Notice of Changes to the McLaren Health Advantage Program Benefits Document
(Summary of Material Modifications)

This summary of material modifications describes changes to the McLaren Health Advantage Program Benefits Document. Several of the sections of the Benefits Document will be modified effective January 1, 2024, to clarify the Plan's obligations related to the network and other issues.

This amendment to the Benefits Document shall apply notwithstanding any other statements in the Plan, the summary plan description, or any other documents. Please attach this document to your Benefits Document for future reference.

1. The third paragraph of the Introduction is replaced in its entirety with the following:

The Plan is a Preferred Provider Organization (PPO) plan administered by McLaren Health Advantage. The Plan is a tiered network and has different coverages levels depending on the provider. You will receive the lowest Out-of-Pocket Expenses at a Tier 1 Provider. Tier 2 Providers are contracted with the Plan but have higher cost-sharing and Out-of-Pocket Expenses. Out-of-Network Providers do not have contracts with the Plan and will in most cases have the highest Out-of-Pocket expenses. You may choose to obtain services from a Tier 1 Provider, Tier 2 Provider or an Out-of-Network Provider, but in most cases you will have higher Member Out-of-Pocket Expenses (e.g., higher Copayments and Deductibles) if you receive services from an Out-of-Network Provider than if you received the services from a Tier 1 Provider or Tier 2 Provider. A provider's benefits tier may change from time to time.

2. The last bullet in the Important Information Section is replaced in its entirety with the following:

- When you see a Tier 1 Provider or Tier 2 Provider, you should always request to have your labs, pathology and other services sent to Tier 1 Provider in order to avoid Balance Billing. Failure to do so may result in significant costs to you. Except if required by an Applicable Surprise Billing Law, we will not pay for labs, pathology and other services sent to a Tier 2 Provider or Out-of-Network Provider at the Tier 1 Provider Cost Sharing. Labs, pathology and other services that are considered Preventive Services and are sent to an Out-of-Network Provider will not be paid for and are not Covered, unless the service cannot be provided by any Tier 1 Provider.

3. The definition of Balance Billing is replaced in its entirety with the following:

Balance Billing means an amount the Member must pay after the Plan has paid its Reimbursement Amount for a Covered Service. Unless the Covered Service is subject to Applicable Surprise Billing Laws, when a Covered Service is obtained from an Out-of-Network Provider who is not a Secondary Network Provider, the Plan will pay the Provider the Reimbursement Amount for the Covered Service. If the provider's charge is greater than the amount paid by the Plan, the balance is referred to as a "Balance Bill" which will be the responsibility of the Member to pay. NOTE – Unless the Covered Service is subject to Applicable Surprise Billing Laws, Balance Billing will apply when a member receives Out-of-Network Covered Services and is approved for payment at the Tier 1 Provider Benefit Level (see Section 7.03.02 for applicability), and the Covered Services are obtained from an Out-of-Network Provider.

4. The definition Deductible is replaced in its entirety with the following:

Deductible is the annual amount of money payable by a Member for Covered Services. A Member's Deductible is included in Schedule of Member Cost Sharing. The Deductible applies to your Out-of-Pocket Maximum. NOTE – there are multiple deductibles that must be met depending on the provider that you use. Amounts applied toward one deductible do not apply towards another deductible. See your Schedule of Cost Sharing for details.

5. The definition of In-Network Provider is deleted.

6. The following is added as a new definition:

Tier 1 Provider means a Provider that is either (1) a McLaren owned or employed provider, or (2) certain other health care providers directly contracted with McLaren Health Advantage listed in the Provider Directory as Tier 1 Providers. Benefits received from Tier 1 Providers are provided at the lowest Out-of-Pocket Expense to the Member. The list of Tier 1 Providers can be found in the McLaren Health Advantage Provider Directory located at www.McLarenHealthPlan.org. See also **Tier 2 Providers** and **Out-of-Network Providers**.

7. The following is added as a new definition:

Tier 2 Provider means a Provider that is not a Tier 1 Provider but is directly contracted with McLaren Health Advantage listed in the Provider Directory as Tier 2 Providers. The list of Tier 2 Providers can be found in the McLaren Health Advantage Provider Directory located at www.McLarenHealthPlan.org. When you obtain services from Tier 2 Providers, your Out-of-Pocket Expenses will be higher than the Out-of-Pocket Expenses if you obtain the services from a Tier 1 Provider.

8. The definition of Out-of-Network Provider is replaced in its entirety with the following:

Out-of-Network Provider means a provider that is not a Tier 1 Provider or Tier 2 Provider. When you obtain services from Out-of-Network Providers, your Out-of-Pocket Expenses will be higher than the Out-of-Pocket Expenses if you obtain the services from a Tier 1 or Tier 2 Provider.

9. The definition of Out-of-Pocket Maximum is replaced in its entirety with the following:

Out-of-Pocket Maximum is the maximum total amount you must pay for your medical and pharmacy Deductible, Copayments and Coinsurance during a Plan Year. This limit does not include your premium, Balance Billing or health care services or supplies that are not Covered Services by the Plan. **NOTE** – see your pharmacy benefit in Section 7.31 for additional information on limitations and exclusions to the Out-of-Pocket Maximum. **NOTE** – you have a different Out-of-Pocket Maximums depending on the provider you see. See your Schedule of Member Cost Sharing for details.

10. The definition of Provider Directory is replaced in its entirety with the following:

Provider Directory is a listing of the names and locations of health care providers who are Tier 1 Providers and Tier 2 Providers. You may call our Customer Service Department to obtain a list of Providers in your area, or you can go to our website at www.McLarenHealthPlan.org.

11. The definition of Reimbursement Amount is replaced in its entirety with the following:

Reimbursement Amount is the maximum amount determined by McLaren Health Advantage to be eligible for payment for a particular service, supply or procedure that the Plan will pay for a Benefit. For Tier 1 Providers or Tier 2 Providers it is the lower of the billed charge or the contracted amount that the Plan pays the Tier 1 Provider or Tier 2 Provider based on the McLaren Health Advantage's contracted rate with the provider in effect on the date of service, less any applicable cost-sharing. For Out-of-Network Providers, it is the lower of the billed charge or the Reimbursement Amount the Plan will pay an Out-of-Network Provider, in accordance with the Reimbursement Methodology in the chart below, less any applicable cost-sharing. When the Reimbursement Amount for Out-of-Network Providers is developed from base Medicare Participating reimbursements, it will exclude any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim (*e.g.*, graduate medical education payments. When a particular service is reimbursed using a Medicare reimbursement rate and the Medicare reimbursement rate is not available or is unable to be determined based on the Claim information submitted, the Reimbursement Amount for Out-of-Network Providers will be the median rate for In-Network Providers for the service, supply or procedure. For Emergency Services, as defined in Section 7.08 and for Emergency Air Ambulance Services, provided by an Out-of-Network Provider, reimbursement will be no more than the Qualifying Payment Amount, or if the Plan cannot determine the Qualifying Payment Amount, it will use the Secondary Network. Additionally, for Emergency Services, if Applicable Surprise Billing Laws do not apply, reimbursement will be at the non-Emergency Out-of-Network Reimbursement Methodology specified below. Unless subject to an Applicable Surprise Billing Law, the following contains the non-Emergency Services Out-of-Network Reimbursement Methodology:

Provider Type	Reimbursement Methodology
Out-of-Network Professional	100% of Medicare Allowable
Out-of-Network ASC	100% of Medicare ASC Repricing
Out-of-Network Hospital	60% of Billed Charges
Out-of-Network Skilled Nursing Facility	60% of Billed Charges
Out-of-Network DME	100% of the Michigan Medicare Allowable
Ground Ambulance	100% of Billed Charges
Emergency Air Ambulance	Qualifying Payment Amount
Out-of-Network Pharmacy	Tier 1 – (Preferred Generic) 25% of Average Wholesale Price (AWP) Tier 2 – (Preferred Brand) 75% of AWP Tier 3 – (Non-Preferred Generic) 25% of AWP Non-Preferred Brand 70% of AWP Specialty Drugs 70% of AWP Preventive AWP 75% of AWP

NOTE – Only to the extent required by law, the Plan will comply with Applicable Surprise Billing Laws. To the extent required by an Applicable Surprise Billing Law, cost-sharing will be calculated at the Qualifying Payment Amount.

12. The definition of Secondary Network Provider is replaced in its entirety with the following:

Secondary Network Provider means a GlobalCare/Zelis that have contracted directly with the Plan. Access to GlobalCare/Zelis is limited to certain circumstances. See Section 7.01.01 below for more information.

13. The definition of Self-refer is replaced in its entirety with the following:

Self-refer means obtaining services from a Tier 2 Provider or Out-of-Network Provider. In most cases, when a Member self-refers to a Tier 2 Provider or Out-of-Network Provider, the Member is responsible for the higher Tier 2 Provider or Out-of-Network Out-of-Pocket Expenses, as applicable.

14. The definition of Specifically Designated Provider is deleted in its entirety.

15. The following is added to the Exclusions in Section 7.09:

- Air ambulance services that are non-emergent

16. Section 1.03 Primary Care Physician (PCP) is replaced in its entirety with the following:

1.03 PRIMARY CARE PHYSICIAN (PCP)

McLaren Health Advantage generally requires the designation of a Primary Care Provider. We encourage you to select a PCP in your geographic area. You have the right to designate any Primary Care Provider who is a Tier 1 Provider and who is available to accept you or your family members. If you do not select a PCP, one will be assigned to you. To select a Tier 1 Provider PCP, please call Customer Service at (888) 327-0671. We can assist you with your request and verify that the PCP you have chosen is accepting new patients. You may also visit our website at www.McLarenHealthPlan.org for the current Provider Directory.

For children under the age of 18 years, you may designate a pediatrician as the Primary Care Provider.

You do not need Prior Authorization from McLaren Health Advantage or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our Tier 1 Provider Network who specializes in obstetrics or gynecology. The Tier 1 Provider health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Tier 1 health care professionals who specialize in obstetrics or gynecology, contact Customer Service at (888) 327-0671.

17. Section 1.05 Expedited Formulary Exception Requests – Prescription Drugs is deleted in its entirety.

18. Section 1.06 Information Used to Determine Medical Necessity is renumbered to Section 1.05.

19. Section 7.01.01 Providers and Provider Networks is replaced in its entirety with the following:

7.01.01 PROVIDERS AND PROVIDER NETWORKS

Tier 1 Providers: When you receive services from Tier 1 Providers and obtain any necessary Preauthorization from the Plan, your health care is provided at the lowest Out-of-Pocket Expense to you. Tier 1 Providers are (1) McLaren owned or employed providers; and (2) certain providers directly contracted with McLaren Health Advantage and listed in the Tier 1 Provider Directory.

Tier 2 Providers: When you receive services from Tier 2 Providers and obtain any necessary Preauthorization from the Plan, your health care is provided at a greater Out-of-Pocket Expense to you. Tier 2 Providers are providers directly contracted with McLaren Health Advantage and listed in the Tier 2 Provider Directory.

Out-of-Network Providers: When you receive services from an Out-of-Network Provider your health care is provided with higher Out-of-Pocket Expenses to you. Out-of-Network Providers are providers who are not Tier 1 Providers or Tier 2 Providers. **Note:** If you choose to receive services from an Out-of-Network Provider, and the services are not subject to Applicable Surprise Billing Laws, in addition to higher Out-of-Pocket Expenses you may also be responsible to pay the "**Balance Bill**", which is the price difference between the cost of the services (the provider's actual charge) and the amount the Plan pays for that service (the Reimbursement Amount). These costs can be significant, so it is important to understand your liability when using an Out-of-Network Provider.

Secondary Network Providers: Secondary Network Providers include GlobalCare/Zelis Providers that have contracted directly with the Plan. Access to GlobalCare/Zelis is limited to the following:

- Urgent Care Services
- NICU
- High Risk OB delivery/inpatient admission
- Additionally, for McLaren St. Lukes covered Members only, claims that are preauthorized in advance because the requested services cannot be provided by Tier 1 Provider in Ohio, as provided in Section 7.03.02.

*If the Plan is unable to Calculate the Qualifying Payment Amount under Applicable Surprise Billing Laws, the Plan may, in its discretion, send a claim to Globalcare/Zelis for the following types of Covered Services:

- Emergency Services
- Emergency Air Ambulance Services
- Inpatient admissions through the Emergency Department

Contact Customer Service at (888) 327-0671 for more information about Secondary Network Providers.

A complete list of Tier 1 Providers and Tier 2 Providers can be found in the Provider Directory at www.McLarenHealthPlan.org. Any other provider not listed in the Directory is also an Out-of-Network Provider. You may call McLaren Health Advantage's Customer Service for assistance in choosing a provider. The contact number for Customer Service is (888) 327-0671.

20. Section 7.01.02 Transitional Care is replaced in its entirety with the following:

7.01.02 TRANSITIONAL CARE

In limited circumstances, with Plan Preauthorization, a Member newly enrolled with the Plan may continue a course of treatment with a Tier 2 Provider or Out-of-Network Provider, and the Plan will Cover such services at the Tier 1 Provider Coverage level ("**Transitional Care**"). However, you may be subject to Balance Billing.

The Preauthorization of Transitional Care is subject to Plan medical review and medical documentation provided by the Member or the treating physician on behalf of the Member.

In general, if the Plan Preauthorizes Transitional Care, the period of time Preauthorized will be one (1) calendar year. Upon request for renewal of Transitional Care, the Plan will conduct a medical review based upon updated medical documentation provided by the Member.

21. Section 7.02.03 Continuing Care as a Result of Termination of an In-Network Provider's Contract is replaced in its entirety with the following:

7.01.03 CONTINUING CARE AS A RESULT OF TERMINATION OF A TIER 1 OR TIER 2 PROVIDER'S CONTRACT

Definitions:

Continuing Care Patient

"Continuing Care Patient" means an individual who, with respect to a Tier 1 Provider or Tier 2 Provider or a Tier 1 Provider Facility or Tier 2 Provider Facility:

- Is undergoing a course of treatment for a Serious and Complex Condition from the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility;
- Is undergoing a course of institutional or Inpatient care from the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility;
- Is scheduled to undergo nonelective surgery from the Tier 1 Provider or Tier 2 Provider, including receipt of postoperative care from such Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility with respect to such surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility or;

- Is or was determined to be terminally ill and is receiving treatment for such illness from such Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility.

“Serious and Complex Condition” means, with respect to the Member:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Process:

A Tier 1 Provider or Tier 2 Provider may choose to terminate his/her contract or arrangement with McLaren Health Advantage. Therefore, we cannot guarantee that a given Tier 1 Provider or Tier 2 Provider will be available to treat a Member during the entire time the Member is Covered by the Plan. If Tier 1 Provider or Tier 2 Provider informs a Member that the Provider will no longer be a contracted Provider, the Member should contact Customer Service at (at 1-888-327-0671) as soon as possible.

If a Tier 1 Provider or Tier 2 Provider’s contract or arrangement with McLaren Health Advantage is terminated, a Member receiving services from the terminating Provider may wish to select a different Tier 1 Provider or Tier 2 Provider in order to continue receiving Covered Services with lower Out-of-Pocket Expenses. However, a Tier 1 Provider will have the lowest Out-of-Pocket Expenses. However, a Member who is undergoing an ongoing course of treatment with the terminating a Tier 1 Provider or Tier 2 Provider may be eligible to continue to be treated by this Provider if:

- The treatment is for a Serious and Complex Condition, in-patient care, a scheduled nonelective surgery, pregnancy, or Terminal Illness;
- The continuation period is approved by the Plan;
- The Provider is still available to continue treating Members;
- The Provider agrees to continue to meet McLaren Health Advantage’s quality standards and comply with McLaren Health Advantage policies and procedures;
- The Provider is not leaving the network due to a failure to meet the McLaren Health Advantage’s quality standards or because of fraudulent conduct; and
- The Provider agrees to accept McLaren Health Advantage’s payment as payment in full at the rates applicable prior to the Provider’s termination, not including applicable Member Copayments, Coinsurance or Deductible.

This continuation of treatment with the Provider may be continued, as applicable:

- For up to 90 days after the Member receives notice from MHA that the Provider is leaving the Provider network;
- Through the second and third trimester of a pregnancy (in the case of a pregnant woman) and through the completion of post-partum care; or

- In the case of a Member with a Terminal Illness, through the remainder of the Member’s life for treatment related to the Terminal Illness if the Member was diagnosed as Terminally Ill prior to receiving notification of the Provider’s termination.

To the extent not covered here, we will provide continuity of care as required by applicable federal law. Notwithstanding anything to the contrary in this Section, the Plan complies with applicable requirements in 42 USC 300gg-113 related to continuity of care. Specifically, if a Tier 1 Provider or Tier 2 Provider contract is “terminated”, as defined in 24 USC 300gg-113(b)(3), or if benefits under this Benefits Document with respect to the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider or Tier 2 Facility are terminated because of a change in the terms of the participation of the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility in the plan or coverage or if the contract between the Group and McLaren Health Advantage is terminated, resulting in a loss of benefits provided under the plan with respect to a Provider or Facility, the Plan will:

- Notify Members who are Continuing Care Patients of the termination and of their right to elect transitional care from a Tier 1 Provider or Tier 2 Provider,
- Provide eligible Members the opportunity to notify us of the need for transitional care, and
- Permit Members to elect to continue benefits under the same terms and conditions that would have applied until the earlier of 90 days after notice provided by the Plan to the Member or the date Member is no longer a Continuing Care Patient

22. The first paragraph of Section 7.03.01 Preauthorization for Covered Services is replaced in its entirety with the following:

Certain services and supplies require Preauthorization by the Plan before they will be Covered. Excluding Emergency Services, this is true whether they are received from a Tier 1 Provider, Tier 2 Provider or Out-of-Network Provider. The Sections of this Benefits Document that describe particular Covered Services include Preauthorization requirements. Providers will assist you in obtaining Preauthorization from the Plan, but the Member is ultimately responsible to ensure any necessary Preauthorization is obtained before the Member receives the service. If the Plan Preauthorizes a service, we will notify the provider who will be providing the service.

23. Section 7.03.02 Preauthorization for Out-of-Network Services to Be Covered at In Plan Level is replaced in its entirety with the following:

7.03.02 PREAUTHORIZATION FOR TIER 2 PROVIDER OR OUT-OF-NETWORK SERVICES TO BE COVERED AT TIER 1 PROVIDER LEVEL

In certain limited circumstances, the Plan may cover Services provided by an Out-of-Network Provider or Tier 2 Provider at the Tier 1 Provider Cost-Sharing. Excluding Emergency Services, this is limited to the following circumstances:

- Hospital to hospital transfers (e.g., an In-Network Hospital transfers a Member to an Out-of-Network Hospital when services cannot be provided In-Network)
- Services are not available from a Tier 1 Provider

- Tier 1 Provider Laboratory sends labs to a Tier 2 Provider Laboratory or Out-of-Network Laboratory because they cannot perform the requested service

Note – Transitional Care may also be Covered at the Tier 1 Cost Sharing (See Section 7.01.02 for details and how to request a pre-authorization).

Members may request the Plan to Preauthorize Coverage of Out-of-Network or Tier 2 Provider services at the Tier 1 Benefit level. If you or your provider believes that Service meets the above listed circumstances, you must request a Preauthorization for Tier 1 Provider Coverage **prior to receiving services**. You or your provider must specifically ask for the services to be covered at the Tier 1 Provider Cost Sharing. A general request for Preauthorization is insufficient. The services will not be Covered under the Tier 1 Provider Cost Sharing if you do not request a Preauthorization in advance. Notwithstanding the foregoing, Members can request a retro review if a Tier 1 Laboratory sends labs to a Tier 2 or Out-of-Network Laboratory because they cannot perform the requested service.

When the Plan receives your Preauthorization request, the Plan will review the clinical indications and factors of the case, and will determine whether the services are available from a Tier 1 Provider. Note – location of a Tier 1 Provider (e.g., driving distance) is not a factor that will be considered. If the Plan determines that the services are not available from a Tier 1 Provider, the Plan will direct the Member to the provider deemed to be the most appropriate to address the Member's medical needs. The Plan's decision with respect to the request will be communicated to the Member in writing. NOTE - You may be subject to Balance Billing.

If the Plan determines that the requested services can be provided by a Tier 1 Provider, services obtained from a Tier 2 or Out-of-Network Provider will not be Covered at the Tier 1 Level; they will be Covered at the applicable Tier 2 or Out-of-Network Benefit Level.

24. Section 7.04 Preventive Services is replaced in its entirety with the following:

7.04 PREVENTIVE SERVICES

Preventive Services are screenings, immunizations, lab tests and other services that are required to be provided in the federal Patient Protection and Affordable Care Act to help prevent illness or help finding diseases or medical conditions before you experience symptoms. Some services are Preventive Services only for specified age groups or genders.

Preventive Services are Covered in full with no Deductible, Coinsurance or Copayment when provided by any Tier 1 Provider.

Note: There is no Coverage for Preventive Services provided by a Tier 2 or Out-of-Network Provider unless the service cannot be provided by a Tier 1 Provider.

The list of Preventive Services is updated by the U.S. Preventive Services Task Force on a regular basis. Therefore, the information below may change. Where there is an update to a recommendation, coverage will be provided for the Plan Year beginning on or after one year after the date the recommendation is issued. If you have a question as to whether a service is considered Preventive please contact Customer Service at (888) 327-0671. You may also visit

the USPSTF website at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ or www.HealthCare.gov.

If a recommendation or guideline does not specify the frequency, method, treatment or setting for the provision of a recommended Preventive Service, the Plan may use reasonable medical management techniques to determine any such coverage limitations. For more information specific to contraceptives, see the "Note" below under Preventive Services for Women.

The following are the general categories of Preventive Services:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration and developed in accordance with 45 CFR 147.130(a)(1)(iv).

The following are services that are currently Covered as Preventive Services:

Physical Exams

Routine well child visits including physical and developmental screenings and assessments for all children in accordance with the recommendations for Preventive Pediatric Health Care issues by Bright Futures/American Academy of Pediatrics.

Immunizations

Doses, recommended ages and who should have these immunizations vary, and include but are not limited to:

- Certain vaccines for children from birth to age 18
- Certain vaccines for all adults

Assessments and screenings newborn to age 21

Recommended ages and who should have these services vary, and include but are not limited to:

- Developmental screening
- Hearing loss screening
- Vision screening
- HIV screening for adolescents
- Sexually transmitted infection screening for sexually active adolescents
- Depression screening for adolescents

- Screening and counseling for obesity

Preventive services for women

Service	Who	Frequency
Obesity prevention in midlife women	Women age 40 to 60 with normal or overweight body mass index	As needed
Well-woman visits (includes pre-pregnancy, prenatal, postpartum and interpregnancy visits)	Adult women	Annually and/or as needed
Gestational diabetes screening	Women 24-28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
Breast Cancer Screening (mammography only)	Women aged 40 to at least age 74	Annually or every 2 years
Cervical Cancer Screening (Pap test)	Women aged 21 to 30 years	Every 3 years
Cervical Cancer Screen (Pap test and Co-Testing for (HPV))	Women aged 30 to 65 years	Every 3 years for Pap Test alone or Co-testing for HPV every 5 years
Sexually transmitted infection (STI) counseling	Sexually-active women	Annually
HIV screening and counseling	• Women aged 15 and older • Sexually-active women	• At least once during their lifetime • Annually, or as appropriate
Risk Assessment and Prevention Education for HIV infection	Women aged 13 and older	As needed
Contraceptive methods*, sterilization procedures and patient education and counseling (including instruction in fertility awareness-based methods, including lactation amenorrhea)	Sexually-active women	As needed
Breastfeeding support, supplies (including a double electric breast pump and breast milk storage supplies) and counseling**	Pregnant and postpartum women	Per pregnancy

Interpersonal and domestic violence screening and counseling	All adolescent and adult women	At least annually and as needed

***Note**: "Contraceptive methods" include Coverage for Preferred Generic and Preferred Brand Name contraceptive medications, devices and appliances when prescribed by a provider and obtained through a Preferred Pharmacy or, as applicable, a Tier 1 Provider. Over-the-counter contraceptives are also Covered, provided you obtain a prescription from your provider and obtain the contraceptive at a Preferred Pharmacy. Additional terms and conditions of Coverage for contraceptive medications, devices and appliances are found in Section 7.31, Prescription Drug Coverage. Some devices and appliances (e.g., IUD's) are Covered under your medical Benefits and are subject to the medical conditions of Coverage. Please contact Customer Service at (888) 327-0671 for additional information.

- The Plan also covers, without cost sharing, contraceptive services and FDA approved, cleared, or granted contraceptive products that your attending provider, who is Tier 1 Provider, and has determined to be medically appropriate for you, even if the contraceptives are not in the categories listed in the then applicable HRSA-Supported Guidelines ("HRSA Guidelines"). This can include contraceptive products more recently approved, cleared, or granted by FDA. Contraceptives must be prescribed and administered by a Tier 1 Provider. When obtained through the pharmacy benefit, contraceptives must be ordered by a Tier 1 Provider and delivered through an In-Network Pharmacy.
- Coverage for contraceptives is subject to reasonable medical management techniques.
    - *HRSA Guidelines* – The Plan covers at least one contraceptive in each HRSA Guidelines category at no cost sharing. See your Formulary for Covered contraceptives within the HRSA Guidelines.
    - *Outside HRSA Guidelines* - For contraceptives not included in the HRSA Guidelines, the Plan will use reasonable medical management techniques to determine which products to cover without cost sharing, when multiple, substantially similar services or products that are not included in a category in the HRSA Guidelines are available and are medically appropriate for you.
- If your Tier 1 Provider determines a contraceptive not listed in the Plan's Formulary is medically necessary (regardless of whether it is in the HRSA Guidelines), you or your Tier 1 Provider may submit an exception to the Plan in accordance with the Plan's exceptions process. The Plan's exceptions process is easily accessible, transparent and when appropriate, expeditious. Please contact Customer Service at (888) 327-0671 for more information on the exception process.
- To the extent required by law, the Plan will defer to the determination of your attending provider, who is an In-Network Provider, that coverage is medically necessary, so you can obtain Coverage for the medically necessary contraceptive service or product without cost sharing.

** **Note:** A list of Tier 1 lactation consultants can be found in the Provider Directory at www.McLarenHealthPlan.org.

Assessments and screenings for adults

Recommended ages and who should have these services vary, and include but are not limited to:

- Blood pressure screening
- Breast cancer screening, mammography and prevention (BRCA genetic testing requires Preauthorization)
- Colorectal cancer screening
- Depression screening
- Diabetes screening
- Alcohol misuse screening
- Medical history
- HIV screening
- Certain sexually transmitted infection (STI) screening
- Sexually transmitted infection (STI) prevention counseling for high risk adults
- Screening and counseling for obesity
- Screening for tobacco use
- Counseling regarding use of aspirin to prevent cardiovascular disease
- Diet counseling – adults at higher risk for chronic disease

Additional assessments and screenings for adult pregnant women include but are not limited to:

- Screening for bacteriuria
- Screening for hepatitis B
- Screening for RH incompatibility
- Screening for syphilis

Tobacco Use Counseling and Interventions for Adults

These services include:

- Screening for tobacco use.
- Tobacco cessation Prescription Drugs for 90 days per quit attempt (limited to two (2) quit attempts per year), when prescribed by your Provider and obtained at a Preferred Pharmacy. (See Section 7.31, Prescription Drug Coverage.)

Drugs other than contraceptive or tobacco cessation medications (prescription required):

Recommended ages and who should have these services vary and include, but are not limited to:

- Oral fluoride supplements
- Folic acid supplements
- Iron supplements

Refer to Section 7.31, Prescription Drug Coverage, for Coverage information.

General Limitations:

Members should note that preventive screenings received more than once a Plan year and/or received before or after the age indicated are not considered Preventive Services, and the Member will be responsible for paying any applicable Copayment, Coinsurance or Deductible for such services. With some limited exceptions (e.g., a post-procedure biopsy on a polyps located as part of a Preventive colonoscopy), services that are performed for diagnostic purposes (as opposed to screening purposes) are likewise not Preventive Services, and the Member will be responsible for paying any applicable Copayment, Coinsurance or Deductible for such services.

Exclusions:

Preventive Services are not Covered when provided by a Tier 2 Provider or Out-of-Network Provider, unless the service cannot be provided by any Tier 1 Provider.

25. The limitations and exclusions section of Section 7.06.03 Maternity Care and Newborn Care – Including Prenatal and Postnatal Visits is replaced in its entirety with the following:

Limitations and Exclusions:

- Genetic testing requires Preauthorization.
- All maternity care, including prenatal services, delivery services and postpartum care, provided by a Tier 2 Provider or Out-of-Network Provider will have higher Member Cost Sharing, even if the care is provided while traveling outside of the State. A routine delivery will not be Covered as a Medical Emergency.
- Services and supplies received in connection with an obstetrical delivery in the home or free-standing birthing center are not Covered.

26. The Second bullet in Section 7.08 Emergency and Urgent Care is replaced in its entirety with the following:

- Services for **medical emergency or accidental injury**, including mental health or substance abuse-related medical emergencies, are Covered when provided by a Tier 1 Provider, Tier 2 Provider or Out-of-Network Provider. **Note, however:** Unless an Applicable Surprise Billing Law applies, when services are provided by an Out-of-Network Provider, the Member may be responsible for any Balance Bill (the difference between the amount paid by the Plan and the amount of the Out-of-Network Provider's charges). Your applicable cost sharing (Copayment, Coinsurance, or Deductible) will apply even if you are directed or otherwise referred to the emergency room by your physician.

27. Section 7.11 Outpatient Services is replaced in its entirety with the following:

7.11 OUTPATIENT SERVICES

Covered Services:

Facility and professional (physician) therapeutic and non-preventive diagnostic laboratory, pathology and radiology services and other procedures when performed in a Tier 1 Provider, Tier 2 Provider or Out-of-Network Provider setting, including outpatient Hospital setting, physician office, free standing center, or dialysis center for the diagnosis or treatment of a

disease, injury or other medical condition when Medically Necessary and, where required, Preauthorized by the Plan. See Section 7.03 for Preauthorization requirements. Outpatient Hospital services include the following:

- Outpatient surgery;
- Outpatient CT scans, PET scans, MRI and nuclear medicine;
- Outpatient procedures for treatment of breast cancer, including outpatient surgery, chemotherapy and radiation treatment;
- Outpatient hemodialysis;
- Professional Services including physician surgical services; also see Professional Physician Services section; and
- Outpatient infusion therapy.

28. The Exclusions in Section 7.19.01 Mental Health Services are replaced in their entirety with the following:

Exclusions:

- Care provided in a non-licensed residential or institutional facility, or other facility on a temporary or permanent basis is not Covered, including the costs of living and being cared for in:
  - Transitional living centers;
  - Domiciliary foster care facilities;
  - Therapeutic boarding schools;
  - Milieu therapies such as recreational or wilderness therapy programs that do not meet the requirements for Residential Mental Health Treatment as described above;
  - Custodial Care;
  - Halfway house services;
  - Three quarter house services.
- Counseling and other services for:
  - Insomnia and other non-medical sleep disorders;
  - Marital and relationship enhancement;
  - Religious oriented counseling provided by a religious counselor; and
  - Experimental/investigational or unproven treatments and services.

29. The definition of Covered Drug in Section 7.31 Prescription Drug Coverage is replaced in its entirety with the following:

Covered Drug: A Tier 1, Tier 2, Tier 3 or Preventive Drug that is prescribed by a provider, included on the Plan Formulary and obtained through a pharmacy, except as excluded in this Benefits Document.

30. Section 5 of the Limitations in Section 7.31 Prescription Drug Coverage is replaced in its entirety with the following:

5. An Over-the-Counter Medication requires a prescription from a Tier 1 Provider and must be included on the Plan Formulary.

31. Section 6 of the Limitations in Section 7.31 Prescription Drug Coverage is added as follows:

6. In order for the Plan to better manage available manufacturer-funded copay assistance, copays for certain specialty medications may vary and be set to approximate the maximum of any available manufacturer-funded copay assistance programs. However, in no case will true out-of-pocket costs to the Member be greater than the maximum copayment published in the Schedule of Cost Sharing. Finally, manufacturer-funded copay assistance received will not be credited to your annual deductible or Out of Pocket Maximum.

32. Section 12 of the Exclusions in Section 7.31 Prescription Drug Coverage is replaced in its entirety with the following:

12. Discounts, coupons, or similar financial assistance provided by drug manufacturers or pharmacies to assist you in covering the cost of your specialty medications or other Drugs (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription) will not be counted toward the Out of Pocket Maximum or Deductible. Only the amount that you pay separate and apart from the financial assistance will be credited as true out-of-pocket payment that will apply to your annual maximum out-of-pocket requirement. For example, if your cost is reduced by a Copayment assistance card, manufacturer coupon or other drug assistance program (other than those the Plan is required to accept by law), only the amount you actually pay will accumulate toward your Deductible, if applicable, or Out of Pocket Maximum.

33. Section 13 of the Exclusions in Section 7.31 Prescription Drug Coverage is added as follows:

13. There is no Coverage for Drugs not included on the Plan Formulary. **NOTE** please check the formulary at www.MclarenHealthPlan.org for Coverage of drugs as the Formulary changes periodically to add or remove drugs.

34. Section 7.33 ABA Therapy is replaced in its entirety with the following:

7.33 ABA THERAPY

The Plan Covers Applied Behavioral Analysis or ABA is Covered when provided by a provider who has the appropriate credentials (Preauthorization is required);

Limitations:

- ABA services must be Medically Necessary as determined by the Plan

Exclusions:

- ABA services not Preauthorized by the Plan;
- All other habilitation services

35. Section 7.18 Hospice Care is replaced in its entirety with the following:

7.18 HOSPICE CARE

Coverage is for the Terminally Ill through a hospice program. Hospice care includes physical, psychological, social and spiritual care for the Terminally Ill person, and short-term grief counseling for immediate family members.

Patients using hospice services have their regular McLaren Health Advantage Benefits relating to their Terminal Illness replaced by the following:

- Home Care Services:
  - Up to eight hours of routine home care per day
  - Continuous home care for up to 24 hours per day during periods of crisis
  - Home health aide services provided by qualified aides. These services must be rendered under the general supervision of a registered nurse

- Facility Services:
  - Inpatient care provided by a
    - Hospice inpatient unit
    - Hospice contracting with the hospice program or
    - Skilled nursing facility contracting with the hospice program
  - Short-term general inpatient care when the Member is admitted for pain control or to manage symptoms. (These services are Covered if they meet the plan of care established for the Member.)
  - Five (5) non-sequential days of respite care during a 30-day period

Exclusions:

- Housekeeping services
- Financial or legal counseling
- These services are not Covered if primarily for the purpose of providing long-term custodial care.

36. Section 8.18 Care Rendered While in Police Custody is replaced in its entirety with the following:

8.18 CARE RENDERED WHILE IN POLICE CUSTODY

Services provided to a Member while in police custody are not Covered. Police custody includes, but is not limited to any time a Member is not free to go, including when a Member was not issued bond.

37. The Schedules of Cost Sharing are replaced in their entirety and are attached to this document. Please review the Schedule of Cost Sharing applicable to your plan.

If you have any questions, please call McLaren Health Advantage Customer Service at (888) 327-0671 or contact McLaren Health Advantage at G-3245 Beecher Road, Flint, MI 48532.