as more fully defined in Section 10.03.

1.02 **"CERTIFICATE" or "SUBSCRIBER CERTIFICATE"** means this document, the Subscriber Application, the Identification Card, and any Riders.

1.03 **"CONTRACT YEAR"** means the period for which this Subscriber Certificate is initially effective and any renewal period.

1.04 **"CO-PAYMENT"** means that portion of the cost, if any, of the Covered Services required to be paid by a Member.

1.05 **"COVERED SERVICES"** means the Basic Covered Services to which a Member is entitled as set forth in Section 10.03 of this Subscriber Certificate, and any Supplemental Covered Services specified for the Subscriber in the Subscriber Application, when provided under the terms of this Subscriber Certificate.

1.06 **"DENTAL SERVICES"** means those services listed in Appendix D hereto, subject to the limitations and exclusions of Appendix E and as more fully defined in Section 10.04(f).

1.07 **"EFFECTIVE DATE"** means the date on which coverage begins under this Subscriber Certificate, as determined by the Program and as established by the terms and conditions of the Group Operating Agreement.

1.08 **"ELIGIBLE DEPENDENT"** means a person meeting the descriptions in the sub-paragraphs below, and for whom the Program has received a completed Subscriber Application during the times permitted by Section 5.01. An Eligible Dependent must at time of enrollment and, except as otherwise indicated, at all times thereafter:

(a) Be the spouse of the Subscriber who:
1. Qualifies for coverage, subject to verification of family income;
2. Is not serving in the Armed Forces of the United States;
3. Is without health care benefits at time of enrollment; and
4. Is not eligible, without regard to the scope of coverage, for Medicare, Medicaid or other employer-sponsored health benefit plan or program.
Or

(b) As defined as in Internal Revenue Code § 152 (f)(1), be a child of the Subscriber, which is defined as a son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the Subscriber until the child reaches the age of 26. An eligible foster child is an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adopted child includes both a legally adopted child of the Subscriber and a child who is lawfully placed with the Subscriber for legal adoption by the Subscriber. An adult child age 19 and over is not eligible for coverage if the adult child has another offer of employer-sponsored coverage.

1.09 **“EMERGENCY”** means (a) an accidental traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a Member’s health or result in serious physical impairment or loss of life, or (b) a life threatening 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 or to seriously jeopardize a Member’s health if not treated immediately. Subject to the retrospective review authorized by Section 10.07, emergency conditions and the medical necessity for treatment on an emergency basis are determined by the treating physician’s diagnosis.

1.10 **“EMERGENCY DENTAL SERVICES”** means Dental Services that are required to alleviate pain that if not treated immediately would result in jeopardy to the dental health of the Member. Subject to the right of the Program, through its Managed Care Providers for Dental Services, to refuse payment for services when, upon retrospective review, the dental conditions and findings do not meet the criteria for Emergency Dental Services, emergency conditions and the necessity for treatment on an emergency basis are determined by the treating dentist’s diagnosis.

1.11 **“SUBSCRIBER APPLICATION”** means the Subscriber Application/Change Form, approved by the Program, that each person must complete in order to become a Subscriber and those documents, approved by the Program, that the Subscriber must complete in order for an Eligible Dependent to become a Member.

1.12 **“ENROLLMENT YEAR”** means that 12 consecutive month period commencing on the date a Member’s enrollment is considered effective.

1.13 **“GROUP”** means the Subscriber’s employer, which may be a company, corporation, partnership, professional corporation, sole proprietorship or other legal entity agreeing to the terms and conditions of this Subscriber Certificate and contracting to provide coverage to eligible employees by the execution of the Group Operating Agreement. “Group” also means a chamber of commerce which has executed a Group Operating Agreement though which its member organizations provide coverage to eligible employers.

1.14 **“GROUP OPERATING AGREEMENT”** means the agreement between the Program and the Group that sets forth the rights and obligations of the Program and the Group and such agreement has been accepted by the managed care provider.

1.15 **“HEALTH PROFESSIONAL”** means a physician, podiatrist, nurse, optometrist, dentist, or other individual licensed or certified to practice his/her profession by the state in which he/she is located.

1.16 **“HOSPITAL”** means an institution which is a health care facility licensed or otherwise authorized to operate in the state in which it is located, which meets such qualifications as may be established from time to time by the Program, which is open 24-hours a day and is operated primarily for the care and treatment of sick and/or injured persons as inpatients, which has a staff of one or more physicians available at all times, which continuously provides organized facilities for diagnostic and major surgery, and which is not primarily a clinic, nursing, rest or convalescent nursing home or similar establishment, nor (other than incidentally) a facility for treatment of alcoholism, substance abuse, or pulmonary tuberculosis or black lung.

1.17 **“IDENTIFICATION CARD”** means the card furnished by the Program to each Member upon approval of the Subscriber Application by the Program, containing such information as may be approved by the Program.

1.18 **“MANAGED CARE PROVIDER”** means an entity with which the Program has directly contracted to provide or arrange with Participating Providers for the provision, coordination, continuity and monitoring of Covered Services to Members. Also known as the “Coordinated Provider Entity” or “CPE”.

1.19 **“MEDICALLY NECESSARY”** means a service, procedure, or supply must be provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or dental problem, and must not be experimental, investigational, or cosmetic in nature, it must be necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or dental problem or its symptoms and must be within generally accepted medical or dental standards within the medical or dental community.

1.20 **“MEMBER”** means a Subscriber or Eligible Dependent.

1.21 **<u>"NON-PARTICIPATING PROVIDER"</u>** means a health professional, a hospital, a pharmacy, or any other institution, organization or person who or which has not contracted in writing either with the Program or with a Managed Care Provider, or subcontracted in writing either with the Program or with a Participating Provider, to look to the Program or Participating Provider for payment of Covered Services rendered to any Member.

1.22 **<u>"PARTICIPATING PHYSICIAN"</u>** means a Contracted Provider who is a physician in general practice licensed to practice medicine or osteopathy or a physician who is board eligible or board certified in the physician's specialty of practice.

1.23 **<u>"PARTICIPATING PROVIDER"</u>** means a health professional, a hospital, a pharmacy or other institution, organization or person who or which has contracted in writing with the Managed Care Provider to look solely to the Managed Care Provider for payment for Covered Services rendered to any Member, except for payment of any Co-payment or deductible amounts.

1.24 **<u>"PREMIUM"</u>** means the payment the Program requires the Group to pay for each Member enrolled in the Program.

1.25 **<u>"PREMIUM PAYMENT DEADLINE"</u>** means:

(a) Except as provided by Section 1.24(b) below, the fifteenth (15th) day of the month immediately preceding the month for which the Premium applies.

(b) Thirty (30) days after the Member's date of enrollment for any Member who is enrolled under Section 5.01(c) or 5.02(c).

1.26 **<u>"PROGRAM"</u>** means HealthChoice of Michigan, a Michigan municipal health facilities corporation, formed in accordance with the provisions of Act 230, Public Acts of 1987, as amended, MCL 331.1101 <u>et</u> <u>seq</u>.

1.27 **<u>"RIDER"</u>** means any supplemental service form issued by the program that may modify the healthcare coverage by either adding to or altering certain provisions of this Subscriber Certificate.

1.28 **<u>"SUBSCRIBER"</u>** means an employee of the Group (or an employee of a member of a chamber of commerce under a contract with HealthChoice) who meets the eligibility requirements of the Program under Section 3.01 and for whom a completed Subscriber Application has been received by the Program.

1.29 **<u>"SUPPLEMENTAL COVERED SERVICES"</u>** means those services listed in Appendices C, D and I hereto, as more fully defined in Section 10.04, subject to the exclusions under and as limited by Appendices B, E and J.

1.30 **<u>"TOTALLY AND PERMANENTLY DISABLED"</u>** means any physical or mental condition, which prevents a person from engaging in substantial, gainful activity and which can be expected to result in death or to be of long, continued, or indefinite duration.

1.31 "**<u>URGENT CARE FACILITY SERVICES"</u>** means a medical facility, separate from a hospital, where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, nonroutine urgent care. This does not include primary care physician or specialist office sites offering after hours or extended hours care.

1.32 "**<u>RESIDENT"</u>** means a person who has his/her fixed, established, or permanent place of residence in the State of Michigan or Wayne County, if eligible for a subsidy of his/her monthly premium, with the intention to remain there permanently or for an indefinite period. HealthChoice applicants and/or Subscribers must provide satisfactory proof of residency. Acceptable forms of proof of residency include a State of Michigan Driver's License, State of Michigan Identification Card, or a United States Passport.

1.33 **<u>"VISION SERVICES"</u>** means those services listed in Appendix I hereto, subject to the limitations and exclusions of Appendix J and as more fully defined in Section 10.04(c).

PART II. IDENTIFICATION CARDS

2.01 The Member must present the Identification Card when Covered Services are requested. The Subscriber shall immediately notify the Group of loss or theft of the Identification Card.

2.02 The Identification Card is the property of the Program. Each Member understands and agrees to return the Identification Card upon termination of the Subscriber Certificate or upon request of the Program.

2.03 The Member may also be required to present other photo identification when Covered Services are requested.

PART III. ELIGIBILITY

3.01 **<u>Subscribers</u>** To be enrolled as a Subscriber, a person must meet all of the following criteria:

(a) Be an employee of a Group qualified under Section 3.02 or Section 3.03 and, at the time of enrollment, have an anticipated work future of more than five (5) months.

(b) Be without current health care benefits at time of enrollment and not eligible, without regard to the scope of coverage, for Medicare, Medicaid or other

employer sponsored health benefit plan or program at time of enrollment or at any time during enrollment as a Subscriber.

(c) At the time of enrollment be working at least twenty (20) hours per week for at least twelve (12) consecutive weeks. If for any reason at any time after enrollment the Subscriber's hours are reduced to less than twenty (20) hours per week for a period of time exceeding twelve weeks the Subscriber will be deemed ineligible for coverage and the Subscriber Certificate will be terminated pursuant to Part XII of the Subscriber Certificate.

(d) Be an employee of a Group that has not offered or contributed to health care benefits for employees in the same or similar job classification as the person desiring to enroll as a Subscriber in the 65 day period immediately preceding the effective date of the Group Operating Agreement.

(e) Complete a Subscriber Application form.

(f) Be a resident of the State of Michigan.

(g) For a Subscriber to be eligible for a subsidy of his/her monthly premium, in addition to meeting the income eligibility requirements, the Subscriber must be a resident of Wayne County and must be part of a Group that has its principal place of business for global operations located in Wayne County.

(h) HealthChoice reserves the right to waive the 65 day waiting period set forth in Section 3.01(d) at the discretion of the Executive Director of HealthChoice upon receipt of a written request for a waiver demonstrating financial hardship and the written agreement of the Managed Care Provider. Any decision of the Executive Director of HealthChoice regarding a waiver of the 65 day waiting period is final, and there is no right to appeal the denial of a request for a waiver.

The above Subscriber eligibility requirements will be monitored on a regular basis, but no less than annually, for continued compliance.

3.02 **Wayne County Group Qualifications** Except where the Group is a chamber of commerce, a Group with its principal place of business in Wayne County shall meet all of the following criteria in order to be qualified to have its employees enrolled as Subscribers:

(a) At the time the Group enters into the Group Operating Agreement, the Group must have two (2) or more employees who are otherwise eligible to enroll as Subscribers.

(b) Have its principal place of business for global operations located in Wayne County.

(c) Initiate and, unless otherwise approved by the Program, maintain coverage under the Program for two (2) employees who are otherwise eligible to enroll as a Subscriber.

(d) At the time the Group enters into the Group Operating Agreement, not less than 50% of all employees or a distinct employee group have an hourly wage of fourteen dollars and fifty cents ($14.50) or less.

(e) A Group Operating Agreement with the Program executed by the Group is in full force and effect.

(f) HealthChoice reserves the right to make an exception to the Group Qualifications Eligibility requirements for any Group that submits a written request for an exception and demonstrates extenuating circumstances or a hardship justifying the exception. Any such exceptions will be made on a case-by-case basis within the sole discretion of the Health Choice Board of Trustees. The decision of the HealthChoice Board of Trustees is final, and there is no right to appeal the denial of a request for an exception.

(g) For all Groups with between 100-200 employees, only those employees who meet the graduated hourly scale (Appendix G) and other eligibility criteria are eligible for enrollment. Eligibility criteria will be monitored annually for continued compliance.

(h) Where the Group is a chamber of commerce that has executed a Group Operating Agreement with the Program, only the criteria set forth in Section 3.02 (b) and the foregoing paragraph shall apply for each employer that is a member of the chamber of commerce.

The above Wayne County Group Qualifications eligibility requirements will be monitored on a regular basis, but no less than annually, for continued compliance.

3.03 **Oakland County Group Qualifications** A Group with its principal place of business for global operations located in Oakland County shall be qualified to have its employees enrolled as non-subsidized Subscribers if it meets all of the following criteria:

(a) At the time the Group enters into the Group Operating Agreement, the Group must have two (2) or more employees who are otherwise eligible to enroll as Subscribers.

(b) At the time the Group enters into the Group Operating Agreement, at least 10% of the employees who enroll as Subcribers must be residents of Wayne County as that term is defined in Section 1.32.

(c) Initiate and, unless otherwise approved by the Program, maintain coverage under the Program for two (2) employees who are otherwise eligible to enroll as a Subscriber.

(d) At the time the Group enters into the Group Operating Agreement, not less than 50% of all employees or a distinct employee group have an hourly wage of fourteen dollars and fifty cents ($14.50) or less.

(e) A Group Operating Agreement with the Program executed by the Group is in full force and effect.

(f) HealthChoice reserves the right to make an exception to the Group Qualifications Eligibility requirements for any Group that submits a written request for an exception and demonstrates extenuating circumstances or a hardship justifying the exception. Any such exceptions will be made on a case-by-case basis within the sole discretion of the HealthChoice Executive Director. The decision of the HealthChoice Executive Director is final, and there is no right to appeal the denial of a request for an exception.

(g) For all Groups with between 100-200 employees, only those employees who meet the graduated hourly scale (Appendix G) and other eligibility criteria are eligible for enrollment. Eligibility criteria will be monitored annually for continued compliance.

(h) The HealthChoice Board of Trustees reserves the right to expand HealthChoice coverage outside of Wayne County. If the Board decides to expand coverage to Counties other than Oakland County, these Oakland County Group Qualifications provisions shall apply to the coverage.

The above Oakland County Group Qualifications eligibility requirements will be monitored on a regular basis, but no less than annually, for continued compliance.

3.04 **Prior Health Coverage** A person shall not be found ineligible to enroll as a Subscriber or to be enrolled as an Eligible Dependent because the person was covered by or enrolled in a plan or policy providing health care benefits prior to the date the Subscriber Application is submitted to the Group for that person.

3.05 **Medicaid/Medicare Eligibility** The Program may require any person to verify their ineligibility for Medicaid or Medicare by completion and submission of an application for Medicaid or Medicare benefits as part of the Program's Subscriber Application for the person or at any time during the period a person is a Member.

Refusal by a Member of a request by the Program or its Managed Care Provider to complete and submit an application for Medicaid or Medicare benefits may result in termination of this Subscriber Certificate for the Member and may also result in

termination of the Group Operating Agreement. Approval of both the Executive Director of HealthChoice and the member or Group's Managed Care Provider is required before a member can be terminated.

PART IV. INELIGIBILITY AND REENROLLMENT

4.01 No person shall be permitted to enroll as either Subscriber or an Eligible Dependent who has had a prior Subscriber Certificate terminated through violation of the terms of the Subscriber Certificate by the person, unless such violation is specifically waived by the Program.

4.02 Unless specifically waived by the Program, a Member whose Subscriber Certificate has been terminated by the Program pursuant to Section 12.02(a)(i) shall not be permitted to reenroll as a Member employed with, or as an Eligible Dependent of a Subscriber employed with, the same Group until the month of Open Enrollment following the date the termination was effective.

Reenrollment shall not be automatic but is subject to the prior approval of both the Executive Director of HealthChoice and the Member or Group's Managed Care Provider.

In addition, reenrollment pursuant to this Section 4.02 may be conditioned upon payment of any late fee or reenrollment fee (See Appendix H) by the reenrolling Member or Group that may be established by the Program.

The Premium Payment Deadline for a Member who has re-enrolled under this Section 4.02 shall be any time during the Open Enrollment Period. The reenrollment under this Section 4.02 of a Member from whom a new Subscriber Application has been accepted and for whom the appropriate advance premium and any reenrollment fee imposed by the Program has been received by the Program on or before the Premium Payment Deadline provided by this Section 4.02, shall be effective and entitle the Member to receive Covered Services commencing January 1 of the following year.

4.03 The Program reserves the right to determine whether a person meets the criteria to be a Subscriber or an Eligible Dependent and whether a Group meets the criteria established by Section 3.02.

PART V. ENROLLMENT

5.01 **Enrollment as a Subscriber** A person who meets the requirements for being a Subscriber, including being employed by a Group that is qualified pursuant to Section 3.02 or Section 3.03 to have its employees enrolled as Subscribers, may enroll with the Program by submitting the completed Subscriber Application form to the Group. The completed Subscriber Application for a person qualified as a Subscriber may be submitted by the Group to the Program at the following times:

(a) At the time the Group submits its Group Operating Agreement to the Program.

(b) Within 90 days after the date of hire for a person hired after the date the Group submits its Group Operating Agreement to the Program.

(c) During open enrollment.

(d) At any time within 30 days after either of the following qualifying events for a person who would have qualified as a Subscriber on a previous date when the person could have submitted an Subscriber Application but did not enroll with the Program at that time:

(i) For a person who had coverage under another group health plan or health insurance at the time the person could have submitted an Subscriber Application, upon the loss of that coverage because of a loss of eligibility for the coverage, the exhaustion of COBRA benefits, or the termination of employer contributions toward the coverage.

(ii) Upon another individual becoming a dependent of the person.

5.02 **Enrollment of an Eligible Dependent** A person who has enrolled as a Subscriber may enroll a person who meets the requirements for being an Eligible Dependent with the Program. Enrollment of an Eligible Dependent requires the Subscriber to submit a completed Subscriber Application form to the Group for the Eligible Dependent, complete a MIChild application from the State Department of Human Services for children from birth to 18 years of age and provide proof of application to HealthChoice, and also provide family income documentation for determination of eligibility of a spouse. The Group may submit a completed Subscriber Application form, MIChild application/proof of application, and family income documentation received for an Eligible Dependent at the following times:

(a) A person who is an Eligible Dependent of a Subscriber on the date of the Subscriber's enrollment may be enrolled at the same time as the Subscriber.

(b) During open enrollment.

(c) At any time within 30 days after any of the following qualifying events:

(i) For a person who is an Eligible Dependent of a Subscriber, on the date of the Subscriber's enrollment and who was not enrolled at a previous time when the person could have been enrolled as an Eligible Dependent because they were covered under another group health plan or other health insurance, upon the loss of that other coverage because of lost eligibility for such coverage, the

exhaustion of such coverage under COBRA, or the termination of employer contributions toward the coverage.

(ii) For a natural child, stepchild or legally adopted child, upon birth, marriage, adoption or placement for adoption (must submit a MIChild application to DHS and proof of application to HealthChoice).

(iii) Upon the person becoming an Eligible Dependent of a Subscriber already enrolled in the Program. Subject to eligibility guidelines for family income for a dependent spouse.

5.03 **Consequences of Enrollment** Enrollment with the Program shall not entitle a Member to the Covered Services until the date coverage is considered effective pursuant to Part VI. However, enrollment with the Program shall authorize the Group with whom the Subscriber is employed to deduct through the mechanism of payroll deduction an amount sufficient to pay that portion of the monthly advance premium which may be charged to the Subscriber by the Group under the Group Operating Agreement for Basic Covered Services and, if selected by the Group for the Subscriber and their Eligible Dependents, for Supplemental Covered Services for the Subscriber and each Eligible Dependent enrolled by the Subscriber.

5.04 **Waiting period** HealthChoice does not impose a waiting period for coverage. However, there may be a period of time between enrollment and the effective date of coverage as set forth in Part VI. To the extent a Group imposes a waiting period on new employees, the waiting period shall not exceed 90 days.

PART VI. EFFECTIVENESS OF COVERAGE

6.01 **Effective Date of Subscriber's Coverage** Except as provided by Section 6.03 below, the effective date of coverage for Covered Services of any person who has enrolled, as a Subscriber shall be as follows:

(a) For a Subscriber who is enrolled under Section 5.01(a), the first day of the month that occurs after the Group submits its Group Operating Agreement to the Program.

(b) For a Subscriber who is enrolled under Section 5.01(b), the January 1 following enrollment.

(c) For a Subscriber who is enrolled under Section 5.01(c)(i), the first day of the month that occurs after the Subscriber Application is submitted by their Group.

(d) For a Subscriber who is enrolled under Section 5.01(c)(ii):

(i) The first day of the month that occurs after the Subscriber Application is

submitted by their Group, if the other individual that becomes a dependent of the Subscriber is a spouse.

(ii) The date of birth, marriage, adoption or placement for adoption, if the other individual that becomes dependent of the Subscriber is a child who becomes a dependent of the Subscriber through birth, marriage, adoption or placement for adoption.

6.02 **Effective Date of an Eligible Dependent's Coverage** Except as provided by Sections 6.03 and 6.04 below, the effective date of coverage for Covered Services of any person who meets the requirements for being an Eligible Dependent set forth in Section 1.08 shall be as follows:

(a) For an Eligible Dependent who has been enrolled under Section 5.02(a), the effective date of coverage for the Eligible Dependent shall be the same as for the Subscriber.

(b) For an Eligible Dependent who has been enrolled under Section 5.02(b), the effective date of coverage shall be on the January 1 following enrollment.

(c) For an Eligible Dependent who has been enrolled under Section 5.02(c)(i), the effective date of coverage shall be the first day of the month that occurs after the Subscriber Application is submitted by their Group.

(d) For an Eligible Dependent who has been enrolled under Section 5.02(c)(ii), the effective date of coverage shall be the date of birth, marriage, adoption or placement for adoption of the child of the Subscriber.

(e) For an Eligible Dependent who has been enrolled under Section 5.02(c)(iii):

(i) In the case of a Subscriber's spouse, the first day of the month that occurs after the Subscriber Application is submitted by the Group.

(ii) In the case of a child, the date of birth, marriage or placement for adoption.

6.03 **Conditions to the Effectiveness of Coverage; Premium Payments**.

(a) Each Member shall be entitled to the Covered Services if, on or before the Premium Payment Deadline, the appropriate Premium has been received by the Program for that Member and the Subscriber Application with respect to the Member has been accepted by the Program.

(b) The Premium attributable to a new Member whose Premium Payment Deadline is established under Section 1.25(b) shall equal the increase in the Premium attributable to that new Member that would have been due from the Subscriber for

all the following periods if the Premium attributable to the Member had been paid before the Premium Payment Deadline established under Section 1.25(a):

(i) The month in which the new Member's coverage became effective.

(ii) If the Premium is not paid on or before the 15th of the month during which the new Member's coverage would have become effective, the coverage will be delayed until the subsequent month contingent upon proper payment of premium.

(c) The Program will not be liable for the costs of Covered Services rendered to a Member who has been enrolled for any period for which a Premium for the Eligible Dependent is due and not paid.

6.04 **Pre-Existing Condition Limitations** If a Member has been treated for an injury or illness within six (6) months prior to becoming eligible for benefits under this Subscriber Certificate, then all health care services incurred as a result of such injury or illness will not be considered as Covered Services until expiration of the maximum period authorized by state or federal law for a pre-existing condition limitation (as reduced by any period of creditable service or by other reductions required by law). A summary of pre-existing condition limitations is attached as Appendix F. This paragraph does not apply to Members, including applicants for enrollment, who are under 19 years of age. A Member under age 19 cannot be denied coverage or benefits based on a pre-existing condition.

6.05 **Effective Date of Coverage of Supplemental Covered Services** Subject to Part X, Covered Services, if the Group has elected, at the time of enrollment of a Member, 1 or more Supplemental Covered Services for the Subscribers employed by the Group and their Eligible Dependents, those Supplemental Covered Services elected by the Group shall be effective in accordance with this Article VI. If the Group does not elect to receive Supplemental Covered Services for the Subscribers employed by the Group and their Eligible Dependents at the time the Group submits a Group Operating Agreement, the Group and its Members may only submit an amended Group Operating Agreement and Subscriber Application amendment during open enrollment of any year to elect 1 or more Supplemental Covered Services.

PART VII. CANCELLATION

7.01 A Subscriber may cancel this Certificate with respect to the Subscriber or any Eligible Dependent by delivery of written notice to the Group by the end of the third (3rd) day following the date of submission of an Subscriber Application to the Group. Any deposits or fees related to the Member cancelled which were paid for a Subscriber canceling this Certificate pursuant to this Section shall be refunded to the Group. The Group shall notify the Program of any cancellations pursuant to this Section.

7.02 Upon cancellation, coverage will terminate and no benefits will be payable. The Subscriber shall be responsible for payment of any services received by the Subscriber or Eligible Dependents during the period the Certificate was in force.

PART VIII. PREPAYMENT OF MONTHLY PREMIUM

8.01 All monthly Premiums established by the Program are payable to the Program by the Group pursuant to the payment instructions of the Program on or before the Premium Payment Deadline (See Section 1.25).

Failure of the Subscriber to reimburse the Group for any Premium paid by the Group to the Program shall not cancel the coverage for the Subscriber and his or her Eligible Dependents for the month for which the Program received payment of the advance Premium.

Failure of the Group to pay the entire monthly premium by the Premium Due Date will cause all Subscribers of the Group and their Eligible Dependents to lose Covered Services for the month for which the premium was due, and may result in termination of the Group by the Program and the cancellation of Covered Services for all Subscribers of the Group and their Eligible Dependents. If the Group is terminated, the Subscribers of the Group and their Eligible Dependents shall not be permitted to reenroll as a Member of the same Group until the month of open enrollment following the date termination was effective; however, any such reenrollment is not automatic, and is subject to payment of any late fee or reenrollment fee (See Appendix H) and the reinstatement of the Group upon the approval of both the Executive Director of HealthChoice and the Group's Managed Care Provider, in their sole discretion.

PART IX. ADJUSTMENTS/CHANGES IN PREMIUM RATES; FAILURE TO PAY; GROUP REINSTATEMENT

9.01 **Notice of Premium Adjustments** Premiums will be established by the Program. Written notice of any changes in Premiums shall be given by the Program to the Group no less than 30 days prior to the effective date of the Premium change.

PART X. COVERED SERVICES

10.01 **Scope of Covered Services** Covered Services consist of the Basic Covered Services listed in Appendix A hereto and as more fully described in Section 10.03, which do not include any of the services described in Appendix B hereto.

Covered Services also include those Supplemental Covered Services, if any, elected for the Subscriber by the Group in the Subscriber Application. The Group may elect one or

more of the Supplemental Covered Services offered for any Subscriber employed by the Group and their Eligible Dependents. If the Group elects one or more of the Supplemental Covered Services for a Subscriber employed by the Group, the Group must elect the same Supplemental Covered Services for all Subscribers employed by the Group and their Eligible Dependents.

The Program has established a network of Managed Care Providers to deliver or arrange for the delivery of Covered Services under this Subscriber Certificate. Each Managed Care Provider has agreed to accept the payment established by the Program except where a Co-payment/deductible is explicitly stated.

10.02 **Selection of Managed Care Providers.**

(a) The Program shall furnish to the Group with whom the Subscriber is employed a list, which may be revised from time to time by the Program, of Managed Care Provider(s), Dental Managed Care Provider(s), and Vision Managed Care Provider(s) to provide all Covered Services and Supplemental Covered Services. The Program reserves the right to determine the number of Managed Care Providers offered and is not required to offer more than one Managed Care Provider, Dental Managed Care Provider, or Vision Managed Care Provider. If more than one Managed Care Provider is offered, the Group shall specify one Managed Care Provider for health care services, one Managed Care Provider for Dental Services (if a dental rider has been selected), and one Managed Care Provider for Vision Services (if a vision rider has been selected) from the Managed Care Providers with which the Program has directly contracted to provide Covered Services and Supplemental Covered Services to all of its Subscribers and their Eligible Dependents. Upon notice from the Program that a Managed Care Provider previously selected by the Group is no longer a Managed Care Provider, the Group shall select, from among the remaining Managed Care Providers, a new Managed Care Provider to whom its Subscribers and their Eligible Dependents will receive the appropriate Covered Services. If a Group fails to select a Managed Care Provider pursuant to this Section or only one Managed Care Provider is offered, the Program may assign the Subscribers of that Group and their Eligible Dependents to any one of the appropriate Managed Care Providers.

(b) Except as may be otherwise specifically provided in this Subscriber Certificate, the Member is entitled to receive Covered Services only when provided, arranged, or authorized by the Managed Care Provider to which the Member has been assigned. **Authorization for any service not provided as a Covered Service under the Subscriber Certificate must be in writing.** In addition, the Program shall not be liable for a claim for any Covered Services submitted to the Managed Care Provider more than one year after the date the Covered Services were provided. Denial of payment or services must be appealed in writing to the Managed Care Provider within 60 days after receipt of the denial. If the Managed Care Provider denies the appeal and the Subscriber disagrees with the denial, the

Subscriber may appeal in writing to the Executive Director of HealthChoice within 45 days after receipt of the denial from the Managed Care Provider. If the Executive Director of HealthChoice denies the appeal and the Subscriber disagrees with the denial, the Subscriber may appeal in writing to the HealthChoice Board of Trustees within 30 days after receipt of the denial from the Executive Director of HealthChoice and a hearing in the matter will be scheduled. The decision of the HealthChoice Board of Trustees is final, and there is no right to appeal unless otherwise required by law.

Except as may be otherwise specifically provided by this Subscriber Certificate, the Program shall not be liable, either financially or otherwise, for any Covered Services of any type whatsoever that are not provided, arranged or authorized by the Managed Care Provider to which a Member is assigned.

(c) The Managed Care Provider for Covered Services, other than Dental and Vision Services, to which each Member is assigned will cause each Member to select or shall assign an available Participating Physician who shall be primarily responsible for providing or arranging to provide such Covered Services to the Member. The Managed Care Providers for Dental and Vision Services (if a dental and/or vision rider was selected) to which each Member is assigned will cause each Member to select, or shall assign, an available Participating Provider who shall be primarily responsible for providing or arranging to provide Dental and/or Vision Services to the Member.

(d) Unless otherwise approved by the Program, after a Group has had its employees enrolled as Subscribers for at least one year, the Group may change its selected or assigned Managed Care Providers during the month of open enrollment of each year. Any change in a Managed Care Provider by a Group shall be effective on January 1 of the immediately following year.

10.03 **Basic Covered Services** Subject to the Co-payments and limitations provided below and by Appendix A, the Program's Basic Covered Services listed in Appendix A shall include the following Medically Necessary services to the extent not excluded in Appendix B:

(a) **Physician Services/Office Visits** All Medically Necessary physician services, including maternity and obstetrical services, delivered in the office of a Participating Physician or, if in the case of a referral approved by the Managed Care Provider or its designee, a physician who is not a Participating Provider.

Physician Services/Office visits under this subdivision (a) shall be subject to a Co-payment of $10.00 per visit. Specialist Physician Services and office visits under this subdivision (a) shall be subject to a Co-payment of $20.00 per visit.

(b) **Inpatient Hospital Services** The following inpatient hospitalization services provided by a Hospital which is a Participating Provider or, upon authorization of

a Managed Care Provider or its designee, a Hospital which is a Nonparticipating Provider when deemed Medically Necessary:

(i) Semi-private room and board.

(ii) General nursing care, services of hospital-based physicians and, where ordered, special duty nursing.

(iii) Use of operating rooms, special care units and services, surgical treatment room, delivery room, birthing center, emergency room, and other special treatment rooms.

(iv) Drugs, medical and surgical supplies, anesthesia, oxygen and biologicals.

(v) Laboratory examinations, including blood typing and pathological laboratory services, which are under the direction of a pathologist retained by the hospital.

(vi) Speech, physical and occupational therapy.

(vii) Administration of whole blood and blood plasma.

(viii) Use of X-Ray and other diagnostic and therapeutic services.

(ix) Medical rehabilitative services and physical therapy that a physician determines can be expected to result in significant improvement of the Member's condition.

(x) Maternity and nursery care of a newborn during the hospital stay of the mother.

(xi) Radiation and inhalation therapy.

(xii) Other inpatient service Medically Necessary for admission.

Inpatient hospitalization provided as a Basic Service to a Member shall not include inpatient care pursuant to a prescribed treatment plan for Member physiologically or psychologically dependent upon or abusing alcohol or drugs unless the Member is eligible to receive inpatient drug and alcohol rehabilitation services described in Section 10.04(d) as Supplemental Covered Services.

Except in the case of childbirth, inpatient hospitalization provided as a Basic Service to a Member shall not exceed twenty (20) days of inpatient care within each Enrollment Year. In the case of childbirth,

the limit will be 48 hours following a normal vaginal delivery and 96 hours following a cesarean section for a Member who is the mother or a newborn child qualified as a Member.

(c) **Outpatient Hospital Services** The following are available for preventive, diagnostic, therapeutic, and rehabilitative care when provided by a Participating Provider or, upon authorization of a Managed Care Provider or its designee, a Hospital which is a Nonparticipating Provider.

The outpatient hospital services are subject to a $10.00 Co-payment per visit.

(i) Outpatient surgical care, including routine surgical procedures, which do not require the use of inpatient hospital facilities.

(ii) Medical and surgical supplies.

(iii) Therapeutic and diagnostic laboratory, pathology, radiology and special diagnostic services which are Medically Necessary.

(iv) Pre-hospital admission screening procedures, which have been authorized by the admitting physician.

(e) **Urgent Care Facility Services are subjected to a Co-payment of $15.00 per person per visit**.

(f) **Emergency Health Services**

(i) Emergency services that do not result in the admission of the Member as an inpatient are subject to a Co-payment of $50.00 if the Emergency health services are provided by a Participating Provider and $100.00 if the Emergency health services are provided by a Nonparticipating Provider located in Wayne, Oakland, Macomb, Monroe or Washtenaw Counties.

(ii) Emergency services that result in an admission will be covered if the Emergency health services are provided by a Participating Provider. No co-payment will be charged for emergency services that result in an admission if the Emergency health services are provided by a Participating Provider.

(iii) If the Nonparticipating Provider is located in Wayne, Oakland, Macomb, Monroe or Washtenaw Counties, coverage will be as follows:

a. Inpatient Emergency services will be covered and reimbursed at 110% of the prevailing Michigan Medicaid DRG rate.

The Member is liable for any and all charges in excess of 110% of the Michigan Medicaid DRG rate for which the Nonparticipating Provider bills.

b. Outpatient Emergency services will be covered and reimbursed at 110% of the prevailing Michigan Medicaid Fee Screen rate, in addition to all applicable co-pays.
The Member is liable for any and all charges that exceed the Michigan Medicaid Fee Screen rate.

c. Coverage for inpatient care at an admitting Hospital that is a Nonparticipating Provider will be limited to one day unless transfer to a Participating Provider or another Hospital will jeopardize the Member's medical condition, in which case benefits will be extended until a transfer is practical or until discharge. Any transfer must be to a participating hospital or if to a non-participating hospital, the transfer must be approved by the Managed Care Provider or its designee.
If a Member refuses a transfer the Member is liable for all charges for all additional health services of any type whatsoever provided by that admitting Hospital.

(iv) If the Nonparticipating Provider is located in other than Wayne, Oakland, Macomb, Monroe or Washtenaw Counties, coverage will be as follows:

(a) Inpatient Emergency services will be covered and reimbursed at 75% of the Michigan Medicaid DRG rate for such inpatient hospital services, but not to exceed $500.00 per day shall be paid.
The Member is liable for any and all charges in excess of 75% of the Michigan Medicaid DRG rate, or any and all charges in excess of $500.00 if the Michigan Medicaid DRG rate exceeds $500.00 per day, for which the Nonparticipating Provider bills.

(b) Outpatient Emergency services provided by a Nonparticipating Provider located in other than Wayne, Oakland, Macomb, Washtenaw or Monroe counties, the Michigan Medicaid Fee Screen rate shall apply for such services, in addition to all applicable co-pays.
The Member is liable for any and all charges that exceed the Michigan Medicaid Fee Screen rate.

(v) A Member's coverage does not include emergency services for obstetrical care outside of Wayne, Oakland, Macomb, Washtenaw or Monroe Counties within 4 weeks of the Member's due date.

(g) **Diagnostic Services** Services provided by a Participating Provider or, upon authorization of a Managed Care Provider or its designee, a Nonparticipating

Provider for the diagnosis, prevention, or treatment of disease or assessment of a medical condition by the microbiological, serological, histological, hematological, immunohematological, biophysical, cytological, pathological, or biochemical examination of material derived from the human body.

(h) **Home Health Services** Services provided under the direction of a Participating Provider who is a licensed nurse for a member who has a medically predictable recurring need for assistance with activities of daily living, treatment of medical conditions, and the skill and knowledge needs regarding medical procedures provided in a non-licensed site where the Member is domiciled.

Home Health Services under this subdivision (g) shall be subject to a Co-payment of $10.00 per visit.

(i) **Ambulance Services** To the extent deemed necessary according to any of the following criteria:

(i) If the Member is admitted as an inpatient to the Hospital immediately following emergency room treatment.

(ii) When necessary for management of shock, trauma, unconsciousness, heart attack or other condition requiring active medical management prior to availability of Hospital care.

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

(iv) In order to transfer the Member from a Hospital that is a Nonparticipating Provider where the Member was admitted to a participating hospital after receiving Emergency health services.

(j) **Prescription Drug Service** Subject to inclusion in the formulary approved by the Program, generic or brand drugs, including psychotherapeutical drugs, prescribed by a Participating Physician or a physician who is a Nonparticipating Physician upon referral approved by the Managed Care Provider or its designee.

Prescription Drug Services provided under this subdivision (j) shall be subject to a Co-Payment of $10.00 per prescription for generic drugs, $15.00 per prescription for brand name drugs, and 50% of the cost of each prescription of psychotherapeutic drugs.

(k) **Radiology** Diagnostic imaging procedures used at the direction of a participating Provider, or a Nonparticipating Provider upon referral approved by the Managed Care Provider or its designee, authorized by law to obtain information for the diagnosis, prevention, or treatment of disease or assessment of a medical condition through the utilization of non-experimental modalities such as, but not limited to, X-ray, ultrasound, MRI, CT scans, or PET.

(l) **Contraceptives** Oral injectable prescription drugs or contraceptive devices prescribed with the intent of preventing pregnancy by a Participating Physician or by a physician who is a Nonparticipating Physician upon referral approved by the Managed Care Provider or its designee, and delivered by a Participating Provider or, upon authorization of the Managed Care Provider with which the Program has directly contracted, a Nonparticipating Provider. Contraceptives do not include those contraceptive drugs that may be implanted or the implantation of any contraceptive drug.

Contraceptives provided under this subdivision (l) shall be subject to a Co-payment of $10.00 per prescription for generic drugs and $15.00 per prescription for brand name drugs.

(m) **Mastectomies and Lumpectomies** Medical and surgical benefits for a mastectomy or lumpectomy shall include, in addition to those Basic Covered Services otherwise available, the following:

(i) All stages of reconstruction of the breast on which the mastectomy or lumpectomy has been performed.

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

(iii) Prostheses and treatment of physical complications of mastectomy or lymphectomy, including lymphedemas.

10.04 **Supplemental Covered Services** In the event the coverage of the Subscriber includes one (1) or more of the Supplemental Covered Services authorized below and the premium payment received by the Premium Due Date includes the premium required for those Supplemental Covered Services elected by the Subscriber, the Covered Services shall include all of those Medically Necessary Supplemental Covered Services subject to the following terms and conditions, to the exclusions provided in Appendix B and to the Co-payments, limitations, and exclusions specified below and the Co-payments, limitations and exclusions set forth in Appendices C, D, E, I and J of this Subscriber Certificate:

(a) **Physical Therapy** Medical rehabilitative services and physical therapy provided on an out-patient basis for conditions which a Participating Physician or, if in the case of a referral approved by the Managed Care Provider or its designee, a physician who is not a Participating Provider expects will result in significant improvement of a Member’s condition within a period of two (2) months.

Physical Therapy visits under this subdivision (a) shall be subject to a Co-payment of $10.00 per visit.

(b) **Durable Medical Equipment** Items which primarily and customarily are used to serve a medical purpose, for which they are prescribed, generally have no other use than the treatment of the ill or injured, are able to withstand repeated or continual use or are used more than once, as opposed to being disposable or expendable, and are appropriate for home use.

Durable medical equipment provided under this subdivision (b) shall be subject to a Co-payment of 50% of the prescribed equipment.

(c) **Vision Exams and Glasses** Comprehensive vision examinations to determine the need for vision corrections prescribed and delivered by a Heritage Total Services, Inc. Participating Provider for the correction of a Member's vision, and the provision of prescribed glasses or contact lenses to correct the Member's vision.

Glasses or contact lenses provided under this subdivision (c) shall be subject to the applicable Co-payments set forth in Appendix I and the limitations and exclusions set forth in Appendix J, and shall be available once in any consecutive twenty-four month period from the date of the last covered service.

(c) **Inpatient Drug and Alcohol Rehabilitation Services** Inpatient care pursuant to a treatment plan for Members physiologically or psychologically dependent upon or abusing alcohol or drugs, when referred by a physician and upon approval of the Managed Care Provider.

Inpatient drug and alcohol rehabilitation services provided under this subdivision (d) shall be subject to a Co-payment of $20.00 per episode for not more than 2 episodes in each Enrollment Year and for episodes of not longer than 72 hours.

(e) **Additional Hospital Inpatient Days** Services identified in Section 10.03(b) above for up to 10 days each Enrollment Year in addition to the days of inpatient hospitalization provided under Section 10.03(b) as a Basic Service.

(f) **Dental Services** Subject to the applicable Co-payments, all services described as Dental Services in Appendix D to be provided either by (i) a dentist who is a Participating Provider, (ii) any dentist if provided as Emergency Dental Services, or, (iii) in the case of a referral approved by the Member's Managed Care Provider for Dental Services or its designee, any other dentist. Dental Services do not include inpatient hospital care for any dental service. The Subscriber shall be liable, as a Co-payment, for all costs of Dental Services (including Emergency Dental Services and approved referral Dental Services) that are not required to be assumed by the Member's Managed Care Provider for Dental Services.

If Emergency Dental Services are received by a Member outside a 50-mile radius from the place designated by the Member's Managed Care Provider

for Dental Services, such Emergency Dental Services shall be paid by the Member. The Member's Managed Care Provider for Emergency Dental Services will reimburse the Member for 50% of the first $100 of all charges for those Emergency Dental Services upon submission of a paid receipt indicating services and charges.

Upon prior approval by the Member's Managed Care Provider for Dental Services, a Non-Participating Provider may perform specified Dental Services. These pre-approved referral Dental Services performed by a Non-Participating Provider will be subject to a Co-payment by the Subscriber in an amount equal to the greater of (i) 50% of the charges for the dental services, or (ii) the attributable Co-payment listed in Appendix D. In addition, the Managed Care Provider shall not be responsible for more than $500 of the costs of Dental Services by a pre-approved Non-Participating Provider to any Member incurred each year, and all such costs in excess of that amount shall be the responsibility of the Subscriber. A Member shall not be eligible to be referred to a Non-Participating Provider for Dental Services until the Member's enrollment with the Managed Care Provider for Dental Services has been effective for 6 months.

10.05 **Cancellation of Election of Supplemental Covered Services** Supplemental Covered Services elected by the Group may only be cancelled during open enrollment of each year.

10.06 **Member Liability for Unauthorized Covered Services** Members who seek and obtain Covered Services other than for an Emergency or as Emergency Dental Services from or through other than a Managed Care Provider to which the Member has been assigned without prior authorization of the Managed Care Provider will be liable for the full cost of those services. Covered Services which are neither for an Emergency nor Emergency Dental Services, but which are Medically Necessary as a follow up to an Emergency or to the prior receipt of the Emergency health services or the Emergency Dental Services involving the Member, must be obtained from a Participating Provider or, upon approval of the Managed Care Provider, a Nonparticipating Provider.

10.07 **Emergency Services; Retrospective Review** Except as provided by this Section, the Program, through its Managed Care Providers, will assume the cost of Covered Services for an Emergency identified in Section 10.03 (d) and in Section 10.03 (e). The Program, through its Managed Care Providers, reserves the right not to pay for such services if, upon retrospective review, the medical conditions and findings do not meet the criteria set forth for determining that the care comprised Emergency health service as defined in Sections 1.09 and 10.03. All prior authorized services will be paid as long as the retrospective reviews confirm the findings and conditions to be as represented at the time the authorization was granted. The Subscriber shall be liable for all of the costs which are not assumed by the Program and its Managed Care Providers as provided in this Section 10.07.

10.08 **Limitation on Liability to Program**

(a) The Program shall not be liable for any delay or failure of a Managed Care Provider or a Participating Provider to provide Covered Services due to lack of available facilities or personnel, if the lack is a result of circumstances beyond the Program's control. In the event of circumstances beyond the Program's control, the Program shall attempt to arrange Covered Services, insofar as practical, according to its best judgment and within the limitations of facilities and personnel then available. Circumstances beyond the Program's control include, but are not limited to complete partial disruption of facilities, war, riot, civil insurrection, epidemic, labor disputes, unavailability of supplies, disability of a significant part of a Participating Provider's personnel or similar causes.

(b) The Program shall not be liable to provide Covered Services to a Subscriber or Eligible Dependent in the following instances:

(i) Beginning the first day of the month immediately following the date on which the Subscriber or Eligible Dependent became ineligible for coverage pursuant to the rules for eligibility set forth in this Certificate or the Group Operating Agreement.

(ii) At any time, in the event the Subscriber falsified or withheld information requested by the Program on an Subscriber Application or as required under this Subscriber Certificate with respect to the Subscriber or an Eligible Dependent.

(iii) With respect to Covered Services provided after a Member's enrollment is considered effective, if the Subscriber or Eligible Dependent did not meet, at time of enrollment, the criteria for enrollment as a Subscriber or as an Eligible Dependent.

(c) The Program shall not be liable for the cost of any services and supplies submitted more than one year after the services or supplies were provided. In addition, any denial of payment must be appealed to the Managed Care Provider within 60 days of the denial; otherwise, the Program will not be liable for payment of any such service and supplies. If the Managed Care Provider denies the appeal and the Subscriber disagrees with the denial, the Subscriber may appeal in writing to the Executive Director of HealthChoice within 45 days after receipt of the denial from the Managed Care Provider. If the Executive Director of HealthChoice denies the appeal and the Subscriber disagrees with the denial, the Subscriber may appeal in writing to the HealthChoice Board of Trustees within 30 days after receipt of the denial from the Executive Director of HealthChoice and a hearing in the matter will be scheduled. The decision of the HealthChoice Board of Trustees is final, and there is no right to appeal unless otherwise required by law.

10.09 **HealthChoice Limitation on Liability** In no event shall HealthChoice have any liability whatsoever to a Subscriber, Member, Group, Managed Care Provider, Participating

Provider, Nonparticipating Provider or any other third party for the provision or payment of any Covered Services.

PART XI. SUBROGATION

11.01 The Program or the Managed Care Provider responsible for delivering services shall have the same right as a Member to recover expenses for treatment of a personal injury, illness or medical psychiatric condition from another person or organization that is legally liable to pay for them. For the purposes of Part XI only, reference to the Program shall also include the Managed Care Provider. The Member agrees that whenever the Member has a right to recover for personal injury, illness or any other medical or psychiatric condition from a third party, the Program shall be subrogated to and succeed to all of the Member's rights to recover the cost of services provided or paid for by the Program under this Subscriber Certificate which relate to that personal injury, illness or other medical or psychiatric condition.

11.02 A Member shall take such action, furnish such information and assistance, and execute and deliver to the Program such assignments and other instruments as the Program may request to facilitate enforcement of the right of the Program as a subrogee hereunder. Members shall not compromise or settle a claim or take any action that would prejudice the rights and interests of the Program under Section 11.01 without the Program's prior written consent.

11.03 A Member shall notify the Program, in writing, within ten (10) days after the making of any claim or demand against any third party seeking recovery for any damages, expenses or losses, relating to any fact, circumstance or occurrence out of which arose a personal injury, illness or other medical or psychiatric condition as to which Covered Services have been provided or paid for under this Subscriber Certificate.

11.04 Members shall hold any amounts received or recovered from any third party as a trustee for the Program until its rights under this Part XI have been satisfied or released.

11.05 Member shall have no right to engage counsel, to enter into an attorney fee arrangement, or otherwise to act on behalf of the Program as Member's subrogee under this Part XI.

11.06 If a Member fails or refuses to seek recovery of benefits which have been provided or paid for under this Certificate and which are or may be the liability of a third party, and the Program takes any action which results in a monetary recovery from a third party in excess of the cost of Covered Services provided or paid for under this Certificate, then the Program shall set-off against such excess its actual legal and other costs incurred in connection with the action. The remaining excess, if any, shall be paid to the Member. The Member shall have no obligation to the Program's legal fees and costs except as stated in this Section 11.05 and in Section 11.08 below.

11.07 A Member or Member's representative who engages legal representation to pursue a claim against a third party shall inform his or her counsel of the right of the Program under this Part XI.

11.08 The Member grants the Program a lien against the proceeds of any recovery by or on behalf of the Member from any third party, regardless of whether such recovery is by way of judgment or verdict in a civil action or as a result of arbitration, mediation, settlement, remedy provided by statute or regulation or otherwise. Such lien shall extend to any and all amounts recovered by or on behalf of the Member regardless of the designation, categorization or allocation of amounts so recovered to losses or damages other than services provided or paid for under this Certificate, and regardless of whether the amount recovered is less than, equal to or in excess of the total loss to or damage to the Member.

11.09 In the event that any recovery by or on behalf of a Member includes the recovery of amounts for future damage or loss, the Member or his/her representative shall hold the same in trust, subject to a continuing lien on behalf of the Program, and shall promptly reimburse the Program for all future services provided and payments made under this Subscriber Certificate which relate to the illness or injury which gave rise to the recovery.

11.10 Anything in this Subscribers Certificate to the contrary notwithstanding, neither the lien granted to the Program nor its rights as a Member's subrogee shall be deemed to exceed in amount or scope the recovery of reimbursement by the Program for past and future services provided and payments made under this Certificate, including reasonable costs and attorney fees incurred by the Program in obtaining a recovery for services provided or paid for by the Program under this Certificate from the Member or a third party.

PART XII. TERM AND TERMINATION

12.01 **Term** Unless terminated sooner pursuant to the provisions of either Section 12.02 below or the Group Operating Agreement, the term of this Subscriber Certificate shall be to the December 31st following the effective date hereof, and thereafter shall automatically renew for successive terms of one year each.

12.02 **Termination**

(a) Subject to rights of continuation specified in Part XIII, this Subscriber Certificate may be terminated by the Program in the event of any of the following:

(i) A premium payment sufficient to pay for Covered Services for all Subscribers of the Group and all of their Eligible Dependents who have been enrolled by those Subscribers, as provided in Part VIII above, has not been paid by the Group on or before its due date for any month. The Group will be given notice of termination of coverage 5 days after the premium due date and each subscriber of

the Group will be given notice after the passage of 10 days after the premium due date that termination will be effective the first day of the month immediately following such notice.

(ii) The Subscriber falsifies information or withholds information requested by the Program on an Subscriber Application or as required under this Subscriber Certificate with respect to the Subscriber or an Eligible Dependent, including a refusal of request by the Program or its Managed Care Providers to complete and submit an application for Medicaid or Medicare benefits, or an application for the MIChild program for dependent children. The termination will be effective immediately.

(iii) The Member becomes ineligible for coverage pursuant to the rules for eligibility set forth in this Certificate and the Group Operating Agreement. Termination will be effective the first day of the month immediately following the last date on which notification of change in status is required under Section 13.01.

(iv) The Member makes an assignment in violation of Part XIII below or aids, attempts to aid, or knowingly permits any other person to obtain services or benefits from or through the Program. Termination will be effective on the date of the occurrence of the event.

(v) The Program terminates its operation or there has been a judicial, legislative, regulatory or administrative change or determination, whether federal or state, which has or would have significant adverse impact on the Program in connection with the provision of services pursuant to this Certificate. Termination will be effective on the effective date of the event.

(vi) The Member fails to report theft or loss of a Member Identification Card. Termination will be effective on the date of the occurrence of the loss of the card.

(vii) Termination of the Group Operating Agreement with the Group. Termination will be effective the first day of the month immediately following the month for which premiums for the Member have been paid.

(viii) A Subscriber fails to pay Co-payments or other charges due for Covered Services to the Subscriber or Eligible Dependents who are Members within thirty (30) days of the date of billing or fails to make acceptable arrangements for payment with the Program or Managed Care Provider. In such event, termination shall be

effective for the Subscriber and Eligible Dependents who are Members upon thirty (30) days' written notice.

(b) The Subscriber Certificate may be terminated by the Subscriber by giving thirty (30) days' prior written notice to the Program and the Group.

12.03 **Prohibited Termination** The Program shall not terminate the Subscriber Certificate because of the frequency of the utilization of Covered Services by the Subscriber or an Eligible Dependent.

12.04 **Payments Upon Termination** In the event the Subscriber Certificate is terminated by the Program, the Subscriber will be charged for Covered Services rendered to the Subscriber or an Eligible Dependent after the effective date of termination and, in accordance with Section 10.08(b), for any period prior the effective date of termination during which the Program is not liable for providing Covered Services.

PART XIII.
CHANGE OF STATUS OF SUBSCRIBER OR ELIGIBLE DEPENDENTS; CONTINUATION OF COVERED SERVICES

13.01 The Subscriber shall notify the Group of any change in the status of the Subscriber or an Eligible Dependent affecting such Subscriber or Eligible Dependent's eligibility hereunder within 30 days of the change in status, and the Group shall immediately notify the Program of any change in status of the Subscriber/Eligible Dependent affecting eligibility under this Certificate. Changes in status include, without limitation, residency, a reduction in hours to less than 20 hours a week, marriage, divorce, attainment of age 65, death, dependent child's attainment of the age of 26 or eligibility for other employer-sponsored coverage after age 19, entrance into or return from military service. The Group shall notify the Program of any change in the status of the Group affecting the Group's ability to have its employees enroll as Subscribers and of any change in the status of the Subscriber affecting such Subscriber's eligibility under this Certificate, including but not limited to the number of Subscribers, location of the Group's principal place of business, Subscriber residency changes, and a Subscriber's reduction in hours to less than 20 hours a week.

13.02 If Members covered under this Certificate cease to be eligible to continue membership by reason of employment termination or other ineligibility due to death of the Subscriber, divorce from the Subscriber or loss of Eligible Dependent status, such Members may elect to receive continuing coverage under this Certificate in accordance with the criteria expressed in COBRA for a qualifying beneficiary (if COBRA is deemed to apply). Continuation coverage pursuant to this Part shall cease and this Certificate may be terminated by the Program for any individual who had elected to receive continuation coverage pursuant to this Part on the first day of the month following the earliest of the following dates:

(a) Continuation coverage is no longer required to be provided by the Group under law.

(b) The first day of the month after the individual notifies the Program that he or she no longer wants coverage from the Program.

(c) Any period for which the Group fails to fully prepay the monthly premium on behalf of the individual.

(d) Upon determination by the Program that the individual has falsified or withheld information requested by the Program on the Subscriber Application.

(e) Upon determination by the Program that the individual made an assignment in violation of Part XV.

(f) The date the Program terminates its operation.

(g) The date the Group Operating Agreement with the Group is terminated.

13.03 Upon election to continue coverage pursuant to Section 13.02, premium payments shall be made by the individual to the Group at the rate and in accordance with the payment schedule established by the Group Operating Agreement for similarly-situated Member groupings, unless otherwise agreed to by the Program in writing, and the Group shall remit such premium payments to the Program. If this Certificate for any individual who had elected to receive continuation coverage pursuant to this Part is terminated, the Program reserves the right to recover from the Group the cost of services rendered during the period for which the premium was due.

13.04 An individual for whom Covered Services continue to be available under this Part is considered to be either a Subscriber or an Eligible Dependent as long as this Certificate has not been terminated pursuant to Section 13.02 for that individual.

13.05 The Program does not assume any of the obligations assigned by COBRA to the Group or any other employer, and the Group warrants that it will perform those obligations in full and, in addition, include an explanation in any notice to potential beneficiaries of their rights or options under COBRA that failure to elect to continue benefits and to remit the applicable premium before the day such premiums are due to the Program for the following month could result in the automatic suspension of benefits by the Program for that following month.

PART XIV. MEDICAL RECORDS

14.01 **Confidentiality** The Program, the Managed Care Provider and the Participating Providers shall not release the Member's medical records except as may be necessary to provide Covered Services under the Subscriber Certificate, for payment of claims,

purposes of claim resolution, or to the Member for inspection upon written request, or except as may be permitted by law. The Program, the Managed Care Provider, and the Participating Providers, shall maintain the confidentiality of all Protected Health Information ("PHI") or electronic PHI, and agree to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the provisions of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act."), along with any accompanying regulations, and all other applicable state and federal statutes regarding confidentiality of health information. See Notice of Privacy Practices on page 29 for detailed information regarding how medical information about you may be used and disclosed and how you can get access to this information.

14.02 **Release** The Member consents to release of medical records of the Member to the primary care physician and any health professional, hospital, or other person or institution rendering Covered Services under this Subscriber Certificate and to the Program and its designated representatives. The Member further agrees to provide and cooperate with the Program by providing necessary health status information and, when requested, by assisting in obtaining copies of prior medical records.

PART XV. ASSIGNMENT

15.01 Covered Services provided to the Member hereunder by the Program are for the personal benefit of the Member and shall not be transferred or assigned. Any attempt to make an assignment in violation of this Part XV shall be null and void, and shall be reason for immediate termination of this Subscriber Certificate by the Program, and the Member shall be responsible for payment for any services rendered to such other person. The Member shall not assign to any health professional or any other person or institution any rights to receive payment from the Program.

PART XVI. NOTICES

16.01 Any notice, offer, demand or communication required or permitted to be given to the Subscriber under any provision of this Subscriber Certificate shall be deemed to have been given to the Subscriber if it is given to the Group in compliance with the provisions of this section. Any notice, offer, demand or communication required or permitted to be given under any provision of this Subscriber Certificate shall be deemed to have been sufficiently given or served for all purposes if delivered personally to the party to whom the same is directed or if sent by first class, registered or certified mail, postage and charges prepaid, addressed to the address of the Program or the address of the Group on record with the Program. Except as otherwise expressly provided herein, any such notice shall be deemed to be given on the date on which the same is deposited in a regularly maintained receptacle for the deposit of United States mail. Either the Program or the Group may change its address for the purposes of this Subscriber Certificate by giving

the other notice of this change in the manner described above provided for the giving of notice.

PART XVII. GOVERNING LAW AND VENUE

17.01 This Subscriber Certificate shall be construed and enforced in accordance with, and governed by, the laws of the State of Michigan. Venue for any and all legal actions shall be the County of Wayne, Michigan.

PART XVIII. ENTIRE AGREEMENT

18.01 This Subscriber Certificate and any Program policies, procedures, rules and interpretations constitute the entire agreement between the Program and the Subscriber. This Certificate supersedes any and all prior understandings and/or negotiations by and between the parties.

18.02 In the event of a dispute regarding the interpretation/application of the provisions set forth herein, the determination of the Executive Director of HealthChoice and/or the HealthChoice Board of Trustees control.

PART XIX. AMENDMENT

19.01 **Notice of Amendments** This Subscriber Certificate may be amended by the Program provided that a clear written statement setting forth such amendment is provided to affected Subscribers no later than thirty (30) days prior to the effective date of such amendments.

19.02 **Delay of Effectiveness** The Program may delay or postpone the effective date of any amendment to this Subscriber Certificate for any 1 or more Group.

PART XX. HEADINGS

20.01 The paragraph, section, headings and titles used herein or on the cover of any booklet containing this Subscriber Certificate are for convenience only and shall not be considered part of or used in construction or interpretation of this Subscriber Certificate.

PART XXI. RULES AND REGULATIONS

21.01 The Program may adopt such policies, procedures, rules and interpretations as may be necessary to provide for the prudent and efficient provision of services under this Subscriber Certificate.

PART XXII. SEVERABILITY

22.01 If any one or more of the provisions contained in this Certificate should be invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions shall not be in any way affected, impaired, prejudiced or limited.

XXIII.
APPENDIX A

HEALTHCHOICE BENEFITS AT A GLANCE

Preventive Services

Health Maintenance Exam	**Covered - $10.00 co-pay**
Annual Gynecological Exam	**Covered - $10.00 co-pay**
Pap Smear Screening	**Covered – Office visit co-pay apply per visit**
Mammography Screening	**Covered – Office visit co-pay apply per visit**
Well Baby and Child Care	**Covered - $20.00 co-pay (may apply if it is not the regular PCP)**
Immunizations – pediatric and adult	**Covered – Office visit co-pay apply per visit**
Prostate Specific Antigen (PSA) screening	**Covered – Office visit co-pay apply per visit**
Hearing Screening	**Covered – Office visit co-pay apply per visit**

Physician Office Visits

Office Visits	**Covered - $10.00 co-pay**
Specialist Visits	**Covered - $20.00 co-pay**

Prescription Drugs

Generic Drugs	**Covered - $10.00 co-pay per prescription**
Brand Name Drugs	**Covered - $15.00 co-pay per prescription**
Psychotherapeutics	**Covered – 50% of each prescription drug**

Emergency Medical Care

Hospital Emergency Visit/Participating Provider	**Covered – At Participating Providers $50.00 co-pay if not admitted; No co-pay if admitted**
Hospital Emergency Visit/Non-Participating Provider located in Wayne, Oakland, Macomb, Washtenaw, or Monroe Counties.	**Co-pay is $100.00 at Non-Participating Providers in Wayne, Oakland, Macomb, Washtenaw, or Monroe counties if not admitted; No co-pay if admitted; Provider is only responsible for 110% of the Michigan Medicaid DRG rate for Emergency Services at Non-Participating Provider located in area; Member is liable for any and all charges in excess of 110% of Michigan Medicaid DRG rate.**
Hospital Emergency Visit/Non-Participating Provider located outside of Wayne, Oakland, Macomb, Washtenaw, or Monroe Counties	**Provider is only responsible for 75% of the Michigan Medicaid DRG rate, but not to exceed $500, if admitted out of area; If not admitted, Provider is only responsible for Michigan Medicaid Fee Screen rate; Member is liable for any and all charges that exceed covered rates.**
Urgent Care Center (24 hour access)	**Covered - $15.00 co-pay per visit**
Ambulance Services – medically necessary	**Covered if admitted - $50.00 co-pay if not admitted**

Diagnostic Services

Radiology	**Covered – No co-pay**
Diagnostic Laboratory	**Covered – No co-pay**

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered - $20.00 co-pay
Delivery and Nursery Care	Covered – No co-pay

Hospital Care

Inpatient physician care, general nursing care, Hospital Services and Supplies	Covered – No co-pay Subject to limitations indicated in the Subscriber Certificate
Outpatient Hospital Services	Covered - $10.00 co-pay

Alternatives to Hospital Care

Home Health Care	Covered - $10.00 per visit

Surgical Services

Surgery – includes all related services and anesthesia. See member certificate for specifics	Covered – No co-pay related to inpatient hospitalization

Mental Health Care and Substance Abuse Treatment

Outpatient substance abuse care services	Not Covered - referral to Wayne County Mental Health care for services available on a sliding scale
Outpatient mental health care services	Not Covered – referral to Wayne County Mental Health care for services available on a sliding scale

Other Rider Services (available if group purchased)

Physical Therapy	Covered - $10.00 per visit
Durable Medical Equipment	Covered – 50% per prescribed equipment
Vision Exam & Glasses	Covered subject to Co-payments set forth on Appendix I and exclusions set forth on Appendix J.
Dental	Covered subject to co-payments set forth on Appendix D and exclusions set forth on Appendix E.
Inpatient Drug & Alcohol Rehab Services	Covered – Limit $20.00 per episode per enrollment year; 72 hours per episode
Additional Ten (10) inpatient hospital days	No co-pay

APPENDIX B

EXCLUSIONS FROM COVERAGE

The Program will not provide coverage:

1. Due to sickness or injury to the extent that benefits otherwise available as Covered Services are payable under Workers' Compensation, Occupational Disease Law or similar legislation under which an exclusion based upon the existence of other coverage is not prohibited by law.

2. Due to sickness or injury arising out of or in the course of employment or activity for wage or profit.

3. For any and all Covered Services, including any Covered Services in the event of an Emergency, related to motor vehicle accidents.

4. For custodial care or chiropractic care or services.

5. For diagnosis and treatment of:

   (i) weak, strained, unstable or flat feet; or

   (ii) any tarsalgia, metatarsalgia or bunion; except for surgeries which involve the exposure of bones, tendons or ligaments.

6. Except for diabetic patients, for treatment of:

   (i) toe nails, other than removal of nail matrix or root; or

   (ii) superficial lesions of the feet, such as corns, calluses and hyperkeratoses.

7. For Covered Services not deemed medically necessary.

8. For hospital, surgical, and medical services or supplies unless the expense is authorized by the primary care physician and incurred upon the recommendation of a physician for diagnosis or treatment of an injury or sickness or unless the expense is incurred for Emergency services.

9. For organ transplants and all organ transplant related costs, including but not limited to, medications.

10. For treatment of an injury or illness which occurs or arises from an act of war, declared or undeclared, from the Member's actions in conjunction with the commission of a felony, an attempt to commit a felony or an illegal business or occupation, or from any self-inflicted injury.

11. For treatment that is experimental in nature.

12. For items of personal comfort or convenience.

13. For treatment of chronic mental disorders extending beyond the period necessary for diagnostic evaluation of chronic mental deficiency or retardation and/or beyond the period where favorable modification cannot result according to generally accepted professional standards.

14. For educational testing or training related to the treatment of mental, nervous or emotional disorders including substance abuse.

15. For services primarily for weight reduction or treatment of obesity by diet control or surgery.

16. For dental work and treatment (including treatment of Temporomandibular Joint Syndrome) except as the extraction of impacted teeth while hospital confined for at least 18 hours due to a hazardous medical condition.

17. For radial keratotomy, lasik surgery, vision exams and vision related services not otherwise a benefit, except when prescribed as a result of cataract surgery or accidental injury to the eye, which occurred either before or after enrollment in the Program.

18. For the purchase of over-the-counter vitamins and contraceptives.

19. For cosmetic surgery. This exclusion does not apply to:

    (i) all stages of reconstructive surgery of a breast on which a mastectomy or lumpectomy has been performed or of the other breast to produce a symmetrical appearance.

    (ii) reconstructive surgery because of a congenital disease or anomaly if the surgery is Medically Necessary to treat a life threatening condition.

20. For services and supplies in a Veteran's Administration Hospital for a Member with a military service-connected disability.

21. For any service or supply performed in association with In-Vitro fertilization, any surgical procedure performed for the sole purpose of inducing or terminating pregnancy, surgical sterilization or reversal of a surgical sterilization, diagnosis, testing or treatment for infertility, gamete or embryo transfer procedures and any other similar types of

procedures whether or not considered investigational or experimental, artificial insemination.

22. For any service or supply relating to sex or gender change.

23. For any condition for which the Member is eligible to receive health care benefits or services pursuant to a public or private health care benefit or services program or any other insurance or other type of plan, including the program of a Member's spouse.

24. For any in-hospital health care provided as a result of an admission prior to acceptance in the Program.

25. For office visits, exams, treatments, tests and reports relating to requirements or documentation of health or medical status for employment, insurance, travel, marriage license, surrogate parenting arrangements, school, sport participation or similar purposes or for legal proceedings and court-related services such as pretrial and court testimony and exams or tests related to legal proceedings in the preparation of court related reports.

26. Unless covered as a Supplemental Service, for any other service not specifically defined or listed as a Basic Service.

27. For any and all Covered Services, including any Covered Services in the event of an Emergency, related to motor vehicle accidents.

28. For treatment of an infectious or communicable disease which occurs or arises from a biological plague or pandemic and is the subject of a United State Center For Disease Control or Michigan Department of Community Health advisory warning.

29. The costs for any services and supplies submitted to the Program for payment more than one (1) year after the date the services or supplies were provided to a Member. In addition, if any appeal to a payment denial is not made within 60 days of the denial, the Program shall not pay the costs of any services or supplies that were the subject of the claim for payment

30. For any life style drugs, whether prescribed or not, taken to satisfy a non-medical or non-health-related goal, such as Viagra (sildenafil).

APPENDIX C

SUPPLEMENTAL COVERED MEDICAL SERVICES

BENEFIT	CO-PAYMENT/BENEFIT LIMITATIONS
PHYSICAL THERAPY	$10.00 per visit
DURABLE MEDICAL EQUIPMENT	50% per prescribed equipment
INPATIENT DRUG & ALCOHOL REHABILITATION SERVICES	$20.00 per episode (Limit of 2 episodes per Enrollment Year; 72 hours per episode)
ADDITIONAL TEN (10) INPATIENT HOSPITAL DAYS	None

APPENDIX D

COVERED DENTAL SERVICES

Description	Member Pays

DIAGNOSTIC AND PREVENTATIVE

Description	Member Pays
Office Visit (regular hours)	$5.00
Exam - Periodic Oral (Established patient)	No Charge
Exam-Initial Oral	No Charge
Prediagnostic Test	No Charge
*Prophylaxis/Routine Cleaning - Adult	No Charge
Prophylaxis/Routine Cleaning - Child	No Charge
Oral Hygiene Instructions	No Charge
Local Anesthesia	No Charge
Fluoride Treatment - Child	No Charge
Fluoride Treatment - Adult	NCB
Sealant - per tooth	$12.00

X-RAY COVERAGE

Description	Member Pays
Periapical - First Film	No Charge
Periapical - Each Additional Film	$2.00
Intraoral - Occlusal Film	No Charge
Bitewing - Single Film	No Charge
Bitewings - Two Films	$8.00
Bitewings- Three Films	$10.00
Bitewings - Four Films	$12.00

ADJUNCTIVE SERVICES

Limited Oral Evaluation - Problem Focused	$20.00
Intraoral - Complete Series	$20.00
Panoramic Film	$25.00
Palliative (Emergency) Treatment	$10.00
Office Visit (after hours)	$45.00
Office Visit - unscheduled appt. (reg hours)	NCB
Recement Inlay, Onlay or Partial Cov. Rest.	$20.00
Recement Crown	$10.00
Recement Cast or Prefab. Post & Core	$20.00
Recement Bridge (fixed partial denture)	$10.00
Consultation (2nd Opinion)	NCB
Sedative Filling	$10.00
Core Buildup (Including Any Pins)	$85.00
Core Buildup for Bridge/Ret.	$85.00
Diagnostic Casts (each)	$10.00

RESTORATIVE (FILLINGS)

Amalgam Filling - One Surface	$21.00
Amalgam Filling - Two Surfaces	$28.00
Amalgam Filling - Three Surfaces	$35.00
Amalgam Filling - Four or More Surfaces	$45.00

Composite Filling - One Surface (Anterior)	$29.00
Composite Filling - Two Surfaces (Anterior)	$39.00
Composite Filling - Three Surfaces (Anterior)	$46.00
Composite Filling - Four or More Surfaces (Anterior)	$62.00
Composite Filling - One Surface (Posterior)	$40.00
Composite Filling - Two Surfaces (Posterior)	$50.00
Composite Filling - Three Surfaces (Posterior)	$60.00
Composite Filling - Four or More Surfaces (Posterior)	$80.00

SPACE MAINTAINERS

Space Maintainer - Fixed - Unilateral	$105.00
Space Maintainer - Fixed - Bilateral	$135.00
Space Maintainer - Removable - Unilateral	$135.00
Space Maintainer - Removable - Bilateral	$135.00
Re-cementation of Space Maintainer	$10.00
Occlusal Guard (night guard)	$225.00

CROWN AND BRIDGE ***

Full Cast Predominantly Base Metal (per unit)	$365.00
Crown Porcelain Fused To Semi Precious Metal	$365.00
Crown Porcelain Fused to Semi Precious Metal	$365.00
3/4 Cast Predominantly Base Metal (per unit)	$385.00
Crown-3/4 cast noble metal	$395.00
Crown - Full Cast High Noble Metal	$395.00

Crown Semi Precious Full Cast	$395.00
Pontic- Cast Noble Metal	$395.00
Prefabricated Stainless Steel-Resin Crown	$70.00
Crown - prefabricated stainless steel - permanent tooth	$70.00
Crown - prefabricated resin crown	$70.00
Crown - Prefabricated stainless steel with resin window	$70.00
Cast Predominantly Base Metal (per unit)	$385.00
Crown - full cast predominantly base metal	$385.00
Porcelain Fused - Predominantly Base Metal (per unit)	$365.00
Crown - porcelain fused to predominantly base metal	$365.00
Porcelain Fused to Noble Metal (per unit)	$385.00
Crown - Porcelain fused to noble metal	$385.00
Crown - 3/4 Cast Predominantly Base Metal (per unit)	$385.00
Crown-3/4 cast noble metal	$395.00
Crown Full Cast Noble Metal	$395.00
Resin-based Composite Crown - Anterior	$185.00
Provisional Crown	$120.00
Cast Post & Core	$105.00
Cast Post And Core	$105.00
Prefabricated Post & Core	$105.00
Prefabricated Post & Core (Bridge)	$105.00

ENDODONTICS (INTERIOR OF TOOTH)**

Anterior Root Canal Therapy	$185.00
Bicuspid Root Canal Therapy	$250.00
Molar Root Canal Therapy	$350.00
Retreat of Previous RCT - Anterior	$290.00
Retrat of Previous RCT - Bicuspid	$350.00
Retreat of Previous RCT - Molar	$410.00
Therapeutic Pulpotomy	$55.00
Retrograde Filling (per root)	$60.00
Apicoectomy/Periradicular Surg. - Anterior	$280.00
Apicoectomy/Periradicular Surg. - Bicuspid (1st root)	$310.00
Apicoectomy/Periradicular Surg. - Molar (1st root)	$350.00
Apicoectomy/Periradicular Surg. - (each additional root)	$100.00
Pulp Cap (direct)	$10.00
Pulp Cap (indirect)	$10.00

PERIODONTICS (GUMS AND SUPPORTING TISSUE)**

Comprehensive Periodontal Evaluation	$25.00
Full Mouth Debridement	$30.00
*Periodontal Maintenance	$35.00
Perio Scaling/Root Planing (4 or more teeth)	$65.00
Pero Scaling/Root Planing (1-3 Teeth)	$55.00

Site Specific Therapy (per tooth)	$50.00
Gingivectomy/Gingivoplasty (4 or more or bounded)	$210.00
Gingivectomy/Gingivoplasty (1-3 or bounded)	$210.00
Gingival Flap Procedure (4 or more or bounded)	$310.00
Gingival Flap Procedure (1-3 or bounded)	$270.00
Osseous Surgery (4 or more or bounded)	$290.00
Osseous Surgery (1-3 or bounded)	$290.00
Occlusal Adjustment (limited)	NCB

PROSTHODONTICS (REMOVABLES)

Complete Upper Denture	$425.00
Complete Lower Denture	$425.00
Immediate Maxillary Denture (Upper)	$495.00
Immediate Mandibular Denture (Lower)	$495.00
Partial Upper Denture Cast Metal Framework with resing base (including clasps, rests and teeth)	$495.00
Partial Lower Denture Cast Metal Framework with resing base (including clasps, rests and teeth)	$495.00
Partial Denture - Upper (Acrylic Resin Base)	$395.00
Partial Denture -Lower (Acrylic Resin Base)	$395.00
Tissue conditioning, maxillary	$55.00
Tissue conditioning, mandibular	$55.00
Adust complete denture - maxillary	$10.00
Adjust complete denture - mandibular	$10.00
Adjust partial denture - maxillary	$10.00
Adjust partial denture - mandibular	$10.00

Interim Complete Denture Maxillary	$165.00
Interim Complete Denture Mandibular	$165.00

REPAIR OF PROSTHESIS

Repair Broken Complete Denture Base	$50.00
Repair Resin Denture Base	$50.00
Replace Missing Or Broken Teeth Complete Denture	$30.00
Replace Broken Teeth - Per Tooth	$30.00
Repair Cast Framework	$80.00
Repair Or Replace Broken Clasp	$75.00
Add Tooth To Existing Partial Denture	$50.00
Add Clasp To Existing Partial Denture	$75.00
Reline Complete Maxillary Denture Chair side	$100.00
Reline Complete Mandibular Denture Chair side	$100.00
Reline Maxillary Partial Denture Chair side	$100.00
Reline Mandibular Partial Denture Chair side	$100.00
Reline Complete Maxillary Denture Laboratory	$125.00
Reline Complete Mandibular Denture Laboratory	$125.00
Reline Complete Mandibular Denture Laboratory	$125.00
Reline Mandibular Partial Denture Laboratory	$125.00

ORAL SURGERY**

Extraction, Coronal remnants - deciduous tooth	$32.00
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$32.00
Surgical Removal Of Erupted Tooth	$60.00
Removal Of Impacted Tooth-Soft Tissue	$85.00
Removal Of Impacted Tooth-Partially Bony	$115.00
Removal Of Impacted Tooth-Completely Bony	$170.00
Removal Of Impacted Tooth-Completely Bony, with Unusual Surgical Complications	$195.00
Surgical Removal of Residual Roots	$150.00
Surgical Exposure Of Impacted Or Unerupted Tooth For Ortho	$180.00
Alveoloplasty In Conjunction With Extractions- Per Quadrant	$75.00
Alveoloplasty In Conj With Ext-Per Quad	$60.00
Alveoloplasty Not In Conjunction With Extraction-Per Quadrant	$95.00
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$95.00
Removal of Lateral Exostosis (maxilla or mandible)	$135.00
Removal of torus palatinus	$135.00
Removal of torus mandibularis	$135.00
Incision And Drainage Of Abscess-Intraoral Soft Tissue	$30.00
Intravenous conscious sedation/analgesia - first 30 minutes	$95.00
Intravenous conscious sedation/analgesia-each additional 15 minutes	$35.00

UNCLASSIFIED TREATMENT

Office Visit For Observation(During Regularly Scheduled Hours)-No Other Service Performed	$10.00
Treatment Of Complications(post-Surgical)-Unusual Circumstances, By Report	$15.00

ANNUAL MAXIMUM for Primary Care Dentistry **UNLIMITED**

ORTHODONTICS

Child (up to age 26) - Lifetime Maximum - comprehensive only	**$1,800.00**
Adult (Member and Spouse) - Lifetime Maximum - comprehensive only	**$1,200.00**

SPECIALTY CARE

ANNUAL MAXIMUM FOR SPECIALTY CARE	**$1,000.00**
(Approved referral from Dental Provider required for all Specialty Care) Members referred to another participating dentist for Specialty Care are responsible for 65% of the Specialist's fee for listed procedures, including evaluations and x-rays.	
Pedodontics is covered at 65% for dependents up to age 7	
There is a six (6) month waiting period for new enrollees - check with GDP	

Prophylaxis - 3 per contract year . 3rd prophylaxis member has a 50% co-payment.

***This co-payment applies if procedure performed by a general dentist. Please see above specialty heading for co-pays at referred specialty offices*

****Crowns and Dentures are covered once in a period of 5 years*

****Porcelain on crowns posterior to the 2nd bicuspid are considered cosmetic dentistry and therefore are not a covered benefit*

All specialty appointments must accompany primary care referral

See member handbook for complete plan limits and exclusions

APPENDIX E

LIMITATIONS AND EXCLUSIONS FROM DENTAL SERVICES

General Exclusions, Limitations and Exceptions

No benefits will be paid under this Policy for the following treatments, services and care, unless otherwise indicated:

1. Dental services not appearing on the Schedule of Benefits.
2. Dental treatment for cosmetic purposes.
3. Dental treatment performed in a hospital and/or any related hospital-fee.
4. Treatment of cleft palate, anodontia and mandibular prognathism.
5. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained.
6. The cost of services secured from physicians, Dentists or Dental Surgeons, other than authorized GDP Providers, will not be paid for unless expressly authorized in writing by the Primary Care Dentist as cited under Emergency Coverage and Out- of-Area Emergency Coverage provision, in Section 5.
7. Treatment for any condition for which benefits of any nature are recovered or found to be recoverable whether by adjudication or settlement under any Workmen's Compensation or Occupational Disease Law, even though You or Your Covered Dependent fails to claim the right of such benefits, provided that this exclusion will only apply to the extent that such benefits are payable through other plans.
8. Treatment for any disease, condition or injuries sustained, as a result of war, declared or undeclared, or any illness or injury occurring after the effective date of the Policy and caused by atomic explosion or exposure whether or not the result of war.
9. Care of treatment obtained from or for which payment is made by any Federal, State, and County, Municipal or other governmental agency including any foreign government.
10. Dental implants or transplants.
11. No Covered Person will be denied dental coverage due to trauma. However, dental care coverage under this Policy may not cover the Covered Person for certain traumatic events that may occur if those procedures are specifically excluded in this Policy. A Covered Person who requires dental care due to a serious trauma will not be covered for dental care in those areas that are specifically described as excluded.
12. A nominal administrative or sterilization fee charged by Select Dental Offices. Please refer to the GDP Provider Directory for further information.
13. Services or appliances started before a Covered Person became eligible under this Policy (for example, teeth prepared for crowns or root canals in progress).
14. Prescription drugs.
15. Nitrous oxide analgesia.
16. Preventive control programs (including home care items).
17. Services started after termination of coverage,
18. Charges for failure to keep a scheduled visit with the Dentist;
19. Lost, missing, or stolen appliances (for example: retainers, occlusal guards, partial or full dentures, or flippers).
20. Duplicate full or partial dentures.

21. Inlays, unless listed as a Covered Service in the Schedule of Benefits.
22. Porcelain, porcelain substrate, and cast restorations on primary (baby) teeth.
23. Cysts and malignancies.
24. Removal of impacted teeth that exhibit no symptoms or pathology.
25. Consultations, or examinations/evaluations for noncovered services.
26. Services or appliances performed by a Dentist whose practice is limited to prosthodontics (prosthodontist).
27. Behavior management fees for Covered Persons requiring additional or unusual efforts to complete a dental procedure.
28. Soft tissue management (irrigation, infusion, or special toothbrush).
29. Restorative work caused by orthodontic treatment.
30. Extractions solely for the purpose of orthodontics.
31. Composite resin restorations on occlusal surfaces of bicuspids and molars.

Orthodontic Exclusions, Limitations and Exceptions

1. Retreatment of prior Orthodontic problems unless provided under this Policy or any extension or renewal of this Policy.
2. Patients with severe disabilities which may prevent satisfactory Orthodontic results.
3. Surgical Orthodontics not normally performed in a dental office by a general dentist or orthodontist.
4. Any charge made by the Orthodontist for the cost of replacement and/or repair of an appliance furnished to the patient which is lost or broken through no fault of the Orthodontist.
5. Periodontal treatment as specified within this Policy.
6. Interceptive Orthodontic Treatment is not a covered benefit.
7. Surgical procedures incidental to orthodontic treatment.
8. Myofunctional therapy.
9. Supplemental appliances not routinely used in typical orthodontic cases.
10. Active treatment extending more than 24 months from the point of banding due to lack of patient cooperation. For cases extending past 24 months, the Covered Person will be charged a monthly fee that is prorated at the Orthodontist's Submitted Fees.
11. Treatment started before the Covered Person became covered under this Policy.
12. Transfer to another Dentist after banding has been initiated.
13. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and are subject to additional charges.

APPENDIX F

EXPLANATION OF PRE-EXISTING CONDITION LIMITATIONS

If a Member has been treated for an injury or illness within six (6) months prior to becoming eligible for benefits under the Program (a "pre-existing condition"), then all expenses incurred as a result of such injury or illness will not be considered as eligible expenses and will not be considered Covered Services until twelve (12) months after the effective date of coverage with the Program. A pre-existing condition exclusion is defined as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.

The Pre-Existing Condition Limitations are as follows:

- A pre-existing condition limitation is allowed for twelve (12) months (eighteen (18) months for late enrollees) after the enrollment date in the Program. This period is reduced, however, by counting certain prior coverage toward the exclusion period. Members with twelve (12) months of coverage with one employer may therefore, move to a new employer with new coverage without becoming subject to the pre-existing condition exclusion of the new employer.
- An Member is credited for prior coverage under a wide variety of health plans, including group health plans, individual policies, HMOs, Medicare, and various governmental programs. Coverage is not counted toward reducing the exclusion period of the employer's new plan, however, if there has been an intervening break in coverage of sixty-three (63) days or more only coverage after the break may be credited.
- An individual's prior plan must supply a certification of coverage at the time coverage ceases or, upon request of the individual, at any time within the next two (2) years. The certification must specify the period of creditable coverage.
- If you do not receive a certificate, you may demonstrate that you have creditable coverage (as well as the time you were in any waiting period) by producing documentation or other evidence of creditable coverage (such as pay stubs that reflect the deduction for health insurance, explanation of benefit forms (EOBs) or verification by a doctor or your former health care benefits provider that you had prior health insurance coverage.
- No pre-existing condition limitation will apply to pregnancy, pregnancy related conditions or conditions related to genetic information.
- No pre-existing condition limitation will apply in the case of a newborn, adopted child or child placed for adoption if covered under creditable coverage within thirty (30) days of birth, adoption or placement for adoption.
- No pre-existing condition limitation will apply to Members, including applicants for enrollment, who are under 19 years of age.

APPENDIX G

GRADUATED HOURLY SCALE

HOURLY RATE	SUBSIDY
$10.00 or less per hour	$67.04
$10.01 to $10.50	$60.80
$10.51 to $11.00	$54.56
$11.01 to $11.50	$48.32
$11.51 to $12.00	$42.08
$12.01 to $12.50	$35.84
$12.51 to $13.00	$29.60
$13.01 to $13.50	$23.36
$13.51 to $14.00	$17.12
$14.01 to $14.50	$11.92
$14.51 and higher	$00.00

APPENDIX H

GROUP FEES

1. Late Fees: $25.00

   This is any premium payment received after the 15th of the month due.

2. Reinstatement Fees: $100.00

   This is any premium payment received after the 25th of the month due.

3. Returned Checks: $35.00

   This is any check that has been sent back to us from the bank as not being able to cash (NSF).

APPENDIX I

COVERED VISION SERVICES
HERITAGE TOTAL SERVICES VISION BENEFITS AT A GLANCE

SERVICES	IN-NETWORK COVERAGE
Comprehensive Eye Exam (Does not apply to Contact Lens Fitting)	100% Covered, No Co-pay
Frames: (Choice of One)	
Standard (Covered) Frames	100% Covered, No Co-pay
Premium Frames	$45.00 Retail Allowance (Member pays all costs over $45.00)
Lenses: (Choice of One) ***Covered Material = Plastic or Glass***	
Single Vision	100% Covered, No Co-pay
Bifocal	100% Covered, No Co-pay
Trifocal	100% Covered, No Co-pay
Lenticular	100% Covered, No Co-pay
Lens Options:	
Tint (Therapeutic Rose Tint #1 or #2)	100% Covered, No Co-pay
Other Lens Options: (i.e. Thinner Lenses, Scratch Coating, Transitions, Anti-Reflective Coating, UV Protection, Roll & Polish, etc.)	A 20% Preferred Pricing Discount will be granted for all lens options not covered by the plan.
Contact Lenses: **(in lieu of eyeglasses)** ***Benefit may be applied to: Contact Lenses, Fitting and/or Follow-up***	
Elective / Cosmetic [1] **Contact Lenses** ($70.00 Retail Allowance)	100% Covered up to a **$70.00 retail maximum** (Member pays all costs over $70.00)
Medically Necessary [1] **Contact Lenses** *(Prior Approval must be obtained to establish Medical Necessity)*	100% Covered, No Co-pay

[1]You are eligible for eyeglasses **OR** contact lenses, not both, in any 24 Month Consecutive Period.
Exam and Material Benefit Frequency is once every 24 Months (from date of last service).

APPENDIX J

LIMITATIONS AND EXCLUSIONS FROM VISION SERVICES HERITAGE TOTAL SERVICES VISION BENEFITS AT A GLANCE

Exclusions / What's Not Covered

Products and services not covered under the plan include:

- Non-prescription lenses
- Two pairs of glasses instead of bifocals
- Lenses and frames furnished under a plan, which are lost or destroyed
- Parts or repair of frame not covered under a manufacturers' warranty
- Medical or surgical treatment of the eyes
- Drugs or medications
- Corrective vision services, treatments, and materials of an experimental nature
- Services not visually necessary
- Industrial (3mm) safety lenses and safety frames with side shields
- Any services not specified in the HealthChoice Scope of Services or Subscriber Certificate

Effective 1/1/11