meridian

HEALTHY MICHIGAN PLAN

Certificate of Coverage

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Meridian of Michigan, Inc. Medicaid Certificate of Coverage
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Read this entire Certificate carefully. It tells you the rights and obligations of Members and of Meridian. It is the Member's responsibility to understand the terms and conditions of this Certificate.

In some circumstances, certain medical services are not Covered or may need prior Authorization from your plan.

SECTION 1. ABOUT THIS CERTIFICATE

This Certificate has been applied for as Medicaid Coverage. This Certificate sets the terms and conditions of Coverage. It also tells you what healthcare services are Covered for Members under the Healthy Michigan Plan.

This Certificate only Covers Medically / Clinically Necessary services or supplies that a person can get while they are a Member. It replaces any Certificate we might have sent you in the past.

Defined terms are capitalized when used in this Certificate. You can find these definitions in Section 16. The terms "We," "Us," and "Our" refer to Meridian. The terms "You," "Your," and "Yourself" refer to the Member.

If you have any questions about Coverage, write to Member Services at:

Meridian
ATTN: Member Services
777 Woodward Ave., Suite 700
Detroit, MI 48226

You can also reach us by phone at **1-888-437-0606** (TTY: **711**).

SECTION 2. MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of the Health Plan, you have the right to:

- Be treated with respect and dignity.
- Be given and maintain privacy.

- Have a Primary Care Provider (PCP) at all times.
- Get culturally and linguistically appropriate services (CLAS).
- A current listing of network Providers and access to a choice of Specialists within the network who can treat chronic (ongoing) problems.
- Get routine OB/GYN or pediatric (childcare) services from network Specialists without a referral, if the OB/GYN or pediatric Specialist is a Participating Provider.
- Continue getting Services from a Specialist Provider who is no longer in the Health Plan's network if it is Medically / Clinically Necessary.
- Continue Coverage with a Provider who is no longer in the Health Plan's network if you are a Member who is pregnant (that includes up to six weeks after you give birth).
- Have no "gag rules" from the Health Plan. Providers are free to discuss all medical care, even if they are not Covered Services.
- Participate in decision-making about your healthcare.
- Refuse care, get a second opinion, and/or get a copy of your medical record upon request.
- Know how the Health Plan pays its Providers.
- Be provided with a telephone number and address to get more details about payment methods, if desired.
- Tell us if you have a complaint about the Health Plan or the care provided and/or if you want to appeal a decision to deny or limit Coverage.
- Know that you or your Provider cannot be punished for filing a complaint or appeal about your care.
- Get details about the Health Plan, including the services, Providers, and your rights and duties.
- Make suggestions about the Health Plan Member's rights and duties.
- Have your medical record be kept confidential by the Health Plan and your PCP.

As a Member, you also have the responsibility to:

- Make an appointment with a PCP within 60 days of enrollment.
- Make appointments in advance and be on time. If you need to cancel an appointment with any Provider's office, call as soon as possible.
- Use the Hospital emergency room (ER) only for Medical Emergencies. If possible, you should call your Provider before going to the ER.
- Give all the information that you can to your Provider and the Health Plan so they can care for you in the best way.
- Ask questions if you do not understand the care you are getting.
- Talk about your care and help your Providers plan the care you will be getting.
- Complete care that you have agreed to and follow all plans for care.

- Tell the Department of Human Services and the Health Plan right away about any changes to your address or telephone number.
- Tell the Health Plan about any problems you have with services.
- Tell us your suggestions in writing or by calling Member Services for help.
- Carry your Health Plan Member ID Card at all times.

SECTION 3. GETTING COVERED SERVICES

A. Primary Care Provider (PCP)

Your PCP plans your medical care. They give you most of your healthcare. They also refer you to Specialists and other Providers when needed. Your PCP can:

- ✓ Order lab tests and X-rays.
- ✓ Prescribe medicines or therapies.
- ✓ Arrange for you to go to the hospital.
- ✓ And more.

You must talk with your PCP about any issues concerning your medical care. We will only Cover services that your PCP gives or refers and that we authorize, unless we tell you otherwise in this certificate.

When you enroll, you can choose a PCP. If you do not choose a PCP, one will be assigned to you. You can change the PCP that was assigned if you want. The Health Plan's Participating Providers are listed in the Provider directory. Each person in the Subscriber's family may have a different PCP if desired. If you need help choosing a PCP, call Member Services at **1-888-437-0606** (TTY: **711**). When you change your PCP, all medical care you are currently getting must be Authorized and approved by your new PCP.

You can also change your PCP. A parent / guardian may change the PCP of a minor or a Member who is not able to choose a PCP on their own. To do this, call Member Services at **1-888-437-0606** (TTY: **711**). The change will take effect on the first day of the month after we get your request. A PCP change can't be made while you are in the Hospital.

B. Who Can Be Your PCP?

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

C. Federally Qualified Health Centers and Rural Health Clinics

You may get services from Federally Qualified Health Centers and Rural Health Clinics without prior approval from the Health Plan. These services include immunizations, family planning services, well-child visits, and visits for Illnesses or Injuries.

D. Termination of Providers' Participation

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

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

E. Care after Regular Office Hours

Your PCP must have telephone coverage 24 hours a day, seven days a week. If you become ill or injured after regular office hours, you should call your PCP's office and tell them you are a Member of the Health Plan. Your PCP or covering Participating Provider may:

- Give advice over the phone.
- Prescribe medicine or therapy.
- Ask you to come into the office during regular business hours.
- Refer you to another Participating Provider, an Urgent Care Center, or an ER to get help.

F. Medical Emergency or Urgent Care

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

1) Inside the Service Area

Urgent and emergent care is covered without prior authorization. If you have a Medical Emergency or

need Urgent Care, get medical help right away. You are responsible for your emergency room and/or Urgent Care center visit co-pay. Remember to show your ID Card at the emergency room or Urgent Care center. Afterward, call your PCP's office to let them know you went to the ER or an Urgent Care center.

2) Outside the Service Area

If you become ill or injured while you are temporarily away from the Service Area, we will Cover your urgent or emergent medical care without prior authorization. You are responsible for your emergency room and/or Urgent Care center visit co-pay. Remember to show your ID Card at the emergency room or Urgent Care center. Afterward, call your PCP's office to let them know you went to the ER or an Urgent Care center.

3) Follow-Up Care

If you get Medical Emergency or Urgent Care services, you must call your PCP's office as soon as reasonably possible after you get the services. This lets your PCP arrange follow-up care.

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

G. Review of Healthcare Services and Supplies

We can review services and supplies that Health Professionals recommend and decide whether those services and supplies should be Covered. If we decide that the services and supplies are not Covered, we will let you know.

If you want our decision to be reviewed, you must call us. Section 12 tells you how to do that.

H. Healthcare Provider Complaint Verification

Upon request, we can give you the licensing verification telephone number for the Michigan Department of Community Health. You can get information about any disciplinary actions or open formal complaints that have been taken against a healthcare Provider in the past three years.

SECTION 4. ENROLLMENT

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

We will Cover Inpatient care for the Member's Newborn from the child's date of birth. The Newborn will automatically be a Health Plan Member for at least the birth month. The Member can choose to change the Health Plan for a future date by calling the State's Enrollment Broker.

A. Notification of Change in Status

The Subscriber must let us know about any changes that affect Coverage under this Certificate of Coverage. The Subscriber does that by calling Member Services. The Subscriber must also call their Department of Human Services to update this information. This must be done for any of the following reasons:

1) Change of address or phone number.

2) Enrollment or disenrollment in Medicare.

3) Covered under other insurance.

4) Any other change that affects Coverage according to this Certificate.

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

However, you do not need to call the State when you want to change your PCP. Instead, call Member Services at **1-888-437-0606** (TTY: **711**) for help.

B. Loss of Eligibility

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

SECTION 5. EFFECTIVE DATES OF COVERAGE

A. General Rules

In most cases, your Coverage will begin on the first day of the month following the month in which the State notifies us of your enrollment.

B. Non-Hospitalization Requirements

If the Subscriber is hospitalized for the care of an Illness or Injury when Coverage would otherwise begin, their Coverage may not begin until their hospitalization ends. You should call us to verify. This rule does not apply to Newborns.

SECTION 6. COPAY INFORMATION

Some Covered services may have a copay. This means that you need to pay a fee to the Health Plan when you get services.

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

Medicaid Service	Co-Payment
Physician Office Visit **Procedure codes 92002-92014, 99201-99205, 99211-99215, 99241-99245,99341-99345, 99347-99350**	$2
Outpatient Hospital Visit **Revenue code 51x**	$2
Emergency Room Visit for Non-Emergency Service **No co-payment for emergency services** **Revenue code 451 billed without 452, or revenue code 456**	$3
Inpatient Hospital Stay	$50
Pharmacy	**$1 generic/preferred brands** **$3 brand/non-preferred brands**
Chiropractic Visit	$1
Dental Visit	$3
Hearing Aid	$3 per aid
Podiatric Visit	$2
Vision Visit	$2
Urgent Care Center Visit **Procedure codes 99201-99205, 99211-99215**	$2

- You only have to pay your copay if you are age 21 and older.
- You will not have a copay for family planning products or services.
- You will not have a copay for any pregnancy-related products or services.
- You will not have a copay for any preventive services.
- In addition to copays, you will be responsible for a contribution equal to 2% of your adjusted gross income if your income is between 100-133% of the Federal Poverty Level. This amount will be paid to the Health Plan.

- Preventive care services assigned a Grade A or B by the United States Preventive Services Task Force (USPSTF) and all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are not subject to copays. The USPSTF list is available at **uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**.

If you have any questions, call Member Services at **1-888-437-0606** (TTY: **711**).

SECTION 7. SCHEDULE OF COVERED SERVICES

You can get the Covered Services below when those services are:

A. Medically / Clinically Necessary.

B. Provided by your PCP, a Participating Provider, or a Non-Participating Provider upon referral from your PCP and an advance Authorization by us when we consider Authorization needed (except in a Medical Emergency).

C. Not excluded elsewhere in this Certificate of Coverage. You should carefully review the rest of this Certificate for information about the extent of your Coverage.

The Covered Services are:

A. PRIMARY CARE. Primary Care is the care provided by your PCP.

1) Health Maintenance and Preventive Care. The following services are Covered Services for each Member, even when they are not provided in connection with the diagnosis and care of an Illness or Injury:

a) Preventive and screening visits.

b) Routine child and adult immunizations for infectious diseases, as recommended by the Advisory Committee on Immunization Practices (ACIP). Immunizations can be provided by the Health Department. No Authorization is needed for immunizations.

c) One routine gynecological examination every 12 months.

d) Maternity care. Covered Services for maternity care are described below.

e) Outreach for included services, especially pregnancy-related physicals.

f) Health education services.

g) Speech services.

h) Parenting and birthing classes.

i) Tobacco cessation treatment (treatment to quit smoking), including pharmaceutical and behavioral support.

j) Therapies (speech, language, physical, and occupational).

k) Care related to the promotion of healthy behaviors.

You do not have to pay a copay for preventive care services assigned a Grade A or Grade B by the USPSTF.

2) Provider Care. All services listed above can be provided by your PCP during an office visit, Hospital visit, or house call for the diagnosis and care of an Illness or Injury. In addition, a Member can visit an OB/GYN for routine care without prior Authorization if the OB/GYN is a Participating Provider. A minor Member does not need prior Authorization to see a pediatrician who is a Participating Provider.

B. SPECIALTY CARE. Specialty Care is care provided by a Participating Provider, Specialist Provider, or Non-Participating Provider. It must be Authorized in advance by us when we consider Authorization needed, except as noted. More visits may be Covered when Authorized.

1) Allergy testing. These are tests ordered by your Provider to see if you're allergic to certain things. See Section 7, Exclusions from Coverage, under "Allergy Testing" for specific allergy testing that is not Covered.

2) Ambulatory surgical services and supplies. This is a medical facility where you get outpatient services. These services and supplies, along with a Covered surgical procedure on the day of the procedure, are Covered.

3) Breast cancer screening. Procedures to help diagnose breast cancer are Covered, including:

- One mammogram every calendar year for individuals ages 40 years and older.
- Surgical breast biopsy.
- Treatment of breast cancer, including related services when Medically / Clinically Necessary and ordered by your Provider.

4) Chiropractic care. A chiropractor is a special doctor who works with the spine. Members can get up to 18 visits every 12 months without Authorization. More visits may be Covered when Authorized.

5) Contraceptive medications and devices. These are services and supplies that can help prevent pregnancy. They do not require a referral. You can get many of these things even if they are for a medical condition other than birth control:

- Birth control pills.
- Contraceptive foams, jellies, ointments, or devices.
- Implantable contraceptive drugs.
- IUDs (including insertion and removal).
- Condoms (up to 12 at one time and no more than 36 per month).

6) Court-ordered services. Services required by a court order, or as a condition of parole or probation, are only Covered when they are Medically / Clinically Necessary. The services are provided according to our procedures with the needed Authorization.

7) Dental Services. Covered for Members ages 21 and up and Members who are pregnant, regardless of age. Pregnant Members are Covered during their pregnancy and for up to three months after the month of their due date. The MDHHS website has a full list of Covered services.

8) **Diabetic supplies.** Diabetic equipment, supplies, and education for the care of diabetes are covered. Some items/services may require prior authorization.

9) **Durable Medical Equipment (DME)**. Durable Medical Equipment (DME) is covered. Some DME items may require prior authorization.

10) **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.** We Cover EPSDT services as Medically / Clinically Necessary in accordance with federal law and state policy. EPSDT services may be Covered whether they are Covered or not under the Michigan Medicaid State Plan.

11) **End-stage renal disease (ESRD).** ESRD services, including dialysis, are Covered when Authorized.

12) **Family planning. The following are Covered Services that do not need a referral if you get these services at an approved family planning center. You can get these services even if you are not Ill or Injured:**

    (a) Help with infertility. This means you are having trouble getting pregnant.

    (b) Advice about contraception and family planning, including childbirth education.

    (c) Care for sexually transmitted infections (STIs).

13) **FDA-approved antineoplastic drugs.** Antineoplastic drugs are drugs that are used to treat cancer. FDA-approved antineoplastic drugs are Covered. Some drugs may be used to treat certain kinds of cancer for which the drugs were not originally approved. We will approve Coverage for these drugs if:

    (a) The drug is ordered by a Provider to treat a certain type of cancer.

    (b) The drug is approved by the FDA for use in cancer therapy.

    (c) The drug is used as part of cancer drug care.

    (d) Current medical research shows that the drug works well.

    (e) Cancer doctors agree that the drug should be used.

    (f) You have agreed with your Provider to use the drug.

14) **Habilitative services.** Habilitative services are services that help a person keep, learn, or improve skills for daily living. These services may include physical and occupational therapy, speech language pathology, and other services.

15) **Hearing care.** Health services provided for the diagnosis and care of diseases of the ear are Covered. Hearing exams and hearing aid evaluations are available from a Participating Provider. Medically / Clinically Necessary hearing aids are Covered once every five years when provided by a licensed hearing aid dealer or audiologist.

We Cover up to 36 disposable hearing aid batteries per hearing aid every six months.

Replacement earmolds for hearing aids requiring custom earmolds are Covered on the following schedule.

- Members 13 and over: once every 12 months per aid.
- Members ages 3 to 13: twice every 12 months per aid.
- Members under 3: four times every 12 months per aid.

16) **Home healthcare.** Intermittent skilled services, including hospice services, that are Authorized in advance by us are Covered as long as they are given in the home by a home healthcare agency, registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist, speech therapist, or another Health Professional as needed. Custodial care is not Covered, even if you receive home health care services along with custodial care.

17) **Hospice care.** This is care that you get near the end of your life. Both Inpatient and Outpatient services are Covered.

18) **Hospital care.** We Cover both Inpatient and Outpatient care.

19) **Mental health Outpatient care.** Outpatient mental health services are covered for individuals with mild to moderate conditions. Coverage includes evaluation, consultation, and psychological testing when necessary for diagnostic purposes. Prior authorization may be required for certain services.

20) **Oral surgery.** We Cover many kinds of surgery for the jaw and mouth. This could be because of:

(a) Broken bones in a person's face.

(b) Tumors on the jaw or mouth.

(c) Repair of the mouth or lip because of a birth defect or Injury.

21) **Orthognathic surgery.** Orthognathic surgery is surgery to move (but not remove) an individual tooth or line of teeth. This kind of surgery should be given with orthodontic care. We will only Cover these services when they are Medically / Clinically Necessary. Services must be Authorized in advance by us with your PCP and a dentist, if needed.

Orthodontic care, which focuses on misaligned teeth and jaws, is not a Covered Service on its own.

22) **Outpatient prescription drugs.** Covered prescriptions must be on our drug list (formulary) or have Prior Authorization. Generic drugs are generally Covered first. Prescriptions will be given in quantities up to a 30-day supply at retail pharmacies, including Coverage for off-label use of FDA-approved drugs when Medically / Clinically Necessary. Certain maintenance medications may be filled for a 90-day supply through a participating mail-order pharmacy, as indicated on our formulary.

23) **Over-the-counter (OTC) drugs and supplies.** The Health Plan Covers OTC items in full with a Participating Provider's order and when given by a participating pharmacy.

24) Pain management. Your PCP can help if you have ongoing pain. Your PCP may also refer you to a pain management Specialist or center. If your pain is an emergency, call **911** or go to the nearest ER.

25) Podiatry. The diagnosis and care of disorders of the foot, ankle, and lower leg are Covered.

26) Prosthetic and orthotic / support devices. These are devices that are worn to replace or support a missing or damaged body part. These devices must be prescribed by your PCP or a Participating Provider. They also must be Authorized in advance by us. These devices can replace all or part of:

(a) An internal organ that is not working right.

(b) An external body part that is missing, damaged, or weakened because of an Injury or Illness.

(c) Breasts that had to be removed because of breast cancer.

When a device is Covered, we will repair or replace the device if needed because of normal growth or normal wear and tear.

27) Provider care. All services listed in this Section provided by a Participating Provider or other Provider during an office visit, Hospital visit, or house call for the diagnosis and care of an Illness or Injury are Covered.

28) Radiology exams and lab procedures. Diagnostic and therapeutic radiology services and lab tests are Covered as long as they are not excluded elsewhere in this Certificate.

29) Reconstructive surgery. Reconstructive surgery to fix birth defects is Covered if we reasonably expect the surgery to fix the condition. We will only Cover surgery within two years of the event that caused the Injury, unless either of the following applies:

(a) The Injury was not recognized at the time of the event. In that case, care must be given within two years of the time that the problem was found.

(b) Your care needs to be delayed because of developmental or medical reasons.

30) Short-term rehabilitative therapy. Physical therapy, cardiac rehabilitation, pulmonary therapy, and occupational therapy or speech therapy are Covered if due to:

- An Injury.
- An Illness.
- A congenital defect for which you have had corrective surgery.

These services are Covered if you get them as an Outpatient or at home. The services must be expected to improve your condition within 60 days. Services are only Covered if a Participating Provider refers, directs, and monitors them and consults with us in the process. Speech therapy for developmental delay and cognitive rehabilitative therapy are not Covered. Services are not Covered if provided by another public agency.

31) Skilled nursing facility care or Inpatient rehabilitation or hospice facility care. Care including physical therapy and semi-private room and board at a skilled nursing, Inpatient rehabilitation, or hospice facility are Covered when the Health Plan has approved in advance. Such services must be supported by a care plan that we have also approved in advance. Custodial care is not a Covered benefit.

32) Substance use. Substance use services provided by the local coordinating agency in your area are Covered. Please call Member Services at **1-888-437-0606** (TTY: **711**) for more information.

33) Telemedicine. Telemedicine is the use of voice or video on a phone, tablet, or computer to connect you with a Participating Provider in a different location. Meridian offers telemedicine for some visits. Please call Member Services at **1-888-437-0606** (TTY: **711**) to see what services qualify for telemedicine visits.

34) Temporomandibular joint syndrome (TMJ syndrome). TMJ syndrome is a condition in which a person has muscle tension and spasms related to the temporomandibular joint (TMJ), facial, and cervical muscles. TMJ syndrome causes pain, loss of function, and neurological (brain and/or nerves) dysfunction. You have Coverage for the following services if they're Authorized in advance by us:

(a) Office visits for medical evaluation and care of TMJ syndrome.

(b) Specialty referral for medical evaluation and care of TMJ syndrome.

(c) X-rays of the TMJ, including contrast studies but not dental X-rays.

(d) Myofunctional therapy.

(e) Surgery to the TMJ, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

35) Transplants. Transplants involve taking out an organ and replacing it. Transplants of the following organs are Covered at a facility approved by us, but only when we have pre-approved the transplant as appropriate, Medically / Clinically Necessary, and non- experimental:

(a) Cornea.

(b) Heart.

(c) Lung.

(d) Kidney.

(e) Bone marrow.

(f) Liver.

(g) Pancreas.

(h) Small bowel.

We will Cover the donor's medical expenses according to Healthy Michigan policy if the person getting the transplant is a Member and the donor's expenses are not Covered by another insurance carrier. The potential donor does not need to be a parent, child, or sibling of the Member getting the transplant to be

Covered. We will Cover expenses for a donor search even if the Member ends up not finding a potential donor. We will Cover FDA-approved drugs used in antineoplastic therapy. We will also Cover expenses such as allogeneic, autologous, and peripheral stem cell harvesting and small bowel transplants. We will Cover computer searches and any subsequent testing needed after the potential donor is identified, unless Covered by another insurance carrier.

36) **Transportation.** Ambulance and other emergency medical transportation are Covered. Hardship-based transportation services for medical visits (and dental visits for pregnant Members and for Members ages 21 and older as described in Section 7 B & C) are also Covered when you get prior Authorization from the Health Plan.

37) **Vision care.** Services and supplies relating to vision care are Covered. This includes one eye exam every 24 months to determine the need for eyeglasses and lenses in all sizes and powers. This includes a selection of approved ophthalmic frames. The repair or replacement of frames or lenses due to loss or breakage is also a Covered benefit.

38) **Voluntary sterilizations.** This means having surgery so that you can no longer have children. Tubal ligation (also called "tying the tubes") is a Covered service. Vasectomy is Covered, only when performed in a physician's office or in connection with other Covered Inpatient or Outpatient surgery. All Members getting voluntary sterilizations must sign the Sterilization Consent Form 30 days before the sterilization. The Member to be sterilized must be at least 21 years of age.

39) **Weight loss programs and bariatric surgery.** Medically / Clinically Necessary weight loss services are Covered when Authorized in advance by the Health Plan. Bariatric surgery is Covered once per lifetime. Unless Medically / Clinically Necessary, a second bariatric surgery is not Covered, even if the initial bariatric surgery happened before Coverage under this plan.

B. MATERNITY CARE.

1) **Hospital and Provider.** Services and supplies given by a Hospital or Participating Provider for prenatal care (before birth), postnatal care (after birth), Hospital delivery, and care for any problems with pregnancy.

2) **Newborn child care.** A Member's Newborn will automatically be enrolled in the Health Plan. If the parent or guardian wants to change the Newborn to another Health Plan, they must call Michigan Enrolls.

3) **Home care services.** Home care services are Covered when combined with the Early Care Healthy Family Program.

4) **Doula services.** A doula is a trained health worker who can help you during your pregnancy, delivery, and postpartum period. Doulas must be certified and registered with MDHHS as a Medicaid Provider for their services to be Covered. Limited to 12 visits.

C. MEDICAL EMERGENCY AND URGENT CARE.

Urgent and emergent care is covered without prior authorization. If you have a Medical Emergency or need Urgent Care, get medical help right away. You are responsible for your emergency room and/or Urgent Care center visit co-pay. Remember to show your ID Card at the emergency room or Urgent Care center. Afterward, call your PCP's office to let them know you went to the ER or an Urgent Care center. The following are Covered Medical Emergency services:

1) Within the Service Area.

(a) Services and supplies that you get for any condition that we determine to have been a Medical Emergency, following our review of the proper medical records.

(b) Emergency services, include stabilization of your condition. This means services are Covered until no further worsening of your condition is likely to occur.

(c) Services and supplies that you get for any condition that we determine to have required Urgent Care at the time you received the services and supplies, following our review of the proper medical records.

(d) Hospitalization for a Medical Emergency in a facility that is a Non-Participating Provider, until, in our determination, it is appropriate for you to be transferred to a Participating Provider.

2) Outside the Service Area. Prior Authorization is required for any services given outside of the Service Area, except for Medical Emergency services or Urgent Care services. We will not Cover services and supplies you get during travel outside the Service Area if the only reason for the travel is to get medical services or supplies (unless we Authorize in writing that we will Cover them).

3) Follow-up care. Services you get from, or upon referral from, your PCP as follow-up care resulting from a Medical Emergency or Urgent Care situation are Covered. For follow-up care received outside of the Service Area, we will only Cover one PCP- approved visit for each Medical Emergency or Urgent Care situation, unless we and your PCP approve more visits in advance.

4) Ambulance services. In the case of a Medical Emergency, ambulance service to the nearest medical facility is Covered. Transfer by ambulance to another facility is also Covered.

SECTION 8. EXCLUSIONS FROM COVERAGE

The following is a list of services and supplies that we do not Cover. This means it is excluded. We will not Cover anything below unless it is required under state or federal law.

1) Acupuncture. This is when a provider uses needles placed just under the skin to treat things like pain. There is no Coverage for acupuncture services.

2) Adaptive aids / self-help items. These are services or supplies that can help you with reaching, eating,

dressing, using the bathroom, and more. There is no Coverage for these services or supplies.

3) **Against medical advice.** There is no Coverage for any care that goes against the advice of a Participating Provider. Also, there may be no Coverage for any service or care plan if you voluntarily discharge yourself, or are otherwise discharged, against the advice of a Provider.

4) **Allergy testing.** Any allergy testing and treatments that have not been proven to work are not Covered.

5) **Biofeedback for mental health diagnoses.** This is when a machine measures what your body is doing when you are feeling a certain way, like if you are anxious or depressed. There is no Coverage for biofeedback testing for mental health.

6) **Care in a federal, state, or governmental entity.** We do not Cover, to the extent permitted by law, services and supplies provided in a Non-Participating Hospital owned or operated by a federal, state, or other governmental entity unless Authorized by us.

7) **Clinical ecology and environmental medicine.** These are medical practices based on the belief that exposure to low levels of many common things in the environment can cause health issues. There is no Coverage for services and supplies that change your physical environment.

8) **Cosmetic services.** Cosmetic surgery or procedures are usually done to improve how the body looks. Some examples are surgery to increase breast size, remove scars or extra skin, or change how a person's nose looks. There is no Coverage for most kinds of cosmetic surgery.

9) **Court-ordered services.** Services required by a court order or as a condition of parole or probation are not Covered unless the services ordered by the court are Covered under this Certificate and are provided according to our procedures.

10) **Custodial care.** Any care you get after you have reached the maximum, in our opinion, level of mental and/or physical function where you won't improve significantly more. This includes room and board, nursing care, home health aides, and personal care designed to help you in the activities of daily living. This also includes home care and adult day care that you get, or could get, from Members of your family.

11) **Ear plugs.**

12) **Educational services and services for behavioral disorders.** The Health Plan does not Cover school-based services. You can get these services through your local school system.

13) **Experimental, investigational, or unproven services.** We do not Cover any drug, device, treatment, or procedure that is experimental, investigational, or unproven. This means:

    (a) The drug or device cannot be sold in the United States because it has not been approved by the Food and Drug Administration (FDA).

    (b) The drug or service is still being studied to see how well it works.

    (c) The drug or service has not been proven to work.

Note: This Section does not exclude Coverage for FDA-approved antineoplastic drugs as described in Section 7, Schedule of Covered Services, above.

14) Hair analysis. This is when a piece of your hair is tested for certain health issues. There is no Coverage for hair analysis.

15) Hypnotherapy. This is when a provider will put you into a state of deep relaxation and concentration as part of therapy. There is no Coverage for hypnotherapy.

16) Infertility and abortions. All services and supplies relating to infertility, such as *in vitro* fertilization or other services meant to achieve pregnancy, are not Covered. Elective abortions (when you choose to end a pregnancy) and services to reverse voluntary sterilization are not Covered.

17) Leave of absence. Charges incurred when you are on an overnight or weekend pass during an Inpatient stay.

18) Marriage / relationship counseling. Neither marriage nor relationship counseling are Covered.

19) Mental health / substance abuse. Only services listed in Section 7 are Covered. Services beyond those listed in Section 7 may be Covered by your local Prepaid Inpatient Health Plan (PIHP) through Community Mental Health Centers (CMH). Call Member Services at **1-888-437-0606** (TTY: **711**) for help getting these services.

20) No legal obligation to pay. Any service or supply that you would not have a legal obligation to pay for without this Coverage. This includes, among other things, any service performed or item supplied by a relative of yours that, if in the absence of health benefits Coverage, you would not be charged for the service or item.

21) No-show charges. Any missed appointment fee charged by a Participating Provider because you did not show up at an appointment, except in the case of a Medical Emergency.

22) Non-Participating Providers. Services and supplies from a Non-Participating Provider. This does not apply in the case of:

(a) A Medical Emergency or when we have Authorized the services and supplies in advance.

(b) The care of communicable diseases, such as TB or sexually transmitted infections (STIs), at a local health department or Healthy Michigan-approved family planning center.

(c) Family planning services given at a Healthy Michigan-approved family planning center or at a local health department.

(d) Services provided at Child & Adolescent Health Centers (CAHCP), Federally Qualified Health Centers (FQHC), or as otherwise stated in this Certificate of Coverage.

(e) Immunizations.

23) Not Medically / Clinically Necessary. Services and supplies that we determine are not medically/ clinically necessary. If you disagree with us about medical /clinical necessity, you (with a participating provider, if you wish) may appeal our decision. Unless and until we agree with you that the services and supplies will be covered services, they will not be a part of your coverage. If we exclude coverage because a service or supply was not medically/clinically necessary, that's a determination about benefits and not a medical care determination or recommendation. You, with your participating provider, may choose to appeal our denial of your claim for coverage.

24) Obstetrical delivery in the home (home birth). Services and supplies related to giving birth at home are not Covered.

25) Personal comfort or convenience Items, household fixtures, and equipment. We do not Cover:

(a) Services and supplies not directly related to your care, such as guest meals and accommodations, phone charges, travel expenses, take-home supplies, and similar costs, among other things.

(b) The purchase or rental of household fixtures, such as escalators, elevators, swimming pools, and similar fixtures, among other things.

(c) The purchase or rental of household equipment that have customary non- medical purposes, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds, and similar equipment, among other things.

26) Private duty nursing.

27) Prosthetic and orthotic / support devices. Orthopedic shoes, shoe inserts, and other supportive devices of the feet for adults ages 21 and over as limited by the Healthy Michigan Plan.

28) Relational, educational, and sleep therapy. We do not Cover these services unless they are part of a Covered Inpatient Hospital service.

29) Religious counseling. We do not Cover religious counseling.

30) Routine foot care. We do not Cover:

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

(b) Cleaning, soaking, and skin cream application for the feet unless Medically / Clinically Necessary.

31) Self-referral. Services and supplies from any Health Professional upon self-referral by you. This exclusion does not apply in the case of:

(a) A Medical Emergency or when we have Authorized the services and supplies in advance.

(b) The care of communicable diseases such as TB or STIs at a local health department or Healthy Michigan-approved family planning center.

(c) Family planning services given at a Healthy Michigan-approved family planning center or at a local health department.

(d) Immunizations.

(e) Mental health services.

(f) Services otherwise stated in this Certificate of Coverage.

32) Services required by third parties. We do not Cover:

(a) Physical exams done more than once per year by your PCP.

(b) Physical exams performed by a Provider other than your PCP.

(c) Services related to you getting or keeping a job.

(d) Services related to you getting or keeping any license issued by a government body.

(e) Services related to you getting insurance Coverage.

(f) Services related to foreign travel.

33) Sex therapy. We do not Cover services and care related to sex therapy.

34) Transitional / residential or assisted living. We do not Cover temporary or permanent non-skilled care given in a home or facility. Examples include room and board, healthcare aids, and personal care that can help you in the activities of daily living.

35) Unauthorized services and supplies. We do not Cover services and supplies that your PCP didn't perform, prescribe, or plan according to the guidelines of this Certificate. This includes services in which a provider did not get prior Authorization from us. This does not apply to services needed to treat a Medical Emergency, Urgent Care situation, family planning, the care of STIs, immunizations, or services otherwise stated in this Certificate of Coverage.

36) Vocational rehabilitation. We do not Cover work-related therapy and evaluations of work sites.

37) Weight control. We do not Cover services and supplies related to weight control, unless the Member is Authorized by the PCP and the Health Plan has decided the condition is severe or life threatening.

SECTION 9. LIMITATIONS

You may only get services from a Participating Provider or another Health Professional. Your PCP must approve or Authorize those services. Services must be Authorized by us in advance when required, unless this Certificate of Coverage says otherwise.

Some Covered Services are subject to maximum limitations. This means there may be a set number of times that you can get the service. Once you have reached the maximum limitation for a Covered Service, you will be responsible for the cost of additional services.

A. Work-Related Illness or Injury

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

B. Services Received as a Member

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

C. Uncontrollable Events

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

SECTION 10. MEMBER CLAIMS RESPONSIBILITIES

In general, you are not responsible for the cost of services that you get. However, you are responsible for the cost of any services you get from Non-Participating Providers, unless those services were arranged by your PCP and Authorized in advance by us, or unless you need them to treat a Medical Emergency or Urgent Care situation, immunizations, family planning services, services for STIs, mental health services, or services otherwise stated in this Certificate of Coverage.

If you must pay a healthcare Provider for Covered Services, you can ask us in writing to be reimbursed for those services. This means we will pay you back for any money you paid. You must give us proof of payment with your request within 90 days of the date you got the services. If you do not ask for reimbursement within one year, we can limit or refuse reimbursement. We will not limit or refuse reimbursement if it is not reasonably possible for you to give us proof of payment in the required time, as long as you give us the required information as soon as reasonably possible. We will never be liable for a claim or reimbursement request if we got proof of payment for it more than one year after the date you got the services, unless you are legally incapacitated. Send your itemized medical bills promptly to us at:

Meridian
Attn: Claims Department
PO Box 8080
Farmington, MO 63640

Before we pay healthcare Providers or reimburse you for services you got, we may ask you to give us more information or documentation to prove that you got Covered Services. Our right to that information or documentation may be limited by state or federal law.

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

SECTION 11. TERMINATION OF COVERAGE

A. Loss of Eligibility

You'll lose your eligibility and your coverage will terminate (end) if you stop meeting the eligibility criteria as required by the Department of Health and Human Services.

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

B. Termination for Cause

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

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

(1) You fail, after repeated tries, to establish or maintain a satisfactory Provider- patient relationship with a Participating Provider.

(2) You refuse to cooperate with us as required by the terms of this Certificate or the Agreement.

(3) We find out you have committed fraud against us or you have been dishonest with us about some important or "material" matter. For example, we may request that the State terminate your Coverage if we find out you gave us wrong or misleading information or you let someone else use your ID Card. Also, we can collect from you the Reasonable and Customary Charges for Covered Services that you got after the effective date of termination, plus our cost of recovering those charges (including attorney's fees).

(4) You act so disruptively that you upset our ordinary operations or those of a Participating Provider.

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

SECTION 12. MEMBER COMPLAINT/GRIEVANCE AND APPEALS PROCEDURE

Member Complaint / Grievance Procedure

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

To report a complaint / grievance, call Member Services at **1-888-437-0606** (TTY: **711**). They will help you fill out a form to begin looking into the problem.

The Health Plan has a process for complaints / grievances. A special person handles the complaints / grievances. We will get back to you within 30 calendar days, except if waiting that long would hurt your health. In those cases, we will get back to you within three calendar days.

Member Appeals Procedure

If the Health Plan has decided to deny, terminate, or reduce any Covered service, you can file an appeal. This means you are asking us to reconsider our decision. You can call or write to the Health Plan when you want to make an appeal. Call Member Services at **1-888-437-0606** (TTY: **711**). Written requests can be mailed or faxed to:

Meridian
ATTN: Appeals Coordinator
P.O. Box 10353
Van Nuys, CA 91410-0353
Fax: 833-341-2044

If needed, Member Services can help you file an appeal. You also have the right to go to a hearing if you wish (see Fair Hearing Process). The Health Plan has 30 calendar days to answer your Appeal.

The Plan's 30-day review period may be delayed by up to 14 days when:

- You request an extension.
- The Plan needs more information and the delay would be in your interest.

If you want to make an Appeal, you must send your request **in writing within 60 calendar days** of the Health Plan's answer to your complaint or denial of services.

Expedited Appeals

You may file an Expedited (fast) Appeal in certain situations. You can file an Expedited Appeal when the Plan's denial of your requested service:

- Could seriously risk your life.
- Could seriously risk your ability to regain maximum function.

- If your Provider believes the Plan's denial would subject you to severe pain that cannot be adequately managed without the requested service.

You must file a request for an Expedited Appeal within 60 Days of the Plan's denial. You can request an Expedited Appeal verbally or in writing. We will decide and notify you verbally within 72 hours of the Expedited Appeal request. We will send you a written notice no later than three days after verbal notification.

External Review

If after your appeal you are still unhappy with the decision that the Health Plan has made about your grievance, you can ask for an external review. This means someone outside the Health Plan will review the case to see if we made the right decision.

You must ask for an external review within 127 days of getting our appeal decision. Requests for external review should be sent to:

Department of Insurance and Financial Services Office of General Counsel-Appeals Section
P.O. Box 30220
Lansing, MI 48909-7220
Phone: 1-877-999-6442
Fax: 1-517-284-8838
difs.state.mi.us/Complaints/ExternalReview.aspx

The Department of Insurance and Financial Services will decide whether your request is eligible and will send it to an Independent Review Organization.

Expedited External Review

You may file an Expedited External Review request when:

- A physician says, either orally or in writing, that the standard time frame for review of the appeal would seriously jeopardize your life or your ability to regain maximum function.
- You have already filed a request for an Expedited Internal Appeal with the Plan.

Expedited External Review requests are sent to the Department of Insurance and Financial Services at the address above. You must send your request within 10 Days. The department decides whether your request should be expedited or not and will assign it to an Independent Review Organization.

Fair Hearing Process

You may also file a complaint directly with the Michigan Office of Administrative Hearings and Rules (MOAHR) for the Department of Community Health. You must exhaust all internal appeals with the Plan before filing a complaint with MOAHR. You must file your complaint with MOAHR within 120 days of your denial from us. Listed below are the steps for the State of Michigan's Medicaid fair hearing process:

Step 1: Call **1-800-648-3397** to ask questions about the hearing process.

Step 2: Fill out the request (complaint) form and return it to the address listed. You will be sent a letter telling you when and where your hearing will be held.

Step 3: The results will be mailed to you after the hearing is held.

Step 4: If your appeal is taken care of before the hearing date, you must call to ask for a hearing request withdrawal form. You can call **1-800-648-3397** to request this form.

SECTION 13. EXTENSION OF BENEFITS

We will continue your Covered Services if the Agreement is terminated while you are in a Hospital. After termination, we will Cover Services only if you are hospitalized and only for the specific medical condition causing that hospitalization. As soon as one of the following happens, you'll stop getting benefits from the Health Plan:

A. The hospitalization is no longer Medically / Clinically Necessary or is for non- Covered Services, such as custodial care.

B. You have Coverage from another health insurance carrier for the Inpatient stay.

SECTION 14. COORDINATION OF BENEFITS

A. Subrogation

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

B. Right of Recovery

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

C. Coordination of Benefits

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

SECTION 15. MEDICARE AND OTHER FEDERAL OR STATE GOVERNMENT PROGRAMS

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

A. Non-duplication of Benefits

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

B. Coordination with Medicare

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

(1) Election Against Coverage. Despite any other provision under this Certificate, Medicare will always be the Primary Payer and we will be the Secondary Payer.

(2) Members Eligible for Medicare ESRD Benefits. Except as provided below, if you are entitled to or are eligible for end-stage renal disease (ESRD) Medicare benefits, the primary payer will be Medicare. If you have primary Coverage under Medicare by reason of age or disability and you later become eligible for Medicare ESRD Coverage, Medicare will remain primary to this Plan.

(3) Eligibility for Medicare. In determining benefits payable under Medicare, you'll be considered enrolled for and Covered by all Medicare (both parts A and B) and other governmental benefits to which you are eligible, whether you are actually enrolled or not.

(4) Legislative and Regulatory Changes. Despite any other provision of this Certificate, if any existing legislation or regulation is adopted or altered, or if any new legislation or regulation is enacted or adopted, further permitting this Plan to be secondary to Medicare, the Health Plan will be secondary to Medicare as permitted by that legislation or regulation.

SECTION 16. DEFINITIONS

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

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

Authorize or Authorization. The process we use to determine whether services or supplies are Covered.

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

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

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

Covered Services, Coverage, Cover, or Covered. Those services and supplies that you are entitled to under this Certificate if they are Medically / Clinically Necessary and you have met all other requirements of the Agreement and this Certificate. The Agreement and this Certificate limit what we will pay for some of those services and supplies. When we say we will "Cover" a service or supply, that means we will treat the service or supply as a Covered Service.

Disabled or Disability. Under the Social Security Act, you are Disabled or have a Disability if — taking into account your age, education, and past work experience — you are unable to do any substantial gainful activity by reason of a medically determinable physical or mental impairment, or a combination of impairments, which can be expected to result in death or which has lasted or can be expected to last at least 12 consecutive (repeated) months.

Durable Medical Equipment (DME). Equipment which is:

(a) Made for repeated use.

(b) Mainly used for a medical purpose.

(c) Appropriate for use at home.

(d) Generally not useful unless a person has an Illness or Injury.

Health Plan or Plan. The Health Plan providing benefits under this Certificate of Coverage.

Health Professional. Someone who gives healthcare services if that person is qualified under state law to give those services.

Health Risk Assessment (HRA). A comprehensive assessment of Member's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS, and social needs.

Healthy Michigan Plan (HMP). Program operated under an 1115 Waiver approved by CMS to give Medicaid Coverage to all adults in Michigan with incomes up to and including 133% of federal poverty level.

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

Hospital. A properly licensed acute care institution that mainly gives Inpatient medical care for ill and injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24- hour-a-day nursing and Physician service.

HRA. Health Risk Assessment.

ID Card. The Member Identification Card you get from us as proof of your enrollment with us.

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

Initial Enrollment. First enrollment in Medicaid Health Plan following determination of eligibility. Reenrollment in a Medicaid Health Plan following a gap in eligibility of less than two months is not considered initial enrollment.

Injury or Injured. Accidental bodily Injury.

Inpatient. When you get services at a medical facility that require you to stay at the Hospital or facility for more than 24 hours.

Maximum Eligible Benefit. The total benefit to which you would be entitled to under the Health Plan for a Covered Service if no other Payer were to give you Coverage for that service.

Medical Director. A Michigan-licensed Physician we have designated to supervise and manage the medical aspects of our healthcare delivery system.

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

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

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

(a) Those services rendered by a Health Professional that don't require the technical skills of such a Provider.

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

Medicaid. The program of medical assistance benefits under Title XIX of the Social Security Act, Michigan Social Welfare Act, MCL 400.1 et seq., and other applicable laws, and regulations, and various Demonstrations and Waivers.

Medicare. Title XVIII of the Social Security Act, the federal health insurance program for people ages 65 or older, people under 65 with certain disabilities, and people with end-stage renal disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare Part A gives Coverage of Inpatient hospital services and services of other institutional Providers, such as skilled nursing facilities and home health agencies. Medicare Part B gives supplementary medical insurance that Covers physician services, Outpatient services, some home healthcare, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and care of Illness or Injury. Medicare Part C gives Medicare beneficiaries with the option of getting Part A and Part B services through a private Health Plan. Medicare Part D gives Outpatient prescription drug benefits.

Member. A person enrolled with us as a Subscriber.

Newborn. A child 30 days old or younger.

Non-Participating Provider. A Health Professional or other entity who hasn't contracted with us to give Covered Services to Members.

Orthognathic Surgery. Surgery of the mouth involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic care.

Outpatient. When you get services at a medical facility that do not require you to stay overnight.

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

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

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

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

Primary Care Provider (PCP). Practitioner of primary care selected by the Member or assigned to the Member by the ICO and responsible for providing and coordinating the Member's healthcare needs, including the initiation and monitoring of referrals for specialty services when required. PCPs may be nurse practitioners, physician assistants, or physicians who are board certified, or a specialist selected by a Member.

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

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

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

Service Area. A geographical area, designated by us and approved by the proper regulatory authority. We publish precise Service Area boundaries, and you may get that information from Member Services.

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

Specialist Provider. A Participating Physician, other than a PCP, under contract with us to give Covered Services upon Authorization in advance by us.

Subscriber. A person who (a.) meets all applicable eligibility requirements of the State of Michigan; and (b.) who has enrolled for Coverage.

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

Urgent Care Center. A certified facility that gives Urgent Care for the immediate care of an Injury or Illness.

We, Us, Our. The Health Plan.

You, Your, Yourself. The Member, whether enrolled with the Health Plan as a Subscriber or Covered Dependent.

SECTION 17. GENERAL PROVISIONS

A. Independent Contractors

We do not agree to directly give any healthcare services under the Agreement, and we have no right or responsibility to make medical care decisions. Those decisions may only be made by Health Providers in consultation with you. We're only obligated to give Members a network of healthcare services. We alone are responsible for making benefit determinations under the Agreement and Our contracts with Participating Providers. Healthcare Providers alone are responsible for making independent medical judgments.

Healthcare Providers and you may choose to continue medical care even if we deny Coverage for that care.

You'll be responsible for the cost of that care. Healthcare Providers and you may appeal any of our benefit decisions. Any appeal must follow the inquiry and grievance procedure explained in Section 12.

B. Authorization to Release Medical Information

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

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

C. Entire Agreement

This Certificate of Coverage, along with the enrollment form, any riders, and any amendments or attachments, is the entire Agreement between you and the State of Michigan and us. Beginning on the effective date of Coverage, the Certificate of Coverage supersedes all other agreements for healthcare services and benefits between you, the State of Michigan, and us.

D. Non-assignment

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

E. Truth in Application and Statements

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

F. Loss or Theft of ID Card

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

G. General Obligations

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

The Health Plan will render Covered Services to Members in the same manner, in accordance with the same standards and within the same time availability as a Physician / Provider offers those services to that Physician / Provider's non-Plan patients. The Physician will not segregate Members in any way or treat them in a location or manner different from any of their non- Health Plan patients.

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