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 were modified effective April 1, 2023, to clarify the Plan's obligations related to surprise billing 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 following are added to the end of the Important Information section:

- Unless an Applicable Surprise Billing Law, you may be Balance Billed when you see an Out-of-Network Provider. This may include Surprise billing laws do not cover all services and in some cases you could consent to Balance Billing.
- When you see an In-Network Provider, you should always request to have your labs, pathology and other services sent to an In-Network 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 an Out-of-Network Provider at the In-Network 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 In-Network Provider.

2. The following is added as a new definition:

Infertility means a disease, condition, or status characterized by:

- a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility;
- a Member's inability to reproduce either as a single individual or with a partner without medical intervention; or
- a licensed physician's findings based on a Member's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

3. The table in the definition of Reimbursement Amount for Out-of-Network Reimbursement Methodology is replaced in its entirety with the following:

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	Sent to Secondary Network

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

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

Secondary Network Provider means a GlobalCare/Zelis and Specifically Designated Providers 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.

5. The following is added as a new definition:

Specifically Designated Provider is a Health Care Provider that has a contractual relationship with McLaren Health Advantage in the Secondary Network. If you see a Specifically Designated Provider, your Out-of-Network Cost Sharing will apply, but there is no Balance Billing. A list of Specifically Designated Providers is available at www.McLarenHealthAdvantage.org. Specifically Designated Providers are not listed in the Provider Directory because they are not In-Network Providers.

6. Section 7.01.01 is replaced in its entirety with the following:

7.01.01 PROVIDERS AND PROVIDER NETWORKS

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

Specifically Designated Providers: Specifically Designated Providers are contracted with McLaren Health Advantage, but are considered Out-of-Network Providers for purposes of Cost-Sharing. You will not be Balance Billed by a Specifically Designated Provider, but your Out-of-Network Cost Sharing will apply, unless an Applicable Surprise Billing Law applies.

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

- Emergency and Urgent Care Services
- Emergency Air Ambulance Services
- Inpatient admissions through the Emergency Department
- 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 an In-Network Provider in Ohio, as provided in Section 7.03.02.

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

A complete list of In-Network Providers can be found in the Provider Directory at www.McLarenHealthAdvantage.org. Out-of-Network Providers who are Specifically-Designated Providers are also included in a separate document at www.McLarenHealthAdvantage.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.

7. Section 7.01.03 is replaced in its entirety with the following:

7.01.03 CONTINUING CARE AS A RESULT OF TERMINATION OF AN IN-NETWORK PROVIDER'S CONTRACT

Definitions:

Continuing Care Patient

"Continuing Care Patient" means an individual who, with respect to an In-Network Provider or an In-Network Facility:

- Is undergoing a course of treatment for a Serious and Complex Condition from the In-Network Provider or In-Network Facility;
- Is undergoing a course of institutional or Inpatient care from the In-Network Provider or In-Network Facility;
- Is scheduled to undergo nonelective surgery from the In-Network Provider, including receipt of postoperative care from such In-Network Provider or In-Network Facility with respect to such surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the In-Network Provider or In-Network Facility or;
- Is or was determined to be terminally ill and is receiving treatment for such illness from such In-Network Provider or In-Network 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:

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

If an In-Network 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 In-Network Provider in order to continue receiving Covered Services with the lower Out-of-Pocket Expense. However, a Member who is undergoing an ongoing course of treatment with the terminating In-Network 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 In-Network 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 In-Network 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 an In-Network Provider contract is "terminated", as defined in 24 USC 300gg-113(b)(3), or if benefits

under this Benefits Document with respect to the In-Network Provider or In-Network Facility are terminated because of a change in the terms of the participation of the In-Network Provider or In-Network 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 an In-Network 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

8. The Gene Therapy bullet in Section 7.03.01 is replaced in its entirety with the following:

- Gene Therapy - Cellular and Gene therapy, intended to restore defective or insufficient structural or functional proteins by inactivating, introducing, or replacing a modified or new gene (treatment is limited to once per lifetime regardless of insurance coverage at the time of initial treatment.)

9. The following is added as a bullet at the end of Section 7.03.01:

- ABA services

10. Section 7.03.02 is replaced in its entirety with the following:

7.03.02 PREAUTHORIZATION FOR OUT-OF-NETWORK SERVICES TO BE COVERED AT IN-PLAN LEVEL

In certain limited circumstances, the Plan may cover Services provided by an Out-of-Network Provider at the In-Network 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 an In-Network Provider
- In-Network Laboratory sends labs to an Out-of-Network Laboratory because they cannot perform the requested service

Note - Transitional Care may also be Covered at the In-Network 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 services at the In-Network Benefit level. If you or your provider believes that Service meets the above listed circumstances, you must request a Preauthorization for In-Network Coverage **prior to receiving services**. You or your provider must specifically ask for the services to be covered at the In-Network Cost Sharing. A general request for Preauthorization is insufficient. The services will not

be Covered under the In-Network Cost Sharing if you do not request a Preauthorization in advance. Notwithstanding the foregoing, Members can request a retro review if an In-Network Laboratory sends labs to an 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 an In-Network Provider. Note – location of an In-Network Provider (e.g., driving distance) is not a factor that will be considered. If the Plan determines that the services are not available from an In-Network 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 an In-Network Provider, services obtained from an Out-of-Network Provider will not be Covered at the In-Network Benefit Level; they will be Covered at the appropriate Out-of-Network Benefit Level.

11. The following is added to Section 7.04:

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.

12. The "**Preventive services for women**" section in Section 7.04 is replaced in its entirety with the following:

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, an In-Network 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 an In-Network 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 an In-Network Provider. When obtained through the pharmacy benefit,

contraceptives must be ordered by an In-Network 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 In-Network 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 In-Network 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 In-Network lactation consultants can be found in the Provider Directory at www.McLarenHealthAdvantage.org.

13. Section 7.05 is replaced in its entirety with the following:

7.05 DIABETIC SERVICES

The following equipment, supplies, drugs and educational training related to the treatment of diabetes are Covered if determined to be Medically Necessary and prescribed by the Member's treating Provider:

- Blood glucose monitors and blood glucose monitors for the legally blind;
- Test strips for glucose monitors, visual reading and urine reading strips, lancets and spring-powered lancet devices;
- Insulin pumps and medical supplies required for the use of an insulin pump*;
- Insulin syringes;
- Insulin**;
- Non-experimental medication for controlling blood sugar**;
- Medications used in the treatment of foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes if prescribed by an allopathic, osteopathic or podiatric physician**; and
- Diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management and treatment of their condition.

* **Note**: Insulin pumps and continuous glucose monitors require Preauthorization.

**Certain diabetic supplies, such as syringes, needles, lancets, and blood glucose test strips, may be purchased at a Provider for DME. Your DME Cost Sharing will apply. These supplies may also be purchased at an In-Network pharmacy and your Prescription Drug Cost Sharing will apply.

**Your Prescription Drug Cost Sharing will apply for Covered Prescription drugs.

Limitations:

Coverage for diabetes self-management training is available if the following conditions apply:

- It is limited to completion of a certified diabetes education program if:
    - Considered Medically Necessary upon the diagnosis of diabetes by the Provider who is managing the Member's diabetic condition and if the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or
    - The Member's treating Provider diagnoses a significant change with long-term implications in the Member's symptoms or conditions that requires changes in the Member's self-management or a significant change in medical protocol or treatment modality.

- It is provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Michigan Department of Health and Human Services (MDHHS). This training shall be conducted in group settings whenever available.

14. The following is added at the end of Section 7.06.01:

Note: If you receive a Covered physician office visit in an Inpatient or Outpatient Facility setting, the Inpatient or Outpatient Cost Sharing, as applicable, will apply (<u>not</u> the Primary Care Physician (PCP) Office Visit or Specialist Office Visit Cost-Sharing).

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

- Air ambulance services that are non-emergent

16. The Limitations and Exclusions in Section 7.19.01 are replaced in their entirety with the following:

Limitations:

- Inpatient Mental Health Services, Partial Treatment Programs and Residential Mental Health Treatment each require Preauthorization by the Plan.
- Medical services required during a period of mental health admission must be Preauthorized separately by the Plan if Preauthorization is otherwise required.

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 who is not an In-Network Provider; and
    - Experimental/investigational or unproven treatments and services.

See Part 8 for additional Exclusions.

17. The limitations and Exclusions in Section 7.19.02 are replaced in their entirety with the following:

Limitations:

- Medically Monitored Intensive Inpatient Treatment, Partial Hospitalization and Residential Substance Abuse Treatment require Preauthorization by the Plan.
- Medical Inpatient services required during a period of substance abuse admission must be Preauthorized separately by the Plan.

Exclusions:

- Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, recreational or wilderness therapy programs, custodial care, halfway house services and health care aids.
- 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 Substance Abuse Treatment as described above);
    - Custodial Care;
    - Halfway house services

- Three Quarter house services.

- Also see Part 8 for additional Exclusions.

18. The Exclusions section of Section 7.20 is replaced in its entirety with the following:
Exclusions:

- Cognitive retraining
- Vocational rehabilitation
- Therapy that provides no meaningful improvement in a Member's ability to do important day-to-day activities that are necessary in the Member's life roles within 60 days of starting treatment
- Services outside the scope of practice of the servicing provider
- Additional speech therapy exclusions
  - Chronic conditions or congenital speech abnormalities
  - Learning disabilities
  - Deviant swallow or tongue thrust
  - Voice therapy
  - Vocal cord abuse resulting from life-style activities

19. Section 7.23.01 is replaced in its entirety with the following:

7.23.01 INFERTILITY

Coverage is available for services for diagnosis, counseling and treatment of Infertility (including the underlying cause(s) of Infertility), except as specifically excluded below or under Part 8. Artificial insemination for the treatment of Infertility includes:

- Intravaginal insemination (IVI)
- Intracervical insemination (ICI)
- Intrauterine insemination (IUI)

Following the initial sequence of diagnostic work-up and treatment, additional work-ups and treatment may begin only when the Plan determines they are in accordance with generally accepted medical practice and meet nationally recognized criteria. Coverage for pharmaceutical drugs prescribed as a part of this treatment are Covered pursuant to the terms and conditions of this Section.

Exclusions:

- In-vitro fertilization procedures, such as GIFT-gamete intrafallopian transfer or ZIFT-zygote intrafallopian transfer, and all related services and prescription drugs;
- Artificial insemination (except for treatment of Infertility); and
- All services related to surrogate parenting arrangements, including but not limited to, maternity and obstetrical care for non-Member surrogate parents.

20. Section 7.23.04 is replaced in its entirety with the following:

7.23.04 TERMINATION OF PREGNANCY

The Plan Covers elective first trimester (3 months) termination of pregnancy, one in each two-year period of Plan Coverage.

Exclusion: Procedures in jurisdictions where the procedure is prohibited by law.

21. Section 7.32 is replaced in its entirety with the following:

7.32 SERVICES FOR GENDER TRANSITION

The Plan Covers Medically Necessary services related to gender dysphoria or gender transition. Such services will be subject to the applicable Member cost sharing and limitations otherwise applicable. (*e.g.*, see Section 7.10 Inpatient hospitalization, Section 7.19 Mental Health Services, Part 8 Exclusions)

Limitations:

- Gender reassignment surgery must be Preauthorized

Exclusions:

- Reversal of prior gender reassignment surgery;
- Surgery that is considered cosmetic in nature and not Medically Necessary when performed as a component of a gender reassignment;
- Services, treatment and surgeries that are considered Experimental and Investigative;
- Exclusions under other benefits (e.g., see Inpatient hospitalization, Outpatient Habilitative Services, Outpatient Rehabilitative Services, Reproductive Care and Family Planning Services, Prescription Drugs, Mental Health Services, and Exclusions

22. The following is added as Section 7.33:

7.33 ABA THERAPY

The Plan Covers Applied Behavioral Analysis or ABA is Covered when provided by a board certified health professional 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

23. Section 8.6 is replaced in its entirety with the following:

8.6 CUSTODIAL CARE

The Plan does not Cover any custodial care, i.e., care that is primarily for maintaining the Member's basic needs for food, shelter and clothing. This means that custodial care is not Covered in settings such as your home, a nursing home, residential institution or any other setting that is not required to support medical and skilled nursing care. Further, we do not Cover Custodial (non-skilled) care when received in a home or facility on a temporary or permanent basis. Examples of such care include three-quarter house or half-way house placement, room and board, health care aids and personal care designed to help in activities of daily living or to keep from continuing unhealthy activities.

24. Section 8.7 is replaced in its entirety with the following:

8.7 COMFORT ITEMS

The Plan does not Cover any personal or comfort items, such as telephone or television. The Plan does not Cover the costs of a private room or apartment.

25. Section 8.9 is replaced in its entirety with the following:

8.9 NON-MEDICAL SERVICES

We do not Cover non-medical services including enrichment programs such as dance therapy, art therapy, equine therapy, ropes courses, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and education/preparatory courses or classes. These services may be paid as part of a treatment program, but they are not payable separately as long as they are expected to improve the Member's condition.

Additionally, we do not Cover fees related to parenting arrangements of any kind, not including maternity care and services.

26. Section 8.10 is replaced in its entirety with the following:

8.10 HABILITATION SERVICES

This Plan does not Cover Habilitation Services except for ABA services for treatment of Autism.

27. Section 8.11 is replaced in its entirety with the following:

8.11 COURT-RELATED SERVICES

- The Plan does not Cover pretrial and court testimony, court-ordered exams that do not meet Plan requirements for Coverage, and the preparation of Court-related reports;

- The Plan does not Cover court-ordered examinations, tests, reports, or treatments that do not meet requirements for Coverage under this Benefits Document, including but not limited to Mental Health or Substance Abuse Services Coverage.

28. Section 8.14 is replaced in its entirety with the following:

8.14 SERVICES COVERED THROUGH OTHER PROGRAMS AND THE PUBLIC SECTOR

The Plan does not Cover any services that are available to you under the following circumstances:

- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or certificate;
- Under any other policy, program, contract or insurance as stated in **Part 3: Other Party Liability;**
- Under any public health care, school or public program supported totally or partly by state, federal or local governmental funds, except where this Plan's Coverage is required by law to be your primary coverage;
- Under any contractual, employment or private arrangement (not including insurance) that you made that promises to provide, reimburse or pay for health, medical or hospital services; and
- Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment.

29. The following is added as Section 8.23:

8.23 ILLEGAL SERVICES

Services that are prohibited to be performed by applicable law are not Covered.

30. For Premier Plus, the following is added to the Schedule of Cost Sharing:

Medical Service	**In Network Providers (Domestic network and MHA Network)** **Member Financial Responsibility**	**Out-of-Network - Secondary Network (Includes Specifically-Designated Providers)** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Applied Behavior Analysis (ABA) Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	

31. For Premier, the following is added to the Schedule of Cost Sharing:

Medical Service	In Network Providers (Domestic network and MHA Network) Member Financial Responsibility	Out-of-Network - Secondary Network (Includes Specifically-Designated Providers) Member Financial Responsibility	Out-of-Network: All Other Hospitals and Physicians Member Financial Responsibility	Limitations and Special Conditions Refer to your Health Benefits booklet for Preauthorization Requirements
Applied Behavior Analysis (ABA) Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	

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.