Welcome to the Molina family.

Michigan MIChild Welcome Kit

- Member Handbook
- Certificate of Coverage

www.MolinaHealthcare.com

Your Extended Family.

Welcome and thank you for choosing Molina Healthcare as your health care plan. Molina Healthcare is a Michigan MIChild Health Plan. We hold a certificate of authority issued by the State of Michigan as a Health Maintenance Organization (HMO). We know how important your health is to you. We will do all that we can to help you with your health care needs.

This book explains how to get the services that you may need. If you need this book in a language other than English or in a different format because of special needs, please contact our Member Services Department at 1-888-898-7969.

Please call our Member Services Department at 1-888-898-7969 for information or to tell us about any concerns you may have.

Molina Healthcare contracts with independent doctors who will take care of you. You can get a list of Molina Healthcare doctors by going to our website at www.molinahealthcare.com. You can contact Molina Healthcare's Member Services Department to get a paper list of doctors. Your Primary Care Provider (PCP) will also arrange any care you need from other doctors. Please call your PCP to make an appointment as soon as possible.

Just as a reminder, please let us know if you change your telephone number or address. Call Member Services between 8:00 AM and 5:00 PM, Monday through Friday, at 1-888-898-7969, and MIChild at 1-888-988-6300

Thank you for choosing Molina Healthcare!

Molina Healthcare Key Contact List

Member Services 1-888-898-7969
TTY/Michigan Relay Service........... 1-800-649-3777

March Vision Care 1-888-493-4070
TTY/TDD 1-877-627-2456

Nurse Advice Line
English 1-888-275-8750
Spanish..1-866-648-3537
TTY/TDD English 1-866-735-2929
TTY/TDD Spanish 1-866-833-4703

MyMolina.Com Support Desk 1-866-449-6848

MIChild 1-888-988-6300

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Member Services

Member Services Department

Molina Healthcare provides you with a toll free direct line to Member Services at 1-888-898-7969. Member Services will answer your questions about plan benefits and help you with any concerns you may have about our services, including:

- General Information
- Change of address or phone number
- Changing doctors
- Claim information
- Wellness information
- Requesting an identification (ID) card
- Benefit information
- PCP address and phone number
- Filing a grievance or appeal

You may contact Member Services by:

visiting the Member Services Department at the Molina Healthcare office

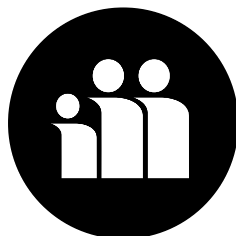
calling the Member Services Department at 1-888-898-7969 during normal business hours, Monday through Friday, from 8 a.m. until 5 p.m., or

visiting our website at www.mymolina.com

Oral interpretation services are available if you are non-English speaking and need interpretive services, we have Spanish and Arabic speaking Member Service Representatives to serve you. All other languages are assisted by the use of our language line at 1-800-752-6096. If you are hearing impaired please use

Michigan Relay at 1-800-649-3777 to speak with a Member Service Representative. If you need written materials in a language other than English or require materials in a different format because of special needs, please contact Member Services at 1-888-898-7969.

Member Online Self Services

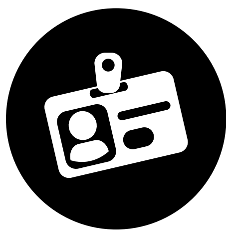


Molina Healthcare offers members help with requests on the MyMolina Web Portal. MyMolina is an easy way to access your personal health information without picking up the phone! By visiting MyMolina, you can change your doctor, request or print an ID card, check your eligibility, view your health record, request materials, and view your benefits. Go to MyMolina.com to get started. If you have any problems with MyMolina, call the Help Desk at 1-866-449-6848.

Changing Your Personal Information

It is important that we are able to get in touch with you. If you change your name, address or telephone number, please call the Member Services Department at 1-888-898-7969 and MIChild at 1-888-988-6300. You can also get this service through the internet at www.mymolina.com.

Member ID Card



When you become a member of Molina Healthcare, you will get a Member ID card. You will need to carry this card with you at all times. You must show your Molina Healthcare ID card when getting care from your doctor, getting your prescriptions filled or using the hospital emergency department.

Your card will have your name and ID number on it as well as your PCP name and number. New ID cards will be mailed to you when you change doctors or you request a new one.

All eligible children will have their own ID card. Only the person on the card may use it for service. You may be asked to show a picture ID when using your Molina Healthcare ID card. This is to make sure no one else is using your card.

Member Out-of-Pocket Cost

Molina Healthcare will pay for all covered services. There are no co-payments, deductibles or any other out-of-pocket cost to you to obtain Molina Healthcare covered services. Members should not sign any agreements to pay for services.

You may be required to pay for services if you ask for and get services that are not covered by Molina Healthcare or MIChild.

If you receive a bill for any covered service, please mail it directly to:

Molina Healthcare of Michigan
Member Services Department
100 W. Big Beaver Road
Suite 600
Troy, Michigan 48084-5209

Disenrollment

Molina Healthcare may ask that you be disenrolled from its membership. Here are some reasons that we may request that you be disenrolled from Molina Healthcare:

- Abusive, threatening and/or violent behavior towards doctors and their staff or Molina Healthcare's staff, or
- Letting someone else use your Molina Healthcare member ID card

Other Insurance

Molina Healthcare needs to know if you have any other health insurance in addition to your MIChild coverage. Please contact Member Services at 1-888-898-7969 and MIChild at 1-888-988-6300 to provide us with your insurance information. This will help us to manage your benefits properly. If Molina Healthcare is not aware of your additional health information, you may experience delays at the pharmacy or at other healthcare provider locations.

Provider Information

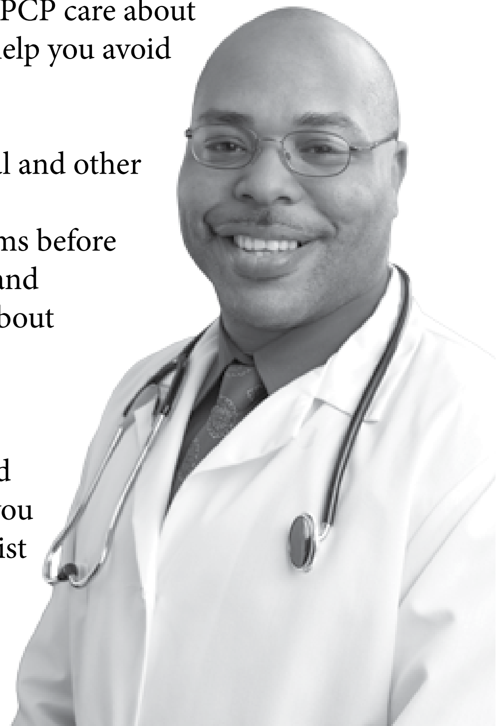
Your Primary Care Provider (PCP)

To get started you must choose a PCP. PCPs are doctors, nurse practitioners, or physician assistants who give care in Family Practice, Pediatrics, and Internal Medicine. Your PCP is responsible for providing your day-to-day health care. Your PCP may also send you for care to specialists, other health care providers and hospitals. You will find a list of PCPs for you to choose from on Molina Healthcare's website at www.molinahealthcare.com or visit the member portal at MyMolina.com. You may request a paper copy list of PCPs by calling Member Services. If you do not choose a PCP, we will select one for you.

Molina Healthcare and your PCP care about your health. Your PCP can help you avoid problems by:

- finding medical, dental and other health problems early,
- treating health problems before they become serious, and
- providing education about your health.

If you have a chronic health condition like diabetes or end stage renal disease (ESRD), you may be able to have a specialist take care of you as your PCP. Call us and we will help you.



Changing Your PCP

You may change your PCP. If your health or safety is in danger, you will be given another PCP right away. If you wish to change PCPs, please call Member Services at 1-888-898-7969 and we will help you choose a new PCP or you can locate and change your PCP online at MyMolina.com.

You can choose a new PCP at any time. Requests that you make will take effect by the 1st day of the next month.

Nurse Advice Line (NAL)

If you have questions about your health or about getting care during an emergency, Molina Healthcare offers a Nurse Advice Line (NAL) to help you. The NAL is available 24 hours a day, 365 days a year. You can reach the NAL by calling Member Services at 1-888-898-7969, or you can call the line toll free direct at 1-888-275-8750 (English), or 1-866-648-3537 (Spanish).

Questions About Your Health After Hours

For non-emergency care after normal business hours, please call your PCP who will provide instructions for getting the care you need. If you cannot reach your PCP, our Nurse Advice Line can assist you.

Routine and Specialty Care Services

Your PCP will help you get your health care services.

- Call your PCP for an appointment.
- If you cannot keep your appointment, call and cancel the appointment as soon as possible.
- Bring your Molina Healthcare ID card with you.
- Please ***be*** on time.

You can get specialist office visits including routine OB/GYN and pediatric care from a Molina Healthcare specialist without a referral from your PCP. Other medical services, equipment, and supplies

may require authorization by Molina Healthcare. You may contact Member Services at 1-888-898-7969 to find out which services require authorization.

Tell your PCP when you receive care from another doctor. You can check Molina Healthcare's website at www.molinahealthcare.com for a list of specialists and other health care providers. You may request a paper copy of our list of specialists and other health care providers by calling Member Services.

Hospital Services

All hospital services, except emergency services, must be approved and/or arranged by your PCP or Molina Healthcare except as otherwise stated in this handbook.

Complex Case Management Program

The Complex Case Management Program is a voluntary program for members with difficult health problems. The program allows you to talk with a nurse about your child's health problems. The nurse can help you learn more about your child's health problems and teach you how to better manage them. Our nurses can help with all types of health problems. We also have special programs for conditions such as:

- Asthma
- Chronic Obstructive Lung Disease
- Congestive Heart Failure
- Coronary Artery Disease
- End Stage Renal Disease
- High Risk Obstetrics
- Organ Transplant
- Pediatrics
- Skilled Nursing Facility and Rehabilitation

Our nurses will work with your child's doctor to make sure your child gets the care he/she needs. We also have a Social Worker to help with your child's medical and mental health needs. If you would like more information about the program, please call us at 1-888-898-7969 If you are hearing impaired, please call Michigan Relay at 1-800-649-3777.

Provider Information and Payment

You can request information about our providers, such as license information, how providers are paid by the plan, qualifications, and what services need authorization. This information will be given upon request. Please call Member Services at 1-888-898-7969 if you have questions.

Molina Healthcare does not prevent our providers from:

- Speaking on the Member's behalf,
- Discussing treatment and services,
- Discussing payment arrangements between the provider and the plan.

You may feel free to ask our plan if we have special arrangements with our panel doctors that can affect the use of referrals and other services that you may need. We want you to know that your health is our main concern. We do not pay our providers or encourage them in any way to withhold or deny medical care or services. Decisions about your health care are based on medical needs.

Call Member Services at 1-888-898-7969 if you have any questions.

Molina Healthcare and its providers cannot refuse to give medical care on the basis of pre-existing health conditions, color, creed, age, national origin, handicap, sex, sexual preference or cost of medical treatment.

New Medical Technology

Molina Healthcare looks at new services and new uses for benefits you have now. Molina Healthcare reviews all the studies done to see if services should be added to your benefit package. Molina Healthcare reviews the type of services listed below at least once a year:

- Medical services
- Behavioral health services
- Medicines
- Equipment

Emergency & Out of Area Services

How to Obtain Emergency Care

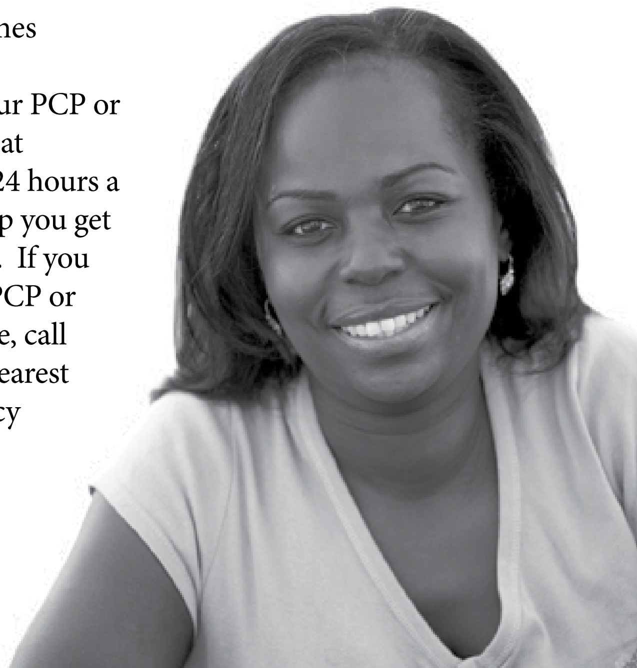
Molina Healthcare will cover all emergency services without prior approval in cases where a person, acting reasonably, would believe that they have an emergency.

You should seek emergency care when you have severe pain or a serious illness or injury that will cause a lifetime disability or death if not treated at once.

Examples of emergency conditions are:

- Chest pains or heart attack
- Choking or breathing problems
- A lot of bleeding or bleeding that will not stop
- Poisoning
- Broken bones

If you can, call your PCP or Member Services at 1-888-898-7969, 24 hours a day. They can help you get the care you need. If you cannot call your PCP or Molina Healthcare, call 911 or go to the nearest hospital emergency department for emergency care.



ALWAYS CARRY YOUR MOLINA HEALTHCARE ID CARD WITH YOU AND SHOW IT WHEN YOU GO TO THE EMERGENCY DEPARTMENT.

NEVER GET ROUTINE CARE THROUGH AN EMERGENCY DEPARTMENT.

Out of State / Out of Area Services

If you are out of town and have a medical emergency or need urgent care, go to the nearest urgent care center or emergency department for care. The hospital or urgent care center may call Molina Healthcare. Remember to follow-up with your PCP after any emergency department or urgent care visits.

Children's Services

What is EPSDT?

Early and Periodic Screening, Diagnosis, and Treatment or **(EPSDT -Well Child Exams)** are provided for your child at ages:

- As a newborn
- 3 – 5 days
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Yearly visits beginning at age 3

During the EPSDT exam the doctor may check:

- The overall health of your child to see if he or she is growing well
- Height, weight and body mass index (BMI)
- Blood pressure
- Ears and eyes
- Diet
- Need for immunizations/shots
- Lab tests
- Blood lead screening
- Dental screening, referral and fluoride varnish treatments
- Developmental and behavioral assessment
- Health education

Well Child Care and Shots

Many health problems begin during childhood, one of the most important steps you can take is to see that your children get the proper shots on time. Call your PCP or Member Services for an immunization schedule and information about EPSDT.

Child and Adolescent Health Care Program Health Centers

As a member of Molina Healthcare, you may choose to get services from a child and adolescent health care program health center without prior authorization or approval. Molina Healthcare will pay for services you get from these programs. You will need to let the center know that you have Molina Healthcare.

Special Programs and Services

Female Preventive Services

Members may see any Molina Healthcare OB/GYN without a referral from their PCP.

- Female members who are sexually active should have a pap smear every year to screen for cervical cancer.
- Female members, ages 16 and older, which are sexually active, should have a Chlamydia test every year to screen for this sexually transmitted disease (STD).

Family Planning Services

Family Planning Services are covered. These services include:

- Counseling to help you to decide when to have children,
- Helping you decide how many children to have,
- Providing information and prescriptions for birth control,
- Treatment for sexually transmitted diseases (STD).

You do not need a referral to receive family planning services. You can receive family planning services from any doctor or clinic.

Prenatal and Maternity Care

Early care is important to the health of pregnant women and their babies.

- If you think you are pregnant, please call your doctor for an appointment. It is important to start prenatal care in the first 12 weeks of pregnancy.
- You can get routine maternity care services from a Molina Healthcare provider without a referral from your PCP or OB/GYN doctor.
- If you need help finding a doctor, call Member Services at 1-888-898-7969.
- If you need help making a doctor's appointment, call the M.O.M. Nurse at 1-888-898-7969 ext. 155428.

- See your doctor throughout your pregnancy.
- Make sure you go to all of your visits when your PCP or OB/GYN tells you to. Do not miss any doctor visits.
- Make sure you go to your doctor right after you have your baby for follow-up care (3-6 weeks after your baby is born).
- Along with prenatal, postpartum and maternity care, we offer information on diet, exercise and other important health care services.

Moms of Molina (M.O.M.) Program

Moms of Molina (M.O.M.) Program
If you are pregnant, Molina Healthcare has a FREE program just for you and your baby; it is called the M.O.M. Program. You and your growing baby are important to us. We want you to have a healthy pregnancy and healthy baby.

Molina Healthcare has a special nurse coordinator to work with you and your doctors to make sure you and your baby get the care you need. All Molina Healthcare mothers-to-be, including teens and high risk, will receive information about the importance of prenatal care and free support services.

We can:

- help find a doctor for you and your new baby
- help set up doctor visits during pregnancy and after the baby is born
- help you stay healthy
- help with special needs while you are pregnant
- help find counseling services, and childbirth and parenting classes
- help find information for getting baby items, food, housing, clothes and give you information about what to expect while pregnant
- keep in touch with you and your doctor

It is good to get early and regular prenatal care and to keep all visits with the doctor even if this is not your first baby. Call the M.O.M. Nurse at 1-888-898-7969 ext. 155428.

Covered Services

What is covered by Molina Healthcare?

Molina Healthcare covers the following MIChild benefits:

- Ambulance Services
- Acupuncture Therapy
- Blood Lead Testing
- Chiropractic Care
- Durable Medical Equipment
- Emergency Services
- Family Planning Services
- Health Education
- Hearing Care
- Hemodialysis and Peritoneal Services
- Home Health Care – 120 days per calendar year
- Hospice Care
- Immunizations
- Inpatient and Outpatient Hospital Services
- Lab, X-ray and Other Imaging Services
- Limited Oral Surgery
- Out of Area Emergency or Authorized Services
- Pharmacy Services
- Physician and Other Professional Provider Services, Medical/Surgical Supplies and Services
- Private Duty Nursing
- Prosthetic and Orthotic Appliances
- Second Surgical Opinion
- Skilled Nursing Facility Services – 120 days per admission
- Therapies (Physical, Speech, Occupational)
- Tobacco cessation program including pharmaceutical and behavioral support counseling
- Transplants (Organ and Tissue)
- Vision Care
- Weight Loss Counseling
- Well Child Care/EPSDT

Please call our Member Services Department at 1-888-898-7969 if you have questions about covered or non-covered health care services. You can also call if you have questions on how to get covered services.

A description of some of the MIChild benefits covered by Molina Healthcare are listed below. Refer to your Certificate of Coverage for detailed benefits, limits and exclusions on MIChild benefits.

Doctor Office Visits

PCP and specialist office visits are covered by Molina Healthcare. Your doctor may provide well child care, annual physical exams, or evaluation and treatment of illnesses.

Urgent Care Services

Urgent care centers are able to treat minor injuries and illnesses when your doctor's office is closed. Examples of conditions in which urgent care treatment is appropriate:

- sore throat
- back pain
- headache
- cold
- minor injury

Call Member Services or visit our website at www.MolinaHealthcare.com to find an urgent care center close to you.

Ambulance Services

Molina Healthcare will cover emergency transportation to or from the hospital, skilled nursing facility or home. You should call 911 when you have an emergency and need immediate transportation to a hospital.

Acupuncture

Benefits include up to 20 visits in a calendar year when performed by a physician.

Chiropractic Care

Benefits include initial office exam, manipulations, x-rays for back or spine, and first aid treatment of musculoskeletal injury. Coverage is limited to 24 visits per calendar year.

Durable Medical Equipment (DME) and Supplies

Benefits include certain medical supplies and equipment. Your PCP or Molina Healthcare can help arrange this for you. The equipment and supplies must be medically necessary to be covered.

Diagnostic Services, Treatment and Surgical Care

These services may require authorization from Molina Healthcare. Benefits include:

- X-rays
- CT scans
- MRI/MRA
- Lab work
- Surgery
- Chemotherapy
- Radiation therapy
- Hemodialysis and peritoneal services
- Abortions (when determined to be medically necessary to save the life of the mother, or in the case of rape or incest)

Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Child and Adolescent Health Centers and Tribal Health Centers

As a member of Molina Healthcare, you may choose to get services from a FQHC, RHC, child and adolescent health care program health center or Tribal Health Centers without prior authorization or approval. Molina Healthcare will pay for services you get from these programs. You will need to let the center know that your child has Molina Healthcare.

Hearing Care

Hearing Care is covered for the following services and supplies payable once in every 36 consecutive months:

- Audiometric examination to measure hearing ability, including tests for air conduction, bone conduction, speech reception, and speech discrimination
- Hearing aid evaluation tests to determine what type of hearing aid(s) should be prescribed to compensate for loss of hearing
- Hearing aids including in-the-ear, behind-the-ear, and on-the-body designs, and binaural aids purchased together
- Dispensing fees for the normal services required in the fitting of a hearing aid
- Hearing aid conformity tests to evaluate the performance of a hearing aid and its conformity to the original prescription after the aid has been fitted

Hearing care benefits are not payable for hearing aid repairs or for the replacement of parts (including batteries and ear molds). Benefits are also not payable for the replacement of lost or broken hearing aids unless the 36-month coverage limitation does not apply.

Health Education

Free classes and written materials are available through our Health Education Program on subjects such as:

- Asthma
- Pre-natal care
- Diabetes
- Birth control
- Immunization shots and well child care
- Diet and weight control

Call Member Services at 1-888-898-7969 for more information.

Hospice Services

Hospice is a covered program that provides end of life care. For information on hospice care, call your PCP or Member Services at 1-888-898-7969

Oral Surgery

Limited to the following:

- the treatment of a jaw fracture, dislocation, or wound
- the treatment of cysts, tumors, or other disease tissues
- other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction
- the alteration of the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- charges for office visits related to the above procedures.

Prenatal and Post-Partum Services

Prenatal care is an important part of a healthy pregnancy. Doctor visits and midwife services for pregnancy care and diagnostic services are covered. Routine pre-natal and post-partum care does not require a referral or authorization. Post-partum stays at a hospital are covered consistent with the minimal hospital stay standard required by law.

Prescription Drugs

If you are a new Molina Healthcare member, please call Member Services at 1-888-898-7969 if you need help with any of your medications. Prescriptions are provided at no cost to you when they are filled at approved pharmacies. Covered prescriptions and over the counter drugs are listed on the drug list. You may request a drug list by calling Member Services at 1-888-898-7969. The list of pharmacies and approved drug list may also be found on the Molina Healthcare website at www.molinahealthcare.com.

Some drugs ordered by your doctor may require prior approval. Prior approval drugs are in gray on the drug list. Your doctor may request a prescription drug prior approval by faxing a drug prior approval form to 1-888-373-3059. Sometimes you may experience a delay in getting your prescriptions filled. This is because Molina Healthcare may have requested additional information from your doctor. Please remind your doctor when your medication requires a prior approval.

If a drug does not appear in the drug list, your doctor may request a review by the Pharmacist by faxing a drug prior approval form to 1-888-373-3059.

Prosthetic and Orthotic Appliances

Benefits include certain prosthetic and orthotic appliances. The benefit includes orthopedic shoe inserts when prescribed by a physician. Your PCP or Molina Healthcare can help arrange this for you. Prosthetic and orthotic appliances must be medically necessary to be covered.

Skilled Nursing Facility

This benefit provides up to 120 days per admission of care in a skilled nursing facility. The benefit renews 90 days after discharge.

Therapy Services

Up to 60 combined visits for physical, occupational and speech therapy are covered a calendar year.

Tobacco Cessation

Tobacco use is the largest preventable cause of illness and early death. It does not matter how old you are or how long you have smoked or used tobacco, it is important to quit. Quitting smoking reduces risks of lung cancer, heart disease, stroke and lung diseases.

Molina Healthcare covers tobacco cessation services for all members, including diagnostic, therapy and counseling services and pharmacotherapy (including coverage of prescription and non-prescription tobacco cessation agents approved by the Federal Drug Administration (FDA). To enroll in the "I Can Quit" program call toll free 1-800-480-7848.

Transplant Services

Molina Healthcare can help coordinate the care for transplants and related care. If you need a transplant, call the Member Services Department at 1-888-898-7969.

Vision Care

March Vision Care provides routine eye exams, glasses and other vision services. Call March Vision at 1-888-493-4070 to make an eye appointment or ask questions about vision services.

Non-Covered Services

Services Not Covered By Molina Healthcare

The following services are not covered by Molina Healthcare, *but are covered by MIChild, call MIChild at 1-888-988-6300 or Member Services at 1-888-898-7969 for information*:

- Routine dental services (see your dental services identification card or call MIChild at 1-888-988-6300),
- Mental Health services including prescriptions written by the Community Mental Health Services Program. Mental health services are covered through community mental health agencies.
- Substance Abuse Drugs and Services through Coordinating Agencies with the Community Mental Health Services Program.
- Services provided by the school district and billed through the Intermediate School District.

Services Not Covered By MIChild or Molina Healthcare

The following services are not covered by MIChild or Molina Healthcare:

- Abortions (elective) and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest
- Services for treatment of infertility
- Non-emergency transportation services, except as otherwise stated in this handbook or the certificate of coverage.
- Experimental / investigational drugs, procedures, or equipment
- Cosmetic surgery (elective)
- Incontinence supplies

If you have questions about these health care services, please call our Member Services Department at 1-888-898-7969.

Grievance and Appeal

Grievance Process

You can file a grievance with Molina Healthcare. If you are not happy with the health plan, this is called a grievance. You can also file a grievance if you are not happy with one of our providers. The grievance process is available for members who have a complaint that cannot be resolved during the initial contact with the Plan and is not a matter subject to an appeal. You have 90 days from the event to file a grievance with the plan.

You can submit a grievance in person, in writing or by telephone. Molina Healthcare's Appeal and Grievance Coordinator can help you write your grievance. We will make a decision regarding your grievance within 30 days of receipt.

The Coordinator will look into your grievance. The Coordinator will ask other staff who know about your issue. This may be a nurse or a doctor who knows about the problem (if it is medical). Molina Healthcare will keep a written account of your grievance. It will be confidential (private). Grievances about the care you receive are sent to the Quality Improvement Department. The Department will investigate the complaint further.

If you would like to make a grievance, please call our Member Services Department at 1-888-898-7969.

Appeal Process:

You can file an appeal if Molina Healthcare denied, suspended, terminated, or reduced a requested service. This is called an adverse determination.

- You have 90 calendar days from receiving the denial to file an appeal.
- You have the right to appeal in person, in writing, or by telephone to the Appeals Review Committee of Molina Healthcare. Molina

Healthcare's Appeal and Grievance Coordinator can help you write your appeal.

- You have the right to include an authorized representative throughout the appeals process and to attend the Appeals Review Committee meeting. You must inform us of your authorized representative in writing.
- You can bring any information that you feel will help the Committee make a better decision.
- The Coordinator will tell you the time and place the appeal will be heard.
- Molina Healthcare will use reviewers who were not involved in the initial decision to review.
- A decision will be mailed to you in 30 days from the date that Molina Healthcare received your appeal.
- Benefits may continue pending resolution of the Appeal. You may be required to pay the cost of the services if the denial is upheld.
- You have a right to ask for the benefit guidelines used to make this decision.
- An additional 10 calendar days are allowed to obtain medical records or other pertinent medical information if Molina Healthcare can demonstrate that the delay is in the member's interest.

Expedited Appeal (Urgent Cases)

If you or your doctor believes that the usual 30 days timeframe for appeals will cause harm to your health, or affect your normal body functions, your appeal may be expedited (urgent). Expedited appeals are decided in 72 hours. You may file an expedited appeal with the Department of Insurance and Financial Services (DIFS) at the same time. You may request an expedited appeal with DIFS immediately after you have filed an expedited appeal with Molina Healthcare. If Molina Healthcare denies your request for an expedited appeal, you may request an expedited external review with DIFS within 10 days of the denial.

External Review by the Department of Insurance and Financial Services

You can ask for an external review if you do not get an answer within 30 calendar days from Molina Healthcare or if you are not happy with the result of your appeal. You may appeal in writing to DIFS for an external review. The appeal request should be sent to:

Department of Insurance and Financial Services (DIFS)
Health Plans Division
P.O. Box 30220
Lansing, MI 48909-7720
1-877-999-6442
Fax Number: 1-517-241-4168

You must appeal in writing to DIFS within 60 calendar days after you receive the final answer from Molina Healthcare. Molina Healthcare can explain the external review process to you. We can also mail the external review forms to you. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal.

You, your authorized representative or your doctor can also request an expedited appeal decision from DIFS at the same address above within 10 days after receiving an adverse determination and immediately after filing an expedited appeal with Molina Healthcare.. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours.

Your Rights and Responsibilities

Member Rights and Responsibilities

Molina Healthcare staff and providers will comply with all requirements concerning your rights.

Molina Healthcare members have the right to:

- Get information about the health plan, its services, its providers and member rights and responsibilities.
- Be treated with respect with recognition of your dignity and right to privacy.
- Take part in decision making with the doctor about your or your child's health care.
- Talk about your treatment options regardless of cost or coverage.
- Get a fair and timely reply to requests for service.
- Voice complaints or appeals about the health plan and the care received.
- Know that your member information will be kept private. It is only used in reports to the state to show that the Plan is following state rules and laws.
- Ask how your doctor is paid.
- To make suggestions regarding the Plan's rights and responsibilities policy.

Molina Healthcare members have the responsibility to:

- Provide Molina Healthcare and its providers with the necessary information needed to care for you.
- Know, understand, and follow the terms and conditions of the health plan.
- Seek out information in order to make use of the services.
- Begin and continue a patient-physician relationship.
- Learn about your medical condition and its importance to your health care.
- Take part in decision-making about your health care.

- To follow the plans and instructions for care that you have agreed upon with your doctor.
- Call and make appointments with your provider.
- Call and cancel your appointment as soon as you know you will not be able to keep the appointment.

About Our Members: Protecting Your Privacy

Your privacy is important to us. We take confidentiality very seriously. Molina Healthcare wants to let you know how your health information is shared or used.

Your Protected Health Information (PHI)
PHI stands for these words: protected health information. PHI means health information that includes your name, member number, or other things that can be used to identify you, and that is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share our members' PHI?

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law.

When does Molina Healthcare need your written authorization (approval) to use or share your PHI?
Molina Healthcare needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways

- To get a list of certain people or places we have given your PHI

How does Molina Healthcare protect your PHI?

Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or PHI in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI.
- Only Molina Healthcare staff with a need to know PHI may use PHI.
- Molina Healthcare staff is trained on how to protect and secure PHI.
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI.
- Molina Healthcare secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

What can you do if you feel your privacy rights have not been protected?

- Call or write Molina Healthcare to file a complaint.
- File a complaint with the U.S. Department of Health and Human Services.

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our members' PHI. Our Notice of Privacy is included below and is on our website at www.molinahealthcare.com. You may also get a copy of our Notice of Privacy Practices by calling our Member Services Department.

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF MICHIGAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of Michigan ("Molina Healthcare", "Molina", "we" or "our") uses and shares protected health information about you to provide your health benefits. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private and to follow the law terms of this Notice. The effective date of this Notice is September 23, 2013.

PHI stands for these words, *protected health information*. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share your PHI?
We use or share your PHI to provide you with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment.
Molina Healthcare may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

For Payment.
Molina Healthcare may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and

decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations.
Molina Healthcare may use or share PHI about you to run our health plan. For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to the following:

- Improving quality;
- Actions in health programs to help members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;
- Address member needs, including solving complaints and grievances.

We will share your PHI with other companies ("business associates") that perform different kinds of activities for our health plan.

We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatment, or other health-related benefits and services.

When can Molina Healthcare use or share your PHI without getting written authorization (approval) from you?
The law allows or requires Molina Healthcare to use and share your PHI for several other purposes including the following:

Required by law.
We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health.
Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight.
Your PHI may be used or shared with government agencies. They may need your PHI for audits.

Research.
Your PHI may be used or shared for research in certain cases.

Legal or Administrative Proceedings.
Your PHI may be used or shared for legal proceedings, such as in response to a court order.

Law Enforcement.
Your PHI may be used or shared with police to help find a suspect, witness or missing person.

Health and Safety.
PHI may be shared to prevent a serious threat to public health or safety.

Government Functions.
Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect or Domestic Violence.
Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

Workers Compensation.
Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures.
PHI may be shared with funeral directors or coroners to help them to do their jobs.

When does Molina Healthcare need your written authorization (approval) to use or share your PHI?
Molina Healthcare needs your written approval to use or share your PHI for a purpose other than those listed in this notice. Molina needs your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?
You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**
  You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need make your request in writing. You may use Molina's form to make your request.

- **Request Confidential Communications of PHI**
  You may ask Molina Healthcare to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to make your request in writing. You may use Molina's form to make your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina Healthcare member. You will need to make your request in writing. You may use Molina's form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases we may deny the request. Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.

- **Amend Your PHI**
  You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to make your request in writing. You may use Molina's form to make your request. You may file a letter disagreeing with us if we deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of your PHI)**
  You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:
  - for treatment, payment or health care operations;
  - to persons about their own PHI;
  - sharing done with your authorization;
  - incident to a use or disclosure as otherwise permitted or required under applicable law;
  - PHI released in the interest of national security or for intelligence purposes;

- as part of a limited data set in accordance with applicable law

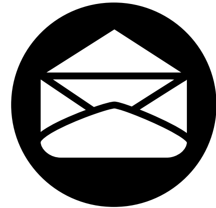
We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You make your request in writing. You may use Molina's form to make your request.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call Member Services Department at 1-888-898-7969.

What can you do if your rights have not been protected?
You may complain to Molina Healthcare and to the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care and benefits will not change in any way.

You may file a complaint with us at:

Molina Healthcare of Michigan
Attention: Supervisor, Member Services
100 West Big Beaver Road, Suite 600
Troy, MI 48084
Phone: 1-888-898-7969



You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health & Human Services
233 N. Michigan Ave. – Suite 240
Chicago, IL 60601
(800) 368-1019;; (800) 537-7697 (TDD)
(312) 886-1807 FAX

What are the duties of Molina Healthcare?
Molina Healthcare is required to:

- Keep your PHI private.
- Give you written information such as this on our duties and privacy practices about your PHI.

- Provide you with a notice in the event of any breach of your unsecured PHI;
- Not use or disclose your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change
Molina Healthcare reserves the right to change its information practices and terms of this notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, Molina will post the revised Notice on our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by Molina.

Contact Information
If you have any questions, please contact the following office:

Molina Healthcare of Michigan
Supervisor, Member Services
100 West Big Beaver Road, Suite 600
Troy, MI 48084
Phone: 1-888-898-7969

Advance Directives (Michigan's Durable Power of Attorney for Health Care)

An advance directive is a written advance care planning document that explains how medical decisions should be made for a patient who is unable to make or express his or her wishes concerning health care.

The durable power of attorney for health care (DPAHC) is the form of advance directive recognized by the Michigan Department of Community Health (1998, Public Act 386). This lets you choose another person to make decisions about your care, custody, and medical treatment if you cannot make these decisions for yourself.

This way, your desire to accept or refuse medical treatment is honored when you cannot make that choice yourself.

According to Michigan Law:

- Anyone age 18 or older, and of sound mind, may have a DPAHC in case something happens and you cannot make decisions for yourself.
- This act allows you to select a relative or other person as your patient advocate to make medical treatment decisions for you.
- You may change the person you appoint as your advocate at any time.
- You may write on the form the types of treatment you do and do not want.
- If you write on the form that you want your patient advocate to order doctors to withhold or withdraw life-sustaining treatment in certain situations, the doctors must honor your wishes.
- You should keep a copy of your DPAHC with you at all times.

For complaints about how Molina Healthcare follows your wishes, write or call:

Bureau of Health Professions (BHP), Grievance & Allegation Division.
PO Box 30670
Lansing, MI 48909-8170
(517) 241-2389 or bhpinfo@michigan.gov

The BHP Grievance & Allegation website is www.michigan.gov/healthlicense (click on "file a complaint").

For complaints about how your health plan follows your wishes, write or call:

Department of Insurance and Financial Services (DIFS)
Toll free at 1-877-999-6442 or www.michigan.gov/difs

Fraud & Abuse

Fraud, Waste & Abuse

Molina Healthcare's Fraud, Waste and Abuse Plan benefits Molina Healthcare, its employees, members, providers, payors and regulators by increasing efficiency, reducing waste, and improving the quality of services. Molina Healthcare takes the prevention, detection, and investigation of fraud, waste and abuse seriously, and complies with state and federal laws. Molina Healthcare investigates all suspected cases of fraud, waste and abuse and promptly reports all confirmed incidences to the appropriate government agencies. Molina Healthcare takes the appropriate disciplinary action, including but not limited to, termination of employment, termination of provider status, and/or the request to terminate membership.

Definitions:

Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the MIChild program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the MIChild program. (42 CFR §455.2)

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Here are some ways you can help stop fraud:

- Do not give your Molina Healthcare ID card or ID number to anyone other than a health care provider, a clinic, or hospital, and only when receiving care.
- Never let anyone borrow your Molina Healthcare ID card.

- Never sign a blank insurance form.
- Be careful about giving out your social security number.

If you think fraud has taken place, you can contact:

Michigan Department of Community Health (MDCH)
Attn: Medicaid Integrity Program Section
Capitol Commons Center Building
400 S. Pine Street, 6th Floor
Lansing, MI 48909
1 (866) 428-0005

You can report potential fraud, waste and abuse without giving us your name by:

Mail: Molina Healthcare of Michigan
Attention: Compliance Director
100 West Big Beaver, Ste. 600
Troy, MI 48084

Phone: 1-866-606-3889

Fax: 1-248-925-1797

Online: molinahealthcare.alertline.com

Certificate of Coverage

Article I. General Conditions

1.1 **Certificate.** This Certificate of Coverage is issued to MIChild Program beneficiaries who have enrolled in Molina Healthcare of Michigan. By enrolling in the Plan, the Member agrees to abide by the terms and conditions of this Certificate.

1.2 **Rights and Responsibilities.** This Certificate describes and states the rights and responsibilities of the Member and the Plan. **It is the Member's responsibility to read and understand this Certificate. Appendix A** of this Certificate lists the Covered Services to which the Member is entitled under the terms and conditions of this Certificate. In some circumstances, certain medical services, equipment and supplies are not covered or may require prior authorization of the Plan.

1.3 **Waiver by Plan; Amendments.** Only authorized officers of the Plan have authority to waive any conditions or restrictions of this Certificate, or to bind the Plan by making a promise or representation or by giving or receiving any information. All changes to this Certificate must be in writing and signed by an authorized officer of the Plan. Any change to this Certificate is not effective until it is approved by the Department of Insurance and Financial Services.

1.4 **Assignment.** All rights of the Member to receive Covered Services under the Member Agreements are personal and may not be assigned to any other person or entity. Any assignment, or any attempt to assign the Member Agreement or any rights under the Member Agreement, is grounds to request the termination of the Member's enrollment in the Plan under Article 9.

Article II. Definitions

2.1 **Applicability.** The definitions in this Article apply throughout this Certificate and any amendments, addenda, and appendices to this Certificate.

2.2 **Certificate** means this Certificate of Coverage between the Plan and the Member, including all amendments, addenda and appendices.

2.3 **Communicable Diseases** means HIV/AIDS, sexually transmitted diseases, tuberculosis and vaccine-preventable communicable diseases.

2.4 **Covered Services** mean the Medically Necessary services, equipment and supplies set forth in Appendix A of this Certificate, which are subject to all of the terms and conditions of this Certificate.

2.5 **Department** means the Department of Community Health or its successor agency which administers the MIChild Program in the State of Michigan.

2.6 **Emergency** means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

2.7 **Emergency Services** means the services which are Medically Necessary to treat an Emergency.

2.8 **Experimental, Investigational or Research Drug, Device, Supply, Treatment, Procedure or Equipment** means a

drug, device, supply, treatment, procedure or equipment meeting one or more of the following criteria: (a) it cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use; (b) it is the subject of a current investigational new drug or new device application on file with the FDA; (c) it is being provided pursuant to a Phase I or Phase II clinical trial; (d) it is being provided pursuant to a written protocol which describes among its objectives the determination of safety, efficacy or efficiency in comparison to conventional alternatives; (e) it is described as experimental, investigational or research by informed consent or patient information documents; (f) it is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (DHHS) or successor agencies, or of a human subjects (or comparable) committee; (g) the predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to medical investigational or research settings; (h) the predominant opinion among experts as expressed in the published authoritative medical or scientific literature is that further experiment, investigation or research is necessary in order to define safety, toxicity, effectiveness or efficiency compared with conventional alternatives; (i) at the time of its use or proposed use, it is not routinely or widely employed or is otherwise not generally accepted by the medical community; (j) it is not investigative in itself pursuant to any of the foregoing criteria, and would not be Medically Necessary, but for the provision of a drug, device, treatment, procedure or equipment which meets any of the foregoing criteria; or (k) it is deemed experimental, investigational or research under the Plan's insurance or reinsurance agreements. Experimental, Investigational or Research Drug does not include an antineoplastic drug which is a covered benefit in accordance with MCL 500.3406e of the Michigan Insurance Code.

2.9 **Family Planning Services** are any medically approved means, including diagnostic evaluation, drugs, supplies, devices, and related counseling, for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases.

2.10 **Health Care Expenses** means the amounts paid or to be paid by the Plan to Participating Providers and Non-Participating Providers for Covered Services furnished to the Member.

2.11 **Health Professional** means a health care provider who is appropriately licensed, certified or otherwise qualified to deliver health services pursuant to Michigan law.

2.12 **Hospital** means an acute care facility licensed as a hospital by the State of Michigan which is engaged in providing, on an inpatient and outpatient basis, medical care and treatment of sick and injured persons through medical, diagnostic and surgical facilities.

2.13 **Hospital Services** mean those Covered Services which are provided by a Hospital.

2.14 **MIChild Contract** is the contract between the Department and the Plan under which the Plan agrees to provide or arrange for Covered Services for Members.

2.15 **Medical Director** means a Physician designated by the Plan to supervise and manage the quality of care aspects of the Plan's programs and services.

2.16 **Medically Necessary** means the services, equipment or supplies necessary for the diagnosis, care or treatment of the Member's physical or mental condition as determined by the Medical Director in accordance with accepted medical practices and standards at the time of treatment. Medically Necessary does not in any event include any of the following:

a. Services rendered by a Health Professional that do not require the technical skills of such a provider; or

b. Services, equipment and supplies furnished mainly for the personal comfort or convenience of the Member, any individual who cares for the Member, or any individual who is part of the Member's family; or

c. That part of the cost of a service, equipment or supply which exceeds that of any other service, equipment or supply that would have been sufficient to safely and adequately diagnose or treat the Member's physical or mental condition, except when rendered by, or provided upon the referral of, a Primary Care Provider, or otherwise authorized by the Plan, in accordance with the Plan's procedures.

2.17 **Medicare** means the program established under Title XVIII of the federal Social Security Act, 42 U.S.C. 1395 et seq.

2.18 **Member** means a MIChild Program beneficiary enrolled in the Plan.

2.19 **Member Agreement** means this Certificate, the membership card issued by the Plan to the Member and the Member's MIChild application including any amendments, addenda and appendices to any of the foregoing.

2.20 **Non-Covered Services** means those health services, equipment and supplies which are not Covered Services.

2.21 **Non-Participating Provider** means a Health Professional, Physician, Hospital or other entity that has not contracted with the Plan to provide Covered Services to Members.

2.22 **Department of Insurance and Financial Services (DIFS)** is the agency which is duly authorized to regulate health maintenance organizations in the State of Michigan.

2.23 Participating Hospital means a Hospital that contracts with the Plan to provide Covered Services to Members.

2.24 Participating Physician means a Physician that contracts with the Plan to provide Covered Services to Members.

2.25 Participating Provider means a Health Professional, Physician, Hospital, physician organization, physician-hospital organization or other entity that contracts with the Plan to provide Covered Services to Members.

2.26 Payer means all insurance and other health plan benefits, including Medicare and other private and governmental benefits.

2.27 Plan means Molina Healthcare of Michigan, a Michigan for Profit Corporation and a licensed health maintenance organization.

2.28 Physician means a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) licensed to practice medicine in the State of Michigan.

2.29 Primary Care Provider means a Participating Physician or other Participating Provider responsible for providing primary health care and arranging and coordinating all aspects of the Member's health care.

2.30 Public Health Code means the Michigan Public Health Code, 1978 PA 368, MCLA 333.1101 et seq.

2.31 Service Area means the geographic area in which the Plan has been authorized by the Department and the DIFS to operate as a health maintenance organization.

2.32 Specialist Physician means a Participating Physician, other than a Primary Care Provider, who provides Covered Services

to Members upon referral by the Primary Care Provider and, if required, prior authorization by the Plan.

2.33 **Urgent Care** means the treatment of a medical condition that requires prompt medical attention but is not an Emergency.

Article III. Eligibility and Enrollment

3.1 **Member Eligibility.** To be eligible to enroll in the Plan an individual must be eligible for the MIChild Program as determined by the Department and must reside within the Service Area. The Department is solely responsible for determining the eligibility of individuals for the MIChild Program. The Department assigns individuals to health plans. Eligible individuals may choose a health plan, or the Department may choose a health plan for the eligible individuals.

3.2 **Effective Date of Coverage.** The Member is entitled to Covered Services from the plan on the first day of the month following the date that the Department notifies the Plan in writing of the assignment of the individual to the Plan. The Plan will notify the Member of the effective date of enrollment in the Plan and coverage under this Certificate.

3.3 **Change of Residency.** The Member shall notify the Department and the Plan when the Member changes residence. Residing outside of the Service Area is grounds to request the termination of the Member's enrollment in the Plan under Article 9.

3.4 **Final Determination.** In all cases, the Department shall make the final determination of an individual's eligibility to enroll in the Plan and the Member's right to continue enrollment in the Plan.

Article IV. Relationship with Participating & Non-Participating Providers

4.1 **Selecting a Primary Care Provider.** By the effective date of enrollment, if the Member does not choose a Primary Care Provider, the Plan may select a Primary Care Provider for a Member. The Plan will use prescribed guidelines to make such a selection.

4.2 **Role of Primary Care Provider.** The Member's Primary Care Provider provides primary care services and arranges and coordinates the provision of other health care services for the Member, including, but not limited to: referrals to Specialist Physicians, ordering lab tests and x-rays, prescribing medicines or therapies, arranging hospitalization, and generally coordinating the Member's medical care as appropriate.

4.3 **Changing a Primary Care Provider.** The Member may change to another Primary Care Provider by contacting Member Services. All changes must be processed by Member Services which will then notify the Member of the effective date of the change. If the Member is a minor or otherwise incapable of selecting a Primary Care Provider, an authorized person should select a Primary Care Provider on behalf of such Member. An authorized person may select a pediatrician as the Primary Care Provider for a Member who is a minor.

4.4 **Specialist Physicians and Other Participating Providers.** Except as otherwise expressly stated in this Section 4.4 or other sections of this Certificate, the Member may receive Covered Services from Specialist Physicians and other Participating Providers. The Plan does not require authorization for most Specialist Physician Services. In some circumstances, certain medical services, equipment and supplies are not covered or

may require prior authorization of the Plan. The Member may contact the Plan to obtain a list of services requiring prior authorization. A female Member may receive an annual well-woman examination and routine obstetrical and routine gynecological services from an obstetrician-gynecologist who is a Participating Provider without prior authorization or referral from the Primary Care Provider or the Plan. A pediatrician may be selected as the Primary Care Provider for a minor Member as indicated in Section 4.1. A member may obtain covered services from a Participating Pediatrician without prior authorization or a referral from the Primary Care Provider or the Plan.

4.5 **Non-Participating Providers.** The Member may occasionally require Covered Services from Non-Participating Providers. Authorization may be required in advance from the Plan in order to receive Covered Services from Non-Participating Providers. However, prior authorization is not required for Emergency Services, Family Planning Services, immunizations or treatment of Communicable Diseases, or services from child and adolescent health centers and programs, Tribal Health Centers, Federally Qualified Health Centers, Rural Health Centers or Primary Care Provider.

4.6 **Independent Contractors.** The Plan and Participating Providers are independent contractors and are not employees, agents, partners or co-venturers of or with one another. The Plan does not itself undertake to directly furnish any health care services under this Certificate. The Plan arranges for the provision of Covered Services to Members through Participating Providers and Non-Participating Providers. Participating Providers and Non-Participating Providers are solely responsible for exercising independent medical judgments. The Plan is responsible for making benefit determinations in accordance with the Member Agreement, the MIChild Contract and its contracts with Participating Providers, but it expressly disclaims any right or responsibility to make medical treatment decisions. Such

decisions may only be made by the Member in consultation with Participating Providers or Non-Participating Providers. A Participating Provider or a Non-Participating Provider and the Member may initiate or continue medical treatments despite the Plan's denial of coverage for such treatments. The Member may appeal any of the Plan's benefit decisions in accordance with the Plan's Grievance and Appeal Policy and Procedure.

4.7 Availability of Participating Providers. The Plan does not represent or promise that a specific Participating Provider will be available to render services throughout the period that the Member is enrolled in the Plan. The Plan or a Participating Provider may terminate a provider contract or limit the number of Members that the Participating Provider will accept as patients. If the Member's Primary Care Provider no longer acts as a Primary Care Provider, the Member must select another Primary Care Provider. As required by MCL 500.2212b, the Plan shall permit the Member to continue an ongoing course of treatment with the Primary Care Provider as follows: for 90 days from the date of notice to the Member by the physician of the physician's termination with the Plan; if the Member is in her second or third trimester of pregnancy at the time of the physicians termination, through postpartum directly related to the pregnancy; if the Member is determined to be terminally ill prior to a physician termination or knowledge of the termination and the physician was treating the terminal illness before the date of termination or knowledge of the termination, for the remainder of the Member's life for care directly related to the treatment of the terminal illness. If a Specialist Physician who is rendering services to the Member ceases to be a Participating Provider, the Member must cooperate with the Primary Care Provider or Plan in selecting another Specialist Physician to render Covered Services.

4.8 Inability to Establish or Maintain a Physician-Patient Relationship. If the Member is unable to establish or

maintain a satisfactory relationship with a Primary Care Provider or a Specialist Physician to whom the Member is referred, the Plan may request that the Member select another Primary Care Provider, or may arrange to have the Member's Primary Care Provider refer such Member to another Specialist Physician.

4.9 Refusal to Follow Participating Provider's Orders. The Member may refuse to accept or follow a Participating Provider's treatment recommendations or orders. The Participating Provider may request that the Member select another Participating Provider if a satisfactory relationship with the Member cannot be maintained because of the Member's refusal to follow such treatment recommendations or orders.

Article V. Member Rights and Responsibilities

5.1 Release and Confidentiality of Member Medical Records.

5.1.1 The Plan must keep a Member's medical information confidential and must not disclose the information to third-parties without the prior written authorization of such Member, except as otherwise provided in this Agreement and the Plan's Notice of Privacy Practices or as permitted or required by law.

5.1.2 The Plan may disclose medical information to third-parties in connection with the bona fide use of de-identified data for medical research, education or statistical studies.

5.1.3 The Plan may disclose medical information to third-parties in connection with the Plan's quality improvement and utilization review programs consistent with the Plan's confidentiality policies and procedures.

5.1.4 The Plan shall have the right to release medical information to Participating Providers and Non-Participating Providers regarding the Member as necessary to implement and administer the MIChild Contract, the Member Agreement with the Plan, subject to the applicable requirements under state and federal law.

5.1.5 By enrolling in the Plan, each Member authorizes Participating and Non-Participating Providers to disclose information concerning such Member's care, treatment, and physical condition to the Plan, the DIFS, the Department, or their designees on request, and also authorizes the Plan, DIFS and Department, or their designees, to review and copy such Member's medical records. Each Member further agrees to cooperate with the Plan, or its designee, and Participating Providers by providing health history information and by assisting in obtaining prior medical records when requested.

5.1.6 Upon the reasonable request of the Plan, a Participating Provider or a Non-Participating Provider, the Member shall sign an authorization for release of information concerning such Member's care, treatment and physical condition to the Plan, Participating Providers, Non-Participating Providers, the DIFS and the Department, or their designees.

5.1.7 Upon reasonable request, an adult Member, or an authorized person on behalf of a minor or incapacitated Member, may review such Member's medical records in accordance with state and federal law. Such review shall take place at the offices of the Participating Provider during regular business hours and at a time reasonably specified by the Participating Provider.

5.2 Grievance and Appeal Policy and Procedure. The Plan has procedures for receiving, processing, and resolving Member concerns relating to any aspect of health services or administrative services. The Grievance and Appeal Policy and Procedure is described in the Plan's Member Handbook.

5.2.1 Grievance Process. The Member may submit a grievance with the Plan either in person, in writing or by telephone. The grievance process is available for members who have a complaint that cannot be resolved during the initial contact with the Plan and is not a matter subject to an appeal. The Member has 90 days from the event to file a grievance with the plan. The Plan's Appeal and Grievance Coordinator may assist the Member filing the grievance. The Plan will make a decision regarding the Member's grievance within 30 days of receipt.

5.2.2 Standard Appeal Process. The Member can file an appeal if The Plan denies, suspends, terminates, or reduces a requested service. This is called an adverse determination. The Member has 90 days from receiving the adverse determination to file an appeal. The Member has the right to appeal in person, in writing, or by telephone to the Plan's Appeals Review Committee. The Plan's Appeal and Grievance Coordinator can help assist with filing the appeal. The Member has the right to include an authorized representative throughout the appeals process and to attend the Appeals Review Committee meeting. The Member must inform the Plan of the authorized representative in writing. The Plan will use reviewers who were not involved in the adverse determination. A decision will be mailed to the Member in 30 days from the date that the Plan received the appeal. An additional 10 calendar days are allowed to obtain medical records or other pertinent medical information if the Plan can demonstrate that the delay is in the member's interest.

5.2.3 Expedited Appeal Process. An expedited appeal process is available if the Member or the Member's physician believes that the usual 30 day timeframe for appeals will cause harm to the Member's health, or affect the Member's normal body functions. Expedited appeals are decided in 72 hours. You may request an expedited appeal with DIFS immediately after you have filed an expedited

appeal with Molina Healthcare and within 10 days of the denial. If the Plan denies the Member's request for an expedited appeal, the Member may request an expedited external review with the Department of Insurance and Financial Services (DIFS) within 10 days of the denial.

5.2.4 External Review by the Department of Insurance and Financial Services**.** The Member may request for an external review if the member does not receive a decision from the Plan within 30 days from the Plan or is not satisfied with the result of the appeal. The member must file for an external review within 60 days of a denial. The appeal request should be sent to Department of Insurance and Financial Services (DIFS), Office of General Council/PRIRA, P.O. Box 30220, Lansing, MI 48909-7720 www.michigan.gov/difs 1-877-999-6442.

5.3 **Member Handbook.** Members will receive a copy of the Member Handbook when they enroll in the Plan and may receive additional copies at any time by telephone request to Member Services. The Member Handbook is also available on the Plan website at www.molinahealthcare.com.

5.4 **Membership Cards.**

5.4.1 The Plan will issue a membership card to each Member. The Member must present the membership card to Participating Providers each time the Member obtains Covered Services.

5.4.2 If the Member permits the use of the membership card by any other person, the Plan may immediately reclaim the card. Permitting the use of the membership card by any other person may be grounds to request the termination of the Member's enrollment in the Plan under Article 9.

5.4.3 If the Member's membership card is lost or stolen, the Member must notify Member Services by the end of the next business day following the Member's discovery of the loss or the date of the theft.

5.5 Forms and Questionnaires. The Member must complete and submit to the Plan such medical questionnaires and other forms as are requested by the Plan or state and federal agencies. Each Member warrants that all information contained in questionnaires and forms completed by the Member is true, correct and complete to the best of the Member's knowledge. The intentional submission of false or misleading information or the omission of material information requested on such forms may be grounds to request the termination of the Member's enrollment in the Plan under Article 9.

Article VI. Payment for Covered Services

6.1 Claims.

6.1.1 It is the Plan's policy to pay Participating Providers directly for Covered Services furnished to Members in accordance with the contracts between the Plan and Participating Providers. However, if a Participating Provider bills the Member for a Covered Service, the Member should contact Member Services upon receipt of the bill. Members should not pay any participating provider for covered services. If the Member pays a bill for Covered Services, the Plan will require the Participating Provider to reimburse the Member.

6.1.2 When the Member receives Emergency Services, or other Covered Services authorized in advance by the Plan, from a Non-Participating Provider, the Member should

request that the Non-Participating Provider bill the Plan. If the Non-Participating Provider refuses to bill the Plan but bills the Member, the Member should submit any such bill and/or receipt of payment to the Plan for reimbursement. If the Non-Participating Provider requires the Member to pay for the Covered Services at the time they are rendered, the Member must submit a request for reimbursement for such Covered Services in writing to the Plan within 60 days after the date the Covered Services were rendered.

6.1.3 Proof of payment acceptable to the Plan must accompany all requests for reimbursement. Failure to request reimbursement for Covered Services within the required time shall not invalidate or reduce any claim if it was not reasonably possible to provide acceptable proof of payment within such time and the Member provides the required information to the Plan as soon as reasonably possible. However, in no event shall the Plan be liable for reimbursement requests for which proof of payment is submitted to the Plan more than 12 months following the date Covered Services were rendered.

6.1.4 The Plan may require the Non-Participating Provider to provide additional medical and other information or documentation to prove that services rendered were Covered Services before paying Non-Participating Providers or reimbursing the Member for such services, subject to applicable state and federal law.

6.2 **Non-Participating Providers.** The Member is financially responsible for payment for all services, supplies and equipment received from Non-Participating Providers unless those services are included as Covered Services on Appendix A of this Certificate and are authorized as required by the Plan. However, prior authorization is not required for Emergency Services, Family Planning Services, treatment of Communicable Diseases, immunizations, or services from child and adolescent health centers and programs, Tribal

Health Centers, Federally Qualified Health Centers, Rural Health Centers or Primary Care Provider.

6.3 Non-Covered Services. The Member may be financially responsible for payment for any Non-Covered Services received by the Member if the Member knew that the services were Non-Covered Services at the time the services were rendered. The Plan may recover from the Member the expenses for Non-Covered Services.

Article VII. Covered Services & Coordination of Care Services

7.1 Covered Services. The Member is entitled to the Covered Services specified in Appendix A when all of the following conditions are met:

7.1.1 The Covered Services are specified as covered services in the MIChild Contract at the time that the services are rendered. All changes, limitations and deletions from MIChild covered services will automatically apply to each Member.

7.1.2 The Covered Services are Medically Necessary. Except as otherwise required by law, a Participating Provider's determination that a Covered Service is medically necessary is not binding on the Plan. Only Medically Necessary services covered by the MIChild Contract are covered benefits.

7.1.3 The Covered Services are performed, prescribed, directed or arranged in advance by the Member's Primary Care Provider, except when a Member may directly access the services of a Specialist Physician or other Participating Provider under the express terms of this Certificate.

7.1.4 The Covered Services are authorized in advance by the Plan, when required.

7.1.5 The Covered Services are provided by Participating Providers, except when this Certificate specifies that a Member may obtain Covered Services from a Non-Participating Provider.

7.2 **Emergency Services.** In case of an Emergency, the Member should go directly to a Hospital emergency department. The Member or a responsible person must notify the Plan or the Primary Care Provider as soon as possible after receiving Emergency Services. All follow-up and continuing care must be coordinated with the Member's Primary Care Provider

7.3 **Urgent Care.** Urgent Care must be obtained at a participating Urgent Care Provider. All follow-up and continuing care must be coordinated with the Member's Primary Care Provider.

7.4 **Out-of-Area Services.**

7.4.1 Covered Services. Emergency Services are covered by the Plan while the Member is temporarily out of the Service Area. The Member or a responsible person must notify the Plan as soon as possible after receiving Emergency Services. Urgent Care rendered outside of the Service Area must be authorized in advance by the Member's Primary Care Provider. Routine medical care while the Member is outside of the Service Area is not a Covered Service unless prior authorized by the Plan.

7.4.2 Hospitalization. If an Emergency requires hospitalization, the Member, the Hospital or a responsible person must contact the Plan and the Member's Primary Care Provider as soon as possible after the Emergency hospitalization begins. The Plan or Member's Primary Care Provider may require the Member to move to a Participating Hospital when it is physically possible to do so.

7.5 **Coordination of Care Services.** The Plan will refer Members to agencies or other providers for certain services which the Member may be eligible to receive, but which are not Covered Services. These services are set forth on Appendix B.

Article VIII. Exclusions and Limitations

8.1 **Exclusions.** The services, equipment and supplies listed on Appendix B are Non-Covered Services.

8.2 **Limitations.**

8.2.1 Covered Services are subject to the limitations and restrictions described in MIChild Contract and this Certificate.

8.2.2 The Plan has no liability or obligation for payment for any services, equipment or supplies provided by Non-Participating Providers unless the services, equipment or supplies are Covered Services and are authorized in advance by the Plan, except when this Certificate otherwise specifies that the Member may obtain Covered Services from Non-Participating Providers.

8.2.3 A referral by a Primary Care Provider for Non-Covered Services does not make such services Covered Services.

8.2.4 The Plan will not cover services, equipment or supplies not performed, provided, prescribed, directed or arranged by the Member's Primary Care Provider as required by the Plan or, where required, not authorized in advance by the Plan, except when this Certificate otherwise specifies that the Plan will cover such services.

8.2.5 The Plan will not cover services, equipment or supplies that are not Medically Necessary.

Article IX. Term and Termination

9.1 Term.

This Certificate takes effect on the date specified in Article 3 and continues in effect from year to year thereafter unless otherwise specified in the MIChild Contract or unless terminated in accordance with this Certificate.

9.2 Termination of Certificate by the Plan or the Department.

9.2.1 This Certificate will automatically terminate upon the effective date of termination of the MIChild Contract. Enrollment and coverage of all Members will terminate at 12:00 Midnight on the date of the termination of this Certificate, except as otherwise provided by the MIChild Contract.

9.2.2 In the event of cessation of operations or dissolution of the Plan, this Certificate may be terminated immediately by court or administrative agency order or by the Board of Directors of the Plan. The Plan will be responsible for Covered Services to Members as otherwise prescribed by the MIChild Contract.

9.2.3 The Department will be responsible for notifying Members of the termination of this Certificate under this Section 9.2. The Plan will not notify Members of the termination of this Certificate. The fact that Members are not notified of the termination of this Certificate shall not continue or extend Members' coverage beyond the date of termination of this Certificate.

9.3 Termination of Enrollment and Coverage by the Department or upon Plan Request.

9.3.1 The Member's enrollment in the Plan and coverage under this Certificate will terminate when any of the following occurs upon approval of the Department:

a. The Member moves out of the Service Area

b. The Member ceases to be eligible for the MIChild Program or the Plan as determined by the Department

c. The Member dies

9.3.2 The Plan may request the Department to terminate the Member's enrollment and coverage for cause, and upon reasonable notice and approval by the Department, for any of the following reasons:

a. The Member is unable to establish or maintain, after reasonable attempts by two Participating Physicians, a satisfactory physician-patient relationship

b. The Member makes material misrepresentations or commits fraud in enrolling or in completing medical questionnaires or other forms requested by the Plan or state or federal agencies

c. The Member misuses or commits fraud in the use of the Member's membership card

d. Violent/life-threatening situations involving physical acts of violence; physical or verbal threats of violence made against Plan providers, staff, or the public at provider or Plan locations; and/or stalking situations.

e. The Member is non-compliant with, misuses or commits fraud in the use of the Plan's benefits and services

9.3.3 The Member's coverage under this Certificate ceases automatically on the effective date of termination of the Member's enrollment, except as provided in Section 9.5.

9.3.4 The Plan will not request the Department to terminate the Member's enrollment and coverage on the basis of the status of the Member's health, health care needs or the act that the Member has exercised the Member's rights under the Plan's Grievance and Appeal Policy and Procedure.

9.3.5 In all cases, the Department will make the final decision concerning termination of a Member's enrollment under this Section 9.3. The Department also will determine the effective date of termination.

9.4 Disenrollment by Member.

9.4.1 A Member may disenroll from the Plan for any reason during the first 90 days of enrollment. After the 90-day period, the Department may require a minimum period of enrollment in accordance with the MIChild Contract. After the minimum period of enrollment, the Member may disenroll from the Plan with or without cause. In the event that the Member wishes to disenroll from the Plan, the Member, or an authorized person on behalf of the Member, should contact the MIChild.

9.4.2 The Member's coverage under this Certificate ceases automatically on the effective date of the Member's disenrollment. The effective date of disenrollment will be determined by the Department.

9.5 Continuation of Benefits. If the Member is an inpatient at a Hospital on the date that the Member's enrollment in the Plan terminates, the Plan is responsible for payment for the inpatient Hospital stay until the date of discharge, subject to the terms and conditions of the Member Agreement.

Article X. Coordination of Benefits

10.1 Purpose. In order to avoid duplication of benefits to Members by the Plan and other Payers, the Plan will coordinate benefits for the Member under this Certificate with benefits available from other Payers that also provide coverage for the Member. The Department will furnish the Plan with notice of all other Payers providing health care benefits to the Member. Each Member, or authorized person, must certify that to the best of the Member's or authorized person's knowledge, the Payers identified by the Department are the only ones from whom the Member has any right to payment of health care benefits. Each Member or authorized person must also notify the Plan when payment of health care benefits from any other Payer becomes available to the Member.

10.2 Assignment.

10.2.1 Upon the Plan's request, the Member must assign to the Plan:

a. All insurance and other health plan benefits, including Medicare and other private or governmental benefits, payable for health care of the Member.

b. All rights to payment and all money paid for any claims for health care received by the Member.

10.2.2 Members shall not assign benefits or payments for Covered Services under the Member Agreement to any other person or entity.

10.3 Medicare. For Members with Medicare coverage, Medicare will be the primary payer ahead of any health plan contracted by the Department.

10.4 **Notification.** Each Member must notify the Plan of any health insurance or health plan benefits, rights to payment and money paid for any claims for health care when the Member learns of them.

10.5 **Order of Benefits.** In establishing the order of Payer responsibility for health care benefits, the Plan will follow coordination of benefits guidelines authorized by the Department and DIFS and applicable provisions of the Michigan Coordination of Benefits Act, Public Act 64 of 1984, as amended, MCL 550.251 et seq., as required by Section 21074 of the Michigan Public Health Code, Public Act 368 of 1978, as amended, MCL 333.21074.

10.6 **Plan's Rights.** The Plan will be entitled to:

10.6.1 Require the Member, a Participating Provider or a Non-Participating Provider to file a claim with the primary Payer before it determines the amount of the Plan's payment obligation, if any; and

10.6.2 Recover from the Participating Provider or Non-Participating Provider, as applicable, the expense of Covered Services rendered to the Member to the extent that such Covered Services are covered or indemnified by any other Payer. Member is held harmless.

10.7 **Construction.** Nothing in this Article shall be construed to require the Plan to make a payment until it has been determined whether the Plan is the primary Payer or the secondary Payer and the benefits that are payable by the primary Payer, if any.

Article XI. Subrogation

11.1 **Assignment; Suit.** If the Member has a right of recovery from any person or entity for the Member's injury or illness, except from the Member's health insurance or health benefit

plan which is subject to Article 10 of this Certificate, the Member, as a condition to receiving Covered Services under this Certificate, must do the following:

11.1.1 Assign to the Plan all sums recovered by suit, settlement, or otherwise for the injury or illness up to the amount of the Plan's Health Care Expenses for the injury or illness, but not in excess of monetary damages collected; or

11.1.2 Authorize the Plan to be subrogated to the Member's rights of recovery, including the right to bring suit in the Member's name at the sole cost and expense of the Plan, up to the amount of the Plan's health care expenses for the injury or illness.

11.2 **Attorney Fees and Costs.** In the event that a suit instituted by the Plan on behalf of the Member, or a suit by the Member in which the Plan joins, results in monetary damages awarded in excess of the Plan's actual health care expenses, the Plan shall have the right to recover the costs of suit and attorney fees out of the excess, to the extent of such costs and fees.

Article XII. Miscellaneous

12.1 **Governing Law.** This Certificate is made and shall be interpreted under the laws of the State of Michigan.

12.2 **Policies and Procedures.** The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Member Agreement, the MIChild Contract and the Plan.

12.3 **Notice.** Except as otherwise provided in any other section of this Certificate, any notice required or permitted to be given by the Plan to the Member under this Certificate must be in writing and either personally delivered or deposited in the U.S. Mail, first class, with postage prepaid and addressed

to the Member at the address of record on file at the Plan's administrative offices. Except as otherwise provided in any other section of this Certificate, any notice required or permitted to be given by the Member to the Plan under this Certificate must be in writing and either personally delivered or deposited in the U.S. Mail, first class, with postage prepaid and addressed to the Plan at the following address:

Molina Healthcare of Michigan
Attn: Member Services
100 W. Big Beaver, Suite 600
Troy, Michigan 48084-5209

12.4 Action Time Frames. No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Appendix A – Benefit of Detail Covered Services

The following are Covered Services under the Member Agreement. All Covered Services are subject to the terms, conditions, limitations and exclusions set forth in the Member Agreement.

1. **Second Surgical Opinion Consultations** are covered when recommended by a Participating Physician or desired by the enrolled Member or Member's representative.

2. **Home Health Care** is covered up to 120 days per calendar year for home health care provided through a Medicare-certified home health care agency when:

- the member is confined to home,
- the member's physician recommends home health care and,
- the member's physician prepares a treatment plan.

Home health care visits do not reduce the available benefit for hospital days. Covered home health care benefits include the following:

- nursing care by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) if the services of an RN are not available
- home health aide services, such as meal preparation, bathing and feeding (with a 4-hour visit being defined as a "day")
- nutritional guidance and social services
- medical and surgical supplies, such as catheters, colostomy supplies and hypodermic needles
- oxygen, laboratory services and drugs
- physical, speech, and occupational therapy

3. Hospice Care is covered when all of the following conditions are met:

- a Participating Physician certifies that the patient is terminally ill (that is, the person has been diagnosed as having six months or less to live)
- the Member or Member's Representative chooses to receive care from a hospice instead of standard benefits for the terminal illness; and
- care is provided by a certified hospice program

The Plan will cover up to 210 days--two periods of 90 days each and one period of 30 days during the patient's lifetime. Covered hospice care benefits include the following:

- nursing care by, or under the supervision of, a Registered Nurse
- home health aide and homemaker services
- short-term inpatient care
- medical supplies and drugs
- physical, speech and occupational therapy
- medical social services (including needs assessment, psychological and dietary counseling)
- bereavement counseling for the family for up to 30 days following the patient's death

Children under 21 years of age may receive hospice care concurrently with curative treatment of the child's terminal illness. This allows the Member or Member's representative to elect the hospice benefit without forgoing any curative service to which the Member is entitled under *MIChild* for treatment of the terminal condition. The need for hospice care must be certified by a physician and the hospice medical director. The Plan will reimburse for the curative care separately from the hospice services. The Plan will not reimburse for these types of treatments when they are used palliatively. As such, they are the responsibility of the hospice and must be included in the per diem cost.

4. Inpatient Hospital admissions are covered up to 365 days per benefit year including the following services and supplies:

- general medical care days
- semi-private rooms and intensive care units
- meals and special diets
- general nursing services
- use of operating and other treatment rooms
- use of delivery room birthing center services
- anesthesia when administered by an employee or agent of the hospital
- laboratory and pathology examinations
- chemotherapy for the treatment of malignant and non malignant disease
- oxygen and other gas therapy
- drugs, biologicals and solutions
- diagnostic and therapeutic x-rays, EKGs, cobalt, isotopes, radiation therapy, CAT, MRI, MRA, and PET scans
- routine nursery care of the newborn when the mother is eligible for maternity care
- dental surgery, including removal of impacted teeth or multiple extractions, and related anesthesia and facility expenses in a hospital only when a concurrent hazardous health condition, diagnosed by a physician, exists
- cosmetic surgery or reconstructive surgery only for the correction of birth defects, conditions resulting from accidental injuries, deformities resulting from certain surgeries, such as breast reconstruction following mastectomies (cosmetic surgery that is not reconstructive in nature is performed solely to improve appearance is not covered)
- hospital-billed ambulance service.

5. Emergency Treatment is covered without prior authorization if medically necessary as defined in MCL 500.3406(k). Emergency health services are medically necessary services for the sudden onset of a medical condition that manifests itself by signs and

symptoms of sufficient severity, including severe pain, such that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the member's health or to a pregnancy, or serious dysfunction of any bodily organ or part. The Plan shall not deny payment for emergency services up to the point of stabilization. Stabilization means the point which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during the transfer of the member.

6. **Outpatient Hospital** is covered for the following services**:**

- emergency department services for accidental injuries treated within 48 hours of the injury
- emergency department services for an illness or disease if the condition is life-threatening (emergency department services are covered for emergencies only)
- surgery
- hemodialysis
- chemotherapy
- diagnostic laboratory, x-ray and EKG services, cobalt, isotopes, radiation therapy, CAT, MRI, MRA, and PET scans
- preadmission testing within 72 hours of inpatient admission
- termination of pregnancy when determined medically necessary to save the life of the mother, or in cases of rape and/or incest
- special hospital programs including home hemophilia services and home hemodialysis services

7. **Well Child Care:**

Well Child/EPSDT is a child health program of early and periodic screening, diagnosis and treatment services for beneficiaries. It supports two goals: to ensure access to necessary health resources and to assist parents and guardians in appropriate use of those resources.

As specified in federal regulations, the screening component

includes a general health screening most commonly known as a periodic Well Child/EPSDT examination. The required Well Child/EPSDT screening guidelines, based on the American Academy of Pediatrics' (AAP) recommendations for preventive pediatric health care, include:

- Health and developmental history
- Height and weight measurements and age appropriate head circumference
- Beginning at age 2, tracking of Body Mass Index (BMI) measurements
- Blood pressure for children 3 and over
- Age appropriate unclothed physical examination
- Age appropriate screening, testing and vaccinations
- Immunization review and administration
- Blood lead testing for children under 6 years of age
- Developmental/behavioral assessment
- Nutritional assessment
- Hearing, vision and dental assessments
- Health education including anticipatory guidance
- Interpretive conference and appropriate counseling for parents or guardians

Additionally, objective developmental/behavioral, hearing, and vision screening and testing must be performed in accordance with the periodicity schedule. Laboratory services for hematocrit, hemoglobin, urinalysis, hereditary/metabolic, or other needed testing as determined by the physician must be provided.

Will provide the following Well Child/EPSDT services:

- Vision services under Well Child/EPSDT must include at least diagnosis and treatment for defective vision, including glasses if appropriate
- Dental services under Well Child/EPSDT must include at least relief of pain and infections. Molina Healthcare is responsible for oral screening and referral and fluoride

varnish treatments four (4) times in a period of twelve (12) consecutive months for Enrollees aged 0 – 3 years
- Hearing services must include at least diagnosis and treatment for hearing defects, including hearing aids as appropriate
- Other health care, diagnostic services, treatment, or services necessary to correct or ameliorate defects, physical illnesses, and conditions discovered during a screening
- A medically necessary service may be available under Well Child/EPSDT if listed in a federal statute as a potentially covered service, even if the *MIChild* program does not cover the service under its State Plan

Molina Healthcare will make appropriate referrals for diagnostic or treatment services determined to be necessary.

- Oral screening should be part of a physical exam with referral to a dental provider as appropriate
- Children should also be referred to a hearing and speech clinic, optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services as necessary
- Referral to community mental health services also may be appropriate

Children at should be tested according to American Academy of Pediatrics (AAP) guidelines. Problems found or suspected during a Well Child visit must be diagnosed and treated as appropriate. Referrals must be made based on standards of good practice and AAP's recommendations for preventive pediatric health care or presenting need.

For example, if a child is found to have elevated blood lead levels in accordance with standards disseminated by DCH, then a referral should be made for follow-up services that may include an epidemiological investigation to determine the source of blood lead poisoning.

Molina Healthcare will provide or arrange for outreach services

to *MIChild* Enrollees who are due or overdue for Well Child/EPSDT visits. Outreach contacts may be by phone, home visit, or mail. Molina Healthcare will meet this requirement by contracting with other organizations and non-profit agencies that have a demonstrated capacity of reaching the Well Child/EPSDT target population. Molina Healthcare will obtain information from the contracted agencies regarding Enrollees who require Well Child/EPSDT services or are overdue for Well Child/EPSDT services. Molina Healthcare will monitor services provided by the Molina Healthcare to these identified Enrollees to ensure that the Enrollees receive the required services.

8. Skilled Nursing Facility benefits are covered up to 120 days per admission for skilled care in a skilled nursing or extended care facility while convalescing from general conditions and pulmonary TB including:

- semi-private room
- meals and special diets
- nursing services
- use of special treatment rooms; x-ray, and laboratory examinations
- physical, speech, and occupational therapy
- oxygen and other gas therapy
- drugs, biologicals, and solutions
- materials used in dressings and casts

After benefit days have been exhausted, they are renewed when there has been a lapse of at least 90 days from discharge date until the next admission date.

9. Physician and other professional provider services and medical/surgical supplies and services including the following:

- physicians' charges for office, nursing home, and clinic visits and consultations for the diagnosis or treatment of an injury, illness, or disease

- surgery
- blood and blood storage when the member donates in preparation for scheduled surgery
- cataract surgery and first lens implant(s)
- technical surgical assistance when an intern, resident, or house officer is not available or qualified
- inpatient and outpatient medical care
- anesthesia and oxygen
- treatment of accidental injuries if treated within 48 hours of injury
- emergency medical treatment
- family planning services
- termination of pregnancy when determined medically necessary to save the life of the mother, or in cases of rape and/or incest
- inpatient consultations including outpatient consultations
- diagnostic and therapeutic EKG, x-ray, radium, isotope and radiation therapy
- diagnostic laboratory and x-ray examinations including CAT, MRI, MRA, and PET scans
- allergy testing
- dermatology
- hemodialysis and peritoneal services
- chemotherapy
- professional ambulance service for a trip to or from the hospital, skilled nursing facility, or home
- private duty skilled care nursing charges, except such care if provided by a person who ordinarily resides in your home or who is a member of your family or the family of your spouse
- allergy extract and extract injection
- papanicolaou (PAP) test once every 12 consecutive months
- physical, occupational, and speech therapy
- prenatal and postnatal care visits whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification in accordance with MCL 500.3046r of the Michigan Insurance Code
- contraceptive devices requiring a prescription or physician

insertion/removal
- first contact lens obtained within one year of cataract surgery
- chelation therapy for certain diagnoses
- eye and ear examinations for the diagnosis of an illness or injury
- pain management including evaluation and treatment of intractable pain
- hypodermic syringes or needles prescribed by an attending physician
- blood lead testing

10. Chiropractic Care benefits are as follows:

- manipulations
- an initial office examination
- x-rays relating to back and spine
- first aid treatment of musculoskeletal injury
- 24 visits per calendar year

11. Acupuncture Therapy treatments are covered up to a maximum of 20 in a calendar year when performed by (not just under the direction of) a physician (M.D. or D.O.) for the treatment of any one of the following illnesses:

- sciatica
- neuritis
- post herpetic neuralgia
- tic douloureux
- chronic headaches, e.g., migraine
- osteoarthritis
- rheumatoid arthritis
- myofascial complaints, e.g., neck and lower back pain

12. Therapeutic Services are covered at home or outside of the home if necessary equipment cannot be brought into the home to restore or improve a functional loss caused by injury, illness, disease or congenital anomaly. The following therapies are limited to a combined maximum of 60 visits per calendar year.

- physical therapy
- speech therapy
- occupational therapy

13. Durable Medical Equipment is covered on a rental or purchase basis when:

- it is reasonably and medically necessary for the treatment of illness, injury or disease
- prescribed by a physician and used in the course of medical treatment
- obtained from a professional supplier approved by the Plan
- Repair of purchased durable medical equipment is covered due to normal wear and tear
- Replacement of purchased durable medical equipment is covered due to the following:
    - the loss or irreparable damage of equipment
    - a change in patient's condition or size

14. Prosthetic and Orthotic Appliances are covered when prescribed by a physician as medically necessary. Prosthetics is defined as artificial and/or mechanical appliances (such as arms, legs, eyes, etc.) which replace all or part of the functions of a permanently inoperative or real functioning body organ. Orthotics is defined as appliances which support or straighten a deformed body part. Coverage includes:

- prosthetic and orthotic appliances that are pre-fabricated or custom-fitted
- the repair, fitting, and/or adjustment of a covered prosthetic or orthotic appliance
- the replacement of appliances when they are damaged beyond repair or worn out, or because of a change in the child's condition or size
- orthopedic shoe inserts are covered when prescribed by a participating provider

15. Organ and Tissue Transplants are covered including the hospital and professional medical services required to receive a non-experimental transplant of a human organ or body tissue as defined by, and according to, established utilization guidelines used by the Plan. Transplants of artificial organs are not covered. The Plan will pay for the covered services for donors if the donor does not have transplant benefits under any other health care plan.

16. Hearing Care is covered for the following services and supplies payable once in every 36 consecutive months:

- audiometric examination to measure hearing ability, including tests for air conduction, bone conduction, speech reception, and speech discrimination
- hearing aid evaluation tests to determine what type of hearing aid(s) should be prescribed to compensate for loss of hearing
- hearing aids including in-the-ear, behind-the-ear, and on-the-body designs, and binaural aids purchased together
- dispensing fees for the normal services required in the fitting of a hearing aid
- hearing aid conformity tests to evaluate the performance of a hearing aid and its conformity to the original prescription after the aid has been fitted

- Hearing care benefits are not payable for hearing aid repairs or for the replacement of parts (including batteries and ear molds). Benefits are also not payable for the replacement of lost or broken hearing aids unless the 36 month coverage limitation does not apply.

17. Vision Care is covered for the following services:

- annual vision exam
- annual glaucoma testing
- eye glasses once every 24 months or once every 12 months with a prescription change
- contact lenses when medically necessary or therapeutic, to correct visual impairment when glasses are insufficient to

correct a visual impairment

18. Pharmacy is covered for each prescription drug or refill purchased up to a 34-day supply for acute medications and up to 102-day supply for maintenance medications.

Prescriptions are to be filled with a generic medication unless the prescribing physician has indicated "dispense as written" (DAW) on the prescription.

Benefits cover the following:

- a drug, biological, or compounded medication which, by federal law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law Prohibits Dispensing without a Prescription";
- injectable insulin, needles and syringes
- hypodermic syringes or needles prescribed by an attending physician
- birth control prescriptions
- covered prescriptions written by a Plan provider

The following are not covered benefits:

- any drug entirely consumed at the time and place it is prescribed
- any refill of a drug if it is more than the number of refills specified by the prescription
- any refill of a drug dispensed more than one year after the latest prescription for that drug
- any drug which is provided while the member is an inpatient in a facility
- any drug provided on an outpatient basis in any facility if benefits are paid under any other part of the plan
- over-the-counter drugs available without a prescription

19. Weight Loss Clinic attendance is covered for morbid obesity when prescribed by a physician.

20. Medically Necessary Weight Reduction Services. Medically necessary weight reduction services are covered for members with life endangering medical conditions. Prior authorization is required.

21. Ambulance Services are covered as follows**:**

- hospital billed ambulance service for a trip to or from the hospital, a skilled nursing facility, or member's home
- professional ambulance service when used to transport the member from the place where injured or emergency occurred to the first hospital where treatment is given
- may include ground or air transport when deemed medically necessary

22. Oral Surgery, limited to the following:
- the treatment of a jaw fracture, dislocation, or wound
- the treatment of cysts, tumors, or other disease tissues
- other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction
- the alteration of the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- charges for office visits related to the above procedures.

23. Tobacco Cessation For all members, including diagnostic, therapy and counseling services and pharmacotherapy (including coverage of prescription and non-prescription tobacco cessation agents approved by the Federal Drug Administration (FDA).

24. Health Promotion Programs are covered for Members with or at risk for a specific disability.

25. Breast Cancer Services as defined in MCL 500.3616 and MCL 500.3406(a) including:

a. Breast Cancer Diagnostic Services intended to aid in the

diagnosis of breast cancer delivered on an inpatient or outpatient basis, including but not limited to mammogram, mammography, surgical breast biopsy, and pathologic examination and interpretation.

b. Breast Cancer Rehabilitative Services intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to reconstructive plastic surgery, physical therapy, and psychological and social support services.
c. Breast Cancer Screening Mammography in order to detect unsuspected breast cancer.
d. Breast Cancer Outpatient Services intended to treat cancer of the human breast delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.
e. Prosthetic devices to maintain or replace body parts of a member who has undergone a mastectomy.

26. Diabetic care which is medically necessary including blood glucose monitors, test strips for glucose monitors, visual reading and urine test strips, lancets, spring-powered lancet devices, syringes, insulin, insulin pumps, medical supplies required for use of an insulin pump, and diabetes self management training and education.

27. Antineoplastic Drug Therapy. Antineoplastic drugs are covered in accordance with MCL 500.3406e of the Michigan Insurance Code.

28. Off-Label Use of Federal Food and Drug Administration Approved Drugs are covered in accordance with MCL 500.3406q of the Michigan Insurance Code.

Appendix B - Exclusions and Limitations

A. Exclusions. The following services, equipment and supplies are not covered by the Plan:

1. Services, equipment or supplies not performed, provided, prescribed, directed, or arranged by the Member's Primary Care Physician or, where required, not authorized in advance by the Plan;

2. Services, equipment and supplies, which are not medically necessary.

3. Routine dental and oral surgery services except as provided in Appendix A.

4. Any examinations required by an employer as a condition of employment or for the purpose of obtaining employment or insurance.

5. Cosmetic surgery as performed to reshape normal structures of the body to improve the member's appearance or self esteem, except for reconstructive breast surgery and to correct a functional defect which is the result of a congenital and/or acquired disease or when performed to repair a part of the body which was previously altered due to injury or surgery.

6. Custodial care in a nursing home or restorative care in excess of 120 days per admission.

7. First aid supplies.

8. Items for personal cleanliness and grooming.

9. Experimental, investigational or research medical, surgical or other health care drug, device, treatment or procedure

as determined by the Medical Director and the Michigan Department of Community Health. This exclusion does not apply to therapies that include off-label uses of FDA-approved anti-cancer drugs if current medical literature substantiates their efficiency and recognized oncology organizations generally accept the treatment.

10. Sex change operations.

11. Reversal of voluntarily induced infertility (sterilization).

12. Any service equipment or supply usually given free of charge. For example, health education material or pharmaceutical samples.

13. Abortions, except to save the life of the mother or following incest or rape.

14. Services provided by school districts and billed through these intermediate school districts.

15. Services unique to and provided only by a community mental health services board as defined by the MIChild Contract including inpatient mental health care, partial hospitalization and outpatient visits.

17. Inpatient services provided by those institutions and nursing care facilities for the mentally challenged and mentally ill, or a mental hospital, as defined by the MIChild Services Agreement.

18. Over-the-counter medications not included in the Plan's formulary.

19. Non-emergency transportation except for Ambulances Services as stated in Appendix A.

20. Personal care services or home help services provided in a

Member's home, as defined by the Code of Federal Regulations on Public Health except as stated in Appendix A.

21. Mental health and substance abuse services and medications including treatment for alcohol and drug dependency. Mental health and substance abuse services may be obtained through the community mental health agency in the Member's county of residence. The Plan or the Primary Care Provider is available to assist the member in obtaining these services.

22. Incontinence supplies

B. Limitations. Please note the limitations on Covered Services:

1. Covered Services are subject to the limitations and restrictions described in the MIChild Contract, Program Provider Manuals, bulletins and other directives.

2. The Plan has no liability or obligation for any services, equipment or supplies provided by a Non-Participating Provider, except for Emergency Services, unless the services, equipment or supplies are authorized by the Plan or the Member's Primary Care Physician.

3. A referral by a Primary Care Physician for Non-Covered Services does not make such services Covered Services.

4. Time limit on certain defenses as stated in MCL 500.3408. After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application of such policy shall be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such three year period.

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