



**McLaren Health Plan Community**

**POS Certificate of Coverage**

**Group: State of Michigan**

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## INTRODUCTION

McLaren Health Plan Community (MHP Community) is a Health Maintenance Organization (HMO) licensed by the state of Michigan. Your Certificate is issued by MHP Community and is an agreement between you, as an enrolled Member, and MHP Community.

If your Coverage is arranged through your employment, your Eligibility and Benefits will also be subject to the contract made between your employer and MHP Community.

Eligible Members are entitled to the HMO services and Benefits described in this Certificate in exchange for the Premium paid to MHP Community.

This Certificate, including the applicable Riders and endorsements; the Application for coverage, the ID card, and the attached papers, if any, constitutes the entire contract of Coverage. No change in this Certificate is valid until approved by an executive officer of MHP Community and unless the approval is endorsed on this Certificate or attached to this Certificate. An agent does not have authority to change this Certificate or to waive any of its provisions.

**Note:** The Schedule of Member Cost Sharing and Additional Limits of Coverage lists the cost sharing between you and MHP Community for Covered Services.

By enrolling in this health plan and accepting this Certificate the Members agree to abide by the terms and conditions of this Certificate. MHP Community Members are entitled to the services and Benefits described in this Certificate in exchange for the Premium paid to MHP Community.

## IMPORTANT INFORMATION

- MHP Community is an HMO that operates on a direct service basis. It is not an insurance company.
- We Cover the Benefits listed in this Certificate only when they are:
  - provided in accordance with this Certificate; and
  - otherwise Preauthorized or approved by MHP Community, when required.
- All Benefits are subject to the limitations and exclusions listed in this Certificate.
- The Benefits listed in your Certificate and Riders are Covered only when they are Medically Necessary. Medical Necessity is determined by MHP Community.
- You are responsible for Copayments, Coinsurance and Deductibles for many of the Benefits listed.  
(See Section 8.01 and the Schedule of Member Cost Sharing and Additional Limits of Coverage.)
- Genetic Testing: MHP Community does not limit Coverage based on genetic information, and it will not adjust Premiums based on genetic information, request/require genetic testing or use any collected or acquired genetic information from an individual at any time for underwriting purposes.
- This Coverage is Guaranteed Renewable unless Terminated under Part 5.
- Balance Billing may occur if you receive Covered Services at a Participating Provider facility but see a Non-Participating Provider in the facility and an Applicable Surprise Billing Law does not apply or you agree to such charges.. Applicable Surprise Billing Laws do not cover all services

and in some cases you could consent to Balance Billing. You may also be subject to Balance Billing if you obtain Emergency Services at a Non-Participating Provider (see Section 8.10 for more information). For Non-Emergency Covered Services provided at a Participating Provider facility, please contact MHP Community in advance to ask whether Balance Billing could occur at that facility. It is your responsibility to contact us in advance.

- Note that some services you receive at a Participating Provider facility in your Service Area may be provided by a Non-Participating Provider (e.g., ER physicians, for Emergency Services (see Section 8.6)) and may be subject to Balance Billing.
- You should always request to have your labs, pathology and other services sent to a Participating Provider in order to avoid Balance Billing. Failure to do so may result in significant costs to you. Except if required by applicable law, we will not pay for labs, pathology and other services sent to a Non-Participating Provider at the Option A level, even if they were sent by a Participating Provider and they will be subject to Balance Billing because the services are not covered by Applicable Surprise Billing Laws or you consented to be Balance Billed.
- As it relates to MHP Community, MHP Community complies with Applicable Surprise Billing Laws.

## ANTI-DISCRIMINATION

MHP Community complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MHP Community does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHP Community:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact MHP Community's Compliance Officer.

If you believe that MHP Community 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 MHP Community's Compliance Officer, G-3245 Beecher Rd., Flint, MI 48532, call: (866) 866-2135, TTY 711, Fax: (877) 733-5788, or Email [mhpcompliance@mclaren.org](mailto:mhpcompliance@mclaren.org).

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, MHP Community'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>.

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

**Arabic:**

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

**Syriac/Assyrian:**

ܡܠܚܘܙܬܐ: ܐܕܐ ܟܢܬܐ ܬܬܚܕܬܐ ܐܕܟܪ ܐܠܟܬܐ، ܐܝܢ ܚܕܡܐܬ ܡܫܥܕܐ ܐܠܟܘܝܬܐ ܬܬܘܐܦܪ ܠܟ ܒܐܡܚܐܢ. ܐܬܠܠ ܒܪܥܡ 1-888-327-0671 (ܪܥܡ ܗܐܬܦ ܐܠܬܠܠ ܒܠܝܬܐܡܐܬܐ: 711).

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

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

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

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

**Bengali:** লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৮৮-৩২৭-০৬৭১ (TTY: ৭১১)।

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

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

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

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



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

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

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

## DEFINITIONS

These definitions will help you understand the terms used in this booklet.

**Acute Illness or Injury** is one that is characterized by sudden onset (e.g., following an injury) or presents an exacerbation of disease and is expected to last a short period of time after treatment by medical or surgical intervention.

**Advanced Illness** means a medical or surgical condition with significant functional impairment that is not reversible by curative therapies and that is anticipated to progress toward death despite attempts at curative therapies or modulation, the time course of which may or may not be determinable through reasonable medical prognostication.

**Adverse Benefit Determination** means 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 a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, 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 or appropriate.
- A Rescission of Coverage determination

**Applicable Surprise Billing Laws** means the applicable surprise billing and cost-sharing protections set forth in PHS Act sections 2799A-1 and 2799A-2 and 45 CFR §§ 149.110 through 149.130 and Michigan law, including but not limited to those in Article 18 of the Michigan Public Health Code.

**Applied Behavioral Analysis or ABA** is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

**Approved Clinical Trial** means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.

**Autism Diagnostic Observation Schedule** means the protocol available through western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the Director, Michigan Department of Insurance and Financial Services, if the Director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

**Autism Spectrum Disorder** means any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical Manual:

- Autistic Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder not otherwise specified

**Balance Bill** or **Balance Billing** is the difference between the Reimbursement Amount paid by MHP Community and the amount of the non-Participating Provider's charges. Balance Billing amounts will not count toward your Out-of-Pocket Maximum.

**Benefit** is a Covered health care service available to a Member as described in this Certificate.

**Certificate** is the booklet we issue to you and the Member that describes Member's Benefits, and includes the Schedule of Member Cost Sharing and Additional Limits of Coverage and any Riders we issue that change Benefits and the Subscriber's application for Coverage.

**Chief Medical Officer** means MHP Community's Medical Director or a designated representative.

**Chronic** means a disease or ailment that is not temporary or recurs frequently. Arthritis, heart disease, major depression and schizophrenia are examples of Chronic diseases.

**Claim** means any request for a Benefit under the Plan made by the Member or the Member's authorized representative that complies with MHP Community's reasonable procedures for making Benefit Claims.

**Coinsurance** is a percentage of MHP Community's Reimbursement Amount that the Member is responsible to pay for certain Benefits. The Coinsurance applies to the Out-of-Pocket Maximum. Refer to Member's Benefits, the Schedule of Member Cost Sharing and Additional Limits of Coverage and applicable Rider(s) to verify your Coinsurance amounts.

**Coinsurance Maximum** means a maximum dollar amount that the Member will pay for Coinsurance for some services. Once the Coinsurance Maximum is reached, the Member will no longer pay Coinsurance for the rest of the Calendar Year. One Member on a two-person or family contract cannot contribute more than the individual Coinsurance Maximum. The Coinsurance Maximum will also count toward the Out-of-Pocket Maximum along with the Deductible and all other cost-sharing. **Note:** Not all plans have a Coinsurance Maximum. Please refer to Section 8.4 and applicable Riders to learn whether your plan includes a Coinsurance Maximum and services excepted from the Coinsurance Maximum.

**Copayment** is a fixed dollar amount that you and the Member are required to pay for some Benefits. The amount can vary by the type of Covered Service. Refer to the Schedule of Member Cost Sharing and Additional Limits of Coverage and applicable Rider(s) to verify which Benefits have a Copayment requirement. Copayments apply to the Out-of-Pocket Maximum.

**Cost-Sharing** is the Copayment, Coinsurance and/or Deductible that is the Member's responsibility as outlined in the Schedule of Cost-Sharing in this Certificate or an applicable Rider.

**Covered Services, Coverage, Cover or Covered** means those Benefits that the Member is entitled to under this Certificate, if they are Medically Necessary and have met all other requirements of this Certificate. This Certificate (including the Schedule of Member Cost Sharing and Additional Limits of Coverage and applicable Riders) describes what MHP Community will pay for some services and supplies.

**Day or Days** means calendar day(s), unless otherwise specified.

**Deductible** is the annual amount of money payable by you or Member for Covered Services. A Member's Deductible is included in the Schedule of Member Cost Sharing and Additional Limits of Coverage and any applicable Rider(s). The Deductible applies to your Out-of-Pocket Maximum. The annual Deductible resets each year at the start of the Plan Year.

**Diagnosis of Autism Spectrum Disorders** means assessments, evaluations or tests performed by a licensed physician or a licensed psychologist to diagnose whether an individual has a diagnosis of Autism Spectrum Disorder.

**Diagnostic and Statistical Manual** means a manual of mental health disorders published by the American Psychiatric Association that contains standard criteria for classification of mental health disorders.

**Effective Date** means the date Coverage under this Certificate begins.

**Eligible or Eligibility** means an individual meets all the requirements to be Covered as a Member by MHP Community under this Certificate.

**Enrollment** means submitting a completed Enrollment form and paying the necessary Premium to MHP Community.

**Family Dependent or Dependent** means one of the following, unless otherwise excluded in the contract between the Group and MHP Community:

- The Spouse of a Subscriber;

A child of the Subscriber or of the Subscriber's Spouse, by birth, legal adoption or legal guardianship who has not attained the age of 26 years. (The child need not be claimed as a Dependent on the federal income tax return of the Subscriber or the Subscriber's Spouse to qualify as a Family Dependent).

**Grievance** means 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 Benefit 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 Community; or

- Other expressions of dissatisfaction not related to an Adverse Benefit Determination.

**Group** is the legal entity that contracted with MHP Community on behalf of its employees to receive the Benefits described in this Certificate.

**Habilitative Services** help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient or Outpatient settings.

**Hospital** is a state-licensed, acute-care facility that provides continuous, 24-hour inpatient medical, surgical, or obstetrical care. It is not primarily a nursing care facility, rest home, home for the aged, or a facility to treat substance abuse, psychiatric disorders, or pulmonary tuberculosis.

**Inpatient Service** is a service provided during the time a patient is admitted to a Hospital or Skilled Nursing Facility.

**Medically Necessary** means services or supplies furnished by a Hospital, physician, or other provider that is the most economical and efficient care to identify or treat an illness or injury that is determined to be:

- Accepted as necessary and appropriate for the patient's condition. For diagnostic services, the results are essential to the diagnosis, care, treatment, and/or management of the patient's condition;
- The most appropriate supply or level of services that can be safely provided to the patient. When applied to an Inpatient Service, it means that the patient's medical symptoms or conditions require that the services or supplies cannot be safely provided to the patient in an outpatient setting;
- Appropriate with regard to standards of good medical practice. Based upon recognized standards of health care specialty involved, it must be based on generally accepted medical or scientific evidence as:
  - Treatment that is appropriate to the Member's diagnosis or condition in terms of type, amount, frequency, level, setting and duration;
  - Effective treatment;
  - Essential Treatment; and
  - Not cosmetic in nature.
- Cost no more than a treatment that is likely to have a similar or otherwise comparable health outcome.

**Member** is the Subscriber or an eligible dependent covered by and entitled to Benefits under this Certificate.

**MHP Community** is McLaren Health Plan Community the health maintenance organization the Member is enrolled in.

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

**Non-Participating Provider** is a provider that is not contracted with MHP Community to provide services to MHP Community Members. Non-Participating Providers also include providers contracted with MHP Community, but not in the Network that is applicable to your Plan.

**Observation Care** is short term treatment and monitoring that is provided on an outpatient basis. This type of care is commonly provided after you visit an emergency room to allow healthcare professionals to determine if you can be discharged or if you need to be admitted as an inpatient for additional treatment. Observation Care is typically limited to 24-48 hours. Even when you are required to stay at the Hospital overnight, if you are receiving Observation Care, you have not been admitted as an inpatient. See below for more information about cost sharing for your outpatient benefit.

**Open Enrollment Period** is a period of time each year when eligible people may enroll in or disenroll from MHP Community.

**Option A Benefits** are Benefits provided by Participating Providers. Option A Benefits are provided at the lowest out-of-pocket expense to the Member. Some services require MHP Community Preauthorization to be Covered, even when provided by a Participating Provider. Refer to Section 8.02 of this Certificate. Only to the extent required by applicable surprise billing laws, MHP Community will include amounts you paid for cost-sharing towards the Option A Benefit.

**Option B Benefits** are Benefits that are provided by a Non-Participating Provider. Option B Benefits may result in significant out-of-pocket expenses to the Member. Some Option B Benefits require MHP Community Preauthorization and not all services in this Certificate are Covered under Option B. (Refer to Section 8.02 and the specific service under Part 8 of this Certificate.)

**Out of Area Member** is an employee of an enrolled Group who does not reside within MHP Community's Service Area.

**Out-of-Pocket Maximum** is the most you have to pay for certain expenses related to Covered Services during a Calendar Year. The Out-of-Pocket Maximum includes your Deductible(s), Copayment and Coinsurance. This limit never includes your Premium, Balance Billed charges or health care services or supplies that are not Covered Services. For members enrolled in a High Deductible Health Plan with self-only Coverage (i.e., no Dependents), the self-only Out-of-Pocket Maximum is the most you have to pay each year for certain expenses related to Covered Services. For members enrolled in a High Deductible Health Plan with other Coverage (i.e., a Subscriber with Dependents), the family Out-of-Pocket Maximum is the most you have to pay each year for certain expenses related to Covered Services. If applicable, and if outlined in your Rider an individual in a family may be subject to his/her own Out-of-Pocket Maximum. See your applicable Rider to see whether this applies to you.

**Participating Provider** is a provider directly contracted with MHP Community to provide services to MHP Community Members. Members who utilize a Participating Provider (with any required Preauthorizations) will avoid significant out-of-pocket expenses. Participating Providers agree not to seek payment from you for Covered Services except for permissible Deductible, Copayment and Coinsurance.

**Plan Year** is the 12-consecutive-month period determined by the Group during which Coverage is provided per the Group's plan documents. If you do not know when your Plan Year begins and ends, please ask your Employer.

**Preauthorized Service, Preauthorization, Preauthorize, Prior Authorized or Prior**

**Authorization** relates to a Benefit that is required to be authorized or approved by MHP Community prior to obtaining the care or service. If such a service is not authorized or approved, it is not a payable Benefit unless provided as an emergency or urgent care service. See Section 8.02 for more information about when and how to obtain a Preauthorization. Note that references to "Prior Authorized" or "Prior Authorization" are specific to pharmacy Benefits. Unless specifically stated otherwise in this Certificate, the requirements related to "pre" authorized services apply to "prior" authorized services.

**Premium** is the amount prepaid monthly for MHP Community Coverage. For Group Coverage, this amount may include employee contributions.

**Primary Care Physician or PCP** is a licensed medical doctor (MD) or doctor of osteopathy (DO) who is a Participating Provider (contracted with MHP Community). You must select a PCP or a PCP will be assigned to you by MHP Community. For Members under the age of 18 years, you or the Member have the option of choosing an MHP Community Participating pediatrician as the Primary Care Physician. Your PCP provides, arranges and coordinates all aspects of your health care to help you receive the right care, in the right place, at the right time.

**Provider Directory** is a listing of the names and locations of Participating Providers who make up the MHP Community Network. You may call our Customer Service Department to obtain a list of Providers in your area, or you can go to our website at [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org). Please carefully review the Provider Directory to ensure that both the treating physician and facility are Participating Providers in order to avoid additional out-of-pocket expenses.

**Qualifying Events** are events that qualify an individual to enroll in this plan outside of the Open Enrollment Period. Circumstances that may be considered as a Qualifying Event include, but are not limited to: marriage, birth, adoption, changing from part-time to full-time employment, return from lay-off or leave (the maximum leave is 12 months; if leave is greater than 12 months, the employee is considered a new hire) and a voluntary or involuntary loss of other qualifying coverage.

**Qualifying Payment Amount** has the same definition that applies in Applicable Surprise Billing Laws.

**Referral** is a document issued by MHP Community that your PCP completes before you receive certain services. See also **Preauthorization**.

**Rehabilitation Services** are health care services that help a person keep, get back or improve skills and functions for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech language pathology and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

**Reimbursement Amount** is the maximum amount MHP Community will pay for a Benefit. For Participating Providers it is the lower of the billed charge or the amount that MHP Community pays the

**Participating Provider.** For Non-Participating Providers, it is the maximum amount MHP will pay a Non-Participating Provider. MHP Community determines payment for Non-Participating Providers as the lower of the billed charge or by using the applicable methodology specified in its Reimbursement to Non-Contracted Providers Policy. Contact Customer Service at (888) 327-0671 for more information.

**Rider** is a legal document that is part of the Certificate of Coverage that explains any additional benefits, limitations or other modifications to the Coverage outlined in the Certificate. For example, a Rider may add or remove benefits from those listed in the Certificate. When there is a conflict between the Certificate and the Rider, the Rider shall control over the Certificate.

**Schedule of Member Cost Sharing and Additional Limits of Coverage** means the document included as a part of this Certificate that details any Copayment, Coinsurance and/or Deductible that is the Member's responsibility. The document also may indicate that a particular service is not Covered under your Benefit plan. Although a service is listed in the Schedule of Member Cost Sharing and Additional Limits of Coverage, it may require MHP Community Preauthorization to be a payable Benefit. Benefits are subject to all conditions, exclusions and/or limitations contained in this Certificate, but when there is a conflict between the Certificate and the Schedule of Member Cost Sharing and Additional Limits of Coverage, the Schedule shall control over the Certificate.

**Service Area** is the geographic area made up of counties or parts of counties, where MHP Community has been authorized by the state of Michigan to market and sell our health plans and where the majority of our Participating Providers are located.

**Skilled Nursing Facility** is a state-licensed, certified nursing home that is contracted with MHP Community and that provides a high level of specialized care to Members. It is an alternative to extended hospital stays.

**Special Enrollment Period** is a period outside the annual Open Enrollment Period, during which you and your Eligible Dependents may enroll in this plan or, if you are already enrolled, during which you may change your coverage elections. You are only eligible to enroll or change your coverage elections during a Special Enrollment Period in certain situations (see **Qualifying Events** above) as explained in Part 1 of this Certificate.

**Spouse** is the opposite sex or same sex individual to whom the Subscriber is married, based upon a marriage that was validly entered into in a jurisdiction where the laws authorize the marriage of two individuals of the opposite sex or same sex, as applicable.

**Subscriber** is the eligible person who has enrolled for health care Coverage with MHP Community. This person is the one whose employment is the basis for Coverage eligibility. This person is also known as a Member. Other Members are those Family Dependents of the Subscriber who are eligible for Coverage.

**Surprise Billing** is where a Member unknowingly receives care or services from a Non-Participating Provider in an Emergency or in certain non-Emergency situations when receiving Covered Services at a Participating Facility and later receives an unexpected bill for the difference between what the Non-Participating Provider charges and what we pay.



**Telemedicine** is a secure real-time health care service, delivered by telephone, internet, or other electronic technology when you're not in your provider's presence. Telemedicine visits are for the purpose of diagnosing, treating, or providing other medical treatment for Covered Services, including behavioral health. Contact for these services must be initiated by you or your treating Participating Provider and must be within your treating Participating Provider's scope of practice. Telemedicine visits are subject to the same Preauthorization requirements as services rendered in an in-office setting. Telemedicine visits are subject to the same Copayment, Coinsurance and Deductible amounts as services rendered in an in-office setting. See your Benefits below for applicable Cost Sharing. If you are enrolled in a Virtual PCP Plan, Telemedicine services are not considered Virtual Visits. See Virtual Visits for details on cost-sharing and coverage.

**Therapeutic Care**, as it relates to Treatment of Autism Spectrum Disorders, means evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist or social worker.

**Treatment of Autism Spectrum Disorders** means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

- Behavioral health treatment;
- Pharmacy care;
- Psychiatric care;
- Psychological care;
- Therapeutic Care;
- Habilitative care.

**Urgent Preauthorization Request** means a request for medical care or treatment for which resolution within MHP Community's normal time frames, due to the medical status of the Member, would seriously jeopardize the life or health of the Member or the ability to regain maximum function, or, in the opinion of the treating Provider, would subject the Member to severe pain that could not be adequately managed without the requested service.

**Willful Criminal Activity** includes, but is not limited to any of the following:

- Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of the State of Michigan.
- Operating a methamphetamine laboratory. As used in this subdivision, "methamphetamine laboratory" means the term as defined in section 1 of 2006 PA 255, MCL 333.26371.
- "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

**Virtual Visit** means, for only those enrolled in a Virtual PCP Plan, a secure real-time health care service, delivered by a McLarenNow provider or a mental health or behavioral health Participating Provider using secure video on a smartphone, tablet, or computer with a webcam. Virtual Visits are available for the purpose of diagnosing, treating, or providing other medical treatment for Covered Services. Contact for these services must be initiated by you or your Participating Provider and must be within your

Participating Provider's scope of practice. Virtual Visits are subject to the same Preauthorization requirements as services rendered in an in-office setting.

## **PART 1: ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE OF COVERAGE**

This section describes Eligibility, Enrollment, and Effective Dates of Coverage for the types of Members listed below.

All MHP Community Subscribers and Members must meet Eligibility requirements established by MHP Community and the Group. Certain requirements depend on whether the individual is:

- A Subscriber;
- A Family Dependent;
- A Dependent under a Qualified Medical Child Support Order; or
- A Principally Supported Child.

All Members must live in the MHP Community Service Area to be eligible for Coverage unless stated otherwise in this booklet.

### **1.01 GROUP SUBSCRIBER**

#### **ELIGIBILITY**

A Group Subscriber must do all of the following:

- Live in the MHP Community Service Area at least nine months out of the year;
- Be an active employee or eligible retiree of a Group; and
- Meet MHP Community's and the Group's Eligibility requirements.

#### **ENROLLMENT**

In most cases, Eligible employees will enroll during the Group's annual Open Enrollment Period. A new employee must enroll within 30 days of becoming Eligible or during an Open Enrollment Period.

**Note:** If the employee declines Enrollment because he/she has other coverage and that coverage end, he/she may enroll if:

- Any COBRA coverage is exhausted;
- The other coverage was terminated as a result of loss of employer contributions or loss of eligibility; and
- The employee applies for MHP Community Enrollment within 30 days after the other coverage ends.

#### **EFFECTIVE DATE**

The Effective Date of Coverage depends on the agreement between the Group and MHP Community.

## 1.02 FAMILY DEPENDENT

### ELIGIBILITY

A Family Dependent may be either:

- The legally married Spouse of the Subscriber, or
- A child of the Subscriber or of the Subscriber's Spouse by birth, legal adoption or legal guardianship, and who has not attained the age of 26 years.

**Note:** A child does not need to be named as a dependent on the parent's federal income tax return to qualify as a Family Dependent.

**Dependent children**— The Dependent's Coverage Terminates at the end of the month he or she becomes 26 years old.

### Exception

An unmarried, Dependent child who becomes 26 while enrolled in MHP Community and who is totally and permanently disabled may continue Coverage if:

- The Dependent child is incapable of self-sustaining employment because of mental or physical disability;
- The Dependent child relies on you for more than half of his or her support, as determined under Section 152 of the Internal Revenue Code, as amended;
- The Dependent child is unmarried; and
- The Dependent lives in the Service Area.

The Subscriber must submit to MHP Community the proof of the disability and dependence within 31 days of the child's 26<sup>th</sup> birthday. MHP Community may require annual proof of continued disability and dependence.

**Note:** A Dependent whose only disability is a learning disability or substance abuse does not qualify for Coverage after age 26 under this exception.

### ENROLLMENT

Any eligible Dependents may be added to the Subscriber's contract:

- During the annual Open Enrollment Period;
- When the Subscriber enrolls;
- Within 30 days of a Qualifying Event, such as birth, marriage, placement for adoption, loss of other coverage.

**Note:** Other non-enrolled Eligible dependents may also be added at the same time as the newly qualified Family Dependent.

**EFFECTIVE DATE OF COVERAGE**

- Coverage is Effective on the date of the Qualifying Event if the Dependent is Enrolled within 30 days of the event.
- If the Family Dependent is not Enrolled within 30 days, Coverage will not begin until the next Open Enrollment Period's Effective date.
- For a dependent who lost coverage and notifies MHP Community within 30 days, Coverage will be Effective when the previous coverage lapses. If you do not notify MHP Community within 30 days, Coverage will not begin until the next Open Enrollment Period's Effective date.
- Adopted children are Eligible for Coverage from the date of placement. "Placement" means when the Subscriber becomes legally responsible for the child; therefore, the child's Coverage may begin before the child lives in the Subscriber's home.

**1.03 DEPENDENT UNDER A QUALIFIED MEDICAL CHILD SUPPORT ORDER****ELIGIBILITY**

The child of the Subscriber or of the Subscriber's Spouse is eligible to enroll in this plan if you provide MHP Community with a copy of a court or administrative order that requires the Subscriber or Spouse to provide health coverage for the child in accordance with state and federal law (a "Qualified Medical Child Support Order" or "QMCSO"). The QMCSO must name the Subscriber or the Subscriber's Spouse as the participant in order to enroll the child. The child must be otherwise eligible for Coverage as a Family Dependent. If MHP Community receives a copy of the QMCSO but you fail to enroll the child for Coverage, the child may be enrolled by the Friend of the Court or by the child's other parent or guardian through the Friend of the Court. We will not Terminate the Coverage of a child who is enrolled under a QMCSO unless:

- The child is no longer eligible as a Family Dependent,
- Premiums have not been paid as required by the Certificate; or
- We receive satisfactory written proof that the QMCSO is no longer in effect or that the child has or will have comparable health coverage beginning on or before the date the child's Coverage with us is Terminated.

**EFFECTIVE DATE OF COVERAGE**

If MHP Community receives notice within 30 days of the court order, Coverage is Effective as of the date of the court order. If MHP Community receives notice more than 30 days from the date of the order, Coverage is Effective on the date MHP Community receives notice.

**1.04 ADDITIONAL ELIGIBILITY GUIDELINES**

The following guidelines apply to all Members:

- Service Area Waiver: Under certain circumstances MHP Community may waive the Service Area residency requirement in writing for a Subscriber and Family Dependents who live outside the Service Area;
- Change of Status: You agree to notify MHP Community within 30 days of any change in Eligibility status of you or any Family Dependents. When a Member is no longer eligible for Coverage, he or she is responsible for payment for any services received;
- Members admitted to a Hospital or Skilled Nursing Facility prior to the Effective Date of Coverage will be Covered for Inpatient Care on the Effective Date of the Certificate only if the Member has no continuing coverage under any other health benefits contract, program or insurance.

## **PART 2: OTHER PARTY LIABILITY**

MHP Community does not pay claims or coordinate Benefits for services that are not provided in accordance with the terms of this Certificate.

### **2.01 NONDUPLICATION**

- MHP Community provides each Member with full health care services within the limits of this Certificate.
- MHP Community does not duplicate Benefits or pay more for Covered Services than the actual fees.
- Coverage for Member's Benefits will be reduced to the extent that the Benefits are available or payable under any other certificate or policy covering the Member, whether or not a claim for the benefits is made.

One source of benefits will be primary, which means it will pay before the other source, and the other source of benefits will be secondary, which means it will pay after the source of benefits that is primary (first).

### **2.02 AUTO POLICY AND WORKERS' COMPENSATION CLAIMS**

This Certificate is a coordinated Certificate. That is, services and treatment for any automobile-related injury that are paid or payable under any automobile or no-fault automobile policy will not be paid by MHP Community. MHP Community will not allow "double-dipping" whereby the Member would receive the benefit of payment for the same services from both MHP Community and the automobile or no-fault carrier.

Services and treatment for any work-related injury that are paid or payable under any workers' compensation program will not be paid by MHP Community.

If any such services are provided by MHP Community, MHP Community has the right to seek reimbursement from the other program or insurer.

**Note**— Special rules apply to injuries while riding a motorcycle. If the injury does not involve an automobile and if the motorcycle insurance plan provides medical coverage, then the motorcycle insurance plan is primary. MHP Community would pay for Covered Services under this Certificate as the secondary plan. If the motorcycle insurance does not provide medical coverage or if medical coverage is exhausted, then MHP Community will pay for Covered Services under this Certificate as the primary plan. Members who ride a motorcycle without a helmet are required by Michigan State law to purchase medical coverage through their motorcycle insurance plan and MHP Community will pay secondary.

## 2.03 COORDINATION OF BENEFITS (COB) AND SUBROGATION

**Note:** For purposes of this Section, “certificate” and “policy” include, but are not limited to, a certificate, contract, plan, or policy group or individual issued by or provided by:

- A health or medical care corporation;
- A hospital service corporation;
- An HMO;
- A long-term care contract, medical care component (such as skilled nursing care);
- A dental care corporation;
- An insurance company;
- A labor-management trustee plan;
- A union welfare plan;
- An employer organization plan; or
- An employer self-insured plan

in connection with a disability benefit plan under which health, Hospital, medical, surgical, or sick care benefits are provided to Members.

**Member Responsibility:** At the time of enrollment and if requested by MHP Community any time after, Members are required to disclose to MHP Community whether they have health coverage under any other certificate or policy. Members must also immediately notify MHP Community if there are any changes in such coverage. If a Member fails to provide such information when requested, or to notify MHP Community upon any changes to the Member’s other health coverage, MHP Community may deny payment for individual claims.

**Determination of Benefits** means determining the amount that will be paid for Covered services.

**Coordination of Benefits or COB** means determining which Certificate or policy is responsible for paying Benefits for Covered services first (primary carrier) when a member has dual coverage. Benefit payments are coordinated between the two carriers to provide 100% coverage whenever possible for services Covered in whole or in part under either plan, but not to pay in excess of 100% of the total amounts to which providers or Members are entitled. Except as otherwise stated in this Certificate, MHP Community will coordinate benefits in accordance with Michigan law, and specifically PA 275 of 2016; MCL 550.251, *et seq.*

If the carriers that issued plans cannot agree on the order of benefits within thirty (30) calendar days after the carriers have received all the information needed to pay the claim, the carriers shall immediately pay the claim in equal shares and determine their relative liabilities following payment. A carrier is not required to pay more than it would have paid had the plan it issued been the primary plan.

#### **COB WITH MEDICARE**

MHP Community will coordinate Benefits with Medicare based on the following:

- If an individual covered by Medicare is also eligible for Coverage under this Certificate and declines MHP Community Coverage, Medicare is primary and MHP Community will not provide any Coverage.
- If a Member is 65 years of age or older and has Coverage under this Certificate based on current employment status (or based on current employment status of a Spouse of any age), the order of benefits is: (a) if the Member's (or Member's Spouse's) employer has 20 or more employees, MHP Community is the primary payer and Medicare is secondary, or (b) if a the Member's (or Member's Spouse's) current employment status, then Medicare is the primary payer and MHP Community is secondary.
- If a Member is entitled to Medicare coverage based on disability (and is less than 65 years of age) and has Coverage under this Certificate based on the Member's (or the Member's Spouse's) current employment status, the order of benefits is: (a) if the Member's (or the Member's Spouse's) employer has less than 100 employees, Medicare is the primary payer and MHP Community is Secondary. If a Member is disabled and has Coverage under this Certificate not based on the Member's (or the Member's Spouse's) current employment status, then Medicare is the primary payer and this Plan is secondary.
- If a Member is eligible for or entitled to Medicare coverage based on End-Stage Renal Disease (ESRD) and has Coverage under this Certificate: (a) for the first 30 months, the Member is eligible for or entitled to Medicare, MHP Community is the primary payer and Medicare is secondary, and (b) after the first 30 months of Medicare eligibility or entitlement, Medicare is the primary payer and MHP Community is secondary. If you are eligible for Medicare Parts A and B, and Medicare is primary, we will pay as if Medicare is primary even if you have not enrolled in both parts of Medicare. By enrolling in Medicare, you will avoid large out of pocket expenses.
- In determining benefits payable under Medicare, you will be considered to be enrolled for and covered by both Part A and Part B of Medicare and any other governmental benefits for which you are eligible, whether or not you are actually enrolled. Therefore, you should enroll in and become covered by any of these benefits for which you are eligible. For example, if you are eligible for Medicare Parts A and B, and Medicare is primary, we will pay as if Medicare is primary even if you have not enrolled in both parts of Medicare. By enrolling in Medicare, you will avoid large out of pocket expenses.

Should any federal law or regulations regarding the coordination of benefits between Medicare and group health plans change, or a new law or regulation is enacted regarding the same, MHP Community shall be secondary to Medicare as permitted by the revised or new federal law or regulation despite any provision in this Certificate to the contrary.



**COB ADMINISTRATION**

If, in accordance with Michigan law, MHP Community determines that Benefits under this Certificate should have been reduced because of benefits available under another certificate or policy, MHP Community has the right to:

- Recover any payments made to the Member directly from the Member; or
- Assess a reasonable charge for services provided by MHP Community in excess of MHP Community's liability.

If Benefits that should have been paid by MHP Community have been provided under another certificate or policy, MHP Community may directly reimburse whoever provided the benefit payments.

For COB purposes, MHP Community may release claims or obtain any necessary information from any insurance company or other organization. Any Member who claims Benefit payments under this Certificate must furnish MHP Community with any necessary information or authorization to do this.

**SUBROGATION**

Subrogation means that MHP Community has the same right as a Member to recover expenses for services for which another person or organization is legally liable, to the extent that MHP Community has provided or paid for the services. MHP Community will be subrogated to the Member's right of recovery against the liable party.

- When you accept an MHP Community ID card, you agree that, as a condition of receiving Benefits and services under this Certificate, you will make every effort to recover funds from the liable party. If you recover any funds for Benefits paid by MHP Community, you will reimburse MHP Community. MHP Community shall have a lien against any such recoveries of funds whether by judgment, settlement, compromise or reimbursement. This applies no matter how the recovered funds are designed, i.e., economic or non-economic damages.
- When you accept an MHP Community ID card, it is understood that you acknowledge MHP Community's right of subrogation. If MHP Community requests, you will authorize this action through a subrogation agreement. If a subrogation lawsuit by you or by MHP Community results in a financial recovery greater than the services and Benefits provided by MHP Community, MHP Community has the right to recover its legal fees and costs out of the excess.
- By accepting Benefits, you and your covered dependents assign to MHP Community any rights you or they may have to recover all or part of the same covered expenses from another source, including another group health plan, insurer or individual, limited, however, to the amount of covered expenses MHP Community has paid on behalf of you and/or your covered dependents. This assignment also grants MHP Community a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage. By virtue of the assignment, MHP Community is entitled to recover 100 percent of the covered expenses it has paid on behalf of you or your covered dependents from all recoveries from a third party (whether by lawsuit, settlement or otherwise). This assignment

allows MHP Community to pursue any claim that you may have against a third party, or its insurer, whether or not you choose to pursue that claim.

- This assignment entitles MHP Community to be reimbursed on a first-dollar basis (that means that MHP Community will have a first priority claim to the recovered funds), whether the funds paid to or for the benefit of you and/or your covered dependents amounts to a full or partial recovery, or whether the funds paid are designated for non-medical charges, attorney fees, pain and suffering, or other costs and expenses. MHP Community's share of the recovery will not be reduced because you or your covered dependent has not received the full damages claimed, unless MHP Community agrees in writing to a reduction.
- MHP Community has an equitable lien against any money or property you or your Covered Dependents recover from any party, including an insurer, another group health plan or individual, but only to the extent of the covered expenses that MHP Community has paid.
- This and any other provisions of the Certificate concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under applicable law and relevant case law. MHP Community's provisions concerning subrogation, equitable liens, and other equitable remedies are also intended to supersede the applicability of the common law doctrines commonly called the "make whole" rule and the "common fund" rule.
- You or your representative will do whatever is necessary to enable MHP Community to implement the provisions of this Section. If you hire a lawyer to pursue a claim, you must inform the lawyer of MHP Community's rights under this Certificate.
- When reasonable collection costs and legal expenses are incurred in recovering amounts that benefit both you and MHP Community, the costs and legal expenses will be divided equitably.
- You agree not to compromise or settle a claim or take any action that would prejudice the rights and interests of MHP Community without getting MHP Community's prior written consent.
- If you refuse or do not cooperate with MHP Community regarding subrogation, it will be grounds for terminating Membership in MHP Community or the reduction of future benefits under the Plan by an amount up to the aggregate amount paid by MHP Community that was subject to MHP Community's equitable lien, but for which MHP Community was not reimbursed.

## **PART 3: MEMBER RIGHTS AND RESPONSIBILITIES**

### **3.01 CONFIDENTIALITY OF HEALTH CARE RECORDS**

Your health care records will be kept confidential by MHP Community in accordance with all applicable state and federal privacy laws. MHP Community will only use and disclose your health care information as permitted by law and as described in the MHP Community Privacy Notice (which is located in your Member Handbook and on the MHP Community website, [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org)).

It is your responsibility to cooperate with MHP Community by providing health history information and helping to obtain prior medical records at MHP Community's request.

### **3.02 INSPECTION OF MEDICAL RECORDS**

You have the right to access your own medical records or those of your minor child or ward at physicians' medical offices during regular office hours. You also have the right to access such records at Hospitals or other facilities, but you must contact their offices to make arrangements for the records to be available. Access to records of a minor without a minor's consent may be limited by law or applicable MHP Community policy.

### **3.03 PRIMARY CARE PHYSICIAN (PCP)**

MHP Community generally requires the designation of a Primary Care Provider. You must select a PCP from the list of MHP Community Participating Providers. We recommend that you choose a PCP that is located in your geographic area. You have the right to designate any Primary Care Provider who is a Participating Provider and who is available to accept you or your family members. For information on how to select a Primary Care Provider, and for a list of the Participating Primary Care Providers, contact Customer Service at (888) 327-0671.

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

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

If you need to change your PCP, please call Customer Service at (888) 327-0671. We can assist you with your request and verify that the PCP you have chosen is accepting new patients. You may also visit our website at [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org) for the current Provider Directory. The change will be effective the first day of the month following notification to MHP Community. You may start seeing your new PCP when the change becomes effective.

### **3.04 REFUSAL TO ACCEPT TREATMENT**

You have the right to refuse treatment or procedures recommended by MHP Community physicians for personal or religious reasons. However, your decision could adversely affect the relationship between you and your physician and the ability of your physician to provide appropriate care for you.

If you refuse the treatment recommended, and the physician believes that no other medically acceptable treatment is appropriate, the physician will notify you. If you still refuse the treatment or request procedures or treatment that MHP Community regards as medically or

professionally inappropriate, MHP Community is no longer financially or professionally responsible for providing Coverage for the condition or resulting complications.

### **3.05 COMPLAINT, GRIEVANCE AND APPEALS PROCEDURES**

At MHP Community, we want to hear your comments so that we can make our services better for our Members. We want you to be able to receive answers to any questions that you have about MHP Community. We also want to provide you ways of reaching fair solutions to any problems that you may have with MHP Community. When you have any comments or concerns, please call Customer Service at (888) 327-0671. Customer Service will assist you in documenting your complaint/Grievance.

#### **STANDARD GRIEVANCES**

Members are encouraged to call Customer Service at (888) 327-0671 if they have questions or concerns. MHP Community staff will try to resolve your concerns during the initial contact. If you are still dissatisfied with MHP Community's response, you may file a formal Grievance. Customer Service staff are available to assist you with filing a Grievance. Customer Service will assist you in documenting your Grievance. The Grievance process will be completed within 30 calendar days. MHP Community will acknowledge receipt of your Grievance in writing within five days of receipt. MHP Community will investigate your Grievance and provide you with a written determination within 15 days of receipt of your Grievance. If you are not happy with our decision you may appeal to MHP Community in writing or by phone, so long as your appeal is received within five days of our written determination. MHP Community will review your Grievance appeal and provide you with a written determination within 30 days from the initial date of your Grievance.

#### **EXPEDITED GRIEVANCES**

A Grievance is considered expedited if a physician, orally or in writing, substantiates that the 30 day time frame would acutely jeopardize the life of the Member or would jeopardize the Member's ability to regain maximum function. Expedited Grievances should be made by telephone. Call Customer Service at (888) 327-0671 to file an expedited Grievance. An initial determination and verbal notification to the Member and appropriate practitioner will be made by MHP Community no later than 72 hours after receipt of an expedited Grievance. Written notification of the determination is sent within two days of the verbal notification. You may, but you are not required to file an appeal of an Expedited Grievance with MHP Community.

#### **STANDARD INTERNAL APPEALS**

Members may file an appeal of an Adverse Benefit Determination with MHP Community. See the definition of Adverse Benefit Determination in the Definitions Section of this Certificate, and also note that an untimely response to a request may become an Adverse Benefit Determination. Members or their authorized representative have **180** days from the receipt of the Adverse Benefit Determination to file a written appeal. You can send your appeal request along with any additional information to:

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

**Email: [MHPAppeals@mclaren.org](mailto:MHPAppeals@mclaren.org)**

Covered Benefits continue pending resolution of the appeal until: the end of the approved treatment period or determination of the appeal, subject to regulatory and contractual obligations. If you wish to have someone else act as your authorized representative to file your appeal, you will need to complete MHP Community's authorized representative form which can be found on our website at [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org). You may call Customer Service at (888) 327-0671 for a copy to be mailed to you. You may designate an authorized representative at any step of the appeals process.

You may request copies of information relevant to your appeal, free of charge, by contacting Customer Service at (888) 327-0671. MHP Community will provide you with any additional evidence considered, relied upon or generated by MHP Community in connection with your appeal as soon as possible and sufficiently in advance of the date on which the decision is required to be made, so that you have a reasonable opportunity to respond. We will provide you with any new or additional rationale for a denial of your claim or appeal as soon as possible and sufficiently in advance of the date on which the decision is required to be made so that you have a reasonable opportunity to respond.

Before MHP Community issues a final adverse determination within the required time frames that is based on a new or additional rationale, MHP Community will provide the new or additional rationale to you as soon as possible and sufficiently in advance of the date of the notice of final adverse determination is due, so that you have a reasonable opportunity to respond.

Members have the right to ask MHP Community to arrange a meeting with the appeal review committee. Members or an authorized representative may attend the meeting in person or by telephone. A person not involved in the initial decision will review the 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 care.

MHP Community has 30 days to complete the internal appeal process for a pre-service appeal request, and 60 days for a post-service appeal request. These time periods may be extended if requested by the Member. MHP Community may also extend the time period for up to 10 business days if it has requested information from a health care facility or health professional and has not received it. You will receive written notification of the final determination within three days after the decision is made. In addition, we may also notify you orally.

#### **EXPEDITED INTERNAL APPEALS**

Members or their authorized representatives may request an expedited appeal either orally or in writing. For expedited appeals, a Member's health care practitioner, with knowledge of the Member's condition, will be allowed to act as the members authorized representative. Where

time is of the essence and when the practitioner represents that he/she has the member's permission to act as the Member's representative for the expedited internal appeal, the practitioner may act as the Member's representative for purposes of the expedited internal appeal without written or oral Member authorization.

MHP Community will handle a Member appeal as an expedited appeal when a physician, orally or in writing, substantiates that the time frame for completion of a MHP Community standard appeal would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function or in the opinion of a practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. For appeals not substantiated by the Member's treating physician, MHP Community will evaluate the Member's request by applying the judgment of a prudent layperson that has an average knowledge of health and medicine to determine if a delay would jeopardize the Member's life or the Member's ability to regain maximum function. If MHP Community determines that your appeal does not qualify as an expedited appeal, MHP Community will transfer it to the standard 30-day process. Expedited appeals are available for pre-service adverse determinations only, including requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility. In most cases, the expedited appeal request will be made by the Member or the Member's physician by telephoning MHP Community at (888) 327-0671.

A request for an expedited appeal should be made by calling MHP Community at (888) 327-0671. MHP Community will make reasonable efforts to give the Member prompt oral notice a denial to treat the appeal as expedited, and in all cases, will provide the Member with written notice of any denial of the expedited request and the offer of a standard appeal within two days of the time MHP Community received the request for an expedited appeal. Expedited appeals are only available for pre-service Adverse Benefit Determinations, including requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

If the appeal is accepted as an expedited appeal, MHP Community will make a determination concerning your expedited appeal and communicate that to you and your physician as expeditiously as the medical condition requires, but no later than 72 hours after receipt of the request for expedited appeal. Generally, MHP Community will notify you and your physician of MHP Community's decision by telephone. If so, you and your physician will be provided with written confirmation of this decision within two calendar days after the telephone notification.

If your physician substantiates either orally or in writing that you have a medical condition where the time frame for completion of an MHP Community expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you or your authorized representative may file a request for an expedited external review **at the same time** you or your authorized representative files a request for an expedited MHP Community appeal. You will need to follow the procedure explained below under the heading, "Expedited External Appeals." If you choose to file a request for an external expedited review, your internal appeal will be pended until the State of Michigan, Department of Insurance and Financial Services (DIFS) determines whether to accept your request for an

expedited external review. If DIFS accepts the expedited external appeal, you will be considered to have exhausted the internal appeal process.

### 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 review with the State of Michigan, Department of Insurance and Financial Services (DIFS). You must do this within 127 days of receiving MHP Community's final appeal decision. If you are not required to exhaust MHP Community's appeals process, you must do this within 127 days from receiving MHP Community's Adverse Benefit Determination. **Note** – External review may be available related to MHP Community's compliance with Applicable Surprise Billing Laws. MHP Community will provide the form required to file an external appeal. Requests should be sent to DIFS:

**Mail:**

DIFS – Office of General Counsel – Appeals Section  
Department of Insurance and Financial Services  
P.O. Box 30220  
Lansing, MI 48909-7720

**Courier/Delivery service:**

DIFS – Office of General Counsel – Appeals Section  
530 W. Allegan St., 7<sup>th</sup> Floor  
Lansing, MI 48933-1521

**Toll Free Telephone:** 1 (877) 999-6442

**Fax:** 517-284-8838

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

[www.michigan.gov/difs](http://www.michigan.gov/difs)

When appropriate, DIFS will request a recommendation by an Independent Review Organization ("IRO"). The IRO is not contracted with or related to MHP Community. DIFS will issue a final order.

### EXPEDITED EXTERNAL REVIEW

As explained above under the section entitled "Expedited Appeals", you may file a request for an expedited external review at the same time you file a request for an expedited internal appeal with MHP Community. Alternatively, if after your expedited review we continue to deny Coverage or the service requested, you can ask for an expedited external appeal with the State of Michigan, Department of Insurance and Financial Services (DIFS). You must do this within 10 days of receiving MHP Community's appeal decision. MHP Community will provide the form required to file an expedited external review. These requests should be sent to DIFS:

**Mail:**

DIFS – Office of General Counsel – Appeals Section

P.O. Box 30220  
Lansing, MI 48909-7720

**Courier/Delivery service:**

DIFS – Office of General Counsel – Appeals Section  
530 W. Allegan St., 7<sup>th</sup> Floor  
Lansing, MI 48933-1521

**Toll Free Telephone:** 1 (877) 999-6442

**Fax:** 517-284-8838

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

[www.michigan.gov/difs](http://www.michigan.gov/difs)

When appropriate, DIFS will request a recommendation by an Independent Review Organization (“IRO”). The IRO is not contracted with or related to MHP Community. DIFS will issue a final order.

### 3.06 FORMULARY EXCEPTION REQUESTS – PRESCRIPTION DRUGS

**Definitions:**

**Exigency or Exigent Circumstance** means a Member is suffering from a health condition that may seriously jeopardize the Member’s life, health or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

**Formulary Drug** means a listing of US Food and Drug Administration (FDA) approved Prescription drugs that MHP Community has approved for use and are Covered under your Prescription Drug Coverage.

**Formulary Exception** means a decision by MHP Community or its agent that a Member is entitled to Prior Authorization of a Non-Formulary Drug.

**Non-Formulary Drug:** A Prescription Drug that is listed on the MHP Community Formulary as “Non-Formulary”. These drugs require Prior Authorization and have higher Copayments.

**Process:**

**Standard Formulary Exception Requests.**

A Member, a Member’s authorized representative, or a Member’s prescribing physician may request a Formulary Exception for a clinically appropriate Non-Formulary Drug. The request must include a justification supporting the need for the Non-Formulary Drug to treat the Member’s condition, including a statement that all Covered Formulary Drugs on any tier will be or have been ineffective, would not be as effective as the Non-Formulary Drug, or would have adverse effects. The request must include a justification supporting the need for the Non-



Formulary Drug to treat the Member's condition, including a statement that all Covered Formulary Drugs on any tier will be or have been ineffective, would not be as effective as the Non-Formulary Drug, or would have adverse effects.

MHP Community will make its determination on a standard Formulary Exception request and notify the Member or the Member's authorized representative and the prescribing physician within 72 hours following receipt of the request.

If MHP Community grants the Formulary Exception, Coverage of the Non-Formulary Drug will be provided for the until MHP Community Coverage Terminates or through the time period required by applicable law, whichever occurs first. Cost-sharing of an approved Formulary Exception Drug will be at the Tier 3 level.

#### **Expedited Formulary Exception Requests.**

When a Member, a Member's authorized representative, or a Member's prescribing physician believes that an Exigent Circumstance exists that requires immediate consideration by MHP Community of a Formulary Exception, the Member, the Member's authorized representative, or the Member's prescribing physician (or other prescriber, as appropriate) may submit a Formulary Exception request to MHP Community or MHP Community's designated agent. The request shall include an oral or written statement that (1) an Exigency exists and the basis for the Exigency (that is, the harm that could reasonably come to the Member if the requested drug were not provided within the timeframes specified by MHP Community's standard drug exceptions process), and (2) a justification supporting the need for the Non-Formulary Drug to treat the Member's condition, including a statement that all Covered Formulary Drugs on any tier will be or have been ineffective, would not be as effective as the Non-Formulary Drug, or would have adverse effects.

MHP Community will make a decision regarding the Formulary Exception request and notify the Member or the Member's designee and prescribing physician (or other prescriber, as appropriate) of its Coverage determination no later than 24 hours after it receives the request.

If MHP Community grants the Formulary Exception based on Exigent Circumstances, Coverage of the Non-Formulary Drug will be provided until MHP Community Coverage Terminates or the time period required by law, whichever occurs first. Cost-sharing of an approved Formulary Exception Drug will be at the Tier 3 level.

#### **External Exception Request Review.**

If MHP Community denies a request for a Formulary Exception (standard or expedited), a Member, a Member's authorized representative or a Member's prescribing physician may request a review by an independent review organization.

MHP Community will notify the Member, the Member's authorized representative and the Member's prescribing physician of the external review decision within 24 hours for an expedited request and within 72 hours for a standard request.

If MHP Community grants the Formulary Exception, Coverage of the Non-Formulary Drug will be provided for the until MHP Community Coverage Terminates or through the time period required by applicable law, whichever occurs first. Cost-sharing of an approved Formulary Exception Drug will be at the Tier 3 level.

### **3.07 MEMBERS' ROLE IN POLICY MAKING**

MHP Community's Board of Directors will include at least one individual who represents the MHP Community Membership. This individual(s) will be appointed by the Board or its designee.

### **3.08 CONTINUING CARE AS A RESULT OF TERMINATION OF A PARTICIPATING PROVIDER'S CONTRACT WITH MHP COMMUNITY**

#### **Definitions:**

#### **Continuing Care Patient**

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

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

#### **Serious and Complex Condition**

"Serious and Complex Condition" means, with respect to a Member -

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

#### **Process:**

A Participating Provider may choose to terminate his/her contract or arrangement with MHP Community. Therefore, MHP Community cannot guarantee that a given Participating Provider will be available to treat a Member during the entire time the Member Is Covered by MHP Community. If a Participating Provider informs a Member that the Provider will no longer be

contracting with MHP Community, the Member should contact MHP Community's Customer Service Department (at 1-888-327-0671) as soon as possible.

If a Participating Provider's contract or arrangement with MHP Community is terminated, a Member receiving services from the terminating Provider will be required to select a different Participating Provider in order to continue receiving Covered Services. However, a Member who is undergoing an ongoing course of treatment with the terminating Participating Provider may be eligible to continue to be treated by this Provider if:

- The continuation period is approved by MHP Community;
- The Provider is still available to continue treating Members;
- The Provider agrees to continue to accept as payment in full reimbursement from MHP Community at the rates applicable before the termination;
- The Provider agrees to adhere to MHP Community's standards for maintaining quality health care, and to provide to MHP Community necessary medical information related to the care;
- The Provider agrees to otherwise adhere to MHP Community's policies and procedures, including, but not limited to, those concerning utilization review, referrals, Preauthorizations and treatment plans; and
- The Provider is not leaving the MHP Community's Participating Provider network due to a failure to meet MHP Community's quality standards or because of fraudulent conduct.

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

- For up to 90 days after the Member receives notice that the Provider is leaving MHP Community's Participating Provider network;
- Through the second and third trimester of a pregnancy (in the case of a pregnant woman) and through the completion of post-partum care directly related to the pregnancy; or
- In the case of a Member with an Advanced Illness, through the remainder of the Member's life for treatment related to the Advanced Illness if the physician was treating the Advanced Illness before the date of termination or knowledge of the termination.

Notwithstanding anything to the contrary in this Section, MHP Community complies with applicable requirements in 42 USC 300gg-113 related to continuity of care. Specifically, if a Participating Provider contract is "terminated", as defined in 24 USC 300gg-113(b)(3), or if benefits under this Certificate with respect to the Participating Provider or Participating Facility are terminated because of a change in the terms of the participation of the Participating Provider or Participating Facility in the plan or coverage or if the contract between the Group and MHP Community is terminated, resulting in a loss of benefits provided under the plan with respect to a Provider or Facility, MHP Community will:

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

**NOTE:** This Section does not create an obligation for MHP Community to provide Coverage beyond the maximum Coverage limits permitted under this Certificate.

### **3.09 INFORMATION USED TO DETERMINE MEDICAL NECESSITY**

You have the right to request and ask for and be given, without cost, a copy of the actual benefit provisions, guidelines, protocol, clinical review criteria or other information used to determine Medical Necessity. All requests must be sent in writing to MHP Community Customer Service Department, G-3245 Beecher Road, Flint, MI 48532.

## **PART 4: FORMS, IDENTIFICATION CARDS, RECORDS AND CLAIMS**

### **4.01 FORMS AND APPLICATIONS**

Applicants and Members must complete and submit any applications, information or other forms that MHP Community requests within reason. You warrant that any information you submit is true, correct, and complete. If you intentionally submit false or misleading information to MHP Community or omit any requested information, it may be grounds for refusing an application or for rescinding or terminating your Coverage.

### **4.02 IDENTIFICATION CARD**

MHP Community issues identification cards to Members. You must present these cards whenever you receive or seek services from a provider. This card is the property of MHP Community. MHP Community may request that the card be returned at any time.

To be entitled to Benefits, the person using the card must be the Member for whom all Premiums have been paid. If a person is not entitled to receive services, the person must pay for the services received.

**If the card is lost or stolen, notify MHP Community immediately.**

### **4.03 MISUSE OF IDENTIFICATION CARD**

If any MHP Community Member does any of the following:

- Misuses the identification card;
- Repeatedly fails to present the card when receiving services from a provider;
- Permits another person to use the card; and/or
- Attempts to or defrauds MHP Community

MHP Community may confiscate the card, and all rights of the Member under this Certificate will Terminate on a date designated by MHP Community.

#### **4.04 MEMBERSHIP RECORDS**

- MHP Community will keep Membership records.
- MHP Community will not provide Coverage unless information is submitted in a satisfactory format by a Group or Member.
- Any incorrect information submitted to MHP Community may (and should) be corrected. You will be responsible for reimbursing MHP Community for any services paid by MHP Community as a result of the incorrect information.

#### **4.05 FILING A CLAIM**

When you receive Covered Services from a Participating Provider, you should not have to pay any amounts to the Participating Provider except for applicable Copayments, Coinsurance and Deductibles. You are not required to submit a claim form to MHP Community for Covered Services provided by a Participating Provider. Benefits are paid directly to the Participating Provider. However, you should always check with the Participating Provider to make sure that the Claim has been filed and that the services have been Preauthorized.

You are responsible for the costs of any services you receive from a Non-Participating Provider, unless MHP Community Preauthorizes the services in advance, or for certain Covered Services related to a Medical Emergency. See Section 8.08 for details on when Emergency Coverage by a Non-Participating Provider.

#### **4.06 MEMBER REIMBURSEMENT**

There is no reason for you to pay a provider for Covered services under this Certificate (other than Copayments, Coinsurance and/or Deductibles), but if circumstances require that you do, and you can prove that you have, MHP Community will reimburse you for those Covered services at MHP Community's Reimbursement Amount. You must give us proof of payment that is acceptable to MHP Community. A statement that shows only the amount owed is not enough. You must send a bill that shows exactly what services were received, including applicable diagnosis and CPT codes, and date and place of service. Also, you must submit proof of payment. Claims must be submitted to MHP Community with one year from the date of service. Submit claims to MHP Community – Attn: Claims, G-3245 Beecher Rd., Flint, MI 48532. Claims submitted beyond one year from the date of service will be denied as untimely.

### **PART 5: TERMINATION OF COVERAGE**

#### **5.01 TERMINATION OF GROUP COVERAGE**

This Certificate and the contract between a Group and MHP Community will continue to be in effect for the period established by MHP Community and the Group. The agreement between the Group and MHP Community may be Terminated as follows:

- The Group or MHP Community may Terminate the Certificate with 30 days' written notice.

- Benefits for all Members of the Group will Terminate on the date the Certificate Terminates. Notice of Termination to the Group will serve as notice to Members of that Group, and any such notice will include the reason for Termination.
- This Coverage may be Terminated if the Group fails to pay the Premium by the due date. A grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the Coverage shall continue in force. However, if the Group is Terminated, any Benefits incurred by a Member and paid by MHP Community after the Termination effective date will be charged to the Group.
- The Coverage may be Rescinded (see Section 5.04) if the Group commits fraud against MHP Community.
- This Coverage may be Terminated if MHP Community exits the applicable market or the plan is terminated pursuant to applicable federal or state laws.
- This Coverage may be Terminated by MHP Community if the Group moves outside of the MHP Community Service Area or the Group ceases to be a member of an association through which the Group has achieved eligibility.

If this Certificate is Terminated, all rights to Benefits end on the date of Termination. MHP Community will cooperate with the Group to arrange for continuing care of Members who are hospitalized on the Termination date.

If a Group has outstanding Premium payments, it still owes the money to MHP Community for coverage in the past 12 months and must pay it to MHP Community.

## 5.02 TERMINATION OF A MEMBER'S COVERAGE

Coverage for a Member may also be Terminated for any of the reasons listed below with 30 days' notice. Such notice will include the reason for Termination and, if applicable, appeal rights, and is effective on the date specified by MHP Community.

- The Member no longer meets Eligibility requirements;
- This plan is withdrawn from the marketplace by MHP Community in accordance with state and federal laws;
- The Group's Coverage is Terminated;
- The Member refuses to cooperate with MHP Community in pursuing subrogation;
- The Member moves out of the MHP Community Service Area;
- The Member acts in an abusive or threatening manner, is obstructive to staff or other patients or intentionally misuses the MHP Community system.

Termination by a Member is only permitted in accordance with MHP Community and the Group's requirements and as otherwise required by applicable law.

## 5.03 RESCISSION OF COVERAGE

**Rescission of Group Coverage** means the Group Coverage ends retroactive to the date the Group committed fraud against MHP Community or a provider of Benefits, or intentionally misstated or intentionally withheld a materials fact. MHP Community will provide at least 30 days' notice of a rescission.

**Rescission of Individual Member's Coverage** means the Member's Coverage ends retroactive to the date a Member committed fraud against MHP Community or a provider of Benefits, or intentionally misstated or intentionally withheld a material fact. MHP Community will provide at least 30 days' notice of a Rescission. A Member may appeal a Rescission of Coverage by following the MHP Community Appeals Procedure. Fraud or intentional misstatement or withholding of a material fact includes:

- Intentional misrepresentation of the eligibility of a Member;
- Fraudulent use of the MHP Community ID card; or
- Fraudulent use of the MHP Community system.

**NOTE:** Any amounts paid by MHP Community after the events are due and owing from the Group or Member, as applicable.

#### **5.04 TIME LIMIT ON CERTAIN DEFENSES**

A. After three years from the date of issue of this Certificate, no misstatements, except fraudulent misstatements made by an applicant in his/her Application for Coverage under this Certificate, shall be used to void this Certificate or to deny a claim for loss incurred or disability commencing after the expiration of such three year period.

B. No claim for loss incurred or disability (as defined in the Certificate) commencing after three years from the date of issue of this Certificate shall be reduced or denied on the ground that a disease or physical condition not excluded from Coverage by name or specific description effective on the date of loss had existed prior to the effective date of Coverage of this Certificate.

#### **5.05 EFFECT OF TERMINATION OR RESCISSION**

If this Certificate is Terminated or is Rescinded by MHP Community, the Group or a Subscriber or the affected Member(s) will no longer have Coverage under this Certificate as of the effective date of Termination or Rescission specified by the Group or MHP Community. If a Member disagrees with a decision to Terminate or Rescind the Member's Coverage, the Member may appeal the decision following the MHP Community Member Appeals Procedure. Members will have Coverage under this Certificate until the effective date of Termination or Rescission. Under certain circumstances, a Member who loses Coverage under this Group Coverage may be eligible to enroll in an individual plan.

### **PART 6: CONTINUATION OF COVERAGE**

#### **6.01 LOSS DUE TO MOVING**

If you no longer meet Eligibility requirements because you move, but you are still eligible for Coverage according to your Group's guidelines, you have two choices. You must choose one of the following within 30 days to avoid a lapse in Coverage:

- You may apply in writing for a waiver of the residency requirement. The waiver must be approved by MHP Community; or
- You must transfer to your Group's alternate carrier, if any.

## 6.02 COBRA COVERAGE

COBRA is the continuation of Group Coverage, but at the Member's expense, for Members who lose eligibility. Most Groups with over 20 employees are required by federal law to offer this opportunity. The Group is the administrator of its COBRA plan. If you have questions, contact the Group.

**Note:** Groups with fewer than 20 employees, church-related groups, and federal employee groups are exempt from COBRA.

If your Group is subject to this federal law, and you are eligible for continuation Coverage under the law, the following information applies to you:

- You may apply and pay for Group continuation Coverage directly to your employer, but you must do so within the time limits allowed by law. You must also comply with other requirements of federal law.
- This Coverage may continue for up to 18, 29, or 36 months, depending on the reason for your initial eligibility.
- You are considered a Group Member for all purposes, including Termination for cause or Rescission; however, events that would otherwise result in loss of eligibility are waived to the extent that the federal law specifically allows continuation.
- Continuation Coverage and all Benefits cease automatically under any of the following:
  - The period allowed by law expires;
  - The Group stops offering MHP Community Coverage;
  - You begin coverage under any other plan (with some exceptions);
  - You become eligible for Medicare; or
  - You do not pay for your Coverage fully and on time.

## 6.03 OTHER AVAILABLE COVERAGE

If the Subscriber or a Family Dependent no longer meets eligibility requirements for this Group Coverage, an alternative to COBRA Coverage may be to purchase individual, non-group coverage directly from MHP Community or on the Michigan Health Insurance Marketplace. Additional information may be obtained from your employer. If you are interested in purchasing Coverage directly from MHP Community, contact our Customer Service Department at (888) 327-0671. If you are interested in purchasing a plan from the Michigan Marketplace, you can review coverage offered by MHP Community or another carrier at [www.HealthCare.gov](http://www.HealthCare.gov). In most cases, you must apply for individual coverage within 30 days of loss of coverage.



## **PART 7: GENERAL PROVISIONS**

### **7.01 NOTICE**

Except for the notices of Termination of Group Coverage which shall be provided directly to the Group on behalf of its employees and their Dependents, any notice that MHP Community is required to give its Members will be:

- in writing;
- delivered personally or sent by US Mail; and
- addressed to the Subscriber's last address on record.

### **7.02 CHANGE OF ADDRESS**

The Subscriber or Member must promptly notify MHP Community immediately of any change of a Member's address.

### **7.03 HEADINGS**

The titles and headings in your Certificate are not a part of the Certificate. They are intended to make your Certificate easier to read and understand.

### **7.04 GOVERNING LAW AND LEGAL ACTIONS**

This Certificate is made and will be interpreted under the laws of the State of Michigan and federal law where applicable. The parties consent to venue in Genesee County, Michigan of any action arising in whole or in part or in connection with this Agreement. A final judgment in any such action will be conclusive and may be enforced in other jurisdictions by suit on the judgment or in any other manner provided by law..

### **7.05 FILING A LAWSUIT AGAINST MCLAREN**

- Any legal action against MHP Community arising under ERISA must be brought within 120 days from the date of MHP Community's alleged violation of law. For all other legal actions, you may not begin legal action against us later than three years after the date of service of your claim. If you are bringing legal action about more than one claim, this time limit runs independently for each claim.
- You must first exhaust the grievance and appeals procedures, as explained in this Certificate, before you begin law action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable. (Members of ERISA qualified groups may bring an action for Benefits under Section 502 of ERISA, but only after completing the appeals process in Section 3.5 prior to filing a civil action.)
- You may not bring any action or lawsuit against MHP Community under this Certificate unless you give MHP Community 30 days advance notice with sufficient details to describe the nature of your action or lawsuit.
- If you are bringing legal action about more than one claim, this time limit runs independently for each claim.

**7.06 EXECUTION OF CONTRACT OF COVERAGE**

By using the MHP Community Coverage, you are agreeing to all terms, conditions and provisions of this Certificate.

**7.07 ASSIGNMENT**

The Benefits provided under this Certificate are for the personal benefit of the Members. They cannot be transferred or assigned to another person.

MHP Community is authorized to make payments directly to providers who have performed covered services for you. MHP Community also reserves the right to make payment directly to you. When this occurs, you must pay the provider and MHP Community is not legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your provider. You also cannot assign any claim or cause of action against MHP Community to any person, Participating Provider, Non-Participating Provider, or other insurance company. MHP Community will not pay any provider except under the provisions of this Certificate. If MHP Community accepts an assignment and pays a Non-Participating Provider, MHP Community may offset Benefits or payment to the provider by amounts that the provider owes MHP Community.

**7.08 MHP COMMUNITY POLICIES**

MHP Community may adopt reasonable policies, procedures, rules, and interpretations in order to administer this Certificate.

**7.09 FILING A LAWSUIT AGAINST MCLAREN**

- Any legal action against MHP Community arising under ERISA must be brought within 120 days from the date of MHP Community's alleged violation of law. For all other legal actions, you may not begin legal action against us later than three years after the date of service of your claim. If you are bringing legal action about more than one claim, this time limit runs independently for each claim.
- You must first exhaust the grievance and appeals procedures, as explained in this Certificate, before you begin law action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable. (Members of ERISA qualified groups may bring an action for Benefits under Section 502 of ERISA, but only after completing the appeals process in Section 3.5 prior to filing a civil action.)
- You may not bring any action or lawsuit against MHP Community under this Certificate unless you give MHP Community 30 days advance notice with sufficient details to describe the nature of your action or lawsuit.
- If you are bringing legal action about more than one claim, this time limit runs independently for each claim.

**7.10 YOUR CONTRACT**

Your Contract with MHP Community consists of all the following:

- This Certificate;
- The Schedule of Member Cost Sharing and Additional Limits of Coverage;
- The agreement between the Group and MHP Community;
- Any applicable Riders;
- The application signed by the Subscriber; and
- The MHP Community identification card.

**7.11 WAIVER BY AGENTS**

No agent or any other person, except a specifically authorized representative of MHP Community, has the authority to do any of the following:

- Waive any conditions or restrictions of this Certificate;
- Extend the time for making payment; or
- Bind MHP Community by making promises or representations or by giving or receiving any information.

**7.12 INFORMATION RECEIVED FROM MHP COMMUNITY CUSTOMER SERVICE**

Information received during a Customer Service call related to eligibility or Covered Services is not a guarantee of payment or verification of eligibility. If Customer Service provides you with a quote or estimate of the cost of Benefits, you are not permitted to rely on the quote or estimate. Customer Service cannot guarantee that a provider will bill the services as quoted. Any payment of Covered Services is subject to the terms, conditions, limitations and exclusions of the Certificate.

**7.13 AMENDMENTS**

This Certificate and the agreement between the Group and MHP Community are subject to amendment, modification, or termination. Such changes must be made in accordance with the terms of this Certificate or by mutual agreement between the Group and MHP Community, with regulatory approval, if required.

**7.14 MAJOR DISASTERS**

In the event of major disaster, epidemic or other circumstances beyond the control of MHP Community, MHP Community will try to perform its responsibilities under this Certificate to the extent it is practical, according to MHP Community's best judgment and within any limitations of facilities and personnel that exist.

If facilities and personnel are not available, causing delay or lack of services, there is no liability or obligation to perform the affected responsibilities.

Circumstances beyond MHP Community's control include, but are not limited to:

- Complete or partial disruption of facilities;
- Disability of a significant part of a facility or MHP Community personnel;
- War;
- Riot;
- Civil insurrection;
- Epidemic or pandemic; or
- Labor disputes not within the control of MHP Community.

#### **7.15 OBTAINING ADDITIONAL INFORMATION**

The following information is available from MHP Community by writing to MHP Community at G-3245 Beecher Road, Flint, MI 48532:

- The current provider network;
- The professional credentials of the Participating Providers with MHP Community;
- The names of Participating Hospitals where individuals Participating Physicians have privileges for treatment;
- How to contact the appropriate Michigan agency to obtain information about complaints or disciplinary actions against a health care provider
- Information about the financial relationships between MHP Community and a Participating Provider.

#### **7.16 CLERICAL ERRORS**

Clerical errors, such as an incorrect transcription of effective dates, termination dates, typographical errors, or mailings with incorrect information will not change the rights or obligations of you and MHP Community 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.

#### **7.17 WAIVER**

If you or MHP Community waives any provision of this Certificate, you or MHP Community 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.

#### **7.18 ERISA PLANS**

For Groups covered by the Employee Retirement Income Security Act, ("ERISA"), MHP Community only acts in a capacity of processing and paying claims and handling appeals. MHP Community is not the Plan administrator as defined by ERISA. The Plan (or its designee) serves as the ERISA required Plan administrator and is responsible for: advising individuals covered under the Plan regarding their rights and Benefits under the Plan (including COBRA rights). MHP Community is the named claims administrator for ERISA Plans but is not a named fiduciary for

any purpose under ERISA. If you have questions about your welfare Benefit plan, you should contact the Group. If you have any questions about this Section, or about your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor.

## **7.19 INDEPENDENT CONTRACTORS**

MHP Community does not directly provide any health care Services under this Certificate. MHP Community has no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by health professionals in consultation with you. Participating Providers and any other health professions providing health care Services under this Certificate do so as independent contractors. MHP Community is not responsible for any treatment decisions, actions, omissions, or outcomes related to a Participating Provider or other health care professional.

## **7.20 COMPLIANCE WITH LAWS**

MHP Community will comply with all applicable state and federal laws and regulations, and where this Certificate does not comply with an applicable law or regulation, it will be deemed amended to the extent necessary to comply with such law.

## **7.21 SURPRISE BILLING**

Applicable Surprise Billing Laws require MHP Community to pay Non-Participating Providers certain rates for Covered Services and prohibit those providers from billing you the difference between what we pay and what the Non-Participating Provider charges. When an Applicable Surprise Billing Law applies, you will only pay the In-Network Cost Sharing applicable to that service. The following situations are covered by Applicable Surprise Billing Laws:

- Covered Emergency Services at a Participating or a Non-Participating Facility subject to an Applicable Surprise Billing Law;
- Covered non-Emergency services rendered by a Non-Participating Provider at certain Participating Facilities
- Certain Covered Air Ambulance services (see Section 8.7 below)

The following applies for Non-Emergency Services furnished by a Non-Participating Provider at a Participating Facility (to the extent required by applicable law) and for Emergency Services are provided by a Non-Participating Provider or at a Non-Participating Emergency facility covered under Applicable Surprise Billing Laws:

- No administrative requirement or limitation may apply that is more restrictive than in-network coverage;
- Cost-Sharing requirements must not exceed in-network requirements and are calculated based on Michigan's Surprise Medical Billing law if applicable, and if inapplicable, the lesser of the billed amount and the Qualifying Payment Amount is used to calculate Cost-Sharing as required by Applicable Surprise Billing Laws;
- Cost-Sharing must be applied to in-network Deductible and Out-of-Pocket Maximum; and

- Direct payment to provider or facility is required and is calculated based on Michigan's Surprise Medical Billing law if applicable, and if inapplicable, payment is determined through federal negotiation and independent dispute resolution process.

**Note:** Please review Section 8.08 for more information regarding Emergency Services.

**Note:** Surprise Billing protections can be waived by the Member if the provider complies with the notice and consent criteria under Applicable Surprise Billing Laws. (When the federal surprise billing rules apply, this does not apply to Ancillary Services as defined under 45 CFR 149.420).

## **PART 8: YOUR BENEFITS**

### **8.01 COPAYMENTS, COINSURANCE AND DEDUCTIBLES**

You are responsible for Copayments (Copay), Coinsurance or Deductibles for many of the Benefits listed. Copayments, Coinsurance or Deductibles may apply to physician, Inpatient and Outpatient services. You pay the specified amount at the time you receive the services. The Copayment, Coinsurance and Deductible amounts are listed in your Schedule of Member Cost Sharing and Additional Limits of Coverage.

### **8.02 PREAUTHORIZATION AND UTILIZATION REVIEW**

#### **8.02.01 PREAUTHORIZATION REQUIREMENTS**

**Preauthorization Requirements:** Certain services and supplies require Preauthorization by MHP Community before they will be Covered under either Option A or Option B. Part 8 of this Certificate and the Sections of Part 8 pertaining to specific services describe in further detail these services and supplies, or you may contact Customer Service for additional information. Participating Providers can assist you in obtaining Preauthorization from MHP Community, but the Member is ultimately responsible to ensure any necessary Preauthorization is obtained. If MHP Community Preauthorizes a service, we will notify your PCP or the provider who makes the request.

If you obtain services from a Non-Participating Provider, they will usually be Covered under Option B. **Please note**, however, that certain services must be Preauthorized by MHP Community in order to be Covered under Option B. For those services, a referral from your PCP or another Participating Provider is not enough if you want the services to be Covered; they must be Preauthorized by MHP Community.

Any information received during a call by you or your Provider related to a Pre-Authorization from MHP Community Customer Service or your nurse case manager is not a guarantee that your services will be Pre-Authorized. Except for urgent preauthorization services where MHP Community notifies you verbally within 72 hours after receiving a request, a Preauthorization request is only valid if in writing by MHP Community.

The complete and detailed list of services requiring Preauthorization is available by calling our Customer Service Department or visiting our website at [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org). The list

may change throughout the Plan Year as new technology and standards of care emerge. Also refer to the specific Benefits in Part 8 of this Certificate to see if a Preauthorization is required. Below are the general categories of services and supplies that require Preauthorization by MHP Community:

- Inpatient and long term acute Hospital services, including inpatient mental health or substance abuse treatment;
- Skilled nursing home;
- Outpatient Hospital and clinic services for dorsal spinal stimulators;
- Oral surgery, TMJ treatments and orthognathic surgery;
- Special surgical procedures (see Section 8.14);
- Durable medical equipment (DME) costing more than \$3,000.00;
- Prosthetics, orthotics and corrective appliances costing more than \$3,000.00;
- Insulin pumps and continuous glucose monitors (CGMs);
- Genetic testing (including BRCA testing Covered under Section 8.05);
- Autism services and Applied Behavioral Analysis (ABA Therapy);
- Electroconvulsive therapy (ECT);
- Nuclear medicine testing, MRI, CT and PET scans;
- Non-emergency ground ambulance services;
- Residential Mental Health services;
- Residential Substance Abuse services;
- Partial Hospitalization for mental health services;
- Partial Hospitalization for substance abuse services;
- Organ and tissue transplants;
- Habilitative services, including Habilitative services for Treatment of Autism Spectrum Disorder;
- Outpatient Rehabilitation Services;
- Voluntary sterilization procedures;
- Termination of pregnancy;
- Infertility treatment;
- Gender reassignment surgery;
- Proton beam radiation;
- Photo chemotherapy;
- Home health care;
- Hospice;
- Inpatient hospice care
- Select injectable and infusion medications provided in the office setting or in an infusion center;
- Pain management services;
- Certain Prescription Drugs;
- Gene Therapy - Cellular and Gene therapy, intended to restore defective or insufficient structural or functional proteins (treatment is limited to once per lifetime regardless of insurance coverage at the time of initial treatment.);
- Certain Prescription Drugs.

### Timing of Request and MHP Community Response

**Definition: Urgent Preauthorization Request** means a request for medical care or treatment for which resolution within MHP Community's normal time frames, due to the medical status of the Member, would seriously jeopardize the life or health of the Member or the ability to regain maximum function, or, in the opinion of the treating Provider, would subject the Member to severe pain that could not be adequately managed without the requested service.

- Except for Urgent Preauthorization Requests, if Preauthorization is required for a service, Preauthorization must be requested at least five business days prior to obtaining the services.
- If the requested service is an Urgent Preauthorization Request, the request for Preauthorization should be submitted to MHP Community by the treating Provider as early in advance of the service as possible. Requests for Urgent Preauthorizations may be made by telephone.

For most non-Urgent Preauthorization Requests, MHP Community or its designee will make a decision within 14 days after receiving the request. For Urgent Preauthorization Requests, MHP Community or its designee will make a decision as expeditiously as possible considering the medical condition of the Member, but no later than within 72 hours after receiving the request. MHP Community may extend the 72-hour maximum response time if the Member fails to provide MHP Community with necessary information.

**Denial of Request for Preauthorization:** If a Member disagrees with a decision regarding a Preauthorization request, the Member or his/her treating practitioner or designee may contact MHP Community to request a re-evaluation of the decision or utilize the appeal process described in Section 3.05 under the heading, **Standard Internal Appeals**.

A Member may request an expedited appeal for denials of Urgent Preauthorization Requests. See Section 3.05, under the heading, **Expedited Appeals**.

### 8.02.02 UTILIZATION REVIEW

MHP Community conducts utilization reviews when you are admitted to any acute care Hospital or other non-acute care facility to assure that you are receiving the right care in the right setting. Utilization reviews are performed on-site at facilities and/or by telephone, including review of medical record information and according to the following timeframes established in MHP Community's utilization review policies:

- Acute care Hospital for a Medical Emergency or Urgent Care admission – upon admission or notification of admission
- Acute care Hospital continued stay – at day 3 or sooner as determined by your condition and plan of treatment, and every 1 – 5 days thereafter until discharge
- Non-acute care facility admission – upon admission
- Non-acute care facility continued stay – 7 – 14 day intervals or sooner as determined by your condition or plan of treatment



### 8.03 OPTION A BENEFITS

Option A works like a traditional HMO. Under this option, your PCP coordinates your medical care and obtains any necessary Preauthorization. All of your health care is provided for the lowest out-of-pocket expense to you. In most cases, in order to receive Option A Benefits, you must obtain Covered Services from a Participating Provider and obtain any necessary Preauthorization from MHP Community (see Section 8.02.01).

### 8.04 OPTION B BENEFITS

Option B Benefits allows you to choose to receive services from non-Participating Providers. In exchange for this flexibility, the out-of-pocket expenses are higher than under Option A. If you choose to receive services from a non-Participating Provider, you may incur costs higher than those received from a Participating Provider, even if the services are identical. In some cases, you may have to pay the price difference between the cost of the services and what MHP Community pays a Participating Provider for the service ("Balance Bill"). These costs can be significant, which is why it is important to understand your liability when using a non-Participating Provider.

Option B does not waive the requirement for Preauthorization for certain services. (See Section 8.02.01, review the specific service in this Certificate, and call Customer Service for a complete, up-to-date list of services requiring Preauthorization.) If Preauthorization is not received from your PCP and MHP Community for those services, no Coverage will be provided.

**Note:** Certain services listed in this Certificate are not Covered under Option B. Refer to the Section of this Certificate specific to the service you wish to have Covered and the Schedule of Member Cost Sharing and Additional Limits of Coverage. If services are not Covered under Option B and you choose to obtain those services from a non-Participating Provider, MHP Community will not Cover the services.

### 8.05 PREVENTIVE SERVICES

Preventive Services are screenings, immunizations, lab tests and other services that have been recommended by the United States Preventive Services Task Force that help prevent illness or help finding diseases or medical conditions before you experience symptoms. Some services are Preventive Services only for specified age groups or genders.

Under Option A, Preventive Services are Covered in full with no Deductible, Coinsurance or Copayment. Additionally, to the extent required by law, items and services that are integral to the furnishing of a Covered Preventive Service are covered in full with no Copayment, Coinsurance or Deductible. In some cases, Preventive Services will be Covered only if provided by a limited panel of MHP Community-designated Preferred Providers. That information is available to Members by viewing the Provider Directory at [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org) or by calling Customer Service at (888) 327-0671.

Under Option B, Preventive Services are either not Covered or are Covered with Member cost sharing. Refer to the specific service in this booklet, any Riders and your Schedule of Member Cost Sharing and Additional Limits of Coverage.

The list of Preventive Services is updated by the U.S. Preventive Services Task Force on a regular basis. Therefore, the information below may change. Where there is an update to a recommendation, coverage will be provided for the Plan Year beginning on or after one year after the date the recommendation is issued.

MHP Community Covers the following general categories of Preventive Services:

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

More detailed information is available on MHP Community's website at [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org), or visit the USPSTF website at <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/> or [www.HealthCare.gov](http://www.HealthCare.gov). This information may also be obtained by calling Customer Service at (888) 327-0671.

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

### **Physical Exams**

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

### **Immunizations**

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

### Assessments and screenings Newborn to age 21

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

- Developmental screening
- Hearing loss screening
- Vision screening
- HIV screening for adolescents
- Sexually transmitted infection screening for sexually active adolescents
- Depression screening for adolescents
- Screening and counseling for obesity

### Preventive services for women

Service	Who	Frequency
Obesity prevention in midlife women	Women age 40 to 60 with normal or overweight body mass index	As needed
Well-woman visits (includes pre-pregnancy, prenatal, postpartum and interpregnancy visits)	Adult women	Annually and as needed
Gestational diabetes screening	Women 24-28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
Breast Cancer Screening (mammography only)	Women aged 40 to at least age 74	Annually or every 2 years
Cervical Cancer Screening (Pap Test)	Women aged 21 to 30 years	Every 3 years
Cervical Cancer Screen (Pap test and Co-Testing for (HPV))	Women aged 30 to 65 years	Every 3 years for Pap Test alone or Col-testing for HPV every 5 years
Sexually transmitted infection (STI) counseling	Sexually-active women	Annually
HIV screening and counseling	<ul style="list-style-type: none"> <li>• Women aged 15 and older</li> <li>• Sexually-active women</li> </ul>	<ul style="list-style-type: none"> <li>• At least once during their lifetime</li> <li>• Annually, or as appropriate</li> </ul>
Risk Assessment and Prevention Education for HIV infection	Women aged 13 and older	As needed
Contraceptive methods*, sterilization procedures and patient education and	Sexually-active women	As needed

counseling (including instruction in fertility awareness-based methods, including lactation amenorrhea)		
Breastfeeding support, supplies (including a double electric breast pump and breast milk storage supplies) and counseling	Pregnant and postpartum women	Per pregnancy
Interpersonal and domestic violence screening and counseling	All adolescent and adult women	At least annually and as needed

**\*Note:** “Contraceptive methods” include Coverage for contraceptive medications, devices and appliances that are Benefits and prescribed by a provider and obtained through a Participating pharmacy. Additional terms and conditions of Coverage for contraceptive medications are found in Section 8.33, Prescription Drug Coverage. Some devices and appliances (e.g., IUD’s) are Covered under your medical Benefits and are subject to the medical conditions of Coverage. Please contact Customer Service at (888) 327-0671 for additional information, and review your drug Formulary at [www.mclarenhealthplan.org](http://www.mclarenhealthplan.org).

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

can obtain Coverage for the medically necessary contraceptive service or product without cost sharing.

### **Assessments and screenings for adults**

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

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

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

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

### **Educational Services**

These services include:

- Education conducted by Participating Providers about managing Chronic disease states such as diabetes or asthma; and
- Maternity education programs. These programs are available through MHP Community. For more information regarding these services call Customer Service at (888) 327-0671.

### **Tobacco Use Counseling and Interventions for Adults**

These services include:

- Screening for tobacco use.
- Tobacco cessation Prescription Drugs (See Section 8.33, Prescription Drug Coverage.)

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

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

- Oral fluoride supplements
- Folic acid supplements
- Iron supplements

Refer to Section 8.33, Prescription Drug Coverage, for Coverage information.

**General Limitations:**

Members should note that preventive screenings furnished more than once a Plan Year or more frequently than the time period specified, and/or done before or after the age indicated are not deemed to be Preventive Services and the Member will be responsible for paying any applicable Copayment, Coinsurance or Deductible for such services. Services that are performed for diagnostic purposes (as opposed to screening purposes) are not Preventive Services, and the Member will be responsible for paying any applicable Copayment, Coinsurance or Deductible for such services.

**8.06 PROFESSIONAL PHYSICIAN SERVICES (NON-MENTAL HEALTH AND SUBSTANCE ABUSE)**

The following services are Covered when provided by a Participating Provider (including Participating Providers who are specialists), Medically Necessary and, as necessary, Preauthorized by MHP Community. **Note:** These services are also Covered when provided by other practitioners (nurses, nurse practitioners or physicians' assistants) when such services are within their licensed scope of practice.

**8.06.01 PHYSICIAN OFFICE VISITS**

Includes:

- Hearing exams
- Diabetes education
- Vision exams
- Home visits
- Specialist visits
- Emergency care
- Consultations
- OB/GYN services (Female Members have the right to obtain routine OB/GYN services without a referral if the OB/GYN is a Participating Provider.)
- General pediatric care

**8.06.02 IMMUNIZATIONS****Covered Services**

Immunizations that are included as Preventive Services are Covered pursuant to Section 8.05. Please refer to the complete list of Preventive Services at [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org) or call Customer Service at (888) 327-0671.

All other immunizations are Covered under Option A only with Copayments, Coinsurance and/or Deductibles detailed in the Schedule of Member Cost Sharing and Additional Limits of Coverage.

**8.06.03 MATERNITY CARE AND NEWBORN CARE – INCLUDING PRENATAL AND POSTNATAL****Covered Services:**

- Hospital and physician care: Services and supplies furnished by a Participating Hospital or other Participating Provider, including a licensed midwife, for prenatal care, including genetic testing, postnatal care, Hospital delivery and care for the complications of pregnancy are Covered. Some prenatal and postpartum services are Covered as a Preventive Services with no Deductible. Refer to Section 8.05 or call Customer Service at (888) 327-0671.

**Note:** Preauthorization is not required for the minimum hospital stay described below. Hospital length of stay begins at the time of delivery, if the delivery occurs in a Hospital, and at the time of admission in connection with childbirth if the delivery occurs outside the Hospital.

Minimum Hospital Stay: The mother and Newborn have the right to an inpatient stay of no less than 48 hours following a normal vaginal delivery or no less than 96 hours following a cesarean section. If the mother and her attending physician agree, the mother and the Newborn may be discharged from the Hospital sooner.

- Newborn child care: Inpatient medical or Hospital services for a healthy newborn following delivery is Covered as a part of the Member mother's Coverage through the date of discharge of the Member mother or the newborn, whichever first occurs. If you want the newborn's Coverage to continue beyond such discharge, you must add the child to your Coverage within 30 days after the child is born.

**Exclusions:**

- All maternity care, including prenatal services, delivery services and postpartum care, provided while you are outside of the Service Area are Covered under Option B only. MHP Community does not consider a routine delivery to be a Medical Emergency.
- Services and supplies received in connection with an obstetrical delivery in the home or free-standing birthing center are not Covered.

**8.06.04 INJECTABLE DRUGS PROVIDED IN THE OFFICE**

**Note:** Certain medications that are injected in the provider's office require Preauthorization. Examples include, but are not limited to: injections related to chronic diseases such as multiple sclerosis, rheumatoid arthritis, hepatitis and colitis.

**8.07 SPINAL TREATMENT****Covered Services:**

- Detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects.
- Other services related to treatment, including diagnosis and x-rays.

**Limitations:**

- The interference, as stated above, must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.
- Treatment must be provided by a Spinal Treatment provider in the provider's office.
- Spinal Treatment benefits are limited to twenty-four (24) visits per Plan Year.
- Spinal Treatment benefits are limited to one (1) visit and treatment per day.

**8.08 EMERGENCY AND URGENT CARE****Definitions:**

**Medical Emergency** – The sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, without limiting what constitutes an emergency medical condition solely based on diagnosis codes, as required by applicable Federal Law.

**Accidental Injury** – A traumatic injury, which if not immediately diagnosed and treated, could be expected to result in permanent damage to your health.

**Emergency Services** – Services provided in Hospitals or freestanding emergency departments to treat emergency conditions as described above.

**Stabilization** – The point at which no material deterioration of a condition is likely, within reasonable probability, to result from or occur during your transfer.

**Urgent Care or Urgent Care Center** – Care provided at an Urgent Care Center instead of a Hospital emergency room, when you need immediate care to treat a non-life threatening illness or injury to limit severity and prevent complications.



**Covered Services:**

- Items and Services for a **medical emergency or accidental injury**, including mental health or substance abuse-related medical emergencies, are Covered up to the point of stabilization when they are Medically Necessary and needed immediately to treat a medical emergency as defined above. Preauthorization is not required. NOTE – some post-stabilization services are subject to and may be subject to Applicable Surprise Billing Laws
- Items and Services for **medical emergency or accidental injury**, including mental health or substance abuse-related medical emergencies, are Covered when provided by a Participating Provider or non-Participating Provider. A Member's cost sharing (Copayment, Coinsurance or Deductible) is the same whether the services are provided by a Participating or Non-Participating Provider. However, unless an Applicable Surprise Billing Law applies, when services are provided by a non-Participating Provider, the Member will be responsible for any Balance Bill (the difference between the Reimbursement Amount paid by MHP Community and the amount of the non-Participating Provider's charges). Your applicable cost sharing (Copayment, Coinsurance, or Deductible) will apply even if you are directed or otherwise referred to the emergency room by your physician.
- Items and Services for treatment of an illness or injury that needs immediate attention, such as cuts or sprains, that is not as serious as a medical emergency, are Covered under **urgent care**. You should call your PCP before you seek urgent care. Your PCP will help you determine the best place to go for care. If you are out of the Service Area at that time, your PCP will determine if you can wait for those services and supplies until you could reasonably return to receive them from a Participating Provider. If you cannot reach your PCP's office and your illness or injury needs urgent care, go to an urgent care center or Hospital emergency room. Present your ID Card and be prepared to pay the required Copayment, Coinsurance or Deductible. Preauthorization is usually not required.

**Limitations:**

- In case of such a **medical emergency or accidental injury**, you should seek treatment at once. We urge you, the Hospital, or someone acting for you to notify MHP Community within 24 hours, or as soon as medically reasonable.
- **Emergency services** are no longer payable as emergency services at the point of the patient's stabilization as defined above.
- If you receive urgent care services from a Non-Participating Provider, contact your PCP's office as soon as possible so your PCP can arrange follow-up treatment. Do not return to the urgent care center or emergency room for follow-up care unless it is an urgent situation or medical emergency. Any follow-up care that is provided by a Non-Participating Provider must be Preauthorized by MHP Community in order to be

Covered.

- **Out-of-Area Emergency Hospitalization:** If you are hospitalized in a non-MHP Community affiliated facility or one that is outside of our Service Area, we may require that you be transferred to a Participating Hospital or another facility within our Service Area as soon as you are stabilized.

## 8.09 AMBULANCE

An ambulance is a vehicle specially equipped and licensed for transporting injured or sick persons. Emergency ground and air ambulance services that meet the requirements described below do not require Preauthorization. Non-emergency ground ambulance services require Preauthorization.

### Covered Services:

The following ambulance services are Covered:

- Non-emergency Medically Necessary ground ambulance services to transport a Member from one facility to another.
- Emergency ground ambulance services when:
  - You are admitted as an inpatient to the Hospital immediately following emergency room treatment.
  - The services are necessary for management of shock, unconsciousness, heart attack or other condition requiring active medical management.
  - The services are needed for emergency delivery and care of a Newborn and mother. See Exclusions below.
  - The ambulance is ordered by an employer, school, fire, or public safety official and you are not in a position to refuse.
- Air ambulance for emergency transport is Covered to the nearest Hospital equipped to treat your condition only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Your symptoms at the time of transport must meet these requirements and the additional requirements for a ground ambulance Coverage and must be verified by the records of the physician who treats you and by the ambulance company.
- For Covered emergency air ambulance transportation, MHP Community complies with Applicable Surprise Billing Laws. Those laws generally include the following requirements:
  - Cost-Sharing requirements must be the same as in-network requirements (see your Schedule of Cost Sharing);
  - Cost-Sharing requirements are calculated based on the lesser of the billed amount and the Qualifying Payment Amount;
  - Cost-Sharing must be applied to in-network Deductible and Out-of-Pocket Maximums; and
  - Payment to providers is made in accordance with applicable laws

**Exclusions:**

- Ambulance services for normal or false labor are not Covered.
- Ambulance services when the Member's condition does not require ambulance transport.
- Ambulance services without transportation are not Covered.
- Transportation and/or medical services provided by public first responders to accidents, injuries or emergency situations including fire or police departments costs, or any associated services provided as part of a response to an accident or emergency situation, like accident clean-up or 911 costs are not a covered Benefit. This is because these services are part of public programs supported totally or in part by federal, state or local governmental funds.
- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
- Air ambulance services when the Member's condition does not require air ambulance transport
- Air ambulance services when a hospital or air ambulance provider is required to pay for the transport under the law.
- Air ambulance services must be provided by a licensed air ambulance company and not a commercial or private airline.

**8.10 INPATIENT AND LONG-TERM ACUTE HOSPITAL SERVICES**

The following Hospital and long-term acute Inpatient Services are Covered when Medically Necessary and when the inpatient admission has been Preauthorized by MHP Community:

- Semi-private room and board, general nursing services, and special diets. Note: A private room is Covered only when Medically Necessary and Preauthorized by MHP Community;
- Operating and other surgical treatment rooms, delivery rooms, and special care units;
- Surgery;
- Professional services, including surgical services;
- Anesthesia, laboratory, radiology and pathology services;
- Chemotherapy, inhalation therapy and hemodialysis;
- Infusion therapy;
- Physical, speech and occupational therapies;
- Other Inpatient Services and supplies necessary for the treatment of the Member;
- Maternity care and routine nursery care of Newborn (see Sections 8.06.03 – "Maternity Care and Newborn Care" and 9.11 for limitations); **Note: Maternity Inpatient Hospital Service Preauthorization requirements are described in Section 8.06.03.**

**Exclusions:**

- Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.
- Sleep studies must be performed in the outpatient setting.
- Non-emergency hospital inpatient stays must Preauthorized in advance by us.

**Note** – An overnight stay for Observation Care may be considered outpatient care.

**Note** – If you are admitted to Hospital Inpatient Care from an emergency room visit, the charges for emergency room services are Covered under the Hospital Inpatient Care benefits and cost sharing described in your Schedule of Cost Sharing. If you are admitted to Observation Care from an emergency room visit, the charges for emergency room services are Covered under the outpatient care benefits and cost sharing described in your Schedule of Cost Sharing.

## 8.11 OUTPATIENT SERVICES

### Covered Services:

Facility and professional (physician) therapeutic and non-preventive diagnostic laboratory, pathology and radiology services and other procedures when performed in a Participating provider setting, including outpatient Hospital setting, physician office, free standing center, or dialysis center for the diagnosis or treatment of a disease, injury or other medical condition when Medically Necessary and, where required, Preauthorized by MHP Community. See Section 8.02.01 for Preauthorization requirements. Outpatient Hospital services include the following:

- Outpatient surgery;
- Outpatient CT scans, PET scans, MRI and nuclear medicine;
- Colonoscopy (**Note:** Preventive Colonoscopies are Covered under Section 8.05);
- Outpatient procedures for treatment of breast cancer, including outpatient surgery, chemotherapy and radiation treatment;
- Outpatient hemodialysis;
- Professional Services including physician surgical services; also see Professional Physician Services section; and
- Outpatient infusion therapy.

**Note** – Observation Care received after an emergency room visit is considered to be outpatient care under this Certificate.

## 8.12 DIAGNOSTIC AND THERAPEUTIC SERVICES AND TESTS

MHP Community Covers Medically Necessary and, as applicable, Preauthorized therapeutic and diagnostic laboratory, pathology and radiology services, and other procedures for the diagnosis or treatment of a disease, injury or medical condition. See Section 8.02.01 for Preauthorization requirements.

Diagnostic and therapeutic services and tests that are included as Preventive Services are Covered pursuant to Section 8.05. Please refer to the complete list of Preventive Services at [www.McLarenHealthPlan.org](http://www.McLarenHealthPlan.org) or call Customer Service at (888) 327-0671. All other such services may be subject to Copayments, Coinsurance and/or Deductibles. Please refer to your Schedule of Member Cost Sharing and Additional Limits of Coverage.

Diagnostic and therapeutic services and tests include the following:

- Pathology services and laboratory tests; and
- Diagnostic procedures.

### 8.13 ORGAN AND TISSUE TRANSPLANTS

An organ or body tissue transplant is Covered when:

- It is Preauthorized by MHP Community;
- It is considered non-experimental in accordance with generally accepted medical practice;
- It is Medically Necessary; and
- It is performed at an MHP Community approved facility.

Coverage is provided for related drugs for treatment of cancer pursuant to Section 8.30 of this Certificate.

For a Preauthorized transplant, MHP Community also Covers the necessary Hospital, surgical, lab and x-ray services for a non-Member donor, unless the non-Member donor has coverage for such services.

**Exclusion:** Services provided at a non-MHP Community designated Participating facility.

### 8.14 SPECIAL SURGICAL PROCEDURES

MHP Community Covers surgical procedures typically considered cosmetic in nature only when they are provided by a Participating Provider, are Medically Necessary and are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. In order for these services to be Covered, you must meet nationally recognized medical necessity criteria and must be Preauthorized by MHP Community. These services may include:

- Morbid obesity weight loss surgery
- Reduction mammoplasty
- Blepharoplasty of upper eyelids
- Panniculectomy
- Surgical treatment of male gynecomastia
- Procedures to correct obstructive sleep apnea
- Rhinoplasty
- Breast reconstruction following mastectomy

**Note:** Covered Benefits for breast reconstruction include:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prosthetics (Covered under Section 8.23); and
- Care for physical complications from all stages of the mastectomy including lymph edemas.

## **8.15 SKILLED NURSING FACILITY SERVICES**

### **Covered Services:**

Up to 120 days skilled nursing care in any Plan Year in a skilled nursing facility are Covered when Medically Necessary for recovery from surgery, disease or injury.

### **Limitations:**

- The services must be Preauthorized by MHP Community to be Covered.
- The Benefit is limited to 120 days in any Plan Year.

### **Exclusions:**

- Custodial care is not Covered.

## **8.16 HOME CARE SERVICES**

### **Covered Services:**

Covered home care services include skilled nursing care and other health care services performed in the Member's home. Home care services are Covered up to 60 visits per Plan Year when Medically Necessary.

### **Limitations**

- Home care services are Covered up to 60 visits per Plan Year
- All services must be Preauthorized by MHP Community

### **Exclusions:**

- Habilitative Services or Rehabilitative Services. Habilitative Services and Rehabilitative Services provided in the home are subject to the Coverage provisions and limitations described in Sections 8.20 and 8.21 of this Certificate
- Housekeeping services
- Services that are primarily for the purpose of providing long-term custodial care

## **8.17 PRIVATE DUTY NURSING**

### **Covered Services:**

Private Duty Nursing is provided for Members who required skilled care and individualized and continuous (24 hours) nursing care. Placement of a nurse in the home is Covered only to meet

the skilled care needs of the Member, and is more intense than Benefits available under the Home Care Services Benefit.

**Limitations:**

- Services must be prescribed for the treatment of an illness or an injury by a Participating Provider, Preauthorized by MHP Community and provided by a MHP Community-approved Provider; and
- The Member must meet the general and medical criteria as established by MHP Community.

**Exclusions:**

- Non-skilled care or care provided by a nurse who ordinarily resides in the Member's home or is a member of the immediate family is not Covered.
- Placement of a nurse in the home for the convenience of the family caregiver or to provide custodial care is not Covered.

## **8.18 HOSPICE CARE**

We provide Coverage to Members with an Advanced Illness through a hospice program. Hospice care includes physical, psychological, social and spiritual care for the Member with an Advanced Illness, and short-term grief counseling for immediate family members.

**Exclusions:**

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

## **8.19 MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES**

### **8.19.01 MENTAL HEALTH SERVICES**

**Definitions:**

**Inpatient Mental Health Service** is the service provided during the time a Member is admitted to a MHP Community approved acute care facility that provides continuous 24-hour nursing care for comprehensive treatment.

**Outpatient Mental Health Services** include individual, conjoint, family or group psychotherapy and crisis intervention.

**Partial Hospitalization** is an intensive, non-residential level of service provided in a structured setting, similar in intensity to Inpatient treatment. A Member is generally in treatment for more than four (4) hours but generally less than eight (8) hours daily. These services are included as

“Inpatient Mental Health Services” in the Schedule of Copayments and Deductibles.

**Residential Mental Health Treatment** is treatment that takes place in a licensed mental health facility that has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 to assist with medical issues, administration of medication and crisis intervention as need. The treatment team is multidisciplinary and led by board certified psychiatrists. Residential Mental Health Treatment is included as “Inpatient Mental Health Services” in the Schedule of Member Cost Sharing and Additional Limits of Coverage. Residential treatment is:

- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
- A structured environment that will allow the individual to successfully reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as a long term means of protecting others in the member’s usual living environment; and
- Not based on a preset number of days such as standardized program (e.g., “30-Day Treatment Program”).

**Coverage:**

This plan Covers evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for mental health conditions. Coverage is provided for Medically Necessary Inpatient Mental Health and Outpatient Mental Health Services, Partial Hospitalization and Residential Mental Health Treatment as defined above. Mental Health Emergency Services are Covered pursuant to Emergency and Urgent Care Coverage. (See Section 8.08)

**Limitations:**

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

**Exclusions:**

- Care provided in a non-licensed residential or institutional facility, or other facility on a temporary or permanent basis is not Covered, including the costs of living and being cared for in:
  - Transitional living centers;
  - Domiciliary foster care facilities;
  - Therapeutic boarding schools;
  - Milieu therapies such as recreational or wilderness therapy programs that do not meet the requirement for Residential Health Treatment as described above;
  - Custodial Care;
  - Halfway house services; or



- Three quarter house services
- Counseling and other services for:
  - Insomnia and other non-medical sleep disorders;
  - Marital and relationship enhancement;
  - Religious oriented counseling provided by a religious counselor who is not a Participating Provider; and
  - Experimental/investigational or unproven treatments and services.
- Also see Part 9 for additional Exclusions.

#### **8.19.02 SUBSTANCE ABUSE SERVICES/CHEMICAL DEPENDENCY**

##### **Definitions:**

**Detoxification** means medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detoxification can occur in an Inpatient, Outpatient or residential setting.

**Medically Monitored Intensive Inpatient Treatment** is care provided in an inpatient facility or subacute unit following full or partial recovery from Acute Detoxification symptoms. These services are included as “Inpatient Substance Abuse Services” in the Schedule of Member Cost Sharing and Additional Limits of Coverage.

**Partial Hospitalization** is an intensive, non-residential level of service provided in a structured setting, similar in intensity to Inpatient treatment. A Member is generally in treatment for more than four hours but generally less than eight hours daily. These services are included as “Inpatient Substance Abuse Services” in the Schedule of Member Cost Sharing and Additional Limits of Coverage.

**Residential Substance Abuse Treatment** means Acute care services provided in a structured and secure full day (24 hour) setting to a Member who is ambulatory and does not require medical hospitalization. Residential Services may include 24-hour professional supervision and may also include counseling, Detoxification, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan. Residential Substance Abuse Treatment is sometimes also called to as inpatient substance abuse treatment or rehabilitation (“rehab”). These services are included as “Inpatient Substance Abuse Services” in the Schedule of Member Cost Sharing and Additional Limits of Coverage.

**Intensive Outpatient Programs** are outpatient services provided by a variety of health professionals at a frequency of up to four hours daily, and up to five days per week. These services are included as “Outpatient Substance Abuse Services” in the Schedule of Member Cost Sharing and Additional Limits of Coverage.

**Outpatient Treatment** means Substance Abuse Services provided in an office setting, generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day. These services are included as “Outpatient Substance Abuse Services” in the Schedule of Member Cost Sharing

and Additional Limits of Coverage.

**Covered Services:**

Medically Necessary Substance Abuse Services defined above are Covered under this plan. These include counseling, medical testing, diagnostic evaluation and Detoxification. Diagnosis and treatment may include drug therapy, counseling, Detoxification services, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Emergency Substance Abuse Services are Covered pursuant to Emergency and Urgent Care Coverage. (See Section 8.08)

**Limitations:**

- Medically Monitored Intensive Inpatient Treatment, Partial Hospitalization and Residential Substance Abuse Treatment require Preauthorization by MHP Community.

**Exclusions:**

- Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, recreational or wilderness therapy programs, Custodial Care, halfway house services and health care aids.
- Care provided in a non-licensed residential or institutional facility, or other facility on a temporary or permanent basis is not Covered, including the costs of living and being cared for in:
  - Room and board
  - Transitional living centers;
  - Domiciliary foster care facilities;
  - Therapeutic boarding schools;
  - Milieu therapies such as recreational or wilderness therapy programs that do not meet the requirements for Residential Health Treatment as described above;
  - Custodial Care;
  - Halfway house services;
  - Three quarter house services
- Also see Part 9 for additional Exclusions.

**8.20 OUTPATIENT HABILITATIVE SERVICES****Covered Services:**

Short term outpatient medical Habilitative services are Covered when they are Medically Necessary for a condition that can be expected to help a Member keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and Applied Behavioral Analysis (ABA) for the Treatment of Autism Spectrum Disorder. (See also Section 8.32).

**Limitations:**

- Physical Therapy, Occupational Therapy and Speech Therapy for Treatment Other than for Autism Spectrum Disorder – Combined Benefit maximum of 90 visits per Plan Year ABA Services, Physical and Occupational Therapy and Speech Therapy for treatment of Autism Spectrum Disorder – Not subject to annual visit limitation; Coverage available only under Option A
- One of more forms of therapy during the same day count as 1 visit
- Habilitative Services, including services for Treatment of Autism Spectrum Disorder, must be Preauthorized by MHP Community in order to be Covered
- Physical Therapy requires a prescription from a referring physician
- Prescription drugs related to Outpatient Habilitative Services, including services for Treatment of Autism Spectrum Disorder, are Covered under Section 8.33, Prescription Drug Coverage.

**Exclusions:**

- No Coverage for Habilitative Services for Treatment of Autism Spectrum Disorder under Option B
- Vocational rehabilitation
- Services provided by any federal or state agency or any local political subdivision, including school districts, are not payable by MHP Community
- Services outside the scope of practice of the servicing provider
- Additional speech therapy exclusions
  - Deviant swallow or tongue thrust;
  - Voice Therapy; and
  - Vocal cord abuse resulting from life-style activities

**8.21 OUTPATIENT REHABILITATION**

Outpatient rehabilitation includes:

- Medical rehabilitation, including cardiac and pulmonary rehabilitation
- Physical therapy
- Occupational therapy
- Speech therapy
- Breast cancer rehabilitation

Short-term Rehabilitation Services are Covered if:

- 90 total combined visits for PT/OT/ST per Plan Year, and
- Treatment is provided for an illness, injury or congenital defect, and
- They are provided in an outpatient setting or in the home, and

- They are not services provided by a federal or state agency or any local political subdivision, including school districts (i.e., such services are not payable by MHP Community), and
- They result in meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 60 days of starting treatment,
- A Participating Provider refers, directs and monitors the services, and
- They are Preauthorized

**Limitations:**

- Rehabilitation Services must be Preauthorized
- Physical Therapy requires a prescription from a referring physician
- 90 total combined visits for PT/OT/ST per Plan Year

**Exclusions:**

- Vocational rehabilitation
- Services provided by any federal or state agency or any local political subdivision, including school districts, are not payable by MHP Community
- Therapy that provides no meaningful improvement in a Member's ability to do important day to day activities that are necessary in the Member's life roles within 60 days of starting treatment
- Services outside the scope of practice of the servicing provider
- Additional speech therapy exclusions
  - Chronic conditions or congenital speech abnormalities;
  - Learning disabilities;
  - Deviant swallow or tongue thrust;
  - Voice therapy; and
  - Vocal cord abuse resulting from life-style activities

**8.22 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES****Covered Services:**

DME is equipment that must be used primarily for medical purposes. It must be intended for repeated use and be useful primarily as a result of illness, injury or congenital defect. Coverage is provided for rental or purchase, and is limited to basic equipment. **If the cost of the DME is greater than \$3,000.00, it must be Preauthorized by MHP Community to be Covered.**

**Note:** All Medically Necessary equipment and supplies for the treatment of diabetes are Covered (Preauthorization required for insulin pumps). See Section 8.02.01.

**Limitations:**

- The equipment must be considered DME by MHP Community and be appropriate for home use;
- Your Provider must prescribe the equipment, and it must be obtained from MHP Community or an MHP Community-designated Participating Provider;
- If the cost of the DME is greater than \$3,000.00, it must be Preauthorized by MHP Community to be Covered;
- The equipment is the property of MHP Community or the supplier. When it is no longer Medically Necessary, you may be required to return it to the supplier; and
- Replacement of DME is Covered only when necessary to accommodate body growth, body change or normal wear.

**Exclusions:**

The equipment listed below is **not** Covered (there may be additional equipment that is not Covered):

- Deluxe equipment (such as motor-driven wheelchairs and beds) unless Medically Necessary for the patient and required so the patient can operate the equipment himself;
- Wheelchair seat elevators;
- Wheelchair power/manual standing feature;
- Items that are not considered medical items;
- Duplicate equipment;
- Items for comfort and convenience (such as bed boards, bathtub lifts, over-bed tables, adjustable beds, telephone arms, air conditioners, hot tubs, water beds);
- Physician's equipment (such as blood pressure cuffs and stethoscopes);
- Disposable supplies (such as sheets, bags, elastic stockings);
- Exercise and hygienic equipment (such as exercycles, bidet toilet seats, bathtub seats, treadmills);
- Self-help devices that are not primarily medical items (such as sauna baths, elevators and ramps, special telephone or communication devices);
- Equipment that is experimental or for research;
- Needles and syringes for purposes other than the treatment of diabetes;
- Repair or replacement due to loss, theft or damage;
- Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers and other equipment not intended for use in the home.

**8.23 PROSTHETICS, ORTHOTICS AND CORRECTIVE APPLIANCES****DEFINITIONS:**

- Prosthetic devices help the body to function or replace a limb or body part after loss through an accident or surgery.
- Orthotic appliances are used to correct a defect of the body's form or function.
- Corrective appliances are items such as eyeglasses or contact lenses.
- Artificial aids are items such as cardiac pacemakers and artificial heart valves.

**PROSTHETICS AND ORTHOTICS:****Covered Services:**

- Basic items and any special features that are Medically Necessary and, if the cost of an item exceeds \$3,000.00, is Preauthorized by MHP Community;
- The cost and fitting of a breast prosthetic device following a mastectomy;
- Replacement when necessary because of body growth, change or normal wear.

**Limitations**

- The item must meet the MHP Community definition of a prosthetic or orthotic item;
- You must obtain the item from MHP Community or an MHP Community-designated Participating Provider or supplier;
- The PCP must prescribe the item; and
- If the cost of a prosthetic or orthotic exceeds \$3,000.00, the item must be Preauthorized by MHP Community to be Covered.

**Exclusions:**

- Repair or replacement due to loss, theft or damage is not Covered.

**CORRECTIVE APPLIANCES AND ARTIFICIAL AIDS****Covered Services:**

Coverage for corrective appliances and artificial aids is provided when the item is Medically Necessary and Preauthorized by MHP Community.

Any implanted items such as cardiac pacemakers, dorsal spine stimulators and artificial heart valves are Covered as part of the Preauthorized inpatient/outpatient service. Prescription lenses (eyeglasses or contact lenses) are Covered immediately following surgery for eye diseases such as cataracts or to replace an organic lens that is missing from birth. You must obtain lenses through MHP Community or from an MHP Community designated Participating Provider or supplier.

**Exclusions:**

The following are not Covered:

- Sports-related braces;
- Dental appliances;
- Hearing aids;
- Eyeglasses or contact lenses (except after surgery as listed above);
- Non-rigid appliances and supplies such as (but not limited to) elastic stockings, garter belts, arch supports, corsets, corrective shoes, wigs or hair pieces, shoe or foot orthotics; and

- Devices or appliances that are experimental or for research.

## **8.24 REPRODUCTIVE CARE AND FAMILY PLANNING SERVICES**

This benefit includes:

- Infertility
- Sterilization
- Reproductive Care and Family Planning
- Genetic Testing

### **8.24.01 INFERTILITY**

Coverage is available for Preauthorized services provided by a Participating Provider for diagnosis, counseling and treatment of infertility except as stated below and in “Elective Procedures,” and except as specifically excluded below or under Part 9. Following the initial sequence of diagnostic work-up and treatment, additional work-ups and treatment may begin only when MHP Community determines they are in accordance with generally accepted medical practice and meet nationally recognized criteria. Coverage for pharmaceutical drugs prescribed as a part of this treatment are Covered as part of this medical Benefit.

**Exclusions:**

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

### **8.24.02 STERILIZATION**

Medically Necessary sterilization services for women are Covered under Preventive Services, Section 8.05.

MHP Community Covers vasectomies when performed in a Participating Physician’s office or when performed in connection with another Covered inpatient or outpatient surgery.

**Exclusion:** Reversal of surgical sterilization.

### **8.24.03 REPRODUCTIVE CARE AND FAMILY PLANNING**

MHP Community Covers the following services when they are provided in accordance with generally accepted medical practice:

- History
- Physical exam
- Lab tests
- Advice and medical supervision related to family planning.

**8.24.04 GENETIC TESTING**

MHP Community Covers medically indicated genetic testing and counseling when they are Preauthorized by MHP Community and provided in accordance with generally accepted medical practice. Certain genetic testing services (e.g., BRCA for women when Medically Necessary) are Covered under Preventive Services Coverage. See Section 8.05.)

**8.24.05 ABORTIONS**

There is no Coverage under this Certificate for any service or supply relating to elective abortions unless specified in your Schedule of Member Cost Sharing.

**8.25 SERVICES FOR GENDER TRANSITION**

MHP Community Covers Medically Necessary services related to gender dysphoria or gender transition. Such services will be subject to the applicable Member cost sharing and limitations otherwise applicable. (E.g., see Section 8.10 Inpatient hospitalization, Section 8.33 Prescription Drugs, Section 8.19 Mental Health Services, Part 9 Exclusions).

**Limitations:**

- Gender reassignment surgery must be Preauthorized

**Exclusions:**

- Reversal of prior gender reassignment surgery;
- Surgery that is considered cosmetic in nature and not Medically Necessary when performed as a component of a gender reassignment;
- Services, treatment and surgeries that are considered Experimental and Investigative;
- Exclusions under other benefits (e.g., see Section 8.10 Inpatient hospitalization, 8.20 Outpatient Habilitative Services, 8.21 Outpatient Rehabilitative Services, Section 8.24 Reproductive Care and Family Planning Services, Section 8.33 Prescription Drugs or in your applicable Prescription Drug Rider., Section 8.19 Mental Health Services, Part 9 Exclusions

**8.26 ORAL SURGERY**

**Note:** Also see Sections 8.27, 8.28 and 9.12

Oral surgery and related services are Covered when Medically Necessary and Preauthorized by MHP Community for:

- Prompt repair and treatment of fractures, suspected fractures of the jaw and facial bones and dislocation of the jaw immediately following an accidental or traumatic injury;
- Prompt repair of injury to the jaw, tongue, cheeks, lips and roof or floor of the mouth immediately following an accident or traumatic injury;



- Prompt medical and surgical services required to correct accidental injuries, including emergency care to stabilize dental structures following injury to sound natural teeth immediately following an accidental or traumatic injury;
- Medically Necessary surgery for removing tumors and cysts within the mouth;
- Hospitalization for: (a) multiple extractions that must be performed in a Hospital due to a concurrent hazardous medical condition, or (b) when general anesthesia is required due to (i) Member's physical or mental condition, (ii) significant trauma in the facial area, (iii) the nature of a special procedure requires general anesthesia, or (iv) the Member's age along with other contributing factors necessitate the use of general anesthesia in a Hospital setting.

**Note:** "Immediately following" means treatment within 72 hours of the injury.

**Exclusions:**

- Routine dental care;
- Pediatric dental services;
- Implants and repair/restoration of the teeth;
- Preparation of oral implants;
- Services provided by an individual who is not a licensed, practicing oral surgeon or a licensed medical or osteopathic physician.

## **8.27 TEMPOROMANDIBULAR JOINT SYNDROME (TMJ) TREATMENT**

TMJ is a condition of muscle tension and spasms related to the temporomandibular joint, facial and/or cervical muscles that may cause pain, loss of function and/or physiological impairment. Medical services and treatment for TMJ listed below are Covered when they are Medically Necessary and Preauthorized by MHP Community.

**IMPORTANT:** Dental services are not Covered.

Covered Services include:

- Office visits for medical evaluation and treatment;
- Specialty referral for medical evaluation and treatment;
- X-rays of the temporomandibular joint, including contrast studies; and
- Surgery to the temporomandibular joint including, but not limited to, condylectomy, meniscectomy, arthrotomy and arthrocentesis.

**Exclusions:**

- Dental and orthodontic services or treatment, prosthetics and appliances for or related to TMJ treatment; and
- Dental X-rays.

**8.28 ORTHOGNATHIC SURGERY**

Orthognathic surgery is oral surgery involving repositioning of an individual tooth, arch segment or entire arch, usually done in conjunction with a course of orthodontic treatment. The services listed below are Covered when they are Medically Necessary and Preauthorized by MHP Community:

- Office consultation with Referral Physician;
- Cephalometric study and X-rays;
- Orthognathic surgery;
- Postoperative care; and
- Hospitalization – only when it is Medically Necessary to perform the surgery in a Hospital setting.

**Note:** Orthodontic treatment is not Covered for any purpose, including orthognathic conditions.

**8.29 APPROVED CLINICAL TRIALS****Covered Services:**

MHP Community Covers Routine Patient Costs for items and services furnished in connection with a Qualified Individual's participation in an Approved Clinical Trial with respect to the treatment of cancer or another life-threatening disease or condition.

For purposes of this Section, the following definitions apply:

- An Approved Clinical Trial means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.
- A Qualified Individual is a Member who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either (i) the referring health care professional is an MHP Community Participating Provider and has concluded that the Member's participation in such trial would be appropriate, or (ii) the Member provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.
- Routine Patient Costs include all items and services that would be Covered for a Member outside of participation in an Approved Clinical Trial.

**Limitations:**

- MHP Community does not Cover the costs of the Approved Clinical Trial itself, but rather just the Routine Patient Costs (e.g., laboratory services) associated with the Approved Clinical Trial.

- Routine Patient Costs that otherwise require Preauthorization, also require Preauthorization when provided as part of an Approved Clinical Trial.

**Exclusions:**

The following are not Covered as Routine Patient Costs:

- The investigational item, device or service itself;
- Items and services that are provided solely to satisfy data collection and analysis needs, and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

**8.30 CANCER DRUG THERAPY (ANTINEOPLASTIC SURGICAL DRUG THERAPY)****Covered Services:**

As required by state law, drugs for cancer therapy and the reasonable cost of administering them are Covered. These drugs are Covered regardless of whether the federal Food and Drug Administration (FDA) has approved the cancer drugs to be used for the type of tumor for which the drugs are being used.

**Coordination of Benefits for Drugs for Cancer Therapy and Cancer Clinical Trials**

Coverage Benefits for drugs for cancer therapy will be payable under your prescription drug Coverage (Section 8.33) before being payable under other sections of this Certificate.

**Limitations:**

Routine patient costs incurred in connection with certain clinical trials may be Covered if approved in advance by our Medical Director. See also Section 8.29.

**Exclusions:**

Experimental, investigational or unproven services are not Covered. Additionally, certain drugs for which a majority of experts believe further studies or clinical trials are needed to determine toxicity, safety, or efficacy of the drug are not Covered.

**8.31 VISION EXAM**

Vision exams are Covered in a provider's office. Vision exams include one (1) routine exam, including refraction, each Plan Year to detect vision impairment. Vision exams performed by an MHP Community Participating Provider do not require Preauthorization.

**Note:** Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

### 8.32 SERVICES FOR TREATMENT OF AUTISM SPECTRUM DISORDER – OTHER THAN ABA SERVICES

**Covered Services:**

Outpatient Treatment of Autism Spectrum Disorders is Covered when performed by an approved MHP Community Participating Provider.

**Note:** Applied Behavioral Analysis or ABA services are Covered under your Outpatient Habilitative Services Benefit, Section 8.20.

Coverage includes the following:

- Diagnosis of Autism Spectrum Disorders, including Autism Diagnostic Observation Schedule, when performed by a physician or licensed psychologist; and
- Medication management;

**Note:** Autism screening for children ages 18 months and 24 months is Covered as a Preventive Health Service (see Section 8.05).

**Limitations:**

Covered Services for Autism Spectrum Disorder:

- Must be Medically Necessary as determined by MHP Community; and
- Will be considered when performed by an approved MHP Community provider, facility or agency along with other criteria set forth in MHP Community medical policies.

**Exclusions:**

- Treatments or services provided by a Non-Participating Provider unless otherwise approved in advance by MHP Community; and
- Treatments for Autism Spectrum Disorder that are in conflict with MHP Community's medical policies.

### 8.33 PRESCRIPTION DRUG COVERAGE

**Definitions:**

**Brand Name Drug:** A prescription drug that the manufacturer markets under a registered trademark or trade name.

**Covered Drug:** A Tier 1, Tier 2, Tier 3 or Preventive Drug that is prescribed by a Participating Provider and obtained through a Participating Pharmacy, except as excluded in this Certificate.

**Dispense as Written or DAW:** A drug dispensed as written, with no substitutions (for example, no substitution of a Tier 1 Drug). A physician or Member can request a DAW, but the Copayment will be affected if a Generic Drug is available.

**Formulary:** A listing of US Food and Drug Administration (FDA) approved prescription drugs that MHP Community has approved for use and are Covered under your Prescription Drug Coverage.

**Generic Drug:** A Drug whose patent has expired, that the FDA has determined to be bioequivalent to Brand Name Drugs and that is not manufactured or marketed under a registered trademark or brand name.

**Mail-Order Pharmacy:** A Prescription Brand Name Drug that can be dispensed through a mail-order service for a 90-day supply, and that is Covered with two (2) Copayments.

**Over-the-Counter Medications:** Drugs that can be obtained without a prescription. A limited number of Over-the-Counter Medications are Covered. Refer to the Formulary at [McLarenHealthPlan.org](http://McLarenHealthPlan.org) or contact Customer Service at (888) 327-0671 for the most current list of Covered Over-the-Counter Medications.

**Participating Pharmacy:** Licensed, MHP Community-credentialed pharmacies selected by MHP Community to provide Prescription Drugs to Members.

**Preauthorization/Step Therapy Drugs:** Drugs listed on MHP Community's Formulary that require review of a Member's medical information to ensure clinical criteria have been met regarding the medical necessity of the drug. This review is performed by MHP Community prior to approving Coverage and may involve the need for documentation for use of previous treatment with another Drug or result in the substitution of an alternative Drug.

**Preferred Brand Name Drug:** A Formulary Preferred Covered Drug that the manufacturer markets under a registered trademark or trade name.

**Preferred Generic Drug:** A Formulary Preferred Covered Drug whose patent has expired, that the FDA has determined to be bioequivalent to Brand Name Drugs and that is not manufactured or marketed under a registered trademark or brand name.

**Prescription Drug:** A medication approved by the FDA and which can, under federal and state law, be dispensed only pursuant to a prescription order.

**Preventive Drugs:** Preventive Drugs are Prescription Drugs that have been recommended by the United States Preventive Service Task Force that help prevent illness. Some Preventive Drugs are Preventive Drugs only for specified age groups or genders. For more information see Section 8.05, Preventive Services.

**Specialty Drugs:** A drug that requires a difficult or unusual process of delivery to the patient (preparation, handling, storage, inventory, distribution, Risk Evaluation and Mitigation Strategy (REMS) programs, data collection or administration, or patient management prior to or following administration (monitoring, disease or therapeutic support systems)). These include, but are not limited to, arthritis injections, growth hormone injections, hepatitis C injections, migraine injections, multiple sclerosis injections, and oral oncology drugs.

**Tier 1 Drugs:** A MHP Community Formulary Drug available with the lowest Copayment. This Tier includes many commonly prescribed low-cost drugs, including commonly prescribed Generic Drugs and may include other low-cost Drugs.

**Tier 2 Drugs:** This Tier includes preferred Brand Name Drugs. Drugs in this Tier will generally have lower Copayments than Non-Preferred Drugs.

**Tier 3 Drugs:** This Tier includes non-preferred Generic and non-preferred Brand Name Drugs. It also includes Specialty Drugs.

**Coverage:**

Coverage is provided for:

1. Tier 1, Tier 2, Tier 3 and Preventive Drugs when prescribed by a Participating Provider, obtained through a Participating Pharmacy, and, where required, Preauthorized by MHP Community.
2. Injectable insulin when prescribed by a Participating Provider.
3. Disposable insulin needles and/or syringes.
4. Specialty Drugs when Preauthorized by MHP Community.
5. Tier 2 or Tier 3 Brand Name Drugs and Preventive Brand Name Drugs by Mail-Order.
6. Compounded Drugs that are Preauthorized by MHP Community.
7. A limited number of Over-the-Counter Medications.

**Copayments:**

Refer to your Schedule of Member Cost Sharing and Additional Limits of Coverage for applicable Copayments. The Copayments will differ based on the following categories and rules:

**Retail Pharmacy**

-- Preventive Drugs

-- Tier 1 Drugs

-- Tier 2 Drugs

-- Tier 3 Drugs

**NOTE:**

- **Contraceptive medications, devices or appliances:** Check your Formulary to confirm which are Covered with no Copayment and which are Covered with a Copayment.
- **Compounded Drugs:** Covered with the same Copayment as Tier 3 Drugs.
- **Covered Over-the-Counter Drugs:** Copayments vary by OTC Drug. Refer to your Formulary and the Schedule of Copayments and Deductibles.

**Mail-Order Pharmacy – Available for Brand Name Only**

- Preventive Drugs – Brand Name Drugs Only
- Tier 1 Drugs – Brand Name Drugs Only
- Tier 2 Drugs – Brand Name Drugs Only
- Tier 3 Drugs – Brand Name Drugs Only

**Specialty Drugs**

Must be filled at a Participating Specialty Pharmacy. Specialty Drugs are limited to a 34-day supply.

**Limitations:**

- Prescriptions Covered under this Certificate are limited to a 34-day supply except as follows:
  - A ninety (90) day supply of Preventive Generic, Tier 1 and Tier 3 Generic Drugs may be dispensed from a Retail Pharmacy if a Member successfully completes a thirty (30) day trial of the Drug. The 90-day supply may be obtained with two (2) Copayments.
  - If a Drug is available through the Mail-Order Pharmacy, a 90-day supply may be dispensed with two (2) Copayments if a Member successfully completes a thirty (30) day trial of the Drug.
  - MHP Community reserves the right to place a maximum supply limit on certain Covered Prescription Drugs. MHP Community does not Cover any prescription refill in excess of the number specified by the physician or any prescription or refill dispensed after one year from the date of the physician's order.

- If a Member obtains Covered Prescription Drugs, needles or syringes, or insulin from a non-Participating Pharmacy when out of area or in urgent situations, MHP Community will reimburse the Member the amount specified on MHP Community's fee schedule, or the actual charge to the Member, whichever is less, minus the Copayment.
- If a Tier 2 Drug is dispensed when a Tier 1 Drug equivalent is on the MHP Community Formulary, the Member must pay the difference between the cost of the Tier 2 Drug and the price of its Tier 1 Drug equivalent in addition to the applicable Copayment. The Tier 2 or Tier 3 Drug will be Covered at the same level as a Tier 1 Drug if MHP Community grants Preauthorization of the Drug on the basis that the Drug is a medically necessary and appropriate alternative, or if a Tier 1 equivalent is not available. If Preauthorization is requested, the Member or his/her provider must provide MHP Community with all information necessary to determine whether the Preauthorization should be granted. MHP Community shall provide a decision regarding the request within twenty-four (24) hours after receiving all such information. For urgent situations, see also Section 3.06, Expedited Formulary Exception Requests.

**Exclusions:**

- There is no Coverage for drugs, needles and syringes, or insulin provided by any private or public agency that are or may be obtained by the Member without cost to the Member.
- There is no Coverage for any drug that is experimental or that is being used for experimental purposes including, but not limited to, those regarded by the FDA as investigational.
- There is no Coverage for any prescription that is filled after the termination of the Certificate or that is filled prior to termination of the Certificate but provides more than a 34-day supply beyond the termination date.
- There is no Coverage for any cosmetic drug or drug used for cosmetic purposes. "Cosmetic drug" or "cosmetic purpose" means any prescription legend drug that is intended to be rubbed, poured, sprinkled or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for the purpose of cleaning, beautifying, promoting attractiveness, promoting hair growth, reducing or eliminating wrinkles or altering the appearance, and any substance intended to be used as a component of the above drugs.
- Some Preventive Drugs, such as certain vaccines, are Covered under Section 8.05 of the Certificate, and are subject to the benefits and limitations of that Section.



- Certain other drugs are Covered elsewhere in this Certificate as a part of medical benefits (e.g., serums, drugs for treatment of infertility, certain cancer drugs). They are not Covered under this Section, but are subject to benefits, limitations, exclusions and Copayment requirements of the other applicable sections of this Certificate. (See, for example, Sections 8.06.04 and 8.30).
- There is no Coverage for any Prescription Drug, insulin, or needles and syringes to the extent that benefits or coverage are available under Medicare or under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.
- There is no Coverage for any drug, needles or insulin that was acquired without cost to the provider, or if the cost is included or includable in the cost of other services or supplies provided to or prescribed for the Member in accordance with generally accepted professional procedures.
- There is no Coverage for Prescription Drugs for which there is an Over-the-Counter equivalent in both strength and dosage form.
- There is no Coverage for medications that are not regulated by the FDA such as medical foods or herbal supplements.

#### **8.34 HEARING AID**

##### **Coverage:**

Coverage is provided for:

- The purchase, fitting and delivery of either a monaural or binaural hearing aid(s) that must be either of the in-the-ear, behind-the-ear or on-the body type. This includes one hearing aid check following the fitting.
- CROS, BICROS, Canal and eyeglass type hearing aids and other special hearing aids, not to exceed the Benefits we would have provided for a unilateral hearing aid, as described above.
- Audiometric examinations and hearing aid evaluations to determine actual hearing acuity and the specific type or brand of hearing aid needed.

##### **Limitations:**

- Coverage is limited to one hearing aid, per ear, every 36 months.
- Hearing aids must be provided by a licensed hearing aid dealer.
- Hearing aids must be Preauthorized by MHP Community.

##### **Exclusions:**

- Hearing aid batteries are not Covered.

- Hearing aid accessories, such as ear molds and other altering devices are not Covered.
- Replacements of hearing aids that are lost or broken are not Covered.
- Other hearing aid replacement parts and repairs are not Covered.
- Hearing aids that do not meet U.S. Food and Drug Administration (FDA) and Federal Trade Commission requirements are not Covered.
- Spare equipment (e.g., an old hearing aid in working condition for back-up use in emergencies) is not Covered.
- Personal FM amplification systems are not Covered.
- Hearing aids requested solely or primarily for the elimination of tinnitus are not Covered.
- Equipment requested solely or primarily for cosmetic reasons or package features relative to cosmetics are not Covered.
- Hearing aids not Preauthorized by MHP Community are not Covered.

### **8.35 SERVICES COVERED BY RIDER ONLY**

Additional services may be Covered if the Group has purchased a separate Rider providing such Coverage. All Riders are subject to the terms and conditions of this Certificate (including the attached Schedule of Member Cost Sharing and Additional Limits of Coverage).

### **8.36 OUT-OF-AREA COVERAGE**

You are Covered when traveling outside of the MHP Community Service Area for Emergency Services that meet the conditions described in Section 8.08 of this Certificate. You are also provided limited Coverage under your Option B Benefits. Please see Option B limitations under Section 8.04 of this Certificate.

### **8.37 TELEMEDICINE**

Telemedicine Services (including telepsychiatry) are Covered subject to the terms and conditions of this Certificate.

#### **Limitations:**

- The same Preauthorization requirements apply as if the service was provided in an in-office setting; and
- Telemedicine services are a method of accessing Covered Services, not a separate Benefit.

#### **Exclusions:**

No Coverage is provided in the following scenarios:

- When you and the treating Provider are in the same location;
- Texting, fax, or email only;
- Services related to administration issues, (e.g., registering, appointment scheduling, billing issues); or

- Services provided without a real time interaction

### **8.38 VIRTUAL VISITS**

MHP Community Covers Medically Necessary Virtual Visits provided by a McLarenNow Provider or a mental health or behavioral health Participating Provider and subject to the terms and conditions of this Certificate. McLarenNow is available through [www.mclaren.org/mclaren-now-virtual-visit](http://www.mclaren.org/mclaren-now-virtual-visit) or you can download the app for iOS or Android. You must create a user account with McLarenNow.

Members will be charged a \$0 Copay for Telemedicine services rendered through a specifically designated McLaren Health Plan Community approved vendor listed on our website to provide telemedicine services.

#### **Limitations:**

- For Virtual Visits provided through McLarenNow, services must be performed by a McLarenNow Provider through your browser or through the app for iOS or Android;
- Cost Sharing for Virtual Visits only applies to Virtual Services provided through McLarenNow or Virtual Visits by a mental health or behavioral health Participating Provider;
- Cost Sharing for Virtual Visits only applies to Virtual Services provided through McLarenNow or Virtual Visits by a mental health or behavioral health Participating Provider;
- In-person office visits, including but not limited to PCP visits, specialist visits and mental health or behavioral health visits are not Virtual Visits and are subject to the applicable Cost Sharing in this Certificate or you applicable Rider(s);
- Any follow-up services, including but not limited to services that cannot be performed during a Virtual Visit, referrals to other providers, labs and other services are not covered under the Virtual Visit Cost Sharing and are subject to the applicable Cost Sharing in this Certificate of your applicable Rider(s);
- All other Covered Telemedicine Services are not Virtual Visits and are subject to Section 8.37

#### **Exclusions:**

- Services related to administration issues, (e.g., registering, appointment scheduling, billing issues);
- Services provided without a real time interaction;
- Fees imposed by McLarenNow or a Virtual Visit Participating Provider for a missed or dropped appointment.

## **PART 9: EXCLUSIONS AND LIMITATIONS**

This section lists exclusions and limitations of your Certificate. Also refer to a specific service within this Certificate for additional exclusions and limitations for that service.

### **9.01 UNAUTHORIZED AND OUT OF PLAN SERVICES**

Services requiring Preauthorization by MHP Community will not be paid without such Preauthorization. Although Participating Providers will assist in obtaining MHP Community Preauthorization, the Member is ultimately responsible for ensuring that any necessary Preauthorization has been obtained.

### **9.02 SERVICES THAT ARE NOT MEDICALLY NECESSARY**

Services that are not Medically Necessary are not Covered unless specified in the Certificate. The final determination of Medical Necessity is the judgment of the MHP Community Chief Medical Officer.

### **9.03 NON-COVERED SERVICES**

- Office visits, exams, treatments, test and reports for any of the following are not Covered:
  - Employment
  - Licenses
  - Insurance
  - Travel (only immunizations for purposes of travel are Covered Benefits)
  - School purposes
  - Legal Proceedings, such as parole, court and paternity requirements
- Housekeeping services;
- Outpatient Rehabilitation Services for speech therapy related to Chronic conditions or congenital speech abnormalities, learning disabilities, deviant swallow or tongue thrust, and vocal cord abuse resulting from life-style choices;
- Deluxe DME such as motor-driven wheelchairs and beds, unless Preauthorized, Medically Necessary and required so that the patient can operate the equipment himself;
- Items that are not considered medical items;
- Duplicate DME;
- Physician's equipment such as blood pressure cuffs and stethoscopes;
- Disposable supplies such as sheets, bags and elastic stockings;
- Exercise and hygienic equipment such as exercycles, treadmills, bidet toilet seats and bathtub seats;
- Self-help devices that are not primarily medical items such as sauna baths, elevators and ramps, special telephone or communication devices;
- Needles and syringes for purposes other than the treatment of diabetes;
- Repair or replacement of DME, prosthetics, orthotics, and corrective appliances due to loss, theft or damage;

- Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers and such equipment not intended for use in the home;
- Sports-related braces;
- Dental appliances;
- Hearing aids;
- Eyeglasses or contact lenses except after a Preauthorized surgery for eye diseases such as cataracts or to replace an organic lens that is missing from birth (see Section 8.23);
- Non-rigid appliances and supplies such as (but not limited to) elastic stockings, garter belts, arch supports, corsets, corrective shoes, wigs or hair pieces, shoe or foot orthotics; and
- All other services specifically defined as “not Covered” or a Benefit exclusion in this Certificate.

#### **9.04 COSMETIC SURGERY**

Cosmetic surgery is surgery primarily to reshape normal structures of the body, improve appearance and self-esteem. We do not Cover cosmetic surgery or any of the related services, such as pre- or post-surgical care, follow-up care, reversal or revision of the surgery or treatment for complications.

#### **9.05 MILITARY CARE**

We do not Cover any care for diseases or disabilities connected with military service if you are legally entitled to obtain services from a military facility, and such a facility is available within a reasonable distance.

#### **9.06 CUSTODIAL CARE**

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

#### **9.07 COMFORT ITEMS**

MHP Community does not Cover any personal or comfort items, such as telephone or television. We do not Cover the costs of a private room or apartment.

#### **9.08 RESEARCH OR EXPERIMENTAL SERVICES**

MHP Community uses the following criteria when evaluating new technologies, procedures and drugs:

- Evidence of clear therapeutic effectiveness when used in the general population as demonstrated in peer-reviewed clinical trials;
- Evidence of patient safety when used in the general population;
- Evidence that the medical community in general accepts the safety and effectiveness of the service outside of investigational setting;
- Evidence of clinical meaningful outcomes; and
- Evidence that clinically meaningful outcomes can be attained at a reasonable cost.

**Covered Services:**

Coverage is available for Routine Patient Costs in connection with an Approved Clinical Trial (see Section 8.31.) For information about which trials are Covered, a Member's PCP should contact MHP Community.

**Non-Covered 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:

- The drug or device has not been approved by the Food and Drug Administration (FDA) and, therefore, cannot be lawfully marketed in the United States;
- 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;
- 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;
- Reliable Evidence shows that the drug, device, treatment or procedure is:
  - Under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or
  - Believed by a majority of experts to require further studies or clinical trials to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis.
- **Reliable Evidence** includes any of the following:
  - Published reports and articles in authoritative medical and scientific literature, or technology assessment and cost effectiveness analysis; or
  - 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
  - Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device or procedure.

**9.09 NON-MEDICAL SERVICES**

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

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

**9.10 COURT-RELATED SERVICES**

- MHP Community does not Cover pretrial and court testimony, court-ordered exams that do not meet MHP Community requirements for Coverage, and the preparation of Court-related reports;
- MHP Community does not Cover court ordered examination, tests, reports or treatments that do not meet requirements for Mental Health or Substance Abuse Services Coverage;

**9.11 ELECTIVE PROCEDURES**

The following elective procedures are not Covered:

- Reversal of surgical sterilization;
- In-vitro fertilization procedures, such as GIFT-gamete intrafallopian transfer or SIFT-zygote intrafallopian transfer and all related services;
- Artificial insemination (except for treatment of infertility);
- All services related to surrogate parenting arrangements, including, but not limited to, maternity and obstetrical care for non-Member surrogate parents;
- Services provided by a lay-midwife and home births;
- Any service or supply relating to elective abortions; and
- Procedures that are not Preauthorized by MHP Community as required in this Certificate.

**9.12 DENTAL SERVICES**

MHP Community does not Cover dental services (including pediatric dental services), dental prosthetics, replacement of teeth, X-rays, orthodontic treatment, oral surgery or anesthesia for procedures relating to the teeth except as stated in Sections 8.26 – 8.28.

**9.13 SERVICES COVERED THROUGH OTHER PROGRAMS AND THE PUBLIC SECTOR**

MHP Community does not Cover any services that are available to you under the following circumstances:

- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or certificate;
- Under any other policy, program, contract or insurance as stated in **Part 2: Other Party Liability**;
- Provided under any public health care, school or public program supported totally or partly by state, federal or local governmental funds, except where your MHP Community Coverage is required by law to be your primary coverage; and
- Under any contractual, employment or private arrangement (not including insurance) that you made that promises to provide, reimburse or pay for health, medical or Hospital services.
- Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment.

#### **9.14 ALTERNATIVE SERVICES**

Any alternative service (treatments not traditionally being used in standard Western medicine and not widely taught in medical schools), including, but not limited to, acupuncture, herbal treatments, massage therapy, light therapy, therapeutic touch or aromatherapy is not Covered. Evaluations and office visits related to alternative services are also not Covered.

#### **9.15 VISION SERVICES**

Except as specifically otherwise stated in this Certificate, the following vision services or items are not Covered:

- Radial keratotomy;
- Laser assisted in situ Keratomileusis (LASIK) surgery;
- Routine non-Medically Necessary vision and optometric exams;
- Refractions, unless Medically Necessary;
- Eyeglasses and eyeglass frames;
- Contact lenses in lieu of eyeglass frames and eyeglass lenses;
- Dilation;
- Visual training; and
- Dyslexia treatment.

#### **9.16 ILLEGAL OCCUPATION OR CRIMINAL ACTIVITY**

MHP Community is not liable for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member being engaged in an illegal occupation or other willful criminal activity.

- "Willful criminal activity" includes, but is not limited to any of the following:
  - Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of the State of Michigan.
  - Operating a methamphetamine laboratory. As used in this subdivision, "methamphetamine laboratory" means the term as defined in section 1 of 2006



PA 255, MCL 333.26371.

- “Willful criminal activity” does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

#### **9.17 CARE RENDERED WHILE IN POLICE CUSTODY**

Services provided to a Member while in police custody are not Covered.

#### **9.18 SERVICES PROVIDED BY FAMILY OR HOUSEHOLD MEMBER(S)**

Coverage is not available for services provided to the Member by the Member, immediate family members of the Member or individuals that have the same legal residence as the Member.

#### **9.19 HEALTH EDUCATION OR HEALTH COUNSELING**

Except as specifically stated as Covered in this Certificate or included as a Preventive Service, health education and health counseling services may be arranged through your Provider but are not Covered; they are payable by the Member.

#### **9.20 NO SHOW CHARGES**

Any missed appointment fee charged by a provider because you failed to show up at an appointment is not Covered.

#### **9.21 ADDITIONAL EXCLUSIONS**

Some services described in this booklet may be excluded in applicable Riders or your Schedule of Member Cost Sharing and Additional Limits of Coverage section of your Certificate. When there is a conflict between this booklet and the Rider or Schedule, the applicable Rider or Schedule will supersede.

#### **9.22 SERVICES PROVIDED BY A NON-PARTICIPATING PROVIDER**

Services that are provided by a Non-Participating Provider when there is no Option B benefits are not covered. In that event, you are responsible for the full costs of any services you receive from a Non-Participating Provider, unless MHP Community Preauthorizes the Non-Participating Provider's services in advance of you receiving the services, or for certain Covered Services related to a Medical Emergency. The following includes, but is not limited to, additional scenarios where MHP Community will not pay for services you receive from a Non-Participating Provider: 1) when a Participating Provider sends labs, pathology or other services to a Non-Participating Provider, 2) you are referred to a Non-Participating Provider by a Participating Provider, 3) services are delivered by a Non-Participating Provider at a Participating Provider facility, 4) when the Participating Provider (e.g., physician) uses a Non-Participating Provider Facility, 5) if you fail to obtain preauthorization in advance to see a Non-Participating Provider, even if MHP Community does not have the services available in-network.

**9.23 SERVICES PROVIDED BY AN UNLICENSED OR UNLAWFUL PROVIDER**

You are responsible for the full costs of any services you receive from a Provider who is not appropriately credentialed or privileged as determined by MHP Community or who is not legally authorized or licensed to provide the services.

**9.24 ILLEGAL SERVICES**

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