



# Certificate of Coverage

# McLaren Health Plan Healthy Michigan Certificate of Coverage

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## MEDICAID CERTIFICATE OF COVERAGE

Agreement Delivered in: Michigan 2017.

Read this entire Certificate carefully. It describes the rights and obligations of Healthy Michigan Members and McLaren Health Plan, Inc. (“MHP”). It is the Member’s responsibility to understand the terms and conditions of this Certificate.

In some circumstances certain medical services are not Covered or may require Preauthorization by MHP.

### SECTION 1. ABOUT THIS CERTIFICATE

This Certificate sets the terms and conditions of your Healthy Michigan Coverage and describes the health care services that are Covered for Members under the MHP Healthy Michigan Plan.

This Certificate only covers Medically/Clinically Necessary services or supplies that are furnished while a person is a Member. It replaces and supersedes any Certificate MHP might have issued in the past.

Defined terms are capitalized when used in this Certificate. You can find these definitions in **Section 16**. The terms “we”, “us” and “our” refer to MHP. The terms “you”, “your” and “yourself” refer to the Member.

If you have any questions about Coverage contact Customer Service in writing at G-3245 Beecher Rd, Flint, MI 48532 or by telephone (888) 327-0671.

### SECTION 2. MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of MHP you have the right to:

- The right to be treated with respect and dignity and right to privacy, including to be free from restraint and seclusion.
- The right to confidentiality.
- Have a Primary Care Provider at all times.
- A current listing of network providers and access to a choice of Specialists within the network who can treat chronic problems.
- Get routine OB/GYN and pediatric services from network Specialists without a referral if the OB/GYN or pediatric Specialist is a Participating Provider.
- The right to receive Federally Qualified Health Clinic (FQHC) services.
- Continue receiving Services from a Specialty Provider who is no longer in MHP’s network if the services are Medically Necessary.
- Continue Coverage with a provider who is providing services related to your pregnancy who is no longer in MHP’s network if you are a female Member who is pregnant (that includes up to 6 weeks after you have your baby).
- Have no “gag rules” from MHP. Doctors are free to discuss all medical treatment even if they are not Covered Services.
- Participate in decision-making regarding your health care.
- Refuse treatment, get a second opinion, and receive a copy of your medical record upon request. Know how MHP pays its doctors.
- Be provided with a telephone number and address to obtain additional information about payment methods, if desired.

- Tell us if you have a complaint about MHP, the care provided and the right to appeal a decision to deny or limit Coverage.
- Know that you or your doctor cannot be penalized for filing a complaint or appeal about your care. Receive information about MHP, including the services, providers of care, and your rights and duties. Make suggestions regarding MHP Members' rights and duties.
- Have your medical record be kept confidential by MHP and your PCP.
- Receive the licensing verification telephone number for the Michigan Department of Health and Human Services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken against a health care provider in the immediately preceding 3 years.
- Be free from other discrimination prohibited by state and federal regulations.

As a Member you also have the responsibility to:

- Schedule an appointment with a Primary Care Physician within 60 days of enrollment.
- Schedule appointments in advance and be on time. If you need to cancel an appointment with any doctor's office, call as soon as possible.
- Use the Hospital emergency room only for emergency care. If possible, you should call your doctor before going to the emergency room.
- Give all the information that you can to your doctors and MHP so they can care for you in the best way. Ask questions if you do not understand the care you are getting.
- Talk about your care and help your doctors plan what you will be receiving.
- Complete treatments that you have agreed to, and follow all plans for care.
- Tell the Department of Human Services and Customer Service right away about any change in address or telephone number.
- Help MHP assist you with your health care by telling us of any problem you have with services. Tell us your suggestions in writing or by contacting Customer Service for assistance.
- Carry your MHP Member ID Card at all times.

### **SECTION 3. OBTAINING COVERED SERVICES**

#### **A. Primary Care Provider (PCP).**

Your PCP arranges your medical care. He or she provides your primary health care, and refers you to and consults with Specialist Providers, Participating Providers, and Non-Participating Providers when necessary. Your PCP provides or coordinates services, such as, among other things, ordering of lab tests and x-rays, prescribing medicines or therapies, and arranging hospitalization. You must talk with your PCP about any issues concerning your medical care. We will only Cover services that your PCP provides or refers and that we Preauthorize, unless we tell you otherwise in this Certificate.

When you enroll, you can choose a PCP. If you do not choose a PCP one will be assigned for you. If you want to you can change the PCP that was assigned. MHP's Participating Providers are listed in the provider directory. Each Member of the Member's family may have a different PCP if desired. If you need help choosing a PCP, call Customer Service at (888) 327-0671. When you change Your PCP, all medical treatment you are currently receiving must be approved by your new PCP.

You can voluntarily change your PCP (and the Parent/Guardian may change the PCP of a minor or a Member who is incapable of choosing a PCP). To do this, contact Customer Service. The change will take effect on the first day of the month after we receive your request. A PCP change cannot be made while you are in the Hospital.

**B. Who Can Be Your PCP?**

You can choose from a list of doctors who specialize in family practice, internal medicine, or pediatrics including a nurse practitioner or physician assistant in one of these offices. People with a chronic disease often need to see a Specialist to obtain care. In these limited cases, it may be better for the Specialist to be your PCP. The Specialist must agree to be your PCP. You should call Customer Service if you think you need a Specialist for a PCP.

**C. FQHCs and RHCs**

You may obtain services from Federally Qualified Health Centers and Rural Health Clinics without Preauthorization from MHP. These services include immunizations, Family-Planning services, well-child visits, and visits for illnesses or injuries.

**D. Termination of Providers' Participation.**

A Participating Provider or MHP can terminate the provider's contract. They or MHP can also limit the number of Members the Participating Provider will accept as patients. We do not promise that you'll be able to receive services from a specific Participating Provider the whole time you are Covered by us. We will let you know if your PCP stops acting as a PCP. You agree to choose another PCP with our help if needed.

A provider other than a PCP who provides services might stop acting as a Participating Provider. If that happens, you must work with your PCP to choose another Participating Provider. Otherwise, any services you receive may not be Covered.

**E. Referrals.**

At times you may need services from a Participating Provider, a Specialist Provider, or a Non-Participating Provider. When that happens, your PCP will direct the care you need. If the service you need is in the office of an MHP Participating Specialist, you do not need a written referral. Your PCP knows which services need to be Preauthorized by us. All services from a Non-Participating Provider must be Preauthorized by MHP with a referral from your PCP before you see a Non-Participating Provider. Otherwise, you must pay for the services. You also must pay for those services beyond those Preauthorized.

**F. Care After Regular Office Hours.**

Your PCP must have telephone coverage 24 hours a day, 7 days a week. If you become Ill or are Injured after regular office hours, you should call your PCP's office and tell them you are a Member of MHP. Your PCP or covering Participating Provider may give advice over the phone, prescribe medicine or therapy, ask you to come into the office, or refer you to an emergency room or another Participating Provider to receive help.

**G. Medical Emergency or Urgent Care.**

You have Coverage for certain Medical Emergency Care and Urgent Care services.

**(1) Inside the Service Area.**

You can receive the emergency room Coverage described in Section 6 in any Medical Emergency. When you need Urgent Care services, you must try to contact your PCP's office before you obtain those services. Otherwise, you may be responsible for any of the services you receive. Your PCP's office will tell you either to go to their office, or to another Participating Provider's office. If you cannot reach your PCP, please contact MHP's After Hours Line by calling (888) 327-0671.

If you have a Medical Emergency, seek medical help immediately. If you need Urgent Care services, call your PCP's office. But remember, if you use an emergency room or an Urgent Care Center for care that is routine, your costs may not be Covered. Present your ID Card at the Urgent Care facility. Afterward, contact your PCP's office for notification or follow-up.

(2) **Outside the Service Area.**

If you become Ill or are Injured while you are temporarily away from the Service Area, we will Cover your medical care. You should contact your PCP's office before obtaining Urgent Care. If you are unable to contact your PCP, call MHP's After Hours Line at (888) 327-0671. If you use an Urgent Care Center for routine care, you'll be responsible for the cost of that care.

(3) **Follow-Up Care.**

If you receive Medical Emergency or Urgent Care services, you must contact your PCP's office as soon as reasonably possible after you receive the services. That allows your PCP to arrange follow up treatment.

Remember, your PCP must provide or arrange all follow up and continuing care. Otherwise, you will not have Coverage for the services you received.

**H. Review of Health Care Services and Supplies.**

We review services and supplies that Health Professionals recommend to decide whether those services and supplies are Covered. If we decide that the services and supplies are not Covered, we will let you know. If you want our decision to be reviewed, you must contact us. Section 12 tells you how to do that.

## **SECTION 4. ENROLLMENT**

To enroll, you may fill out an enrollment form or call the State. On the enrollment form, you must list every person being enrolled and give the information asked for about each of those people.

We will Cover inpatient care for the Member's Newborn child from the child's date of birth. The Newborn will automatically be an MHP Member for at least the birth month. The Member can choose to change health plans for a future date by contacting the State's Enrollment Broker.

**A. Notification of Change in Status.**

The Member must let us know about any changes that affect Coverage under this Certificate. The Member does that by calling Customer Service. The Member must also contact their Department of Human Services caseworker to update this information. That must be done if, for example, any of the following happens to anyone Covered under this Agreement:

- (1) **Change of address or telephone number;**
- (2) **Enrollment or disenrollment in Medicare; or**
- (3) **Covered under other insurance.**

Remember, these are just examples and the Member must let us know about any other change that, according to this Certificate, affects Coverage. The Member must let us know about the change within 31 days after the change happens.

You do not need to contact the State when you want to make a PCP change. Contact Customer Service at (888) 327-0671 and we will help you.

**B. Loss of Eligibility.**

You will lose your eligibility and your Coverage will terminate if you stop meeting the eligibility criteria as set forth by the Department of Human Services.

**SECTION 5. EFFECTIVE DATES OF COVERAGE**

**A. General Rules.**

Except as explained below in subsection B, your Coverage will begin on the first day of the month the state notifies us of your enrollment.

**B. Non-Hospitalization Requirements.**

If the Member is hospitalized for treatment of an Illness or Injury when Coverage would otherwise begin, his or her Coverage may not begin until that hospitalization ends. You should call us to verify.

The non-hospitalization rule does not apply to a Newborn.

**SECTION 6. COPAYMENT INFORMATION**

Some Covered services may have a Copayment requirement. This means that you need to pay a fee to MHP when you get those services.

This will tell you what services need Copayments and how much you need to pay:

Covered Services	Copayment	
	Income less than or equal to 100% FPL	Income more than 100% FPL
Physician Office Visits (including Free-Standing Urgent Care Centers)	\$2	\$4
Outpatient Hospital Clinic Visit	\$1	\$4
Emergency Room Visit for Non-Emergency Services <ul style="list-style-type: none"><li>• Copayment ONLY applies to non-emergency services</li><li>• There is no Copayment for true emergency services</li></ul>	\$3	\$8
Inpatient Hospital Stay (with the exception of emergency admissions)	\$50	\$100
Pharmacy	\$1 generic; \$3 brand	\$4 generic; \$8 brand
Chiropractic Visits	\$1	\$3
Dental Visits	\$3	\$4
Hearing Aids	\$3/aid	\$3/aid
Podiatric Visits	\$2	\$4
Vision Visits	\$2	\$2

- You will not have a Copayment for family planning products or services.
- You will not have a Copayment for any pregnancy related products or services. You will not have a copayment for preventive services.

- In addition to Copayments, you will be responsible for a contribution equal to 2% of your adjusted gross income if your income is between 100-133% of the Federal Poverty Level. This amount will be paid to MHP.
- If you have any questions, call Customer Service at (888) 327-0671.

## SECTION 7. SCHEDULE OF COVERED SERVICES

You are entitled to the Covered Services described below when those services are:

- A. Medically/Clinically Necessary; and
- B. Provided by your PCP, or a Participating Provider including a Podiatrist, Certified Nurse Midwife, Certified Pediatric and Family Practice Nurse Practitioner, Physician Assistant or a Non-Participating Provider upon referral from your PCP and preauthorization by us when we consider Preauthorization necessary; and
- C. Not excluded elsewhere in this Certificate. You should carefully review the rest of this Certificate to fully understand your coverage.

The Covered Services are:

- A. **PRIMARY CARE.** Primary Care is the care provided by your PCP.
  - (1) **Health Maintenance and Preventive Care.** The following services are Covered Services for each Member even though they are not provided in connection with the diagnosis and treatment of an Illness or Injury:
    - a) Preventive and screening visits.
    - b) Routine child and adult immunizations for infectious diseases, as recommended by the Advisory Committee on Immunization Practices (ACIP). Immunizations can be provided by the Health Department. No Preauthorization is needed for immunizations.
    - c) One routine gynecological examination every twelve (12) months.
    - d) Maternity care. Covered Services for maternity care are described below in Section 7.C.
    - e) Outreach for included services, especially pregnancy related physicals.
    - f) Health Education services.
    - g) Speech services.
    - h) Parenting and birthing classes.
    - i) Tobacco cessation treatment including pharmaceutical and behavioral support.
    - j) Therapies (speech, language, physical and occupational).
    - k) Care related to the promotion of Healthy Behaviors.
  - (2) **Provider Care.** Provider Care is all services listed above provided by your PCP during an office visit, hospital visit, or house call, for the diagnosis and treatment of Illness or Injury. In addition, a female Member has Coverage to access an OB/GYN Specialist for annual well woman exams and for routine obstetrical and gynecological services without Preauthorization, if the OB/GYN is a Participating Provider. Also, a minor Member does not need Preauthorization to see a pediatrician who is a Participating Provider.
- B. **REFERRAL CARE.** Referral Care is care provided by a Participating Provider, Specialist Provider, or Non-Participating Provider. It must be provided upon referral from your PCP and Preauthorized by us



when we consider Preauthorization necessary. Most Covered Services require a referral from your PCP-unless noted. Additional visits may be covered when Preauthorized by MHP.

- (1) **Allergy testing, evaluations and injections including serum costs.** See Section 8 (4), Exclusions From Coverage, below for specific allergy testing that is not Covered.
- (2) **Ambulatory Surgical Services and Supplies.** Outpatient services and supplies furnished by a surgery center along with a Covered surgical procedure, on the day of the procedure.
- (3) **Breast Cancer Screening.** Procedures to aid in the diagnosis of breast cancer including:
  - 1 screening mammography every calendar year for women 40 years and older;
  - Surgical breast biopsy;
  - Treatment of breast cancer including reconstructive plastic surgery, chemotherapy and/or radiation therapy, physical therapy and psychological and social support services or other services when Medically Necessary and ordered by your doctor.
- (4) **Chiropractic Care.** Up to 18 visits per member every twelve (12) months. Additional visits may be Covered when Preauthorized by MHP.
- (5) **Contraceptive Medications and Devices.** These services and supplies do not require a referral and include, among other things, birth control pills; implantable contraceptive drugs; condoms, contraceptive foams or devices; I.U.D.s (including insertion and removal); contraceptive jellies and ointments, even if for a medical condition other than birth control. Condoms for Members are to be dispensed in quantities no greater than 12 at one time and no more than 36 in a 30-day period.
- (6) **Court Ordered Services.** Services required by a court order, or as a condition of parole or probation are only Covered when they are Medically/Clinically Necessary, and the services are provided according to our procedures with the necessary Physician referrals.
- (7) **Dental Services.** Diagnostic, preventive, restorative, prosthetic and medically/clinically necessary oral surgery services (including extractions) are covered Department of Health and Human Services website contains the list of covered services.
- (8) **Diabetic Supplies.** All equipment, supplies and educational training for the treatment of diabetes are Covered.
- (9) **Durable Medical Equipment.** All Durable Medical Equipment is Covered when ordered by a provider, Preauthorized by MHP and allowed through Healthy Michigan guidelines.
- (10) **End-Stage Renal Disease.** End-stage renal disease services including dialysis are Covered when Preauthorized according to our procedures with the necessary Physician referrals.
- (11) **Family Planning.** The following are Covered Services and do not require a referral if you receive these services at an approved family planning center. The following are Covered Services for each Member even if they are not provided in connection with the diagnosis and treatment of an Illness or Injury:
  - a) Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility.

Examples of Covered Services are, among other things, sperm count, endometrial biopsy, hysterosalpiogography, and diagnostic laparoscopy.

- b) Diaphragms, including measurement and fitting.
  - c) Advice on contraception and family planning, including childbirth education.
  - d) Treatment for sexually transmitted diseases (STDs).
- (12) **Habilitative Services.** Habilitative Services are services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech language pathology and other services.
- (13) **Hearing Care.** Health services provided for the diagnosis and treatment of diseases of the ear. Hearing exams and hearing aid evaluations are available from a Participating Provider. We allow Coverage for the purchase and fitting of hearing aids including batteries.
- (14) **Home Health Care.** Intermittent skilled services, including hospice services, Preauthorized by MHP and furnished in the home by a Home Health Care Agency or by a registered nurse, licensed practical nurse, physical therapist. Occupational therapist, respiratory therapist, speech therapist, or other Health Professional as needed. Custodial care is not Covered, even if you receive home health care services along with Custodial care.
- (15) **Hospice Care.** Both inpatient and outpatient.
- (16) **Hospital Care.**
- a) Inpatient Care. Hospital inpatient services and supplies, including services performed by Health Professionals, semi-private room and board, general nursing care, and related services and supplies.
  - b) Outpatient Care. Hospital services and supplies that you receive on an outpatient basis.
- (17) **Mental Health.** Outpatient Care. Evaluation, consultation, or treatment, including psychological testing, necessary to make a diagnosis. Your Coverage is limited to 20 visits every calendar year. Read Sections 7 and 8 to learn more about Coverage limitations and exclusions. No referral is necessary for mental health visits.
- (18) **Antineoplastic Drugs.** FDA approved drugs used in antineoplastic therapy and the reasonable cost of their administration. Coverage will be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the FDA if all of the following conditions are met:
- a) The drug is ordered by a Physician for the treatment of a specific type of neoplasm.
  - b) The drug is approved by the FDA for use in antineoplastic therapy.
  - c) The drug is used as part of an antineoplastic drug regimen.
  - d) Current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment.
  - e) The Physician has obtained informed consent from the patient for the treatment regimen, which includes FDA approved drugs for off-label indications.
- (19) **Oral Surgery.**
- a) Reduction or manipulation of fractures of facial bones.
  - b) Removal of tumors or cysts of the jaw, other facial bones, mouth, lip, tongue, accessory sinuses, salivary glands or the ducts.

- c) Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury.
- (20) **Orthognathic Surgery.** “Orthognathic surgery” is defined as oral surgical therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment. We will only Cover the following orthognathic surgery services, and only when the services are Preauthorized by our Chief Medical Officer in consultation with your PCP (and if necessary, a dental consultant) as Medically/Clinically Necessary.
- a) Referral care for evaluation and orthognathic treatment.
  - b) Cephalometric study and x-rays.
  - c) Orthognathic surgery and post-operative care (but Orthognathic Surgery will only be Covered if it is Medically/Clinically Necessary to correct a demonstrable bodily dysfunction).
  - d) Hospitalization.

Orthodontic treatment is not a Covered Service.

- (21) **Outpatient Prescription Drugs.** Prescription must be on our Formulary or Preauthorized. Covered with a generic substitution process and copayment. Prescriptions will be dispensed in quantities prescribed by providers up to a 90-day supply, including Coverage for an off-label use of a FDA- approved drug when Medically Necessary.
- (22) **Over the Counter Drugs and Supplies.** MHP covers these drugs and supplies in full with a Participating Provider’s order, and when dispensed by a participating pharmacy.
- (23) **Pain Management.** Your PCP provides the evaluation and treatment of pain or your PCP can refer you to a pain Specialist or center. If your pain is a Medical Emergency call 911 or go to the nearest emergency room.
- (24) **Podiatry.** The diagnosis and treatment of disorders of the foot, ankle and lower leg.
- (25) **Reconstructive Surgery.** Reconstructive surgery to correct congenital birth defects, if we reasonably expect the surgery to correct the condition. We will only Cover the surgical services described above if you receive them within two years of the event that caused the impairment, unless either of the following applies:
- a) The impairment was not recognized at the time of the event. In that case, treatment must be given within two years of the time that the problem has been identified.
  - b) Your treatment needs to be delayed because of developmental or medical reasons.
- (26) **Prosthetic and Orthotic/Support Devices.** Surgically implanted internal prosthetic devices and special appliances/devices that are worn externally, when the appliances or devices:
- a) Temporarily or permanently replace all or part of the functions of an inoperative or malfunctioning internal body organ, or an external body part lost or weakened/deformed as a result of Injury or Illness (including replacement of a breast after mastectomy) and when they are;
  - b) Prescribed by your PCP, or prescribed by a Participating Provider upon referral from your PCP and Preauthorized by MHP.

When an appliance or device is Covered, we will repair or replace it if that need arises because of normal growth or normal wear and tear.

- (27) **Provider Care.** All services listed in this Section provided by a Participating Provider or referral Provider during an office visit, Hospital visit, or house call, for the diagnosis and treatment of an Illness or Injury.
- (28) **Radiology Examinations and Laboratory Procedures.** Diagnostic and therapeutic radiology services and laboratory tests, not excluded elsewhere in this Certificate.
- (29) **Routine Foot care.**
- a) Medically/Clinically Necessary routine foot care, including corn or callous removal, nail trimming, and other hygienic or maintenance care;
  - b) Cleaning, soaking, and skin cream application for the feet when Medically/Clinically Necessary.
- (30) **Short-Term Rehabilitative Therapy.** Physical therapy, cardiac rehabilitation, pulmonary therapy, and occupational therapy or speech therapy if due to: (a) an Injury; (b) an Illness; or (c) a congenital defect for which you have received corrective surgery. These services are Covered if you receive them as an outpatient or in the home if they can reasonably be expected to improve your condition within 60 days of the date you start therapy, as determined by our Medical Director in consultation with your PCP. Also, the services are only Covered if a Participating Physician refers, directs and monitors them, and consults with us in the process. Speech therapy for developmental delay and cognitive rehabilitative therapy are not Covered services. Services are not covered if provided by another public agency.
- (31) **Skilled Nursing Facility Care or Inpatient Rehabilitation or Hospice Facility Care.** Care and treatment, including physical therapy and room and board in semi-private accommodations, at a Skilled Nursing or Inpatient Rehabilitation, or Hospice Facility which MHP has Preauthorized.
- Such services must be supported by a treatment plan we have approved in advance. Custodial care is not a Covered benefit.
- (32) **Substance Abuse.** You are entitled to receive substance abuse services, which are provided by the local coordinating agency in your area. Please call Customer Service at (888) 327-0671 for more information.
- (33) **Temporomandibular Joint Syndrome (TMJS).** “Temporomandibular Joint Syndrome” or “TMJS” means muscle tension and spasm related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction. You have Coverage for the following services if they are Preauthorized by MHP:
- a) Office visits for medical evaluation and treatment of TMJS.
  - b) Specialty referral for medical evaluation and treatment of TMJS.
  - c) X-rays of the temporomandibular joint including contrast studies, but not dental x-rays.
  - d) Myofunctional therapy.
  - e) Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

- (34) **Transplants.** Transplants of the following organs at a facility approved by us, but only when we have Preauthorized the transplant as appropriate. Medically/Clinically Necessary, and non-experimental:
- a) Cornea.
  - b) Heart.
  - c) Lung.
  - d) Kidney.
  - e) Bone marrow.
  - f) Liver.
  - g) Pancreas.
  - h) Small bowel.

We will Cover the donor's medical expenses according to Healthy Michigan policy, if the person receiving the transplant is a Member and the donor's expenses are not Covered by another insurance carrier. The potential donor does not need to be a parent, child, or sibling of the Member proposed to receive the transplant to be Covered. We will Cover expenses for a donor search even if the Member ends up not finding a potential donor. We will Cover FDA-approved drugs used in antineoplastic therapy. We will also Cover expenses including allogenic, autologous, and peripheral stem cell harvesting and small bowel transplants. We will Cover computer searches and any subsequent testing necessary after the potential donor is identified, unless Covered by another insurance carrier.

- (35) **Transportation.** Ambulance and other emergency medical transportation are Covered. Hardship-based transportation service for medical services is also Covered when Preauthorized by MHP.
- (36) **Vision Care.** Services and supplies relating to vision care, including, among other things: One eye exam every 24 months to determine the need and proper prescription for corrective lenses, one pair of single vision, multi-focal, or cataract lenses and ophthalmic frames. Ophthalmic lenses include standard crown glass or CR 39 plastic lenses in all sizes and powers. Lenses include the following designs:
- a) Standard single vision
  - b) Standard bifocal (Flattop 25 and 28, round 22mm)
  - c) Standard trifocals (CV 7/25 and 7/28)

Ophthalmic frames include a selection of approved ophthalmic frames. Repair or replacement of frames/lenses due to loss or breakage is a Covered benefit.

- (37) **Voluntary Sterilizations.** MHP covers tubal ligation. A vasectomy is also covered when performed in a Physician's office, or performed in connection with other Covered inpatient or outpatient surgery. All members must sign the Sterilization Consent Form 30 days before the sterilization. Coverage for sterilization is available only for Member's 21 years of age or older.
- (38) **Weight Loss Programs.** Medically Necessary weight reduction services are Covered when Preauthorized by MHP.

## C. MATERNITY CARE.

- (1) **Hospital and Provider.** Services and supplies furnished by a Hospital or Provider for prenatal care (including genetic testing), postnatal care, Hospital delivery, and care for complications of pregnancy.

- (2) **Newborn Child Care.** A Newborn child of a Member will automatically be enrolled with MHP. If the parent or guardian wants to change the Newborn to another health plan they must contact Michigan Enrolls.
- (3) **Home Care Services.** Home Care Services are Covered when Preauthorized by MHP.
- (4) **Maternal Infant Health Program.** Services for high risk mothers and infants to ensure healthy deliveries which may include home visits and social services.

#### **D. MEDICAL EMERGENCY AND URGENT CARE.**

NOTE: If you are admitted to a Hospital after a Medical Emergency, you (or someone on your behalf) must let your PCP's office know about your admittance as soon as it is reasonably possible to provide that notice.

You should contact your PCP's office before obtaining Urgent Care. If you are unable to contact your PCP, call MHP's After Hours Line. If you use an Urgent Care Center for routine care, you will be responsible for the cost of that care.

The following are Covered Services:

- (1) **Within the Service Area.**
  - a) Services and supplies that you receive for any condition that, following our review of the proper medical records, we determine to have been a Medical Emergency.
  - b) Emergency services include stabilization of your condition. This means services are Covered until no further deterioration of your condition is likely to occur.
  - c) Services and supplies that you receive for any condition that, following our review of the proper medical records, we determine to have required Urgent Care at the time you received the services and supplies.
  - d) Hospitalization for a Medical Emergency in a facility that is a Non-Participating Provider, until, in our judgment, it is appropriate for you to be transferred to a Participating Provider.
- (2) **Outside the Service Area.** In most cases Coverage outside the Service Area is the same as Coverage within the Service Area. However, we do not Cover services and supplies you receive during travel outside the Service Area if the only reason for the travel is to obtain medical services or supplies, (unless such services are Preauthorized by MHP). We do not cover services provided outside the United States.
- (3) **Follow-Up Care.** Services you receive from, or upon referral from, your PCP as follow-up care resulting from a Medical Emergency or Urgent Care situation. For follow-up care received outside of the Service Area, we will only Cover one PCP-approved visit for each Medical Emergency or Urgent Care situation, unless MHP and your PCP approve Preauthorize additional visits.
- (4) **Ambulance Services.**
  - a) In the case of a Medical Emergency, ambulance service to the nearest medical facility that can provide Medical Emergency care.
  - b) Inter-facility ambulance transfers.

## SECTION 8 EXCLUSIONS FROM COVERAGE

The following is a list of exclusions from your Coverage. We will not Cover any service, treatment, or supply listed in the exclusions, unless Coverage is required under applicable state or federal law.

- (1) **Acupuncture.**
- (2) **Adaptive Aids/Self-Help Items.** Services and supplies designed for self-assistance. Examples include, among other things, reachers, feeding, dressing, and bathroom aids.
- (3) **Against Medical Advice.** There is no Coverage for any service or treatment plan if you voluntarily deny that service or treatment plan, or any related service or treatment plan, against the advice of a Participating Provider. Also, there may be no Coverage for any service or treatment plan if you voluntarily discharge yourself, or are otherwise discharged, against the advice of a Provider.
- (4) **Allergy Testing.** Any allergy testing and treatments that have not been proven to be effective are not Covered.
- (5) **Biofeedback for Mental Health Diagnoses.**
- (6) **Clinical Ecology and Environmental Medicine.** Services and supplies provided to effect changes in or treatment to you and/or your physical environment. When we say “clinical ecology” and “environmental medicine” we mean medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems.
- (7) **Court Ordered Services.** Services required by a court order or as a condition of parole or probation are not Covered unless the services ordered by the court are Covered under this Certificate and are provided according to our procedures.
- (8) **Cosmetic Services.** Cosmetic surgery or procedures done primarily to improve the way any part of the body looks. Coverage is excluded for, among other things: surgery for sagging or extra skin, any procedure to increase or reduce the size of a portion of the body, such as: mammoplasty, liposuction, keloids, and rhinoplasty.
- (9) **Custodial Care.** Custodial Care is generally defined as:
  - a) Non-health-related services, such as domiciliary care and personal care/assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
  - b) Health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient who requires the service is not changing.
  - c) Services that do not require administration by a trained medical personnel in order to be delivered safely and effectively.
  - d) Services that can be trained by skilled personnel for non-skilled personnel to perform.
- (10) **Ear Plugs.**

- (11) **Educational Services and Services for Behavioral Disorders.** MHP does not cover school-based services. These services can be obtained through your local school system and include:
- a) Services for remedial education, including treatment of learning disabilities, developmental and learning disorders, and behavioral training.
  - b) Services related to learning disabilities, developmental delays, or adult attention deficit disorders.
  - c) Education testing or training.
  - d) Services and supplies for intellectual disability and senility.
  - e) Speech therapy for developmental delay.
  - f) Cognitive rehabilitation.
- (12) **Experimental, Investigational, or Unproven Services.** Any drug, device, treatment, or procedure that is experimental, investigational, or unproven. A drug, device, treatment, or procedure is experimental, investigational, or unproven if one or more of the following applies:
- a) The drug or device cannot be lawfully marketed in the United States without the approval of the Food and Drug Administration (FDA) and that approval has not been granted;
  - b) An institutional review board or other body oversees the administration of the drug, device treatment, or procedure, or approves or reviews research concerning safety, toxicity or efficacy;
  - c) Informed consent documents describe the drug, device, treatment, or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity, or efficacy;
  - d) Reliable Evidence shows that the drug, device, treatment, or procedure is:
    - i) The subject of on-going phase I or phase II clinical trials;
    - ii) The research, experimental study, or investigational arm of on-going phase of clinical trials, or
    - iii) Otherwise under study to determine its toxicity, safety, or efficacy compared with a standard means of treatment or diagnosis; or
  - e) Reliable Evidence shows that a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety, or efficacy of the drug, device, treatment, or procedure as compared with a standard of means of treatment or diagnosis. “Reliable Evidence” includes any of the following:
    - i) Published reports and articles in authoritative medical and scientific literature;
    - ii) A written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same or a similar drug, device, treatment, or procedure; or
    - iii) Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device, treatment, or procedure.
- This exclusion for experimental services does not apply to off-label uses of FDA approved anti-cancer drugs.
- (13) **Hair Analysis.**
- (14) **Hypnoherapy.**
- (15) **Infertility and Abortions.** All services and supplies relating to infertility treatment and abortions including, among other things artificial insemination, in vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, prescription drugs designed to achieve pregnancy, elective abortions and services to reverse voluntary sterilization.



- (16) **Leave of Absence.** Charges incurred when you are on an overnight or weekend pass during an inpatient stay.
- (17) **Marital Counseling.** Services and treatment related to marital or relationship counseling.
- (19) **Mental Health/Substance Abuse.** Only services listed in Section 7 are Covered.
- (20) **No Legal Obligation to Pay.** Any service or supply that you would not have a legal obligation to pay for without this Coverage. This includes, among other things, any service performed or item supplied by a relative of yours if in the absence of health benefits Coverage, you would not be charged for the service or item.
- (21) **No-Show Charges.** Any missed appointment fee charged by a Participating Provider because you failed to show up at an appointment, except in the case of a Medical Emergency.
- (22) **Non-Participating Providers.** Services and supplies from a Non-Participating Provider. This exclusion does not apply in the case of:
- a) Medical Emergency or when we have Preauthorized the services and supplies;
  - b) The treatment of communicable diseases such as TB or sexually transmitted infections (STIs) at a local health department or Healthy Michigan approved Family Planning Center;
  - c) Family planning services received at a Healthy Michigan approved family planning center or at a local health department;
  - d) Services provided at Federally Qualified Health Centers (FQHC) or as otherwise stated in this COC; and
  - e) Immunizations.
- (23) **Not Medically/Clinically Necessary.** Services and supplies that we determine are not Medically/Clinically Necessary. If you disagree with us about Medical/Clinical Necessity, you (with a Participating Provider if you wish) may appeal our determination. But unless and until we agree with you that the services and supplies will be Covered Services, they will be excluded from Coverage. If we exclude Coverage because a service or supply was not Medically/Clinically Necessary, that is a determination about benefits and not a medical treatment determination or recommendation. You, with the Participating Provider, may choose to go ahead with the planned treatment at your own expense, and appeal our denial of your claim for Coverage under our inquiry and grievance procedure.
- (24) **Obstetrical Delivery in the Home.** Services and supplies related to obstetrical delivery in the home.
- (25) **Personal Comfort or Convenience Items, Household Fixtures, and Equipment.**
- a) Services and supplies not directly related to your care, such as: guest meals and accommodations, telephone charges, travel expenses, take home supplies, and similar costs.
  - b) The purchase or rental of household fixtures, such as: escalators, elevators, swimming pools, and similar fixtures.
  - c) The purchase or rental of household equipment that has customary non-medical purposes, such as: exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds, and similar equipment.
- (26) **Private Duty Nursing.**

- (27) **Prosthetic and Orthotic/Support Devices.** Orthopedic shoes, shoe inserts, and other supportive devices of the feet as limited by the Healthy Michigan plan.
- (28) **Relational, Educational, and Sleep Therapy.** Relational, educational, or sleep therapy and any related diagnostic testing. But this exclusion does not apply to therapy or testing provided as part of a Covered inpatient Hospital service.
- (29) **Religious Counseling.** Services and treatment related to religious counseling.
- (30) **Self-Referral.** Services and supplies from any Health Professional upon self-referral by you. But this exclusion does not apply in the case of:
- a) Medical Emergency or when we have Preauthorized the services and supplies;
  - b) The treatment of communicable diseases such as TB or sexually transmitted infections (STIs) at a local health department or Healthy Michigan approved Family Planning center;
  - c) Family planning services received at a Healthy Michigan plan approved family planning center or at a local health department;
  - d) Immunizations;
  - e) Mental health services; or
  - f) As otherwise stated in this COC.
- (31) **Services Required by Third Parties.** Physical examinations in excess of one per year performed by your PCP; physical examinations performed by a Physician other than your PCP; diagnostic services related to: getting or keeping a job, getting or keeping any license issued by a governmental body, getting insurance Coverage, and foreign travel.
- (32) **Sex Change or Transformation.** Any procedure or treatment designed to change your physical characteristics from your biologically determined sex to those of the opposite sex. This exclusion applies despite any diagnosis of gender role or psychosexual orientation problems.
- (33) **Sex Therapy.** Services and treatment related to sex therapy.
- (34) **Transitional/Residential or Assisted Living.** Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living.
- (35) **Treatment in a Federal, State, or Governmental Entity.** Services and supplies provided in a Non-Participating Hospital owned or operated by a federal, state, or other governmental entity, to the extent permitted by law, unless Preauthorized by MHP.
- (36) **Unauthorized Services and Supplies.** Services and supplies that your PCP didn't perform, prescribe, or arrange according to the guidelines of this Certificate. By way of an example, if a Participating Specialist provides services without the required Preauthorization by MHP, those services are unauthorized. This exclusion does not apply to services necessary to treat a Medical Emergency, Urgent Care situation, family planning, the treatment of sexually transmitted infections (STIs), immunizations or as otherwise stated in this COC.
- (37) **Vocational Rehabilitation.** Work-related therapy and evaluations of the work site.

- (38) **Weight Control.** All services and supplies related to weight control treatment unless the Member is authorized by the PCP and MHP has detained the condition is severe or life threatening.

## **SECTION 9. LIMITATIONS**

You may only receive services from a Participating Provider or another Health Professional with Preauthorization. Your PCP must approve those services, and they must be Preauthorized by MHP, unless this Certificate says otherwise.

Some of the Covered Services are subject to maximum limitations, such as number of visits. Once you have reached a maximum for a Covered Service, you will be responsible for the cost of additional services.

### **A. Work-Related Illness or Injury.**

We will not Cover services for any work related Illness or Injury if the services are Covered under any worker's compensation program or other similar program.

### **B. Services Received as a Member.**

We will only pay for Covered Services you receive while you are Covered under the Agreement and you are a Member. A service is considered to be received on the date on which services, supplies, or materials are provided to the Member. We will only Cover services and supplies for the diagnosis or treatment of Illness or Injury, except as specifically provided elsewhere in this document.

### **C. Uncontrollable Events.**

A national disaster, war, riot, civil insurrection, epidemic, or other event we cannot control may make our offices, personnel, or financial resources unable to provide or arrange for the provision of Covered Services. To the extent that happens, we will not be liable if you do not receive those services or if they are delayed. But we will make a good faith effort to see that they're provided, considering the impact of the event.

## **SECTION 10. MEMBER CLAIMS RESPONSIBILITIES**

Ordinarily you are not responsible for the cost of services that you receive. However, you are responsible for the cost of any services you receive from Non-Participating Providers unless those services were arranged by your PCP and Preauthorized by MHP, or unless you need them to treat a Medical Emergency or Urgent Care situation, immunizations, family planning services, services for sexually transmitted infections (STIs), mental health services or as otherwise stated in this COC.

When you must pay a health care provider for Covered Services, ask us in writing to be reimbursed for those services.

With your request, you must give us proof of payment that's acceptable to us. We request that you give us proof of payment within 90 days of the date you obtained the services. If you do not ask for reimbursement within 1 year, we can limit or refuse reimbursement. We will not limit or refuse reimbursement if it is not reasonably possible for you to give us proof of payment in the required time, as long as you give us the required information as soon as reasonably possible. We will never be liable for a claim or reimbursement request if we obtain proof of payment for it more than 1 year after the date you receive the services, unless you are legally incapacitated. Send your itemized medical bills promptly to us at: P.O. Box 1511, Flint, MI 48501-1511.

Before we pay health care providers or reimburse you for services you receive, we may require you to give us more information or documentation to prove they are Covered Services. Our right to that information or documentation may be limited by state or federal law.

If you are not satisfied with any benefit determination we have made, you can dispute it under the inquiry and grievance procedure. Read Section 12 to find out more about that procedure.

## **SECTION 11. TERMINATION OF COVERAGE**

### **A. Loss of Eligibility.**

You will lose your eligibility and your Coverage will terminate if you stop meeting the eligibility criteria as required by the Department of Human Services.

If you lose your eligibility, Coverage will terminate at 11:59 p.m. on the date you lose your eligibility.

### **B. Termination for Cause.**

We cannot request termination of your Coverage based on your health or your health care needs. Also, we will not request termination of your Coverage just because you used the COC grievance procedure to make a complaint against us.

We can recommend the termination of your Coverage to the State for any of the following reasons:

- (1) You fail, after repeated attempts, to establish or maintain a satisfactory provider-patient relationship with a Participating Provider;
- (2) You refuse to cooperate with us as required by the terms of this Certificate;
- (3) We find out you have committed fraud against us or you have been dishonest with us about some important, or “material” matter. For example, we may request that the State terminate your Coverage if we find out you gave us wrong or misleading information or you let someone else use your ID Card. Also, we can collect from you the Reasonable and Customary Charges for Covered Services that you have received after the effective date of termination, plus our cost of recovering those charges (including attorney’s fees);
- (4) You act so disruptively that you upset our ordinary operations or those of a Participating Provider.

If we notify you we intend to request termination of your Coverage, you can ask for a grievance hearing within 30 business days. (Read Section 12 to learn more about grievance hearings.) Your Coverage will remain in place until the State of Michigan disenrolls you from MHP.

## **SECTION 12. MEMBER COMPLAINT/GRIEVANCE AND APPEALS PROCEDURE**

### **Member Complaint/Grievance Procedure**

A complaint/grievance is something you are unhappy with. You can call or write to MHP when you have a problem. We would like to hear what you think so we can make our services better. We want to know if you have a complaint about a doctor’s office. You can tell us if you think the office was not clean or safe. You can also tell us if there was not enough space in the waiting room or the exam room. In this case, Customer Service will help you.

To report a complaint/grievance, call Customer Service at (888) 327-0671. They will help you fill out a form to begin looking into the problem.

MHP has a process for complaints/grievances. A special person handles the complaints/ grievances. We will get back to you within 15 calendar days. If you disagree with our decision, you have 5 days to request an appeal of the decision. MHP will make a final decision within 30 days from your initial complaint/grievance. If waiting that long would hurt your health, we will get back to you within 72 hours.

### **Member Appeals Procedure**

If MHP has decided to deny, terminate, or reduce any Covered Service, you can file an appeal. You can call or write to MHP when you want to appeal a denial, by calling Customer Service at (888) 327-0671.

If needed, Customer Service can help you file an appeal. A special committee will discuss your problem. You also have the right to go to a hearing if you wish (see Fair Hearing Process). MHP has 30 calendar days to complete the process regarding your concern.

If you want to request an appeal with MHP's Appeals Committee, you must send your request in writing **within 90 calendar days** of MHP's answer to your complaint or denial of services.

If, after your appeal, you are still unhappy with the decision that MHP has made about your grievance, you can ask for an external appeal. You must do this within 120 calendar days of receiving our appeal decision. Call Customer Service to get the form you need or contact the Department of Insurance and Financial Services at:

Department of Insurance and Financial Services  
Office of General Counsel-Appeals Section  
611 West Ottawa, Third Floor  
P.O. Box 30220  
Lansing, MI 48909-7220  
Phone (877) 999-6442

### **FAIR HEARING PROCESS**

You may also file a complaint directly with the Michigan Administrative Hearing System (MAHS) for the Department of Health and Human Services. You do not have to file a complaint with MHP's Customer Service before you contact the MAHS. You must file your complaint with MAHS within 90 days of your denial from us. Listed below are the steps for the State of Michigan's Medicaid fair hearing process:

- Step 1: Call (877) 833-0870 or email the MAHS at [administrativetribunal@michigan.gov](mailto:administrativetribunal@michigan.gov) to have a hearing request (complaint) form sent to you. You may also call to ask questions about the hearing process.
- Step 2: Fill out the request (complaint form) and return it to the address listed on the form.
- Step 3: You will be sent a letter telling you when and where your hearing will be held.
- Step 4: The results will be mailed to you after the hearing is held. If your appeal is taken care of before the hearing date, you must call to ask for a hearing request withdrawal form. You can call (877) 833-0870 to request this form.

### **SECTION 13. EXTENSION OF BENEFITS**

We will continue Covering your Covered Services if Coverage is terminated while you are confined for medical treatment in a Hospital. After termination we will Cover Covered Services only if you are hospitalized and only

for the specific medical condition causing that confinement. As soon as one of the following happens, you will stop receiving benefits from MHP:

- A. The hospitalization is no longer Medically/Clinically Necessary or is for non-Covered Services such as custodial care;
- B. You have Coverage from another health insurance carrier for the inpatient stay.

#### **SECTION 14. COORDINATION OF BENEFITS**

##### **A. Subrogation.**

Subrogation means MHP will have the same right as the Member to recover expenses for treatment of an Illness or Injury for which another person or organization is legally liable. To the extent MHP provided benefits for services in such situations, MHP will be subrogated to the Member's right of recovery against the responsible person or organization. The Member is required to sign and deliver any documents and papers and do whatever is necessary to obtain these rights. The member agrees not to take any action, without MHP's consent, which would harm the rights and interests of MHP. Any money received by suit, settlement, or otherwise for medical, Hospital, or other services provided by MHP must be paid over to MHP. When collection costs and legal expenses are included to recover sums benefiting both the Member and MHP, a fair division of the collection costs and legal expenses will be made. Refusal or failure of a Member, without good cause, to cooperate with MHP may result in Member's disenrollment or recovery by MHP from the Member of costs for services provided under claim of subrogation, subject to the Member's grievance rights.

##### **B. Right of Recovery.**

Whenever benefits have been provided by MHP under this Certificate and another person or organization is responsible for payment, MHP shall have the right to deny payment or to recover from the other responsible person or organization the reasonable cash value of the service.

##### **C. Coordination of Benefits.**

Coordination of Benefits shall be conducted in accordance with the Michigan Coordination of Benefits Act, 1984, P.A. 64. In establishing the order of carrier responsibility applicable to health plans covering the Members, the Health Plan will follow the Coordination of Benefits guidelines established by the Michigan Department of Consumer and Industry Services or any successor agency. Benefits will be payable in accordance with Public Act 64 of 1984, Coordination of Benefits Act, as amended.

#### **SECTION 15. MEDICARE AND OTHER FEDERAL OR STATE GOVERNMENT PROGRAMS**

If you obtain Medicare Coverage you will be disenrolled from the MHP Healthy Michigan Plan. Until disenrollment the following will apply:

##### **A. Non-duplication of Benefits.**

Your benefits under this Certificate cannot be doubled up with any benefits you are, or could be, eligible for under Medicare or any other federal or state government program. If we Cover a service that's also covered by one of those programs, any sums payable under that program for that service must be paid first.

##### **B. Coordination with Medicare.**

The following rules apply with respect to coordination with Medicare, except as required otherwise by applicable law:

- (1) **Election Against Coverage.**  
Despite any other provision under this Certificate, Medicare will always be the Primary Payer and we will be the Secondary Payer.
- (2) **Members Eligible for Medicare ESRD Benefits.**  
Except as provided below, if you are entitled to or are eligible for end-stage renal disease (ESRD) Medicare benefits, the Primary Payer will be Medicare. If you have primary Coverage under Medicare by reason of age or Disability and you later become eligible for Medicare ESRD Coverage, Medicare will remain primary to this Plan.
- (3) **Eligibility for Medicare.**  
In determining benefits payable under Medicare, you will be considered to be enrolled for and Covered by all Medicare (both parts A and B) and other governmental benefits to which you are eligible, whether or not you are actually enrolled.
- (4) **Legislative and Regulatory Changes.**  
Despite any other provision of this Certificate, if any existing legislation or regulation is adopted or altered, or if any new legislation or regulation is enacted or adopted, further permitting this Plan to be secondary to Medicare, MHP will be secondary to Medicare as permitted by that legislation or regulation.

## SECTION 16. DEFINITIONS

**Agreement.** The Agreement between the State of Michigan and MHP. The Agreement is a contract for health benefits. The Agreement includes this Certificate, the enrollment form, any amendments, and any attachments. A copy of the Agreement is available on request from us and may also be available from the State of Michigan.

**Allowable Expense.** See Covered Services, Coverage, Cover, or Covered.

**Certificate of Coverage.** The document that Members receive from us that describes Member's and MHP rights and duties. It includes the enrollment form, amendments, and attachments to the document. The Certificate is part of the Agreement.

**Contract Year.** The period of time that starts on the day the Agreement is effective and ends 365 days later (unless the Agreement says otherwise).

**Copayment.** A fixed dollar amount that you are required to pay for some Covered Services. The copayment amount is payable to MHP. See Section 6.

**Cosmetic Surgery.** Surgery performed to reshape structures of the body in order to improve the patient's appearance and self-esteem.

**Covered Services, Coverage, Cover, or Covered.** Those services and supplies that you are entitled to under this Certificate. The Agreement and this Certificate limit what we will pay for some of those services and supplies. When we say we will "Cover" a service or supply, that means we will treat the service or supply as a Covered Service.

**Disabled or Disability.** Under the Social Security Act you are Disabled, or have a Disability if, taking into account your age, education and past work experience, you are unable to perform any substantial gainful activity by reason of a medically determinable physical or mental impairment, or a combination of impairments,

which can be expected to result in death or which has lasted or can be expected to last at least 12 consecutive months.

**Durable Medical Equipment.** Equipment which is: (a) made for repeated use; (b) mainly used for a medical purpose; (c) appropriate for use at home; and (d) generally not useful unless a person has an Illness or Injury.

**Formulary.** A listing of FDA-approved prescription drugs that MHP has approved for use.

**Health Professional.** A person who is qualified under state law to provide certain health care services.

**Healthy Michigan Plan or HMP.** Program operated under a 1115 Waiver approved by CMS to provide Medicaid coverage to all adults in Michigan with incomes up to and including 133 percent of federal poverty level.

**Home Health Care Agency.** An agency or organization certified to provide skilled nursing services and other therapeutic services in the home.

**Hospital.** An acute care, properly licensed institution that mainly provides inpatient medical care and treatment for Ill and Injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24 hour-a-day nursing and Physician services.

**ID Card.** The Member Identification Card you receive from us as evidence of your enrollment with us.

**Ill or Illness.** A sickness or disease, including congenital defects or birth abnormalities.

**Injury or Injured.** Accidental bodily injury.

**Initial Enrollment.** First enrollment in Medicaid Health Plan following determination of eligibility; re-enrollment in a Medicaid Health Plan following a gap ineligibility of less than two months is not considered initial enrollment.

**McLaren Health Plan or MHP.** MHP providing benefits under this Certificate of Coverage.

**Medical Director.** A Michigan-licensed Physician we have designated to supervise and manage the medical aspects of Our health care delivery system.

**Medical Emergency.** A sudden onset of a medical condition so acute that, if you don't receive immediate care or treatment, it could result in serious jeopardy to your health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious jeopardy to a pregnancy.

**Medically/Clinically Necessary.** The services or supplies needed to diagnose, care for or treat your physical or mental condition. The Medical Director, or anyone acting at the Medical Director's request, in consultation with the PCP, determines whether services or supplies are Medically/Clinically Necessary. The services and supplies must be widely accepted professionally in the United States as effective, appropriate, and essential, based upon nationally accepted standards of the health care Specialty involved.

All of the following are considered not to be Medically/Clinically Necessary:

- (a) Those services rendered by a Health Professional that don't require the technical skills of such a provider;



- (b) Those services and supplies furnished mainly for the personal comfort or convenience of you, anyone who cares for you, or anyone who is part of your family.

**Medicaid.** Title IX of the Social Security Act, as amended.

**Medicare.** Title XVIII of the Social Security Act, as amended.

**Member.** A person enrolled with the MHP Healthy Michigan Plan.

**Newborn.** A Newborn is a child 30 days old or younger.

**Non-Participating Provider.** A Health Professional or other entity who has not contracted with us to provide Covered Services to Members.

**Orthognathic Surgery.** “Orthognathic surgery” is defined as oral surgical therapy involving the requisitioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment.

**Participating Hospital.** A Hospital that contracts with us to provide Covered Services to Members.

**Participating Physician.** A Physician who contracts with us to provide Covered Services to Members.

**Participating Provider.** A Health Professional or other entity that contracts with us to provide Covered Services to Members.

**Physician.** A state licensed doctor of medicine or osteopathy.

**Preauthorize or Preauthorization.** A review and approval that must be performed by MHP before a health service is provided in order for it to be a Covered Service payable by MHP.

**Primary Care Provider (“PCP”).** The Participating Provider, as chosen under Section 3.A, who is responsible to provide, arrange, and coordinate all aspects of your health care.

**Prosthetics and Orthotics.** Prosthetic devices are devices that aid body functioning or replace a limb or body part after accidental or surgical loss or to correct a birth defect. Orthotic appliances are appliances that are used to correct a defect to body form or function.

**Reasonable and Customary Charges.** The Medicaid fee-for-service rate.

**Reconstructive Surgery.** Surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormality trauma, infection, tumors, or disease. Reconstructive surgery generally is done to improve function, but may also be done to improve appearance.

**Service Area.** A geographical area within the State of Michigan, designated by us and approved by the proper regulatory authority. We publish precise Service Area boundaries and you may obtain that information from Customer Service.

**Skilled Nursing or Inpatient Rehabilitation or Hospice Facility.** A facility that is licensed by the proper regulatory authority to provide inpatients with skilled nursing care and related services or short-term rehabilitative therapy.

**Specialist Provider.** A Participating Physician, other than a PCP under contract with us to provide Covered Services upon referral by the PCP and Preauthorization by MHP.

**Urgent Care.** Services provided at a certified facility other than a Hospital to treat non-life threatening conditions that require immediate medical attention to limit severity and prevent complications.

**Urgent Care Center.** A certified facility that provides Urgent Care for the immediate treatment of an Injury or Illness.

## **SECTION 17. GENERAL PROVISIONS**

- A.** MHP has responsibility for making benefit determinations under this Certificate. Health care providers are responsible for making independent medical judgments. At times, MHP and health care providers will jointly determine whether a service is Medically Necessary.

Health care providers and you may choose to continue medical treatment even if we deny Coverage for those treatments. You will be responsible for the cost of those treatments. Health care providers and you may appeal any of our benefit decisions. Any appeal must follow the inquiry and grievance procedure explained in Section 12.

- B. Authorization to Release Medical Information.**

We care about your privacy. The information we collect about you is private. Only people who have both the need and the legal right may see your information. Unless you give permission in writing, we will only disclose your information for purposes of treatment, payment, business operations, or when we are required by law to do so.

You agree to cooperate with us and our Participating Providers by providing health history information and by helping us to obtain your medical records if we ask. If we ask you for a signed authorization for release of medical records, you agree to provide us with one.

- C. Entire Agreement.**

The Agreement with the State of Michigan, including this Certificate of Coverage, the enrollment form, any riders, and any amendments or attachments, is the entire Agreement. Beginning on the effective date of Coverage, the Agreement supersedes all agreements for health care services and benefits between you, the State of Michigan, and MHP.

- D. Non-assignment.**

You may not assign or transfer any of your rights to benefits or services under this Certificate.

- E. Truth in Application and Statements.**

You agree to complete and submit to us the enrollment form and other forms as we reasonably request. You will ensure, and warrant that all information contained in such forms is true, correct, and complete.

- F. Loss or Theft of ID Card.**

You must promptly notify us of the loss or theft of your ID card upon discovery of the loss or theft.

- G. General Obligations.**

MHP will not discriminate against Members because of race, color, ancestry, religion, age, sex, national origin, marital status, health status, or Disability.

## Discrimination is against the law

McLaren Health Plan, (McLaren) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. McLaren does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

McLaren:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact McLaren's Compliance Officer. If you believe that McLaren has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

- McLaren's Compliance Officer
  - Write: G-3245 Beecher Rd., Flint, MI 48532
  - Call: (866) 866-2135, TTY: 711
  - Fax: (810) 733-5788
  - Email: [mhpcompliance@mclaren.org](mailto:mhpcompliance@mclaren.org)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, McLaren's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue  
SW Room 509F, HHH Building  
Washington, D.C. 20201  
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

**Arabic:**

ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-327-0671 (رقم هاتف الصم والبكم: 711).

**Syriac/Assyrian:**

ܡܠܚܘܙܬܐ: ܐܝܢܐ ܐܢܬܐ ܬܬܚܕܬ ܐܢܟܪ ܐܠܘܡܬܐ، ܐܝܢ ܟܘܨܡܐܬ ܐܠܘܡܬܐ ܐܠܘܡܬܐ ܬܬܘܘܦܪ ܠܟ ܒܐܡܚܘܢܐ. ܐܬܘܠ ܒܪܩܡ 1-888-327-0671 (ܪܩܡ ܗܘܬܐܬ ܐܠܘܡܬܐ ܘܒܝܚܘܢܐ: 711)

**Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671 (TTY : 711)。

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-327-0671 (TTY: 711).

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

**Bengali:** লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৮৮-৩২৭-০৬৭১ (TTY: 711)।

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

**Italian:** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (TTY: 711).

**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-327-0671 (TTY:711) まで、お電話にてご連絡ください。

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-327-0671 (телетайп: 711).

**Serbo-Croatian:** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-327-0671 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711).

