

## **BCN 1 – General Provisions**

The member hereby expressly acknowledges its understanding the BCN General Provisions constitutes a contract solely between Subscriber and BCN, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting BCN to use the Blue Cross and Blue Shield Service Mark (s) in Michigan, and that BCN is not contracting as the agent of the Association. The member further acknowledges and agrees that it has not entered into this contract based upon representations by any person other than BCN and that no person, entity, or organization other than BCN shall be held accountable or liable to the member for any of BCN’s obligations created under the BCN General Provisions. This paragraph shall not create any additional obligations whatsoever on the part of BCN other than those obligations created under other provisions of this agreement.

### **BLUE CARE NETWORK**

#### **GENERAL PROVISIONS**

The Blue Care Network is a network of health maintenance organizations licensed by the State of Michigan and affiliated with Blue Cross and Blue Shield of Michigan. This Certificate is issued by your Blue Care Network Health Plan and is an agreement with persons who have enrolled as Members. By enrolling in our Health Plan as outlined in this Certificate, the Member agrees to abide by the rules of the Health Plan as outlined in this Certificate and recognizes that, except for emergency health services, only those health care services provided or authorized by the Health Plan are a benefit under this Certificate. Members are entitled to the health maintenance organization services and benefits described in this Certificate in exchange for the premium paid to Health Plan.

#### **I. DEFINITIONS**

- 1.01 AUTHORIZED SERVICE** is any health care which is a benefit under this Certificate and which has been authorized by Health Plan.
- 1.02 CERTIFICATE** means this Certificate including both the General Provisions and Schedule of Benefits and any riders and official attachments to it.

- 1.03 FAMILY DEPENDENT** means a member of a Subscriber's family who meets eligibility requirements and for whom a completed enrollment application and premium payment have been received by Health Plan.
- 1.04 GROUP** means the legal entity which has contracted with Health Plan on behalf of its employees or members for the benefits described in this Certificate.
- 1.05 GROUP LETTER OF AGREEMENT** means the written agreement between Health Plan and a Group pursuant to which coverage under this Certificate is offered to eligible employees or member of Group.
- 1.06 HEALTH PLAN** means the local Blue Care Network health maintenance organization in which the Member is enrolled.
- 1.07 MEDICAL OFFICE** means an ambulatory facility or physician office operated and staffed by Health Plan Physicians and personnel who are under contract with Health Plan to serve Health Plan Members.
- 1.08 HOSPITAL** means a state licensed acute care facility which has a contract with the Health Plan or its sponsoring parent organization, Blue Cross and Blue Shield of Michigan, to provide hospital services to Members and which provides continuous inpatient medical, surgical, or psychiatric diagnosis, treatment, and care for injured or sick persons by or under the supervision of a staff of physicians with 24 hour nursing service by registered nurses. A hospital is not, other than incidentally, a nursing or rest home or a place for the aged or for the treatment of substance abuse or pulmonary tuberculosis.
- 1.09 MEMBER** means a Subscriber or an enrolled Family Dependent entitled to coverage under this Certificate.
- 1.10 HEALTH PLAN PERSONNEL** means the personnel engaged by Health Plan to assist in carrying out its obligations under this Certificate including but not limited to physicians, optometrists, nurses, nurse practitioners, physician assistants, medical technicians, administrative personnel, clerical personnel and others.
- 1.11 OPEN ENROLLMENT PERIOD** means a period of time at least once each calendar year agreed upon by Health Plan and the Group when eligible persons in the Group are given an opportunity to enroll or disenroll in Health Plan.

- 1.12 PLAN PHYSICIAN** means a licensed medical doctor or doctor of osteopathy contracted or employed with Health Plan or primary care physician affiliated with Health Plan to render services to Members which are benefits under this Certificate.
- 1.13 REFERRAL PHYSICIAN** means a doctor of medicine or osteopathy to whom a Member is referred by a Plan Physician.
- 1.14 PREMIUM** means the amount of money prepaid monthly by a Group, including Subscriber contributions, if any, on behalf of the Subscribers and Family Dependents enrolled through that Group.
- 1.15 SERVICE AREA** means the geographic area approved by state authorities, which is served by Health Plan.
- 1.16 SKILLED NURSING FACILITY** means a state licensed nursing home which is certified as a skilled nursing facility and which has contracted with Health Plan or with Blue Cross and Blue Shield of Michigan to provide skilled nursing facility services to Health Plan Members.
- 1.17 SUBSCRIBER** means a person who meets eligibility requirements and for whom a completed enrollment application and premium payment have been received by Health Plan.

## **II. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE**

### **2.01 ELIGIBILITY**

- A. Subscribers. To be eligible for membership as a Subscriber, an individual must:
1. Reside in the service area;
  2. Be a bona fide member of, an active employee of, or an eligible retiree of a Group which has executed a Group Letter of Agreement with Health Plan;
  3. Meet the Group's eligibility requirements to participation in a health benefits plan.

- B. Family Dependents. To be eligible for membership as a Family Dependent, an individual must:
1. Reside in the service area;
  2. Meet the Group's eligibility requirements for dependents coverage;
  3. Be the spouse of the Subscriber; or
  4. Be an eligible dependent child as defined by the Group's eligibility criteria. Enrollment of a child will terminate at the end of the calendar year in which the child reached 25 years of age except that a child who reaches 25 years of age while enrolled in the Health Plan will not be terminated if the child, in the opinion of Health Plan, is totally and permanently disabled and is both incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon Subscriber for support and maintenance. To continue coverage for a child meeting these criteria, proof of disability and dependence must be furnished to Health Plan by Subscriber within 30 days of the child's 25<sup>th</sup> birthday. Health Plan may require that the Subscriber submit subsequent satisfactory proof of continued disability and dependence but in no event will such proof be required more frequently than once a year.
- C. Principally Supported Child. To be eligible to enroll a Principally Supported Child as a Family Dependent, the child must meet Health Plan's eligibility criteria as described in this subsection and must meet the enrollment requirement in Section 2.02. Some Groups have specific requirements for Principally Supported Children which may differ in part from the criteria and requirements contained in this Certificate. The Group's requirements will be recognized by Health Plan and will supersede the criteria in this Certificate to the extent that they differ, provided that the Health Plan has agreed in writing with the Group to recognize the specific Group criteria. To be eligible to enroll as a Family Dependent a Principally Supported Child must be a child (other than a child described in subparagraph b.4) who is related to the Subscriber by blood or marriage and who meets the following conditions:
1. The child must be under 19 years of age and unmarried.

2. The child must actually live full-time in the home with the Subscriber.
  3. The child must not be eligible for Medicare.
  4. The Child must be dependent on the Subscriber for principal support in accordance with the standards of the Internal Revenue Service and must have met the IRS standards for at least six full months prior to the submission of application for enrollment of the child.
- D. If a Member covered under this Certificate becomes eligible to enroll in Medicare, the Member shall automatically be converted to the Health Plan's Medicare program.
- E. Waiver. Health Plan at its discretion may permit Subscriber and Family Dependents residing outside the service area to enroll or remain enrolled in Health Plan upon execution of a waiver in writing related to utilization of services within the service area.
- F. Change of Status. Subscriber agrees to notify the Group and the Group agrees to notify Health Plan within 30 days of any change in his or her eligibility status and the eligibility status of any Family Dependents. Subscriber and Family Dependents are jointly and severally responsible for payment for any services or benefits received from Health Plan after the Subscriber or Family Dependent ceases to be eligible for coverage pursuant to the terms of this Certificate regardless of whether or not notice was given.

## **2.02 ENROLLMENT**

- A. Persons who are eligible to enroll in Health Plan during an Open Enrollment Period must enroll at that time or must wait until the next Open Enrollment Period.
- B. Persons who first become eligible to enroll at a time other than during the Open Enrollment Period must enroll within 30 days of becoming eligible. For example, new Employees will be allowed 30 days from the date of becoming eligible to enroll in Health Plan regardless of when the Group's Open Enrollment Period is.
- C. Eligible newborn children will be covered from birth if enrolled within 30 days of birth.

- D. To enroll, a completed enrollment application must be submitted to the group and the application and appropriate premium amount must be received by Health Plan from the Group.
- E. Enrollment of a Principally Supported Child.
  - 1. Application for enrollment of a principally supported child as a Family Dependent may be made when the child has met the IRS dependency standards for six full months.
    - a. The Subscriber must submit evidence that the child was reported as a dependent on the Subscriber's most recently filed tax return; or
    - b. The Subscriber must provide evidence and a sworn statement that the child qualifies for dependent tax status in the current year.
  - 2. The Subscriber must furnish proof of eligibility for a principally supported child annually.

### **2.03 EFFECTIVE DATE OF COVERAGE**

Coverage for principally supported children will be effective the first monthly renewal date of the Group coverage 90 days after application and verification of eligibility has been received by Health Plan and the other requirements listed below have been met. Subscribers and other Family Dependents will be covered under this Certificate on the effective date of coverage agreed upon between the Group and Health Plan after all of the requirements below have been met:

- A. The name of the Subscriber and enrolled Family Dependents have been received from the group in writing by Health Plan.
- B. The appropriate premium has been received by Health Plan from the Group for all listed Subscribers and enrolled Family Dependents.
- C. If a Member was admitted to a hospital or skilled nursing facility prior to the effective date of the Certificate, coverage for inpatient care will begin on the effective date of the Certificate only if: 1) the Member has no continuing coverage under any other health benefits contract, program, or insurance; 2) Health Plan is notified of the admission prior to the effective date and medical management of the Member is

transferred to a Plan Physician before or on the effective date; and 3) the Plan Physician authorizes inpatient care as medically necessary.

### **III. OTHER PARTY LIABILITY**

Health Plan does not pay claims or coordinate benefits for services which are not provided or authorized by a Plan Physician and which are not benefits under this Certificate.

#### **3.01 NONDUPLICATION**

Health Plan provides each Member with full health care services within the limits of this Certificate. Health Plan does not duplicate benefits provided or paid for by another party nor provide a Member with greater benefits than the actual expenses incurred. Benefits under this Plan will be reduced to the extent that they are available or that reimbursement is payable under any other group certificate, group insurance policy, or other group program covering the Member whether or not a claim is made for the benefits. Benefits will be coordinated, as outlined below, to provide 100% coverage in whole or in part under either plan but in no event will benefits be provided which would result in payments in excess of 100% of the total amounts to which providers or Members are entitled. As a health maintenance organization, Health Plan is not required to pay claims or coordinate benefits for services which are not provided or authorized by the Health Plan or Plan Physician and which are not a benefit under this Certificate. Under state law Health Plan is prohibited from making any direct monetary payment or reimbursement to Members related to services received except as specifically allowed by law.

#### **3.02 WORKERS' COMPENSATION AND AUTO NO-FAULT**

Benefits under this Certificate exclude services and treatment for any work related injury to the extent that benefits are paid or payable under any workers' compensation program or other similar program. Where services are provided by Health Plan, Health Plan is assigned the Member's rights to seek reimbursement from the other program or insurer. Benefits under this Certificate will not be reduced because of the existence of coverage under a Member's non-coordinated no-fault automobile policy, the health plan will assume primary liability to provide benefits available under this Certificate in accordance with this Certificate's terms and conditions.

### **3.03 COORDINATION OF BENEFITS**

- A. When a Member has coverage for health care services under more than one health or insurance plan, coordination of benefits (COB) is used to determine which plan has primary liability and which has secondary liability. COB insures that a Member who is covered under two or more plans will have up to 100% of covered services paid or provided, but it precludes the Member from receiving coverage from both plans in excess of total expenses. COB is governed by state law. If a Member has coverage under a plan which does not contain COB, the benefits under that plan will be deemed to be primary and Health Plan will be secondary. This Certificate will be coordinated in accordance with the Michigan COB Act, Public Act 64 of 1984 and any subsequent amendments.
- B. If it is determined that benefits under this Certificate should have been reduced because of benefits available under another certificate or policy in accordance with COB rules, Health Plan has the right to recover from the other plan or from the Member if payment was received from the other plan or to assess a reasonable charge for rendered services in excess of Health Plan's liability. Similarly, if benefits due from Health Plan have been provided under another certificate or policy, Health Plan may directly reimburse the organization which provided the benefits.
- C. For purposes of coordination of benefits, Health Plan may release, claim or obtain any necessary information from any insurance company or other organization. In addition, any Member claiming benefits under this Certificate shall furnish Health Plan with information, as requested, necessary for administering this provision.
- D. Benefits available under this Certificate will not be reduced or otherwise limited under this section because of the existence of a group contract for which the subscriber pays more than 50% of the premium or non-group contract which is issued as a hospital indemnity, surgical indemnity, specified disease, or other policy of disability insurance as defined in Section 3400 of the Insurance Code of 1956, Act No. 218 of the Public Acts of 1956, being Section 500.3400 of the Michigan Compiled Laws.

### **3.04 SUBROGATION**

- A. Subrogation means that Health Plan will have the same right as a Member to recover expenses for treatment of an injury or illness for

which another person or organization is legally liable. To the extent Health Plan provides services in such situations, Health Plan will be subrogated to the Member's right of recovery against the responsible person or organization. Health Plan will not subrogate against insurers on policies issued to and in the name of the Member.

- B. The Member agrees, by acceptance of an identification card from Health Plan, that as a condition to receiving benefits and services under this Certificate, the Member will make a good faith effort to pursue recovery from the liable party, and upon collection of any recoveries for any benefits and services provided by Health Plan will reimburse Health Plan. Health Plan shall have a lien for any benefits and services rendered on any such recoveries whether by judgement, settlement, compromise, or reimbursement.
- C. Upon acceptance of the Health Plan identification card, the Member is deemed to have granted Health Plan authorization to be subrogated to the Member's right to bring suit at Health Plan's expense and at the Health Plan's request, the Member shall execute a subrogation agreement affirming this authorization. If a suit brought by Health Plan on behalf of a Member results in a monetary recovery in excess of the services and benefits provided by Health Plan, Health Plan shall have the right to recover its legal fees and costs out of the excess.
- D. The Member or his or her representative shall execute and deliver to Health Plan any instruments and papers and do whatever else is necessary to enable Health Plan to implement the provisions of this Section. A Member who engages legal representation to pursue a claim shall inform his or her counsel of the rights of Health Plan under this Certificate. When reasonable collection costs and legal expenses are incurred in recovering sums which benefit both the Member and Health Plan, an equitable division of the costs and legal expenses will be made.
- E. The Member shall not compromise or settle a claim or take any action which would prejudice the rights and interests of Health Plan without Health Plan's prior written consent.

## **IV. MEMBER RIGHTS AND RESPONSIBILITIES**

### **4.01 CONFIDENTIALITY OF HEALTHCARE RECORDS**

- A. Information from medical records of Members and information received from health care providers incident to the doctor-patient relationship will be kept confidential. Except in connection with the administration of this Certificate, when required by law, for use of nonidentifying data for statistical studies or in bona fide medical research or education, information from medical records will not be disclosed without the consent of the Member. The Member agrees to cooperate with Health Plan by providing health history information and by assisting in obtaining prior medical records as requested.

### **4.02 INSPECTION OF MEDICAL RECORDS**

Members may review their own medical records and those of their minor children or wards at the Medical Office by appointment during reasonable business hours. Parental or guardian access to a minor's medical records without the minor's consent may be limited as required by law or policy established by the Health Plan.

### **4.03 PRIMARY CARE PHYSICIAN**

You may select a Primary Care Physician from the list of BCN physicians in your geographical area. BCN will make every attempt to honor your choice. A female Member may also directly access any affiliated obstetrician gynecologist for all obstetric and routine gynecologic care without a referral. The female Member retains the right to receive the obstetrical and/or gynecological services directly from her Primary Care Physician.

The parent or guardian of a BCN Member under the age of eighteen (18) years (referred to as a "Minor") may select an affiliated pediatrician as the Minor's Primary Care Physician. Alternatively, the parent or guardian of a Minor may select a BCN affiliated family practitioner or general practitioner as the Minor's Primary Care Physician, and may access a BCN affiliated pediatrician for general pediatric services for the Minor (hereinafter "Pediatric Services"). No referral is required for a Minor to receive Pediatric Services from the affiliated pediatrician.

A Member wishing to change Primary Care Physicians may do so by making arrangements with BCN. If after reasonable efforts, the Member

and Primary Care Physician are unable to establish and maintain a satisfactory physician-patient relationship, BCN may transfer the Member to another Primary Care Physician. If a satisfactory physician-patient relationship cannot be established and maintained, BCN may ask you to disenroll. In some cases, the contract may be terminated, which will affect all the Members on the contract. See Section 6.03

#### **4.04 REFUSAL TO ACCEPT TREATMENT**

A Member may refuse, for personal or religious reasons, to accept procedures or treatment recommended as necessary by Plan Physicians. Although such refusal is the Member's right, in some situations it may be regarded as a barrier to the continuance of the physician-patient relationship or to the rendering of the appropriate standard of care. When a Member refuses a recommended, necessary treatment or procedure and the Plan Physician believes that no professionally acceptable alternative exists, the Member shall be so advised. If the Member still refuses the treatment or procedures which the Plan Physician does not believe medically or professionally appropriate, the Physician and Health Plan are relieved of further professional and financial responsibility to provide further care for the condition under treatment.

#### **4.05 COMPLAINT AND GRIEVANCE PROCEDURE**

The Health Plan has established a complaint and grievance procedure to assist any Member who has a problem or complaint regarding any aspect of Health Plan's services. A copy of the complaint and grievance procedure is provided to each new Subscriber and may be obtained at any time upon request from the Health Plan. Grievance not satisfactorily settled through the Health Plan grievance procedure may be appealed to the Office of Financial and Insurance Services, Division of Insurance, Health Plans Division, 611 Ottawa, Second Floor, P.O. Box 30220, Lansing, Michigan 48909-7720.

#### **4.06 MEMBER'S ROLE IN POLICY-MAKING**

Not less than one-third of the Board of Directors of Health Plan consists of Members elected by the Subscribers. Nomination and election procedures are provided to Subscribers in the Health Plan newsletter.

## **V. FORMS, IDENTIFICATION CARDS, RECORDS, CLAIMS FORMS**

### **5.01 FORMS AND APPLICATIONS**

Applicants and Members shall complete and submit to Health Plan any applications, medical questionnaires, and other forms as are reasonably requested. Members warrant that all information contained in such applications, questionnaires, and forms is true, correct, and complete.

### **5.02 IDENTIFICATION CARD**

Identification cards are issued to Members for identification purposes only and must be presented when services are sought. Possession of an identification card does not confer a right to benefits under this Certificate. To be entitled to benefits, the holder of the identification card must be the Member on whose behalf all applicable premiums have actually been paid. Persons receiving services or other benefits to which they are not entitled shall be charged for the services. The identification card is the property of Health Plan and its return may be requested at any time. Loss or theft of an identification card should be reported to Health Plan immediately.

### **5.03 MISUSE OF IDENTIFICATION CARD**

If any Member misuses or permits the use of the identification card by any other person or otherwise attempts to or defrauds Health Plan, Health Plan may initiate civil and/or criminal action against the Member. The Member shall reimburse Health Plan in full for any services obtained fraudulently or through misuse of the identification cards.

### **5.04 MEMBERSHIP RECORDS**

Health Plan will keep membership records. Health Plan is not liable for any obligation dependent upon information to be supplied by the Group or a Member prior to receipt in a satisfactory form. Incorrect information furnished may be corrected if Health Plan has not acted to its prejudice by relying on it.

### **5.05 AUTHORIZATION TO RECEIVE INFORMATION**

Health Plan is entitled to receive from any provider of services to Members information reasonably necessary in connection with the administration of

this Certificate but subject to applicable confidentiality requirements. By acceptance of coverage under this Certificate, the Member authorizes providers rendering services hereunder to report to and disclose information concerning the care, treatment and physical condition of the Member to Health Plan upon request and to permit copying of records by Health Plan.

#### **5.06 CLAIM PROVISION**

It is not anticipated that a Member will make payment to any other person or institution providing authorized services under this Certificate, but if the Member furnishes evidence satisfactory to Health Plan that he or she has paid a claim for authorized services, the Member will be reimbursed by Health Plan so long as Health Plan is not prejudiced on account of any payment made prior to receipt of such evidence. Written proof of the claim must be furnished to Health Plan within ninety days after the rendering of the service. Failure to furnish proof within the required time shall not invalidate the claim if it was not reasonably possible to give proof within such time, provided proof is furnished as soon as reasonably possible but in no event more than 12 months after the date of service. Claims submitted more than 12 months after the date of service will not be processed or paid.

### **VI. TERMINATION OF COVERAGE**

#### **6.01 TERMINATION OF GROUP COVERAGE**

This Certificate and the Group Letter of Agreement shall continue in effect for one year from the effective date and from year to year thereafter, subject to the following:

- A. This Certificate may be terminated by the Group or Health Plan with 30 days prior written notice. Benefits will terminate for all Members of the Group as of the date of termination of this Certificate.
- B. If a Group terminates this Certificate, pursuant to Paragraph A, all rights to benefits shall cease as of the effective date of termination. Health Plan will cooperate with the Group in attempting to make arrangements for continuing care of Members who are hospitalized on the termination date.

## **6.02 TERMINATION FOR NONPAYMENT**

A Group failing to pay the premium for this Certificate when due is in default and if the default continues, the Group and all Members enrolled through the Group may be terminated 30 days from the premium due date. Any services rendered or benefits provided to a Member during a period of default will be charged to the Group if the default is not fully corrected within the 30 days. Health Plan will make reasonable efforts to notify Subscribers enrolled through a Group and their collective bargaining representative, if any, in the event of termination for default.

## **6.03 TERMINATION OF A MEMBER'S COVERAGE**

Coverage under this Certificate for a Member and the enrolled family unit, when applicable, shall terminate as provided below. Termination under this paragraph is subject to reasonable notice and grievance rights.

- A. If the Member ceases to meet the eligibility requirements of Article II, coverage shall terminate automatically. The termination becomes effective the last day of the month in which the eligibility terminates without further action by Health Plan.
- B. If this Certificate terminates pursuant to Section 6.01 or 6.02, the Member's coverage shall terminate automatically.
- C. If a Member has repeatedly acted in a manner abusive or obstructive to staff or other patients or has repeatedly and intentionally misused the Health Plan system, with the Member's and the Group's consent the coverage shall terminate and the Member will be transferred to the Group's alternate carrier.

## **6.04 EXTENSION OF BENEFITS**

All benefits cease as of the date of termination of coverage for any Member except as provided in this paragraph. In the event that coverage terminates because of termination of eligibility as provided in paragraph 6.03 (A) or if Health Plan initiates termination under paragraph 6.01 (A), all benefits will automatically cease except that coverage will continue for an authorized inpatient admission to a hospital or skilled nursing facility which began prior to the effect of termination. The extension of benefits will continue only for the condition under treatment at the date of termination and only until whichever of the following events occurs first:

- A. Discharge

- B. Expiration of the benefits
- C. Determination by a Plan Physician that inpatient treatment or care is no longer medically necessary.
- D. The person becomes eligible for coverage under any other health plan.

## **VII. CONVERSION COVERAGE**

**7.01** If a Subscriber ceases to meet eligibility requirements of this Certificate, the Subscriber may apply for conversion to nongroup coverage. No lapse in coverage will occur provided that written application for conversion is received and approved by Health Plan along with applicable premium charges within 30 days of the date on which the Subscriber ceases to be eligible for coverage under this Certificate. Nongroup conversion coverage will be of the kind then available and at the rate in effect at that time.

- A. If a Subscriber ceases to meet eligibility requirements because of change of residence but remains eligible for health care coverage under the Group's standards, the Subscriber may apply for waiver of the residency requirement under paragraph 2.01 or must transfer to the Group's alternate carrier, if any. If the Group does not maintain alternate coverage, or if transfer is not possible, the Subscriber may apply through the Group and Health Plan for conversion coverage from Blue Cross and Blue Shield of Michigan. No lapse in coverage will occur provided that written application for waiver or for conversion is received and approved by Health Plan or BCBSM along with applicable premium charges within 30 days of the change of residence.
- B. If a Family Dependent covered under this Certificate ceases to be eligible to continue membership because of death of the Subscriber, change of residence, or loss of dependent status, the Member is entitled to the same conversion privilege as provided for the Subscriber. A minor or totally disabled child as defined in Section 2.01 B(4) may convert only as a dependent on a parent's conversion contract.

- C. If a Member covered under this Certificate ceases to be eligible to enroll in Medicare, the Member will be notified and will be converted to Health Plan's Medicare program.

**7.02** Most employers of over 20 employees are required by federal law to offer Members who lose eligibility continuation of group coverage at the Member's expense. If the Member's Group is subject to this requirement and the Member meets the definition of a person eligible for continuation coverage under the law, the following applies:

- A. If a Member ceases to meet the eligibility requirements of this Certificate, the Member may apply directly to his or her employer for continuation of group coverage. The Member must comply strictly with the time limits for electing and paying for continuation coverage and other requirements of federal law.
- B. Continuation coverage may continue for up to 18, 29, or 36 months depending on the reason for the initial eligibility. A Member in continuation coverage status is considered a Member under the Group's coverage for all purposes including for purposes of termination for cause but events which would otherwise result in loss of eligibility for coverage are waived to the extent that federal law specifically allows continuation rights. Continuation coverage and all benefits under this Certificate cease automatically upon the occurrence of any of the following:
  - 1. Expiration of the maximum period applicable to the Member as specified by law;
  - 2. The Group ceases to offer this Health Plan's coverage;
  - 3. The Member becomes covered under any other group health plan, with some exceptions;
  - 4. The Member becomes eligible for Medicare;
  - 5. The Member fails to make full and timely payment of premium.
- C. If a Member in continuation coverage status maintains uninterrupted coverage in good standing, the Member may elect to change from continuation coverage to nongroup conversion coverage at any time during the last six months of the maximum benefit period. No lapse in coverage will occur provided the member submits a written application and applicable premium payment to Health Plan before

the last day of the maximum benefit period. The nongroup conversion coverage will be of the type then available and at the rates in effect at that time. A minor or totally disabled child age 19 or over may convert only as a dependent on a parent's conversion contract.

## **VIII. GENERAL PROVISIONS**

### **8.01 NOTICE**

Any noticed required or permitted to be given by Health Plan shall be deemed appropriately given if in writing and either personally delivered or deposited in the United States Mail with postage prepaid and addressed to the Subscriber or Member at the last address of record.

### **8.02 CHANGE OF ADDRESS**

The Subscriber must promptly notify Health Plan of any change of address or of the address of any Family Dependent.

### **8.03 HEADINGS**

The catchline headings and captions in this Certificate are not to be considered a part of this Certificate and are inserted only for purposes of convenience.

### **8.04 GOVERNING LAW**

This Certificate of coverage is made and shall be interpreted under the laws of the State of Michigan.

### **8.05 EXECUTION OF CONTRACT OF COVERAGE**

The parties acknowledge and agree that the Subscriber's signature or execution on the application form shall be deemed execution of this Certificate. By electing coverage or accepting benefits, Members are deemed to agree to all terms, conditions and provisions of this Certificate.

### **8.06 ASSIGNMENT**

The benefits provided under this Certificate are for the personal benefit of the Member and cannot be transferred or assigned. Any attempt to assign

this Certificate will automatically terminate all rights. No payment will be made by Health Plan to any physician except under the provision of this Certificate.

#### **8.07 POLICIES AND REGULATIONS**

Health Plan may adopt reasonable policies, procedures, rules, and interpretations to promote orderly and efficient administration of this certificate.

#### **8.08 ARBITRATION AND LITIGATION**

- A. No action or lawsuit shall begin upon or under this Certificate until 30 days after written notice of the claim has been given to Health Plan by the Member.
- B. In accordance with Michigan law, Health Plan will offer an Arbitration Agreement to each Member.

#### **8.09 ENTIRE CERTIFICATE**

This Certificate along with the Schedule of Benefits, the Group Letter of Agreement, applicable riders, if any, and the application form completed by the Subscriber constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

#### **8.10 WAIVER BY AGENTS**

No agent or other person, except an executive officer of Health Plan, has authority to waive any conditions or restrictions of this Certificate, to extend the time for making payment, or to bind Health Plan by making promises or representations or by giving or receiving any information. No changes in this certificate shall be valid unless evidenced by an endorsement signed by an authorized executive officer.

#### **8.11 AMENDMENTS**

This Certificate and Group Letter of Agreement shall be subject to amendment, modification or termination in accordance with its provision or by mutual agreement between Health Plan and the Group and any affected collective bargaining organizations, without the consent or concurrence of the Member.

## **8.12 MAJOR DISASTERS**

In the event of any major disaster, epidemic or other circumstances beyond its control, Health Plan shall render or attempt to arrange covered services insofar as practical, according to its best judgment and within the limitations of facilities and personnel as are then available. However, no liability or obligations are incurred for delay or failure to provide any such services due to lack of available facilities or personnel, if such lack is the result of such disaster, epidemic or other circumstances include complete or partial disruption of facilities, war, riot, civil insurrection, labor disputes not within the control of Health Plan, disability of a significant part of hospital or Health Plan personnel or similar causes.