## TABLE OF CONTENTS

**Section 1** About this Certificate ..... 2
**Section 2** Definitions ..... 2
**Section 3** Member Rights and Responsibilities ..... 5
**Section 4** Obtaining Covered Services ..... 6
**Section 5** Enrollment ..... 8
**Section 6** Termination of Coverage ..... 9
**Section 7** Schedule of Covered Services ..... 10
**Section 8** Exclusions from Coverage ..... 19
**Section 9** Limitations ..... 24
**Section 10** Member Claims Responsibilities ..... 24
**Section 11** Member Complaint/Grievance and Appeals Procedure ..... 25
**Section 12** Extension of Benefits ..... 29
**Section 13** Coordination of Benefits ..... 30
**Section 14** Medicare and other Federal or State Government Programs ..... 30
**Section 15** General Provisions ..... 31

# MEDICAID CERTIFICATE OF COVERAGE

Read this entire Certificate carefully. It describes the rights and obligations of Members and McLaren Health Plan, Inc., ("McLaren" or "MHP").

It is the Member's responsibility to understand the terms and conditions of this Certificate.
Certain medical services are not Covered or may require Preauthorization by MHP.

## SECTION 1. ABOUT THIS CERTIFICATE

This Certificate has been applied for as Medicaid coverage. This Certificate sets the terms and conditions of Coverage and describes the health care services that are Covered for Members.

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

Defined terms are capitalized when used in this Certificate. You can find these definitions in **Section 2**. 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. DEFINITIONS

**Adverse Determination.** Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of Member's eligibility to participate in MHP's Medicaid plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigation or not Medically Necessary.

**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 MHP and may also be available from the State of Michigan.

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

**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. This list is subject to change by MHP.

**Grievance.** A formal complaint on behalf of a Member concerning any of the following:

- The availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to utilization review;
- Benefits or claims payment, handling, or reimbursement for health care services;
- Matters pertaining to the contractual relationship between a Member and MHP; or
- Other expressions of dissatisfaction not related to an Adverse Determination.

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

**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.

**McLaren Health Plan, McLaren or MHP.** The health plan providing benefits under this Certificate.

**MDHHS.** The Michigan Department of Health and Human Services.

**MDHHS Guidelines.** Coverage guidelines provided by the Michigan Department of Health and Human Services (MDHHS) including but not limited to the MDHHS Medicaid Provider Manual.

**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 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 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.

Services that are not considered to be Medically Necessary include, but are not limited to the following:
(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 entitled to Coverage under the MHP Certificate of Coverage.

**MPPL.** The Michigan Medicaid Pharmaceutical Product List, which is periodically updated by MDHHS or its designee.

**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 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.

**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, Preauthorized 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 4.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 then current Medicaid fee-for-service rate.

**Reconstructive Surgery**. Surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, 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 MHP 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 MHP 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 3. MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of MHP you have the right to:

- Confidentiality.
- Be treated with respect and with due consideration for your dignity and privacy,
- Be free from restraint and seclusion used as a means of coercion, discipline, convenience or retaliation.
- Have a Primary Care Provider at all times, including access to them or a designee 24 hours a day, 365 days a year for urgent care.
- Receive culturally and linguistically appropriate services (CLAS).
- Receive covered benefits consistent with your contract and State and Federal regulations.
- 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.
- Receive Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC) services without Preauthorization.
- 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 12 months 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.
- Receive information on available treatment options and alternatives, presented in a manner appropriate

to your condition and ability to understand.

- Be provided with a telephone number and address to obtain additional information about payment methods, if you want.

- Tell us if you have a complaint about MHP or the care provided, the right to appeal a decision to deny or limit Coverage, and the right to a State Fair Hearing and/or external review under the Patient's Right to Independent Review Act if you disagree with an appeal outcome.
- Know that you or your doctor cannot be penalized for filing a complaint or appeal about your care.
- Receive information about you and MHP information, 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.
- Be free from discrimination prohibited by state and federal regulations.

As a Member you also have the responsibility to:

- Schedule appointments in advance and be on time to them. If you need to cancel an appointment with a 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 Health and Human Services and Customer Service right away about any change in your address or telephone number.
- Help MHP assist you with your health care by telling us of any problems 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 4. OBTAINING COVERED SERVICES

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

Your PCP provides your primary care and arranges your other medical care. You must talk with your PCP about any issues concerning your medical care. Your PCP provides or coordinates services. This includes, among other things, ordering of lab tests and x-rays, prescribing medicines or therapies, and arranging Hospital stays. We will only Cover services that your PCP provides or refers and that we Preauthorize, unless we tell you otherwise in this Certificate. Your PCP will refer you to Specialist Providers, Participating Providers, and Non-Participating Providers when necessary. All referrals to Non-Participating Providers require Preauthorization by MHP unless stated otherwise in this Certificate. A referral from your PCP does not require MHP to Cover services from a Non-Participating Provider. You may be responsible for payment if you do not receive a written approval from MHP prior to obtaining services from a Non-Participating Provider.

When you enroll, you can choose a PCP. If you do not choose a PCP, we will assign one to you. If you want to, you can change the PCP that was assigned to you. MHP's Participating Providers are listed in the provider directory. Each Member of the Member's family may have a different PCP if you want. 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. 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. You can also choose 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 to have a Specialist as your PCP. A Specialist must agree to be your PCP. You should call Customer Service if you think you need a Specialist for a PCP.

## C. FQHC's and RHC's.

You may obtain services from Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) 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 participation with MHP. Also, a Participating Provider or MHP may limit the number of Members the Participating Provider will accept as patients. We do not promise that you will 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 a 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.

*NOTE*: If your PCP suggests a service that is not Covered by MHP, you may be responsible for the cost of that service.

## 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. Tell them you are a Member of MHP. Your PCP or covering Participating Provider may give advice over the phone, prescribe medicine or therapy, or ask you to come into the office. In some cases, they may refer you to an emergency room or another Participating Provider.

## 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 emergency room Coverage as described in Section 7 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 Nurse 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.

### (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 unless you are outside of the United States. You should contact your PCP's office before obtaining Urgent Care. If you are unable to contact your PCP, call MHP's After Hours Nurse Line, (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 5. ENROLLMENT

## A. Eligibility.

To be eligible for Coverage under this Certificate, you must be eligible for Medicaid as determined by MDHHS. MDHHS is responsible for determining eligibility. In order to enroll, you may be required to fill out an application for Medical benefits. For more information, please contact your local Health and Human Services office.

**B. Enrollment.**

You are entitled to Covered Services on the first day of the month following the date that MDHHS notifies MHP in writing of your assignment to MHP. However, if you are an inpatient at a Hospital on this date, MHP is not responsible for payment for the inpatient Hospital stay or any charges connected with that stay. If you had other insurance, they may be responsible for payment. Contact the other insurer or your local Health and Human Services office. MHP is only responsible for Covered Services from the time of discharge forward. Except for Newborns, as specified in Section (C) below, MHP will not be responsible for paying for health care services during a period of retroactive eligibility prior to the date of your enrollment with MHP. MHP will notify you of the effective date of enrollment and coverage under this Certificate. You should call us to verify.

**C. Newborns.**

Newborns of women who are enrolled with MHP at the time of the child's birth will be automatically enrolled with MHP. Newborns are eligible for at least the birth month. You can choose to change the health plan for a future date by contacting the MDHHS Enrollment Broker.

**D. Notification of Change in Status.**

You must let us know about any changes that affect Coverage under this Certificate. You can do that by calling Customer Service. You must also contact your MDHHS caseworker to update this information. You must do this if, for example, any of the following happens to anyone Covered under this Certificate:

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

Remember, these are just examples. You must let us know about any other change that, according to this Certificate, affects Coverage. You must let us know about the change as soon as possible.

You do not need to contact MDHHS when you want to make a PCP change. You can contact Customer Service at (888) 327-0671. We will help you.

## SECTION 6. 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 MDHHS.

MDHHS will notify you of any changes to your Medicaid eligibility. Your coverage will terminate if you lose your eligibility.

**B. Termination for Cause.**

We cannot request that you be disenrolled based on your health or your health care needs. We will not request that you be disenrolled just because you used the grievance procedure to file a complaint.

We can recommend that you be disenrolled 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. Note that we will not request that you be disenrolled because of your diminished mental capacity, or uncooperative or disruptive behavior resulting from your special needs (except when your continued enrollment seriously impairs MHP's ability to furnish services to you or other enrollees).

Notwithstanding the foregoing, we are prohibited from requesting your disenrollment for reasons other than those permitted in our contract with MDHHS.

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 7. SCHEDULE OF COVERED SERVICES

### A. General.

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

(1) Medically Necessary; and

(2) Provided by your PCP, or provided by a Participating Provider including a Podiatrist, Certified Nurse Midwife, and a Certified Pediatric and Family Practice Nurse Practitioner, Physician Assistant or a Non-Participating Provider upon referral from your PCP and Preauthorization by MHP when we consider Preauthorization necessary (except in a Medical Emergency); and

(3) Not excluded elsewhere in this Certificate. You should carefully review the rest of this Certificate to fully understand your Coverage.

### B. 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:

a) Well child care. Well child care is defined as routine physical examinations, clinical screening and immunizations, and blood lead testing for Members under the age of 21. Depending on the age of the child the number of well child visits will vary.
b) Periodic examinations for Members age 21 and above.
c) Routine pediatric 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.
d) Vision (up to age 20) and hearing screenings available during each well child visit to determine vision and hearing losses. Vision screenings do not include refractions. A refraction is a test to determine an eyeglass prescription.
e) One routine gynecological examination every twelve (12) months.
f) Maternity care. Covered Services for maternity care are described below in Section 7(C).
g) Outreach for included services, especially pregnancy related and well-child care.
h) Health Education services.
i) Speech services.
j) Parenting and birthing classes.
k) Tobacco cessation treatment including pharmaceutical and behavioral support.
l) Therapies (speech, language, physical and occupational).
m) Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") services, as defined by MDHHS and in accordance with MDHHS Guidelines for members under the age of 21.

(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.

## C. 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 Preauthorization by us when we consider Preauthorization necessary. The fact that a Covered Service does not explicitly require Preauthorization in this Certificate does not mean that it does not require Preauthorization. Contact MHP for current Preauthorization requirements. Most Covered Services require a referral from your PCP, -unless noted. Additional visits may be Covered if Preauthorized by MHP.

(1) **Abortion.** Medicaid only covers an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met.

(2) **Allergy testing, evaluations and injections including serum costs.** See SECTION 8 (Exclusions from Coverage), under allergy testing for specific allergy testing that is not Covered.

(3) **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.

(4) **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.
f) Listed as a covered drug under the MPPL.

(5) **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.

(6) **Cochlear Implant.** Cochlear implants are Covered when ordered by a provider, Preauthorized by MHP, and covered in accordance with MDHHS Guidelines.

(7) **Chiropractic Care.** Chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine are Covered. Up to 18 visits per member per calendar year. Additional visits may be Covered if Preauthorized by MHP. See SECTION 8 (Exclusions from Coverage) for chiropractic care that is not Covered.

(8) **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 age 10 and above are to be dispensed in quantities no greater than 12 at one time and no more than 36 in a 30-day period.

(9) **Court Ordered Services.** Services required by a court order, or as a condition of parole or probation are only Covered when they are Medically Necessary, and the services are provided according to our procedures with the necessary Physician referrals.

(10) **Dental Services.** For Members age 21 and older, diagnostic, preventive, restorative, prosthetic and Medically Necessary oral surgery services, including extractions, are Covered. MDHHS' website contains the list of Covered Services. Certain dental services require Preauthorization. Dental surgical services are Covered when they are Medically Necessary. See SECTION 8 (Exclusions from Coverage) for excluded dental services. Dental custodial services (Oral-maxillofacial surgeons providing Medically Necessary services are Covered when Preauthorized by us.)

(11) **Diabetic Supplies.** All equipment, supplies and educational training for the treatment of diabetes

are Covered. See Section 20 below for coverage of outpatient prescription drugs.

(12) **Doula Services.** Up to 12 total doula visits are Covered during the prenatal and postpartum periods. Only 1 visit is Covered for attendance during labor and delivery. Additional visits may be covered when Preauthorized by us.

(13) **Durable Medical Equipment.** Durable Medical Equipment is Covered when ordered by a provider, Preauthorized by MHP, and covered in accordance with MDHHS Guidelines.

(14) **End-Stage Renal Disease**. End-stage renal disease services including dialysis are Covered when Preauthorized according to MHP procedures with the necessary Physician referrals.

(15) **Family Planning.** The following are Covered Services and do not require a referral if you receive these services at a Medicaid 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, hysterosalpingography, and diagnostic laparoscopy.
b) Diaphragms and Intrauterine Devices (IUDs), including measurement and fitting.
c) Advice on contraception and family planning, including childbirth education.
d) Treatment for sexually transmitted infections (STIs).

(16) **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.

Coverage for hearing aids for age 21 and older is only once every five (5) years.

We allow Coverage for Members under age 21, for the purchase and fitting of one hearing aid in a 12-month period, including batteries, which meets the minimum specifications required and is Medically Necessary.

This includes, hearing aid services to individuals under the age of 21 which are a Covered benefit by MHP and in accordance with MDHHS Guidelines.

(17) **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. See SECTION 8 (Exclusions from Coverage) below for the Custodial Care exclusion.

(18) **Hospice Care.** Both inpatient and outpatient.

(19) **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.

(20) **Mental Health.** Outpatient Care.
Evaluation, consultation, or treatment, including psychological testing, necessary to make a diagnosis. Read **Sections 8** and **9** to learn more about Coverage limitations and exclusions. No referral is necessary for mental health visits.

(21) **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.

(22) **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 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 Necessary to correct a demonstrable bodily dysfunction).
d) Hospitalization.

Orthodontic treatment is not a Covered Service. See SECTION 8 (Exclusions from Coverage) below.

(23) **Outpatient Prescription Drugs.** Prescriptions must be on our Formulary or Preauthorized. Prescriptions must be obtained through an in-network pharmacy. Coverage of drugs is subject to our Formulary requirements, including but not limited to Preauthorization, step-therapy, quantity limits, age restrictions and gender restrictions. Drugs are also subject to a generic substitution process. Prescriptions will be dispensed in quantities prescribed by providers up to a 30-day supply. Off-label drug use is Covered if Preauthorized by us and subject to the following requirements:

Any drug or device prescribed for use or dosage other than those specifically approved by the FDA and the reasonable cost of Medically Necessary supplies used to administer them are Covered if the prescribing provider can substantiate that the drug is recognized for treatment of a condition for which it was prescribed and the Drug or device is Preauthorized by us. In accordance with MCL 500.3406q, if Preauthorization is requested, you or your provider must provide us with all supporting documentation necessary to determine whether the Preauthorization should be granted. Documentation of the following is required:

- The Drug is approved by the FDA;
- The Drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:
    - A life-threatening condition so long as the Drug is Medically Necessary to treat that condition and the Drug is on the Formulary or accessible through MHP's

Formulary procedures;

- A chronic and seriously debilitating condition so long as the Drug is Medically Necessary to treat that condition and the Drug is on MHP's Formulary or accessible through MHP's Formulary procedures.

- The Drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:
  - The American Medical Association Drug evaluations;
  - The American hospital formulary service drug information;
  - The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional";
- Two articles from major peer-reviewed medical journals that present data supporting the proposed Off Label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

For purposes of this Section:

- "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration, and that causes significant long-term morbidity.
- "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

A compounded drug must meet the following additional requirements in order to be Preauthorized and Covered:

a) FDA-approved for the route of administration and medical condition for which it is prescribed; and

b) At least one of the ingredients of the compound is an FDA-approved drug and listed on the MPPL.

See SECTION 8 (Exclusions from Coverage) below for non-covered and excluded services.

(24) **Over The Counter (OTC) Drugs and Supplies.** MHP Covers these drugs and supplies if covered on the MPPL and listed on MHP's Formulary. These drugs and supplies must have a Participating Provider's order, and must be dispensed by an in-network pharmacy.

(25) **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.

(26) **Podiatry.** The diagnosis and treatment of disorders of the foot, ankle and lower leg.

(27) **Reconstructive Surgery.** Reconstructive surgery to correct congenital birth defects, if we reasonably expect the surgery to correct the condition and if Preauthorized by us. 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.

(28) **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, Preauthorized by MHP and covered in accordance with MDHHS Guidelines.

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.

Some prosthetic and orthotic/support devices are not covered or excluded. See SECTION 8 (Exclusions from Coverage) below for non-covered and excluded services.

(29) **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.

(30) **Radiology Examinations and Laboratory Procedures.** Diagnostic and therapeutic radiology services and laboratory tests, not excluded elsewhere in this Certificate. Genetic testing must be Preauthorized by us and be provided in accordance with MDHHS Guidelines.

(31) **Routine Foot Care.**

(a) Medically Necessary foot care, including corn and callous removal, nail trimming, and other hygienic or maintenance care.

(b) Medical Necessary cleaning, soaking, and skin cream application for the feet.

(32) **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 Provider refers, directs and monitors them, and consults with us in the process. Services are not covered if provided by another public agency.

(33) **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 and covered in accordance with MDHHS Guidelines. Coverage is limited to up to 45 days in a rolling 12-month period.

Such services must be supported by a treatment plan Preauthorized by MHP. Custodial care is not a Covered benefit. See Section 8 below.

(34) **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.

(35) **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.

(36) **Transplants.** Transplants of the following organs at a facility approved by us, but only when we have Preauthorized the transplant as appropriate, Medically Necessary, and non-experimental:

a) Cornea.
b) Heart.
c) Lung.
d) Kidney.
e) Bone marrow or stem cell.
f) Liver.
g) Pancreas.
h) Small bowel.

We will Cover the donor's medical expenses, according to MDHHS Guidelines, 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 in accordance with Section 3 above. We will also Cover expenses including allogenic, autologus, 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.

(37) **Transportation**. Ambulance and other emergency medical transportation are Covered. Non-emergency transportation (NEMT) is available free of charge for doctor's visits, lab visits, radiology services, prescription pick up, dental services and other covered services. These NEMT services are available 24 hours a day, 7 days a week, 365 days a year. Please call Customer Service for assistance with non-emergency transportation questions at 888-327-0671.

(38) **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. Replacements are limited to two pairs of eyeglasses per year for Members under age 21 and to one pair of replacement eyeglasses

for Members age 21 and over. One year is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered.

(39) **Voluntary Sterilizations.** MHP Covers tubal ligation. A vasectomy is also Covered if it is 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 that meets Medicaid's consent requirements before the service can be covered. The Consent Form must be signed 30 days before the sterilization. Coverage for sterilization is available only for Members 21 years of age or older. Sterilization reversals are excluded.

(40) **Weight Loss Programs.** Medically Necessary weight reduction services are Covered when Preauthorized by MHP.

(41) **Telemedicine/Virtual Care** Telemedicine appointments are covered in accordance with MDHHS Guidelines. You can call Customer Service at (888) 327-0671 for more information.

## D. 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. Genetic testing must be Preauthorized by us.

**Newborn Child Care.** Newborns of women who are enrolled with MHP at the time of the child's birth will be automatically enrolled with MHP. Newborns are eligible for at least the birth month. You can choose to change the health plan for a future date by contacting the MDHHS Enrollment Broker.

(2) **Group Prenatal Care**. Services associated with in-person, group prenatal care when delivered by accredited Centering Pregnancy providers.

(3) **Home Care Services.** Home Care Services are Covered in conjunction with the McLaren Moms Program.

(4) **Maternal Infant Health Program (MIHP).** Services for high risk mothers and infants to ensure healthy deliveries which may include home visits and social services.

## E. 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 Nurse 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 review of the

proper medical records, MHP has determined 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 for Medical Emergencies and Urgent Care outside of 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 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) **Autopsy.**

(6) **Biofeedback.** Biofeedback for any diagnosis, including mental health diagnoses.

(7) **Charges for time involved in completing necessary forms, claims, or reports.**

(8) **Chiropractic Care.** Only one of the spinal manipulation procedure codes is billable per

day, per Member. Clinical signs and symptoms must be consistent with the level of subluxation. If documentation other than x-rays supports the medical necessity of spinal manipulation for children, the x-ray requirement may be waived. MHP reserves the right to request x-ray documentation if deemed necessary. Additionally, the following services are not Covered when rendered by a chiropractor: consultations, fracture care, home visits, injections, laboratory tests, maintenance therapy, medical supplies, evaluation and management services, plaster casts, and inpatient hospital visits.

(9) **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.

(10) **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.

(11) **Cosmetic Services.** Drugs, Cosmetic Surgery or procedures 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, among other things: mammoplasty, liposuction, keloids, and rhinoplasty.

(12) **Custodial Care.** Any care you receive if, in the opinion of MHP, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. 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 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.

(13) **Dental Services.** For members under age 21, all dental services, including, among other things: routine dental services; dental x-rays; dental surgery (except as specifically stated in Section 7); orthodontia; orthodontic x-rays; Orthognathic Surgery (except as specifically stated in Section 7); dental prostheses; and treatment of congenital or developmental defects of dental origin, such as missing teeth.

(14) **Ear Plugs.**

(15) **Educational Services and Services for Behavioral Disorders.** MHP does not cover school-based services.
These services can be obtained through your local school system.

(16) **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 can not 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) The patient 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 as 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.

(17) **Habilitative.** All habilitative care and services, unless covered under a Member's EPSDT benefit.

(18) **Hair Analysis.**

(19) **Home and Community Based Waiver Program Services.**

(20) **Hypnotherapy.**

(21) **Infertility and Abortions.** Except as listed in **Section 7**, 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 (abortions that are not a result of rape/incest or because of serious risk to the mother's health) and services to reverse voluntary sterilization.

(22) **Leave of Absence.** Charges incurred when you are on an overnight or weekend pass during an inpatient stay.

(23) **Marital Counseling.** Services and treatment related to marital or relationship counseling.

(24) **Mental Health/Substance Abuse.** Only services listed in **Section 7** are Covered.

(25) **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.

(26) **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.

(27) **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 Medicaid-approved Family Planning Center;
(c) Family planning services received at a Medicaid-approved Family Planning Center or at a local health department;
(d) Services provided at Child & Adolescent Health Centers (CAHCP), Federally Qualified Health Centers (FQHC) or as otherwise stated in this Certificate; and
(e) Immunizations.

(28) **Not Medically Necessary.** Services and supplies that we determine are not Medically Necessary. If you disagree with us about Medical 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 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.

(29) **Obstetrical Delivery in the Home.** Services and supplies related to obstetrical delivery in the home.

(30) **Orthodontic.** Orthodontic treatment is not a Covered Service. Additionally, the extraction of teeth for orthodontic purposes is not Covered.

(31) **Outpatient Drugs.** Drugs in the categories listed on the MDHHS carve-out list are not Covered. Drugs not listed on the MPPL are not Covered. Drugs that are not Preauthorized are not Covered. Drugs that are not covered in accordance with MDHHS Guidelines.

(32) **Over the Counter Items.**

a) Dietary supplements, drinks, thickeners, and formulas used for non-medical reasons
b) Baby formula
c) Maternity support bands.

(33) **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 have customary non-medical purposes, such as: exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds, rain covers for strollers, and similar equipment.
d) Equipment for recreational purposes.
e) Gym memberships.

(34) **Private Duty Nursing.**

(35) **Prosthetic and Orthotic/Support Devices.** Orthopedic shoes, shoe inserts, and other supportive devices of the feet for adults age 21 and over as limited MDHHS Guidelines.

(36) **Psychiatric**. Inpatient hospital psychiatric services and outpatient partial hospitalization psychiatric services.

(37) **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.

(38) **Religious Counseling.** Services and treatment related to religious counseling.

(39) **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 Medicaid-approved Family Planning Center;
c) Family planning services received at a Medicaid-approved Family Planning Center or at a local health department;
d) Immunizations;
e) Mental health services; and
f) As otherwise stated in this Certificate.

(40) **Services Billed through PIHPs or CMHSPs.** This includes all services billed through PIHPs or CMHSPs. Additionally, transportation for services provided persons with developmental disabilities which are billed through the Community Mental Health Services Program (CMHSP).

(41) **Services Required by Third Parties.** More than one PCP physical examination per year; 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.

(42) **Sex Therapy.** Services and treatment related to sex therapy.

(43) **Transitional/Residential or Assisted Living.** Non-skilled care received in a home or facility on a temporary or permanent basis. Examples include room and board, health care aids, and personal care designed to help you in activities of daily living.

(44) **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 are excluded to the extent permitted by law unless Preauthorized by MHP.

(45) **Unauthorized Services and Supplies**. Services and supplies that your provider didn't perform, prescribe, or arrange according to the guidelines of this Certificate. By way of an example, if a Participating Provider provides services without the required MHP Preauthorization, 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 Certificate.

(46) **Vision.**
- a) Non-prescription ophthalmic lenses and frames.
- b) Special independent diagnostic tests or treatment procedures.
- c) Any eye or vision service not specifically listed in **Section 7** of this Certificate.

(47) **Vocational Rehabilitation.** Work-related therapy and evaluations of the work site.

(48) **Weight Control.** All services and supplies related to weight control treatment unless the Member receives Preauthorization by MHP, and MHP has determined the condition is severe or life threatening. Conservative measures to control weight and manage the complications must have failed. MHP does not cover treatment specifically for obesity or weight reduction and maintenance alone.

## SECTION 9. LIMITATIONS

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 any 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 by MHP under the Certificate 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 can not control may make our offices, personnel, or financial resources unable to provide or arrange for the provision of Covered Services.

If that happens, we will not be liable if you do not receive those services or if they're delayed. But we will make a good faith effort to see that they are 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 referred 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 Certificate.

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 will deny reimbursement to you. 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. We are prohibited from making payment as applicably restricted in Section 1903(i) of the Social Security Act.

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. See **Section 11** to find out more about that procedure.

## SECTION 11. MEMBER COMPLAINT/GRIEVANCE AND APPEALS PROCEDURE

### A. Member Complaints.

We want to hear your comments so that we can make our services better for our Members. We want you to receive answers to any questions that you have about MHP. We will do our best to fairly resolve any problems that you may have with us. Please contact us when you have any comments or concerns. We are here to help.

We can help complete forms and take other steps. We also have interpreter and TTY services available to you.

### B. Standard Grievances.

A grievance is a complaint about having a problem calling MHP or if you're unhappy with the way a provider or a MHP employee treated you. Call Customer Service if you have questions or concerns. McLaren staff will try to resolve your concerns during the first contact. If you are still unhappy with McLaren's response, you may file a formal Grievance. You can mail a Grievance to us at:

McLaren Health Plan
G-3245 Beecher Road
Flint, MI 48532
Attn: Member Appeals

You can also send us a Grievance by email to MHPAppeals@mclaren.org.

Note that Grievances do not include appeals. See the appeals section below for more information on appeals. Customer Service staff can help you document and file a Grievance. McLaren will acknowledge receipt of your Grievance in writing within 5 days of receipt. We will complete the Grievance process within 30 days. Individuals who make decisions on your Grievance will not be involved in a previous level of review. They will also not be a subordinate of a person who made a decision. If required, we will use an appropriate clinical person. McLaren has a two-step process for reviewing Grievances. We will complete Step 1 within 15 days of receipt of a Grievance. McLaren will provide you with a written decision. If you are not happy with our decision you may move to Step 2 by appealing to McLaren in writing or by phone. We will only start Step 2 if we receive your appeal within 5 days of our written decision. McLaren will review your Grievance appeal. We will provide you with a final decision within 30 days from the initial date of your Grievance. Our decision will be in writing.

### C. Expedited Grievances.

We will treat your Grievance as expedited if a physician substantiates that the 30 day time frame would jeopardize your life or your ability to regain maximum function. Call Customer Service to file an expedited Grievance. We will quickly make a decision. We will call you and your physician and tell you of our decision within 72 hours. We will send you a written letter with our decision within 2 days after we call you. You may, but you are not required to file an appeal of an Expedited Grievance with McLaren.

You may file a request for an expedited external review at the same time you file a request for an expedited internal grievance. If you file a request for an expedited external review, you may be considered to have exhausted McLaren's internal grievance process. If you file a request for an external expedited review, your internal expedited Grievance will be pended until the Michigan Department of Insurance and Financial Services (DIFS) decides whether to accept your request. If DIFS accepts your expedited external request, you will be considered to have exhausted McLaren's internal Grievance process.

## D. Standard Internal Appeals.

You may file an appeal of an adverse benefit determination with McLaren. Note that an untimely response to a request may become an adverse benefit determination. You or your authorized representative have 60 days from the date of the adverse benefit determination letter to file an appeal.

You can have someone else act as your authorized representative to file your appeal. However, you will need to complete McLaren's authorized representative form. It is available on our website at www.McLarenHealthPlan.org. You may also call Customer Service. We can mail a copy to you. You may appoint an authorized representative at any step of the appeals process. Your estate representative may represent you if you are deceased. We can not start the appeals process until we receive your signed authorized representative form. Please send it to us as soon as possible.

You or your authorized representative can appeal in writing or orally. If submitting your appeal in writing, send your appeal request along with any additional information to:

McLaren Health Plan
G-3245 Beecher Road
Flint, MI 48532
Attn: Member Appeals

You can also email us at MHPAppeals@mclaren.org or Fax your request to (810) 600-7984.

McLaren will acknowledge receipt of your appeal in writing within 5 days of receipt.

When McLaren makes a decision subject to appeal, McLaren will provide a written adverse benefit determination notice to you and the requesting provider, if applicable. Adverse action notices for the suspension, reduction, or termination of services must be made at least 10 days prior to the change in services. McLaren will continue your benefits if all the following conditions apply:

- The appeal is filed timely, meaning on or before the later of the following:
  - Within 10 days of McLaren mailing the notice of action
  - The intended effective date of McLaren's proposed action
- The appeal involves the termination, suspension, or reduction of previously authorized course of treatment
- The services were ordered by an authorized provider
- The authorization period has not expired
- You request an extension of benefits

If McLaren continues or reinstates your benefits while the appeal is pending, the services will be continued until one of the following occurs:

- You withdraw the appeal
- You do not request a fair hearing within 10 days from the date McLaren mails an adverse action notice
- A State Fair Hearing decision adverse to you is made
- The authorization expires or authorization service limits are met

If we reverse the adverse action decision or if it is reversed by a State Fair Hearing, we will pay for services provided while the appeal was pending and authorize or provide the disputed services. McLaren will do this as fast as your health requires. This will this be no more than 72 hours after we receive notice of a reversal.

If an adverse State Fair Hearing decision is made, you may be required to pay the cost of your services. However, McLaren may only do this as allowed by State policy.

You may request copies of information relevant to your appeal, free of charge, by contacting Customer Service. McLaren will provide you with any new or additional evidence considered, relied upon or generated by us related to your appeal. This is free of charge to you. We will also provide you with any new or additional rationale for a denial of your claim or appeal. We will give you a reasonable opportunity to respond.

Once we receive your appeal request, we will send you a letter within 5 days telling you that we received your appeal. The letter will tell you about the appeals process. It will also include the time and location of the appeal meeting. You or your authorized representative may speak before the committee in person or by phone. You can present evidence, testimony and make legal and factual arguments. You must contact McLaren if you want to take part in the appeal meeting. You can provide documents and other information to us. We will consider this information during your appeal.

A person not involved in the initial decision will review your appeal. The person will not be a subordinate of anyone who previously made a decision on your appeal. If the appeal is based in whole or in part on medical judgment, the person who reviews the appeal will be of the same or similar specialty as would typically manage the case.

We will make a decision as fast as your health condition requires. Normally we have 30 days to complete the internal appeal process. We may extend this time period at your request. We may also extend the time period for the shorter of 14 calendar days or 10 business days if we requested information from a health care provider but we have not received it. But, the extension must be in your best interest. We will call you if we need to request an extension. We will also send you a letter telling you of the delay. If you disagree with the extension you may file an appeal.

You will receive a written letter telling you of our final determination within 3 days after the decision is made. In addition, we may call you and tell you of our decision.

**E. Expedited Internal Appeals.**

If your physician tells us that he or she believes that due to your medical status, resolution of your appeal within McLaren's normal time frames would seriously jeopardize your life or health or ability to regain maximum function, the expedited appeals process may be used.

A request for an expedited appeal should be made by calling McLaren at (888) 327-0671. You can also make this request in writing. You must request an expedited appeal within 10 days of the adverse benefit determination. Expedited appeals are only available for pre-service adverse benefit determinations. This includes requests concerning admissions, continued stay or other health care services if you have received emergency services but have not been discharged from a facility. We may decide not to treat your appeal as expedited. If so, we will make reasonable efforts to call you and tell you this. We will also mail you a letter within 2 days of your request to tell you that your appeal is not expedited. Your appeal will be treated as a standard appeal and processed within 30 day timeframe.

If we accept your appeal as expedited, we will tell you and your physician of our decision as fast as your medical condition requires. This will be no later than 72 hours after we receive your request. Generally, McLaren will notify you and your physician of McLaren's decision by phone. We will send you and your physician a written letter of our decision within 2 days after we call you.

You may request an extension of an expedited appeal. But if you request an extension, we may deny your request for an expedited appeal. If so, we will move your appeal to the standard 30 day timeframe.

Your physician may validate on the phone or in writing that you have a medical condition where the time frame for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. If so, you or your authorized representative may file a request for an expedited external review. You can do this at the same time you or your authorized representative files a request for an expedited appeal with McLaren. See the Expedited External Appeal section below for more information on how to do this. If you choose to file a request for an external expedited review, your internal appeal will be pended until DIFS decides whether to accept your request. If DIFS accepts your expedited external appeal, you will be considered to have exhausted the internal appeal process.

**F. External Review.**

If after your appeal we continue to deny payment, coverage, or the service requested, or you do not receive a timely decision, you can ask for an external appeal with DIFS. You must do this within 127 days of receiving McLaren's final adverse benefit determination. If you are not required to exhaust McLaren's appeals process, you must do this within 127 days from receiving McLaren's adverse benefit determination. McLaren will give you the form required to file an external appeal. Requests should be sent to DIFS:

Department of Insurance and Financial Services
Office of Research, Rules and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Delivery service:
Department of Insurance and Financial Services
Health Plan Division
P.O. Box 30220
Lansing, MI 48909-7720

Toll Free Telephone: 1 (877) 999-6442
FAX: 517-284-8838
www.michigan.gov/difs

Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

When appropriate, DIFS will request an opinion from an Independent Review Organization (IRO). The IRO is not contracted with or related to McLaren. DIFS will issue a final order.

**G. Expedited External Appeals.**

If after your expedited internal appeal, we continue to deny Coverage or the service requested, you can ask for an expedited external appeal with DIFS. You must do this within 10 days of receiving our appeal decision. You may also file a request for an expedited external appeal at the same time you file a request for an expedited internal appeal with McLaren. McLaren will provide the form required to file an expedited external appeal. These requests should be sent to DIFS:

Department of Insurance and Financial Services

Office of Research, Rules and Appeals – Appeals Section P.O. Box 30220
Lansing, MI 48909-7720

Courier/Delivery service:
Department of Insurance and Financial Services
Office of Research, Rules and Appeals – Appeals
Section
P.O. Box 30220
Lansing, MI 48909-7720

Toll Free Telephone: 1 (877) 999-6442
FAX: 517-284-8838
www.michigan.gov/difs

Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

When appropriate, DIFS will request an opinion from an IRO. The IRO is not contracted with or related to McLaren. DIFS will issue a final order.

### H Fair Hearing Process

If we uphold our decision after your appeal, you may have additional appeal rights. You can file a complaint with the Michigan Office of Administrative Hearing and Rules (MOAHR) with the Department of Health and Human Services. You must file your complaint with MOAHR within 120 days of our appeal decision. If we do not meet the notice and timing requirements required by law, you are considered to have exhausted McLaren's appeals process and you can proceed to a Fair Hearing. Listed below are the steps for the State of Michigan's Medicaid fair hearing process:

Step 1: Call MOAHR at (800) 648-3397 or send an email to 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 resolved before the hearing date, you must call to ask for a hearing request withdrawal form. You can call the phone number listed in Step 1 to request this form.

## SECTION 12. EXTENSION OF BENEFITS

We will continue Covering your Covered Services if the 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'll stop receiving benefits from MHP:

**A.** The hospitalization is no longer Medically Necessary or is for non-Covered Services such as custodial care;

**B.** You have coverage from another health plan or insurance carrier for the inpatient stay.

## SECTION 13. 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. If 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 must tell us immediately, and in writing about any situation that might allow MHP to invoke its rights of recovery. The Member is required to cooperate with MHP. 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. The Member agrees that MHP's rights of recovery precede any other party's rights of recovery.

### 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, MHP will follow the Coordination of Benefits guidelines established by the Michigan Department of Insurance and Financial Services or any successor agency. Benefits will be payable in accordance with Public Act 64 of 1984, Coordination of Benefits Act, as amended.

## SECTION 14. MEDICARE AND OTHER FEDERAL OR STATE GOVERNMENT PROGRAMS

If you obtain Medicare Coverage and remain enrolled in MHP, the following applies:

### 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 is 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 by applicable law:

(1) Election Against Coverage.

Notwithstanding 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 (Parts A, B and D) and other governmental benefits to which you are eligible, whether or not you are actually enrolled. If you are eligible for Medicare, MHP will pay as if Medicare is primary, even if you have not enrolled in Medicare.

(4) Legislative and Regulatory Changes.
Notwithstanding 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 15. GENERAL PROVISIONS

### A. MHP's Relationship with Providers.

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.

Healthcare 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 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.

This Certificate of Coverage and any riders, amendments or attachments, is the entire agreement. Beginning on the effective date of Coverage, this Certificate supersedes all agreements for health care services and benefits between you and MHP.

## D. Non-Assignment.

The benefits provided under this Certificate are for the personal benefit of Members. They cannot be transferred or assigned to another person. If any Member tries to assign this Certificate to another person, all rights will be automatically terminated. You also cannot assign any claim or cause of action against MHP to any person, provider, or other insurance company. MHP will not pay any provider except under the provisions of this Certificate.

## E. Truth in Statements.

You agree to complete and submit to us any forms as we reasonably request. You will ensure, and warrant, that all information contained in any form 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.

## H. Clerical Errors.

Clerical errors, such as an incorrect transcription of effective dates, termination dates, or mailings with incorrect information will not change the rights or obligations of you and MHP under this Certificate. These errors will not operate to grant additional benefits, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

## I. Waiver.

In the event that you or MHP waive any provision of this Certificate, you or MHP will not be considered to have waived that provision at any other time or to have waived any other provision. Failure to exercise any right under this Certificate does not act as a waiver of that right.

## J. Consent to Text Messages.

As a condition of your membership with us, you agreed to receive text messages regarding your benefits and related plan information. We may contact you by text message at the phone number that you provided as part of your membership application or that you have provided to us by other means. We will not send individually identifiable information in a text message to you unless the message is secure. We may, upon your request and with your consent send unsecure text messages which may include individually identifiable health information. Because these text messages are not encrypted, there is some risk that the messages could be read by someone other than you. You are not required to request unencrypted texts and you do not

have to provide this consent. We will not condition your eligibility for benefits, treatment, enrollment or payment of claims on whether you provide this consent. If you would like to stop receiving text messages from us, you can do this by texting STOP to 35394 at any time. You can also call Customer Service at 888-327-0671. For additional help, text HELP to 35394. Message and data rates may apply.

**Discrimination is Against the Law**

McLaren Health Plan, McLaren Health Plan Community, McLaren Health Advantage and McLaren Medicare Supplement (collectively McLaren) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). McLaren does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

McLaren:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 Health Plan'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

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 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
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at McLaren's website: www.mclarenhealthplan.org.

We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-327-0671 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-888-327-0671 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 1-888-327-0671 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电 1-888-327-0671 (TTY: 711) 或咨询您的服务提供商。

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܡ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܬܫܡܫܝܬ̈ܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܒܡ ܡܓܢ ܦܪܝܣܐ ܩܠܘܒܟܘܢ ܕܠܐ ܐ̄ ܚܪܢܐ. ܐܦ ܬܫܡܫܝܬ̈ܐ ܦܘܫܝܬ̈ܐ ܠܡܫܝܚܐ ܠܡܘܕܥܬܐ ܕܡܥܠܝ̈ܬܐ ܒܦܘܪܡܐ ܕܡܬܡܨܝܢܐ ܡܛܘܝ ܦܪ̈ܝܣܐ ܕܠܐ ܐ̄ ܚܪܢܐ. ܡܩܪܘܢ ܥܠ 1-888-327-0671 ܐܘ ܗܡܙܡܘܢ ܥܡ ܡܫܡܫܢܘܬܟܘܢ. TTY: 711ܡܘܩܪܝܢܐ

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 1-888-327-0671 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-888-327-0671 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다. 1-888-327-0671 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-888-327-0671 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-888-327-0671 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-327-0671 TTY: 711 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre

disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-888-327-0671 TTY: 711 o parla con il tuo fornitore.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。1-888-327-0671 TTY: 711 までお電話いただくか、ご利用の事業者にご相談ください.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-327-0671 TTY: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 1-888-327-0671 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

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