Welcome to

Molina Healthcare.

Your Extended Family.

Michigan Member Handbook

Medicaid

Last Updated March 2021

MOLINA® HEALTHCARE

Molina Healthcare of Michigan (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
    - Skilled sign language interpreters
    - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
    - Skilled interpreters
    - Written material translated in your language
    - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (888) 898-7969.
Hearing Impaired: MI Relay (800) 649-3777 or 711.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (248) 925-1765.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call 1-800-368-1019; TTY 800-537-7697.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-898-7969 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-898-7969 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-898-7969 (رقم هاتف الصم والبكم: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-898-7969（TTY：711）。

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܓܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܨܝ ܒܬܘܢ ܕܩܒܠܝܬܘܢ ܐܝܠܦܢܝܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-888-898-7969 (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-898-7969 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-898-7969 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-898-7969 (TTY: 711) 번으로 전화해 주십시오.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-888-898-7969 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-898-7969 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-898-7969 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-898-7969 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-898-7969（TTY: 711）まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-898-7969 (телетайп: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-898-7969 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-898-7969 (TTY: 711).

Thank you for choosing Molina Healthcare!

Ever since our founder, Dr. C. David Molina, opened his first clinic in 1980, it has been our mission to provide quality health care to everyone. We are here for you. And today, as always, we treat our members like family.

The most current version of the handbook is available at **MolinaHealthcare.com/Medi-Handbook.**

In this handbook you will find helpful information about:

Your Membership (pg 03)

- Member ID card
- Quick Reference
- Phone Numbers

Your Doctor (pg 07)

- Find your Doctor
- Schedule your First Visit
- Molina Doctors and Hospitals

Your Benefits (pg 11)

- Medical Services
- Hearing Aids
- No-Cost Cell Phone
- Vision and Dental
- Covered Drugs

Your Extra Benefits (pg 17)

- Molina Mobile App
- Health Education
- Health Programs
- Community Resources
- Transportation

NOTE: If you have any problem reading or understanding this or any Molina Healthcare information, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). We can explain in English or in your primary language. We may have it printed in other languages at no cost to you. You may ask for it in braille, large print, or audio at no cost to you. If you are hearing or sight impaired, special help can be provided at no cost to you.

Your Policy (pg 27)

Your Policy (continued)

Healthcare is a journey and you are on the right path.
These are the steps you need to take ...

1. Review your Welcome Kit

You should have received your Molina Healthcare ID card. There is one for you and one for every member of your family. Please keep it with you at all times. If you haven't received your ID card yet, visit **MyMolina.com** or download the **Molina Mobile App** from the Apple App Store or Google Play Store. You can also call Member Services at (888) 898-7969, Monday- Friday, 8 a.m. to 5 p.m. (TTY: 711). You need both a Molina Healthcare ID card and a Medicaid mihealth card from the Michigan Department of Health and Human Services (MDHHS). Both cards are required for covered services along with your valid ID.

2. Register for MyMolina and the Molina Mobile App

Signing up is easy. Visit **MyMolina.com** and download the **Molina Mobile App** from the Apple App Store or Google Play Store to register. Once registered, you'll be able to change your Primary Care Provider (PCP), view service history, request a new ID card and more. Connect from any device, any time!

3. Talk about your health

We'll call you for a short talk about your health. It will help us identify how to give you the best possible care. Please let us know if your contact information has changed.

4. Get to know your PCP

PCP stands for Primary Care Provider. He or she will be your personal doctor. To choose or change your doctor, go to **MyMolina.com** or the **Molina Mobile App**. You can also call Member Services at (888) 898-7969, Monday- Friday, 8 a.m. to 5 p.m. (TTY: 711) . Please call your doctor within the next 60 days to schedule your first visit.

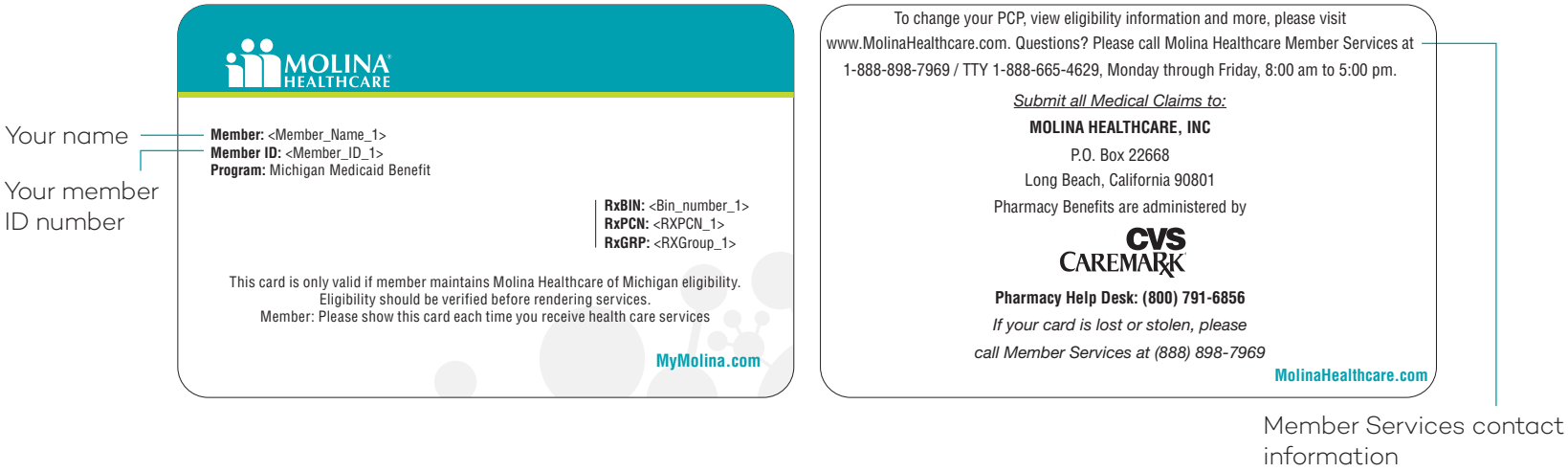
5. Get to know your benefits

With Molina, you have health coverage and free extras. We offer free rides to your doctor. We also offer help with your health.

Your Membership

ID Card

There is one ID for each member.



You need your ID card to:

- See your doctor, specialist or other provider
- Go to an emergency room
- Go to urgent care
- Go to a hospital
- Get medical supplies and/or prescriptions
- Have medical tests

Quick Reference

Need	Emergency	Online Access	Getting Care

		- Find or change your doctor
		- Update your contact information
		- Request an ID card
		- Get health care reminders
		- Track office visits
			- Preventive Care
			- Urgent Care
			  - Minor illnesses
			  - Minor injuries
			- Immunizations (shots)
			- Physicals and Check-ups

Action	Call 911	Go to **MyMolina.com** or download the **Molina Mobile App** and sign up. Find a provider at: **MolinaHealthcare.com/ProviderSearch**	**Call Your Doctor:** Name and Phone Urgent Care Centers Find a provider or urgent care center **MolinaHealthcare.com/ProviderSearch** 24-Hour Nurse Advice Line **(888) 275-8750 (English)** **(866) 648-3537 (Spanish)** **TTY/TDD English: (866) 735-2929** **TTY/TDD Spanish: (866) 833-4703**

Your Plan Details

- Questions about your plan
- Questions about programs or services
- ID card issues
- Language services
- Transportation
- Help with your visits
  - Prenatal care
  - Well-infant visits with (PCP) or OB/GYN

Member Services
(888) 898-7969
Monday through Friday during normal business hours, 8 a.m. – 5 p.m.

To schedule a ride to an appointment, please call Member Services.

Changes/Life Events

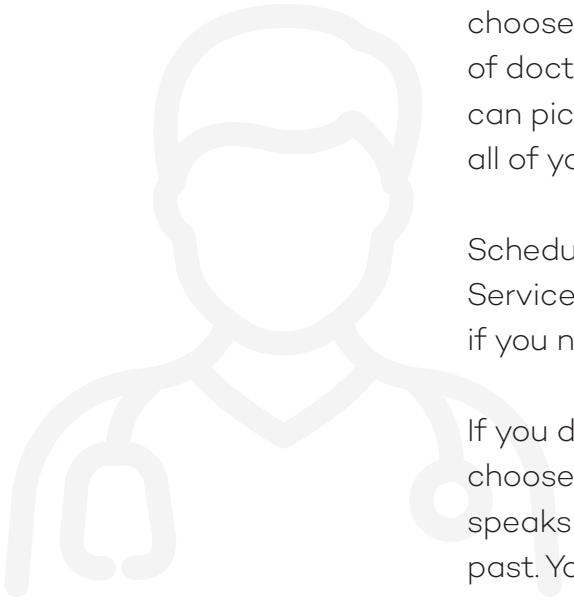
- Coverage
- Contact Info
- Marriage
- Divorce
- Child Birth
- Death

Member Services
(888) 898-7969, TTY: 711

MDHHS Beneficiary HelpLine
(800) 642-3195, TTY (866) 501-5656

Social Security Administration
(800) 772-1213
TTY/TDD: 800-325-0778

Your Doctor



Find Your Doctor

Your Primary Care Provider (PCP) knows you and takes care of your health needs. Your doctor should make you feel comfortable. It's easy to choose one with our Provider Directory. The Provider Directory is a list of doctors, hospitals, pharmacies, etc. You can pick one for you. And you can pick another for others in your family. Or you can pick one who sees all of you.

Schedule your first visit to get to know your doctor. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) if you need help making an appointment or finding a doctor.

If you do not choose a doctor, Molina will do it for you. Molina will choose a doctor that is in your area. We will find you a doctor that speaks your language. You can also see doctors you have seen in the past. You can change your PCP anytime.

PCP: _____

PCP Phone Number: _____

Schedule Your First Visit

Visit your doctor within 60 days of signing up. Learn more about your health. And let your doctor know more about you.

Your doctor will:

- Treat you for most of your routine health care needs
- Review your tests and results
- Prescribe medications
- Refer you to other doctors (specialists)
- Admit you to the hospital if needed

Interpreter Services

If you need to speak in your own language, we can get an interpreter to talk to you. They can also help you talk to your doctor or provider. An interpreter can help you:

- Make an appointment
- Talk with your doctor or nurse
- Get emergency care
- File a complaint, grievance, or appeal
- Get information about taking medicine
- Follow up about prior approval you need for a service
- With sign language

This is a free service. If you need an interpreter, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

You must see a doctor that is part of Molina.
If for any reason you want to change your primary doctor, go to **MyMolina.com** or the **Molina Mobile App**. You can also call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Remember, you can call the 24-Hour Nurse Advice Line at (888) 275-8750 (English) or (866) 648-3537 (Spanish). TTY: (866) 735-2929 (English) or (866) 833-4703 (Spanish). at any time. Our nurses can help if you need urgent care.

Your Benefits

Medical Services

We have a growing family of doctors and hospitals. To find a doctor or pharmacy, please visit **MolinaHealthcare.com/ProviderSearch.**

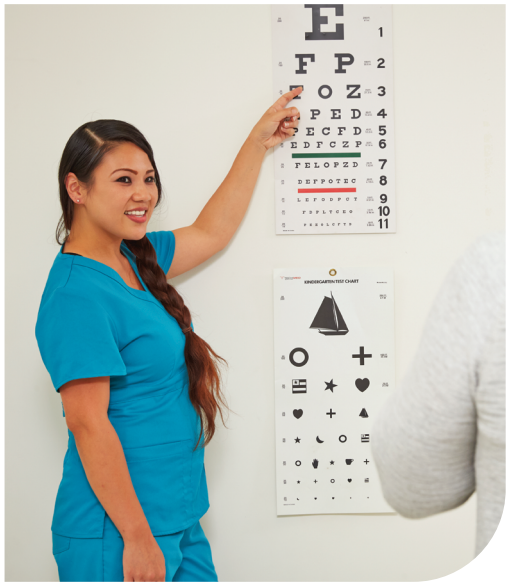
The online directory contains provider information such as names, telephone numbers, addresses, specialties and professional qualifications.

Hearing Aids

Hearing exams and supplies, including hearing aid batteries, maintenance and repair of hearing aids, are covered for all ages. Medicaid covers hearing aids once every 5 years. Members can receive 36 hearing aid batteries every 6 months. If you have any questions regarding this benefit, please call Member Services at (888) 898-7969, Monday-Friday, 8 a.m. to 5 p.m., EST (TTY: 711). You may also visit **MolinaHealthcare.com**.

Vision and Dental

Vision



Every 2 years, Molina covers eye exams for members 2 years of age and up, and 1 pair of glasses. If glasses are lost, broken or stolen, replacement glasses are covered. Replacements are limited to 2 pairs a year for members under 21 and 1 pair a year for members 21 and up. Contact lenses are covered only if vision problems cannot be fixed with glasses.

Please check your Molina Healthcare Provider Directory to find optometrists or physicians that can give you these services at **MyMolina.com** or the **Molina Mobile App**.

Molina Healthcare's vision benefit includes eye exams and replacement glasses.

To find a vision provider, or to see if your existing provider is included, visit **MolinaHealthcare.com** to view the vision providers available to you in the Provider Directory. If you are a new member with Molina, you may continue seeing your current vision provider for 90 days, if the doctor is not listed. Your provider may contact Molina Healthcare, if they want to be included within our network. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) if you have any questions.

Dental

Molina Healthcare provides dental services to pregnant women. Pregnant Medicaid members are able to use their Molina Healthcare Medicaid ID card to obtain dental services.

Molina Dental Services under Medicaid are provided to members at no cost. Molina's dental benefit includes cleanings, fillings and other preventive services.

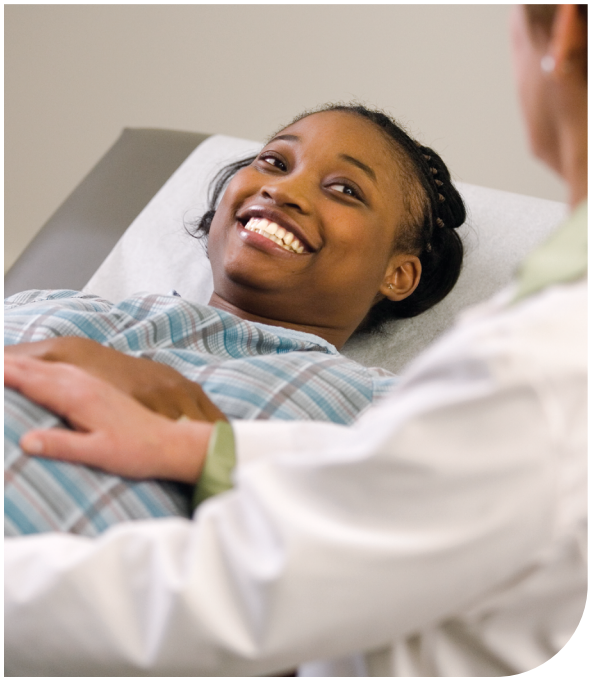
Description	Limitations
Diagnostic and Preventative Services	N/A
Emergency Dental Care	N/A
X-Rays	N/A
Oral Surgery Services	N/A
Fillings and Other Restorative Services	N/A
Topical Fluoride Treatment	Under Age 21
Tooth Extractions	N/A

Pregnant Medicaid members get dental coverage from the first day of the month when Molina finds out about the pregnancy through the postpartum period. The postpartum period is 3 months following end of pregnancy.

Please visit **MyMolina.com** if you would like to review your healthcare coverage. To find a Molina Dental Services

provider, visit **MolinaHealthcare.com**, select Medicaid, then Find a Doctor or Pharmacy to view the Molina Dental Services Providers available to you.

We are confident you will find an appropriate Molina Dental Services Provider near you.



It is important that pregnant women get proper dental care during their pregnancy for the health and wellbeing of the mother and infant. Molina Healthcare will provide the names of participating dentists in your area who are available to provide dental services. Molina provides unlimited round-trip or one-way trips for covered, medically necessary services each calendar year. Pregnant Medicaid members can use this benefit to visit any Molina Healthcare provider.

If you have questions about this benefit, please contact us. We're here to help. Please call the M.O.M. Program at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). You may also visit **MolinaHealthcare.com**.

All non-pregnant Medicaid members can call the Michigan Medicaid Beneficiary HelpLine for help with finding a dentist at (800) 642-3195 or visit **www.medicaiddentistry.com.** Healthy Kids Dental is a Medicaid health care program, available for low-income children under age 21. If you are currently enrolled in Healthy Kids dental and become pregnant, you will stay in Healthy Kids dental for prenatal dental services. To find out more about Healthy Kids Dental, the dental benefits your child may be eligible to receive and to locate a dentist in your area, please visit **www.HealthyKidsDental.org**.

No-cost Cell Phone

Get a phone to use 24/7. You can receive <1,000> minutes and <1GB> of FREE data every month. As a Molina member, you also get unlimited texts. If you are interested in a no-cost cell phone, please call (877) 631-2550.

Covered Drugs

Molina Healthcare covers your medically necessary medications. There is no cost to get these drugs.

All Michigan Medicaid Plans use a Single Preferred Drug List (PDL). These are drugs that the state prefers your provider prescribes. You can find a list of the preferred drugs at **MyMolina.com.**

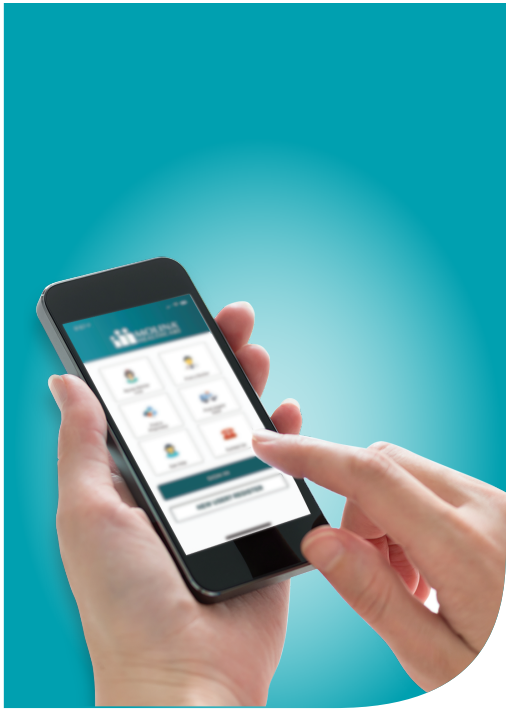
There are also drugs that are not covered. For example, drugs for erectile dysfunction, weight loss, cosmetic purposes and infertility are not covered.

We are on your side. We will work with your doctor to decide which drugs are the best for you.

Your Extra Benefits

MyMolina.com: Manage your health plan online

Connect to our secure portal from any device, wherever you are. Change your doctor, update your contact info, request a new ID card and much more. To sign up, visit **MyMolina.com.**



Molina Mobile App

You can manage your health care anytime, anywhere with the Molina Mobile App. With the new mobile application, you can view your Member ID card, find a doctor or facility nearby, call the 24-Hour Nurse Advice Line or 24-Hour Behavioral Health Crisis Line, and more.

When you download the Molina Mobile App, you can access all the same features as on **MyMolina.com** plus:

- Improved virtual ID cards with sharing and printing options
- Urgent Care Finder
- Pharmacy Finder
- Symptom Checker
- Favorite Doctor Option
- Face ID Recognition

Download the Molina Mobile App Today!
The Molina Mobile App can be used on any Apple or Android smartphone:

1. Download the QR Reader through the Apple App Store or Google Play Store.
2. Scan the below QR code to direct you to the app. You can also search Molina Mobile in the App Store or Google Play Store.
3. Download the Molina Mobile App.
4. Open the app and enjoy your great Molina benefits in the palm of your hand!

Member Advisory Council

At Molina Healthcare, we want to serve you better. We value your opinion and would like to invite you to apply for the Molina Member Advisory Council. The Member Advisory Council discusses and recommends ways for Molina to improve its services provided to Molina members. Council members must be at least 21 years old and be current Molina members. The Council will meet once a year in your area. Advisory Council members will be expected to participate in discussions concerning their experiences with Molina services and providers. Molina will use the member's information about their experiences and their suggestions to improve the healthcare services Molina provides to all members. If you would like to apply or would like more information about the Molina Member Advisory Council, please call (888) 898-7969, Monday – Friday, 8 a.m. to 5 p.m., EST (TTY/TDD: 711).

Health Education and Incentives Programs

Live well and stay healthy! Our free programs help you control your weight, stop smoking or get help with chronic diseases. You get learning materials, care tips and more. We also have programs for expectant mothers. If you have asthma, diabetes, heart problems or any other chronic illness, one of our nurses or Care Managers will contact you. You can also sign up on **MyMolina.com**, our secure member portal, or please call Member Services at (888) 898-7969, Monday – Friday, 8 a.m. to 5 p.m. (TTY: 711).

If you are pregnant, we want you to have a healthy pregnancy and baby. Molina Healthcare has a FREE program just for both of you. It's called the Moms of Molina (M.O.M.) Program. A special nurse coordinator works with you and your doctors to make sure you get the care you need. We give information about prenatal care and free support services to all mothers-to-be.

We can help you:

- Stay healthy
- Find a doctor for you and your new baby
- Set up doctor visits during your pregnancy and after your baby is born
- Get rides to your doctor visits
- Handle special needs while you're pregnant
- Find childbirth and parenting classes and counseling
- Get information finding food, housing and baby clothes, and what to expect while you are pregnant
- Keep in touch with you and your doctor

Remember to get early, regular prenatal care and to keep all your doctor appointments, even if this is not your first baby. Please call Member Services at (888) 898-7969, Monday- Friday, 8 a.m. to 5 p.m. (TTY: 711) and ask for the M.O.M. Nurse.

Transportation

Molina Healthcare will provide transportation to covered services. Transportation is provided when you have no other means to get to your doctor appointments, x-rays, lab tests, pharmacy, medical supplies or other medical care. To save another trip, get your scripts filled right after a medical visit. Please call Member Services at (888) 898-7969, Monday-Friday, 8 a.m. to 5 p.m. (TTY: 711) to schedule. It is important to call 3 business days in advance of your appointment to schedule a free ride. You can request same-day for urgent non-emergency medical transportation (NEMT).

If you must travel to receive services and do not have your own way to get there, Molina will always help you. Additionally, for each member, Molina provides unlimited round-trip or one-way trips (Prior Authorization may be required for long distances) for covered, medically necessary services each calendar year. Members can use this benefit to visit any Molina Healthcare provider.

Molina Healthcare will also cover emergency transportation to the hospital. You should call 911 when you have an emergency and need immediate transportation.

Have your Member ID Card handy.

Care Management

We have a team of nurses and social workers ready to serve you. They are called Care Managers. They are very helpful. They will give you extra attention if you have the following health problems:

- Asthma
- Behavioral health disorders
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- High blood pressure
- High-risk pregnancy

Additional services are available. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) if you think you could benefit from Care Management.

Community Connectors

The Community Connector Program is a program designed to improve the access of care through the involvement of a Molina Community Connector. Molina Community Connectors help members find:

- Housing resources for homeless
- A medical home
- Food bank locations
- Support group information
- Utility bill assistance
- Transportation options

Community Connectors assist members with:

- Food stamp applications
- Social Security determinations
- Health and social services applications
- Meals on Wheels set-up
- Health goals
- Determining Medicaid eligibility
- Primary Care Provider discussions

How We Serve

- Home, community and shelter visits
- Face-to-Face and Phone interviews
- Act as a member advocate
- Help to remove barriers to care
- Help to schedule appointments with providers
- Assist with pharmacy issues
- Conduct home safety checks

If you could benefit from our Community Connector Program, please call Member Services toll-free at (888) 898-7969, Monday – Friday, 8 a.m. to 5 p.m. EST (TTY: 711).

Case Management

Molina Healthcare staff will help coordinate your care.
Living with health problems and managing them can be hard. We offer special services and programs for members who need extra help with a health problem. This can be any adult or child who is receiving health services for an ongoing health problem. The programs are offered at no cost to you.

Molina Healthcare staff can help you:

- Access services that you are eligible to receive.
- Set up appointments and tests.
- Set up transportation.
- Identify any gaps in care or health care needs.
- Access resources to help you with special health care needs and/or your caregivers deal with day-to-day stress.
- Coordinate the move from one setting to another. This can include being discharged from the hospital.
- Assessing eligibility for long-term care services and supports.
- Connect with community resources.
- Find services that might not be benefits. This includes community and social services programs such as physical therapy with the schools or "Meals on Wheels".
- Set up services with a primary care provider (PCP), family members, caregivers and any other identified provider.
- Assist you in navigating the health care system.
- Assist you with medication needs.
- Assist you in understanding new diagnoses.

How do members enroll?

The Case Management programs are voluntary but a member must meet certain requirements. You can also be referred to one of the programs through:

- Provider referrals
- Self referrals

Who do I contact for more information?

Please call (866) 891-2320 (TTY: 711). Our staff can give you more information. They can also let you know what programs you are currently enrolled in. You can also ask for a referral or ask to be removed from a program.

Community Resources

We are part of your community. And we work hard to make it healthier.

Local resources, health events and community organizations are available to you. They provide great programs and convenient services. Best of all, most of them are free or at low cost to you.

- Dial 2-1-1. This is a free and confidential service that will help you find local resources. Available 24/7
- MDHHS Beneficiary Help Line (800) 642-3195, TTY (866) 501-5656
- Women, Infant, Children (WIC) (800) 942-1636

The Women, Infants and Children (WIC) Program offers pregnant women and young children FREE food and other services. You do not need to ask your PCP to get WIC services. To find out more, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) or the M.O.M. Nurse at (866) 449-6828.

For a full listing of Community Resources, please visit **https://tinyurl.com/Molina-Community-Resource.**

Annual Molina HOPE Coat Drive

Since 2016, Molina Healthcare of Michigan has given away more than 25,000 coats to Michigan residents in need. Winter accessories are also distributed, including hats, gloves and scarves. Every year, Molina invites Molina Michigan members and the community to attend the Molina HOPE Coat Drive. They will receive a brand-new coat for each member of their family and winter accessories. They will also have the opportunity to enjoy refreshments, food, face painting, arts, crafts and more.

If you are interested in learning more about the Annual Molina HOPE Coat Drive, please call (248) 729-4923 or email **MHMCommunityOutreach@MolinaHealthcare.com**.

Your Policy

Member Services Department

Molina Healthcare provides Member Services toll-free at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). We answer questions about plan benefits and other concerns, including:

- General Information
- Change of address or phone number
- Changing doctors
- Claims
- Wellness
- Requesting an identification (ID) card
- Benefits
- PCP address and phone number
- Filing a grievance or appeal
- Enrollment or disenrollment questions

Contact Member Services by:

- Visiting the Molina Healthcare office
- Calling Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711)
- Visiting **MyMolina.com**

If you don't speak English, we have Spanish and Arabic-speaking Representatives to serve you. For any other language, please call our language line at (800) 752-6096. If you are hearing impaired, use Michigan Relay at (800) 649-3777. For written materials in a language other than English or in a different format because of special needs, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). These materials are provided at no cost to you.

Changing Information

If you change your name, address, telephone number or if your family size changes, please call the MDHHS Beneficiary Help Line at (800) 642-3195, TTY (866) 501-5656.

These changes include coverage, contact information, marriage, divorce, child birth, and death.

You can change your address and phone number using the MIBridges portal and also find other useful resources. This can be done on your mobile phone. Please go to **https://www.mibridges.michigan.gov/access/**

Member Materials

You can request print or electronic copies of member materials including provider directories, member handbooks and appeal and grievance notices. We can explain in English or in your primary language. We may have it printed in other languages. You may ask for it in braille, large print, or audio at no cost to you. If you are hearing or sight impaired, special help can be provided at no cost to you. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) to request a copy of member materials free of charge.

You will receive member handbooks within 5 business days of request.

Redetermination for Medicaid eligibility

The Redetermination process is important to complete in order to retain Medicaid benefits. When you are up for Redetermination, you should receive your Medicaid redetermination paperwork from MDHHS. Once you have completed your Redetermination paperwork, you must return it to your assigned case worker. Your Redetermination paperwork should be taken to your local MDHHS office or returned by mail to your local MDHHS office by the date listed on your Redetermination paperwork. To renew your benefits online and access your case, please visit **www.mibridges.michigan.gov/access.**

If you aren't sure about when you redetermination date is or if you need assistance completing your paperwork, please call the Michigan Medicaid Beneficiary HelpLine at (800) 642-3195.

If you need help or have any questions, please contact the Molina Benefit Renewals Team at 866-916-0917, Monday through Friday, 10:00 a.m. to 7:00 p.m. EST (TTY: 711).

Provider Information Section

Your Primary Care Provider (PCP)

To get started, you must choose a PCP. PCPs are doctors, nurse practitioners, or physician assistants who offer Family Practice, Pediatrics, or Internal Medicine services. Your PCP provides most of your care. Your PCP may also send you to specialists, other health care providers and hospitals.

You will find a list of PCPs at **MolinaHealthcare.com** or **MyMolina.com**. To request a paper copy of our list of PCPs at no cost to you, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). If needed, a specialist can be your PCP. If you do not choose a PCP within 30 days of enrollment, we will select one for you. We will make sure that PCP services and hospital services are available within 30 miles or 30 minutes from your home.

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

- Finding medical, dental and other issues early
- Treating problems before they become serious and
- Educating you about your health

If you have a chronic health condition like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. Please call us and we will help you.

Changing Your PCP

You may change your PCP or choose a new PCP at any time. Your requests will take effect immediately. To change your PCP, visit **MyMolina.com** or please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) and we will help. You can also request a new PCP in writing. Please call Member Services and ask for a PCP Selection Form with a pre-paid return envelope. If your health or safety is in danger, you will be given another PCP right away.

Transition of Care (TOC)

If you are new to Molina Healthcare, you can keep your doctors and services for at least 90 days from your enrollment date. Examples include medical, behavioral health, and pharmacy services.

If you are pregnant, you can stay with your doctor through pregnancy and post-partum.

If you are a Molina member and your doctor no longer participates with Molina, you can see your current doctor if you are receiving treatment for certain chronic diseases.

Molina will not approve continued care by a non-participating doctor if:

- You only require monitoring of a chronic condition
- The doctor has a restriction and you might be at risk
- The doctor is not willing to continue your care
- Care with the non-participating doctor was started after you enrolled with Molina
- The doctor does not meet Molina's policies or criteria

Molina will help you choose new doctors and help you get services in the Molina network. Your doctor may call Molina at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. if they want to be in our network.

Restrictions for Providers

Molina members may access participating providers in any contracted network. With the understanding that some provider organizations may have their own network requirements.

Network Adequacy Standards

Network adequacy is the health plan's ability to provide access to an adequate number of in-network primary care providers (PCPs), specialists, hospitals, pharmacies and dental providers to provide care to their members. Members can request a print copy of the MDHHS' published Network Adequacy Standards at no cost by calling Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Routine and Specialty Care Services

Your PCP will help you get your health care services.

- Please call your PCP for an appointment
- If you cannot keep your appointment, please call and cancel the appointment as soon as possible.
- Bring your Molina Healthcare ID card, your Medicaid mihealth card and valid ID with you.
- Please be on time.
- A parent or legal guardian must take a minor child to the medical appointment. If a parent or legal guardian is unable to take a minor child, please contact your doctor to find out the next steps before your child is seen by a doctor.

You can get specialty care from a participating provider including routine and preventive health care services from an OB/GYN, women's health specialists and pediatric providers. There is no cost to get these services. While Molina Healthcare of Michigan doesn't require referrals, check with your PCP to make sure there are no other referral needs.

You can check **MolinaHealthcare.com** for a list of Molina specialists and other providers. You may request a paper copy of our list of specialists and other providers at no cost to you by calling Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Type of Care/Appointment Guidelines

If applicable, your doctor's/dentist's office should make appointments in this time frame:

Type of Medical Care/ Appointment	Length of Time
After Hours Care (Emergency Services)	Immediately - 24 hours/ day, 7 days a week
Urgent Care	Within 48 hours
Routine Primary Care	Within 30 business days of the request
Preventive Care Appointment	Within 30 business days of the request
Non-Urgent Symptomatic Care	Within 7 business days of the request
Specialty Care	Within 6 weeks of the request
Acute Specialty Care	Within 5 business days of the request

Type of Medical Care/ Appointment	Length of Time
Behavioral Health*	• Immediately for life threatening emergency • Routine care within 10 business days of request • Non-life threatening emergency within 6 hours of request • Urgent Care within 48 hours of request

*Behavioral Health is limited to Covered Services

Dental Appointment Guidelines	Length of Time
Emergency Dental Services	Immediately - 24 hours/ day, 7 days a week
Urgent Care	Within 48 hours
Routine Care	Within 21 business days of the request
Preventive Care	Within 6 weeks of the request
Initial Appointment	Within 8 weeks of the request

Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) if you have trouble scheduling or can't get an appointment in the respective time frame. If there is an emergency, go to the emergency room.

Women's Preventive Services

Women may see any Molina Healthcare OB/GYN or women's health specialist for well woman care. There is no cost to get these services. While Molina Healthcare of Michigan doesn't require referrals, check with your PCP to make sure there are no other referral needs.

- Women age 50 or over should have a mammogram to screen for breast cancer once every year
- Women should have a pap smear every year to screen for cervical cancer
- Women age 16 – 25 who are sexually active should have a Chlamydia test every year to screen for this sexually transmitted disease (STD)

Women's Health and Cancer Rights Act: Women's health benefits include breast reconstruction services if elected after a mastectomy.

Family Planning Services

Family Planning Services are covered. These services include:

- Counseling to help you to decide when to have children
- Help to decide how many children to have
- Information about and prescriptions for birth control. For example, condoms and birth control pills. There is no cost to get these items.
- Treatment for sexually transmitted diseases (STD)

While Molina Healthcare of Michigan doesn't require referrals, check with your PCP to make sure there are no other referral needs to get family planning services. You can get family planning services from any doctor, clinic or Local Health Department, in or out of network. Family planning services are voluntary and confidential. Medicaid will pay for all services received out of network. You will use your mihealthcard to receive services.

Prenatal & 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.
- While Molina Healthcare of Michigan doesn't require referrals, check with your PCP to make sure there are no other referral needs for routine maternity care services.
- If you need help finding a doctor, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).
- If you need help making a doctor's appointment, please call the M.O.M. Nurse at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).
- Make sure you go to your doctor right after you have your baby for follow-up care (3 - 8 weeks, 21 - 56 days after your baby is born). If you had a C-section, you would follow up within 1 - 2 weeks of surgery.
- We offer prenatal, postpartum and maternity care.
- We offer information on diet, exercise and other important health care services.

At birth, your child becomes a member of Molina Healthcare. It is important that you tell your MDHHS worker and Molina about your child's birth as soon as possible. If you have any questions about your new baby's enrollment in Molina Healthcare, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

We will make sure that:

- Your baby gets healthcare
- Your baby's doctor is listed on the Molina Healthcare ID card

Maternal Infant Health Program (MIHP) Services

The Maternal and Infant Health Program (MIHP) is a covered service that helps pregnant members and infants get the right food, support and transportation for all health services. The Program also helps you to understand the importance of getting prenatal care, well childcare and immunizations when they are scheduled.

This home visiting program helps to promote healthy pregnancies, positive birth outcomes and healthy infant development. These services include:

For Mom and Baby:

- Birth control information.
- Nutritional counseling, WIC and food pantries.
- Childbirth/Breastfeeding Education.
- Transportation to medical & WIC appointments.
- Cribs/Car seats/Car seat safety.
- Housing assistance
- Parenting classes
- Education on infant care and safety

You and your baby can get a visit from a nurse in your home or in a location you choose.

Dental:
Pregnant women receive free dental care for cleanings, fillings and other services.

Visit **MolinaHealthcare.com/ProviderSearch** to find a dentist.

Quit Smoking:

Smoking during pregnancy can harm your baby. Visit https://michigan.quitlogix.org for help quitting or reducing smoking.

WIC:
The Women, Infants and Children (WIC) Program offers pregnant women and young children free food and other services. You do not need to ask your PCP to get services from WIC. Visit https://tinyurl.com/Michigan-WIC for more information.

If you would like more information about these support services, please call the M.O.M. Program at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Covered Services

Approval Process

Prior Approval or Prior Authorization (PA) is a request for service from your doctor. You do not need it for most medical services. But some services do require it. Molina Healthcare's medical staff and your doctor review the need for this care before services are given. They make sure it is right for your health condition.

For a list of covered services that require Prior Authorization, please refer to the Covered Services chart. You may also visit **MolinaHealthcare.com** or please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Covered Services (at Participating Providers)	
Ambulance transportation	PA (Prior Approval) is not required, except for non-emergency air ambulance.
Behavioral Health: Mental Health	PAs are required for some neuropsychological and psychological testing and outpatient ECT. Molina covers outpatient mental health services.

Covered Services (at Participating Providers) - Continued	
Blood lead testing for members under age 21	PA is not required.
Breast pumps; personal use, double-electric	PA is not required.
Certified nurse midwife services	PA is not required.
Certified pediatric and family nurse practitioner services	PA is not required.
Chiropractic (back) services	PA is not required.
Dental Services for Pregnant Medicaid members	Routine services do not require PA. Dental services other than routine care require PA. Dental services will be provided to pregnant women by a participating dental doctor. Medicaid covers: • Periodic oral exams • Extractions • Preventative and restorative services • Dentures and partials

Covered Services (at Participating Providers) - Continued	
Diagnostic services (x-ray, lab and imaging)	Selected diagnostic services (including CT Scans, MRIs, MRAs, PET Scans, and SPECT) require PA.
Durable medical equipment (such as crutches and wheelchairs)	Some durable medical equipment items require PA.
Emergency services	PA is not required.
End stage renal disease services	PA is not required.
Family planning services	PA is not required for family planning services, drugs, supplies and devices.

Covered Services (at Participating Providers) - Continued	
Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Tribal Health Centers (THC) services	PA is not required. You may choose to get services from a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Tribal Health Center (THC) located in your county. You do not need to ask your PCP to receive FQHC, THC or RHC services. You can also get services from out-of-network FQHCs, RHCs and THCs without prior approval.
Habilitative and Rehabilitative Services	PA is required for PT, OT and speech evaluations. PA is not required for habilitative services.
Health Education	PA is not required.

Covered Services (at Participating Providers) - Continued	

Hearing Aids for all ages	PA is not required, unless benefit is exceeded.
	• Hearing Aids – Once every 5 years
	• Hearing Aid Batteries – 36 disposable every 6 months
	• Replacement Ear Molds –
	  • 4 per 12 month per hearing aid (age 0 to 2)
	  • 2 per 12 months per hearing aid (age 3 to 12)
	  • 1 per 12 months per hearing aid (age 13 and older)

Home health services	Effective January 1, 2020, PA is required after initial evaluation plus 6 visits
Hospice services	PA is not required.

Covered Services (at Participating Providers) - Continued	
Inpatient hospital services	Inpatient hospital services (except for emergency admissions) and elective admissions, including pregnancy delivery services, and all inpatient surgeries, require PA. Notification to Molina Healthcare is required within 24 hours of admission or by the next business day for emergency admissions. Also includes Skilled Nursing Facilities (SNF) and Long Term Acute Care (LTAC) Facility.
Interpretative services for non-English speaking members and interpretive by phone services for the hearing impaired	PA is not required.

Covered Services (at Participating Providers) - Continued	
Maternal and Infant Health Program services	PA is not required. Risk Identifier and up to 9 visits for the mom with a MIHP provider. Risk Identifier and up to nine visits for the infant with a MIHP provider and an additional 9 with a doctor's order. Substance exposed infants may receive up to 18 additional visits.
Medical supplies	Some medical supplies require PA.
Medically necessary weight reduction services	PA is required.
Nursing facility services for an intermittent or short-term restorative or rehabilitative stay, up to 45 days	Nursing facility services require PA. Nursing facility stays are covered for members. Members in need of nursing services should call Member Services for information on available providers.

Covered Services (at Participating Providers) - Continued	
Obstetrical (maternity care: prenatal and postpartum including at-risk pregnancy services) and gynecological services	PA is not required.
Office Visits (routine)	PA is not required. You should see your doctor 2 times a year for preventive visits. This includes annual physical exams and screenings, including: • Complete physical exam • Immunization review and update • Age-appropriate heart disease screenings (blood pressure, blood glucose and cholesterol tests) • Cancer risk screenings (pelvic exam, pap smear, prostate and colorectal screenings) • Sexually-transmitted disease testing

Covered Services (at Participating Providers) - Continued	
Office Visits (routine)	• Evaluation for signs of depression • Alcohol, depression, obesity and tobacco counseling
Out of State/Out of Area services (authorized by the Plan)	PA is required. Emergency services are excluded.
Outpatient hospital services	Some outpatient services require PA.
Outreach services, including pregnancy and well child care	PA is not required.
Parenting and birthing classes	PA is not required.
Podiatry (foot) services	If the doctor is PAR (participating), in office procedures and services are covered with no PA required.
Practitioner Services	PA is not required for PAR practitioners.
Prescription drugs, including certain prescribed over-the-counter drugs	Selected drugs, including injectables and some over-the-counter drugs, require PA. There is no cost to get these drugs.

Covered Services (at Participating Providers) - Continued	
Preventive services	PA is not required. There is no cost to get these services.
Primary Care Provider services	PA is not required.
Prosthetics and Orthotics	PA is required.
Renal dialysis (kidney disease)	PA is not required.
Restorative or Rehabilitative Services (in a place of service other than a nursing facility)	PA is required.
Screening and counseling for obesity (for bariatric services)	PA is not required. Screening and counseling for obesity requires a referral by a provider.
Shots (immunizations)	PA is not required.
Specialist services	Office visits to see a specialist do not require PA. Some specialist services do require PA.
Telehealth	If your provider offers telehealth services, it is covered.

Covered Services (at Participating Providers) - Continued	
Therapies (language, physical and occupational and therapies to support activities of daily living), excluding services provided to persons with developmental disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts	PA is required for: Occupational Therapy: After initial evaluation plus 36 visits per treatment year for office, and outpatient settings. Physical Therapy: After initial evaluation plus 36 visits per treatment year for office and outpatient settings. Speech Therapy: After initial evaluation plus 6 visits for office and outpatient home settings.
Tobacco cessation program including pharmaceutical and behavioral support	PA is not required
Transplant Services	PA is required.
Transportation, including ambulance and other emergency medical transportation	PA is not required, except for non-emergency air ambulance.

Covered Services (at Participating Providers) - Continued	
Treatment for communicable diseases, including sexually transmitted diseases (STD) HIV/AIDS, tuberculosis and vaccine preventable diseases; treatment may be received from a local health department without prior health authorization	PA is not required when services are received at local health department.
Vision services	PA is not required.
Well-child/EPSDT exams for children under the age of 21	PA is not required.
Women's health specialist services	PA is not required.
Yearly well-adult exams	PA is not required.

This is not a complete list. If you have a question about if a service is covered, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Some hospitals and providers may not provide some covered services you need because of moral or religious grounds. If you have questions about a service or how to access those services, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Non-Covered Services Section

Services Not Covered by Molina Healthcare

Molina Healthcare will not pay for services or supplies received without following the directions in this handbook. The following services are not covered by Molina Healthcare, but may be provided by Medicaid or other programs:

- Custodial services in a nursing home
- Dental Services
  **Pregnant Medicaid members are eligible for dental services
- Home and Community – Based Waiver Program services
- Inpatient hospital psychiatric services
- "Off and on" or short-term restorative or rehabilitative services in a nursing facility after 45 days
- Mental health services for enrollees meeting the guidelines under Medicaid policy for serious mental illness or severe emotional trouble
- Outpatient partial hospitalization psychiatric care
- Personal care or home help services
- Services provided by school district and billed through the Intermediate School District
- Services, including therapies (speech, language, physical, occupational) provided to persons with developmental disabilities and billed through Community Mental Health Services Program providers or duplicate services at an Intermediate School District
- Substance abuse treatment and detoxification services
- Transportation for services not covered by Molina Healthcare
- Traumatic Brain Injury Program services

Services Not Covered by Medicaid

The following services are not covered by Medicaid:

- Abortions (elective) and related services. Abortions and related services are covered when medically necessary to save the life of the mother, if the pregnancy is a result of rape or incest, treatment is for medical complications occurring as a result of an elective abortion or treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy
- Services for treatment of infertility
- Experimental/investigational drugs, procedures, or equipment
- Cosmetic surgery (elective)

This is not a complete list of the services that are not covered by Medicaid or Molina Healthcare. If you have a question about whether a service is covered, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). You can also call if you need help obtaining these services.

If You Need to See a Doctor that is Not Part of Molina

If a Molina Healthcare provider is unable to provide you with necessary and covered services, Molina Healthcare must cover the needed services through an out-of-network provider. The cost to you should be no greater than it would be if the provider were in Molina Healthcare's network. This must be done in a timely manner for as long as Molina's provider network is unable to give the service.

If you are outside of the Molina Healthcare service area and you need non-emergency medical care, the provider must first contact Molina Healthcare to get approval before giving any services. It is important to remember that you must get services covered by Molina Healthcare from facilities and/or providers in Molina Healthcare's network.

Telehealth

Telehealth is 24/7 access to doctors by phone or video. Our U.S. board-certified providers can diagnose, treat and even prescribe medicine, if needed, for a wide range of medical needs, including the flu, allergies, rash, upset stomach and much more. If your provider offers telehealth services, it is covered.

Urgent Care vs. Emergency Room (ER)

Did you know that there are other places to go for treatment besides the Emergency Room (ER) when your medical need is not life threatening? These places are called Urgent Care and After Hours Clinics.

What are Urgent Care and After Hours Clinics?

Urgent Care and After Hours Clinics treat medical problems that may not wait until your next doctor visit, but are not life threatening.

Advantages of an Urgent Care & After Hours Clinic

- Shorter wait times
- You can be seen on a walk-in basis
- Many are open evenings and weekends
- Patients receive care from the same people as an emergency room or primary care clinic

If you cannot see your doctor, you can go to an Urgent Care or an After Hours Clinic if you have any of the following:

- Twisted or sprained ankle
- Cough, cold, or sore throat
- Minor skin rash
- Earache

- Cuts, bumps, & sprains
- Fever or flu symptoms
- General wound care
- Animal bite
- Urinary tract infection
- Fever
- Mild asthma
- Flu shot

You should go to the ER for sudden injury or sickness such as:

- Poisoning (Poison Control Center toll free (800) 222-1222, TTY: 711)
- A lot of bleeding
- A very bad burn
- Very bad shortness of breath (trouble breathing)
- Drug overdose
- Gunshot wound
- Chest pain
- Broken bones

Remember...

- Your Doctor
- Urgent Care/After Hours Clinic
- Emergency Room

If you think you have a life threatening emergency, call 911.

For an Urgent Care or After Hours Clinic near you, please call your Molina Healthcare of Michigan 24-Hour Nurse Advice Line at (888) 275-8750 (English) or (866) 648-3537 (Spanish.) TTY: 711.

How to Get 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 get 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:

- Chest pains or heart attack
- Choking or breathing problems
- A lot of bleeding
- Poisoning
- Broken bones

If you can, call your PCP or please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). 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 room for emergency care.

ALWAYS CARRY YOUR MOLINA HEALTHCARE ID CARD AND MIHEALTH CARD WITH YOU AND SHOW YOUR VALID ID WHEN YOU GO TO THE EMERGENCY ROOM.

NEVER GO TO AN EMERGENCY ROOM FOR ROUTINE CARE.

Molina Healthcare will also cover emergency rides to the hospital. You should call 911 when you have an emergency and need immediate transportation.

Molina Healthcare has a 24-Hour Nurse Advice Line to help you understand and get the medical care you need. Please call (888) 275-8750 for English or (866) 648-3537 for Spanish.

You might need care after you leave the ER. If you do, don't go to the ER for follow up care. Schedule an appointment with your doctor. If you need help seeing a doctor, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). If you don't have an emergency, don't go to the ER. Please call your doctor. If you need non-emergency care after normal business hours, you can also visit an Urgent Care Center. You can find Urgent Care Centers in the Provider Directory. If you need help finding one, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). You may also visit **MolinaHealthcare.com.**

Out of State/Out of Area

If you are out of town and have a medical emergency or need urgent care:

- Go to the nearest urgent care center or emergency room for care. The hospital or urgent care center may call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).
- Remember to follow-up with your PCP after any emergency room or urgent care visits.

Covered Drugs

Molina Healthcare uses the same Single Preferred Drug List (PDL) as all Medicaid managed care plans and Medicaid Fee-for-Service (FFS) in Michigan.

Using one drug list across all managed care plans and Fee-for-Service helps prescribers and members know which drugs are covered with or without prior approval.

To be sure you are getting the care you need, we may require your provider send in a request to us called a Prior Authorization (PA). Your provider will need to explain why you need a certain drug or a certain amount of a drug. We must approve the PA request before you can get the medication. Reasons why we may require PA of a drug include:

- There is a drug without a brand name or another alternative drug available
- The drug can be misused or abused
- The drug is listed as non-preferred on the Preferred Drug List (PDL)
- There are other drugs that must be tried first

Some drugs may also have quantity (amount) limits and some drugs are never covered. Some drugs that are never covered are:

- Drugs for weight loss
- Drugs for erectile dysfunction
- Drugs for infertility

If we do not approve a PA request for a drug, we will send you a letter. The letter will explain how to appeal our decision. It will also detail your rights to a State Fair Hearing.

Some drugs require that the generic be used when available. If your provider believes you need the brand name drug, the provider may submit a PA request. Molina Healthcare has a process to determine whether to approve the brand name drug.

The Preferred Drug List (PDL) can change. It is important for you and your provider to check the PDL when you need to fill or refill a medication. Remember to fill your prescriptions before you travel out of state.

Refer to our Provider Directory to find an in-network pharmacy. You can find an in-network pharmacy by visiting **MolinaHealthcare.com,** select Medicaid, then select What's Covered and then Prescription Drugs. You can also call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) to find a network pharmacy near you.

You can also access Michigan's Common Drug Formulary by visiting our website at **MolinaHealthcare.com,** select Medicaid, then select What's Covered and then Prescription Drugs. You may request an electronic or print copy of the formulary, free of charge, by calling Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Specialty Pharmacy Drugs

Specialty pharmacy drugs can be delivered to your home, your doctor's office or available for pick-up at a local CVS Pharmacy. The program is called Specialty Connect. After dropping off your prescription at the pharmacy, you will receive insurance guidance and dedicated clinical support by phone from a team of specialty pharmacy experts, trained in each therapeutic area, who are available 24 hours a day, 365 days a year. Please call Member Services at (888) 898-7969, Monday – Friday, 8 a.m. to 5 p.m. (TTY: 711) for more information.

Second Opinions

If you do not agree with your provider's plan of care for you, you have the right to a second opinion. Talk to another provider or out-of-network provider. This service is at no cost to you. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) to learn how to get a second opinion.

Community-Based Supports and Services

Community-based supports and services address health needs, encourage prevention and health education, and are created for the needs of the community. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) to find out where and how to get community-based supports and services.

Mental Health

Molina Healthcare covers outpatient visits for mental health services. While Molina Healthcare of Michigan doesn't require referrals, check with your PCP to make sure there are no other referral needs for mental health services. Be sure to go to a Molina mental health provider. If you have a serious mental illness, you may be referred to the Community Mental Health Services Program in your county. If you have questions about this, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Substance Abuse

You may have a substance abuse problem if:

- Anyone has ever told you that you should cut down on your drinking
- Your drinking or behavior annoys people
- You feel guilty about drinking or taking drugs
- You ever had a drink first thing in the morning to steady your nerves or get rid of a hangover

Please get help. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) for more information on how to get these services.

Durable Medical Equipment

Molina Healthcare covers medically necessary equipment. For information, please call your PCP or Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Hospice Services

Hospice is a covered program that provides end of life care. For information on hospice care, please call your PCP or Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Tribal Health Centers (THC) services

You may choose to get services from a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Tribal Health Center (THC) located in your county. You do not need to ask your PCP to receive FQHC, RHC or THC services.

You can also get services from out-of-network FQHCs, RHCs and THCs without prior approval.

Tobacco Cessation

Molina Healthcare covers tobacco cessation services for all members, including diagnostic, therapy and counseling services and pharmacotherapy (including coverage of prescription and non-script tobacco cessation agents approved by the Federal Drug Administration (FDA).

To enroll in the "I Can Quit" program, please call the Michigan Tobacco Quit Line toll-free (800) 480-7848. Tobacco use is the largest preventable cause of illness and early death. No matter your age or how long you've smoked or used tobacco, it is important to quit. Quitting reduces your risk of lung cancer, heart disease, stroke and lung diseases.

Some of the benefits of quitting:

After 20 minutes — blood pressure decreases

- After 24 hours — the chance of a heart attack is lower
- After 1 year — excess risk of heart disease is decreased
- After 5 to 15 years — the risk of stroke is reduced

There are many ways to quit smoking. You may even have to try different ways before you succeed. Don't lose hope. The important thing is that you quit. Keep in mind that it's never too late – especially if you're living with a chronic disease.

TIPS TO HELP YOU QUIT:

1. Admit the problem to yourself and those around you.
2. Keep track of when and why you smoke.
3. Set a quit date.
4. Limit the time you spend with people who smoke.
5. Write down the list of reasons for not smoking. Keep that list with you. Make sure to review those reasons when you feel the need to smoke.
6. Talk to your doctor about treatment options.
7. Please call the Michigan Tobacco Quit Line toll-free (800) 480-7848 to enroll in the "I Can Quit" program.

How to Access Hospital Services

Inpatient Hospital Services

You must have a Prior Authorization to get hospital services except in the case of an Emergency or Urgent Care Services. However, if you get services in a hospital or you are admitted to the hospital for Emergency or out-of-area Urgent Care Services, your hospital stay will be covered.

Medical/Surgical Services

We cover the following inpatient services in a participating hospital or rehab facility, when the services are generally and customarily provided by acute care general hospitals or rehab facilities inside our service area:

- Room and board, including a private room if medically necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of participating providers, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our Drug Formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Prescription Drugs and Medications")
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans, and ultrasound imaging
- Blood, blood products and their administration, blood storage (including the services and supplies of a blood bank)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehab program)
- Respiratory therapy
- Medical social services and discharge planning

Provider Information and Payment

You can request information about our providers, such as:

- License information
- How providers are paid by the plan
- Qualifications
- What services need prior approval

Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711), if you have questions.

Molina Healthcare does not prevent our providers from:

- Speaking on behalf of you, the member
- Discussing treatment and services
- Discussing payment arrangements between the doctor and the plan

Feel free to ask us if we have special arrangements with our doctors that can affect 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 stop or deny medical care or services. Decisions about your health care are based on medical need.

MIChild Premium Payment

Molina Healthcare of Michigan covers MIChild members with the same great Medicaid benefits. Your coverage is the same, but you will be responsible to pay a premium.

The MIChild premium payment is $10 per family, per month. MIChild will send you a letter if you have to pay a premium. If you have questions regarding the premium, please call MIChild at (888) 988-6300 or TTY: (888) 263-5897.

Medicaid Payment and Bills

There are no co-payments or other charges for covered medical services. If you get a bill from a plan provider for approved and covered services, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). Do not pay the bill until you have talked to us. We will help you. You may have to pay for services that are not covered. You may also have to pay for services from providers not part of our network. If the services were an emergency, you don't have to pay. If you need help, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Looking at What's New

We look at new types of services, and we look at new ways to provide those services. We review new studies to see if new services are proven to be safe for possible added benefits. Molina Healthcare reviews the type of services listed below at least once a year:

- Medical services
- Mental health services
- Medications
- Equipment

Disenrollment

Molina Healthcare may ask that you be disenrolled from our membership for abusive, threatening and/or violent behavior towards doctors and their staff or Molina Healthcare's staff.

You may request an exception to enrollment if you have a serious medical condition and are getting active treatment for that condition with a doctor who does not participate with the health plan at the time of enrollment.

You may request a "disenrollment for cause" from Molina Healthcare at any time during the enrollment period that would allow you to enroll with another health plan. These reasons may include:

- Lack of access to providers or necessary specialty services
- Concerns with quality of care
- Services are not performed due to moral or religious objections
- If the open enrollment period was not available due to temporary loss of Medicaid eligibility

Other Insurance

Molina Healthcare needs to know if you have any other health insurance in addition to your Molina Medicaid coverage. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). This will help us to manage your benefits the right way. If Molina Healthcare is not aware of your additional health information, you may experience delays at the pharmacy or at other healthcare provider locations.

Children's Special Health Care Services (CSHCS) Program

CSHCS is a state of Michigan program that serves children, and some adults, with special health care needs. Molina offers these health care services and will work with the families to coordinate care. For covered services, we will provide free rides, help address pharmacy and medical supply needs that are ordered by various doctors.
CSHCS members do not have co-payments.
CSHCS members are given the same level of care provided to all Molina members.
CSHCS covers more than 2,700 medical diagnoses.

Additional Benefits for Medicaid Health Plan Enrollees with Children's Special Health Care Services

1. Help from your Local Health Department with:
   - Community resources – schools, community mental health, financial support, childcare, Early On, and the Women Infants and Children (WIC) program
   - Transitioning to adulthood
   - Orthodontia
     - Only for specific CSHCS qualifying diagnosis, such as Cleft Palate/Cleft lip
     - Medically necessary, related to condition
     - Not for cosmetic purposes
   - Respite
     - CSHCS covers 180 hours of respite care annually when a beneficiary requires skilled nursing and a CSHCS nurse consultant determines appropriate
2. Help from the Family Center for Children and Youth with Special Health Care Needs
   - CSHCS Family Phone Line – a toll-free phone number (800) 359-3722, available Monday through Friday from 8 a.m. to 5 p.m.

- Parent-to-parent support network
- Parent/Professional training programs
- Financial help to go to conferences about CSHCS medical conditions and "Relatively Speaking," a conference for siblings of children with special needs

3. Help from the Children's Special Needs (CSN) Fund The CSN Fund helps CSHCS families get items not covered by Medicaid or CSHCS. To see if you qualify for help from the CSN Fund, please call (517) 241-7420.

Examples include:

- Wheelchair ramps
- Van lifts and tie downs
- Therapeutic tricycles
- Air conditioners
- Adaptive recreational equipment
- Electrical service upgrades for eligible equipment

For more information, please call our CSHCS specially-trained staff at (888) 898-7969, Monday- Friday, 8 a.m. to 5 p.m. (TTY: 711).

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT makes sure that members get appropriate preventive, dental, mental health and developmental and specialty services. These services are given at no cost to you. For more information about EPSDT, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

Grievance and Appeals

Filing a Grievance or 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.

You can submit a grievance by phone or in writing. Molina Healthcare's Appeals and Grievance (AnG) Specialist can help you with your grievance. If you would like to make a grievance, please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711). You may also send in a grievance in writing to:
Molina Healthcare of Michigan
Attention: Appeals and Grievance Department
880 West Long Lake Road, Suite 600
Troy, MI 48098-4504

If your grievance is sent in by a representative, but we haven't received your written approval for the representative, we will not begin the grievance until after we receive it. You must inform us of your Authorized Representative in writing by completing the Authorized Representative Designation form. We will make a decision regarding your grievance within 90 calendar days of receipt.
The AnG Specialist will look into your grievance. The AnG Specialist will ask other staff who know about the 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. This Department will look into the complaint further.

Appeal Process
There are two kinds of Internal Appeals: Standard Appeal and Expedited (Quick) Appeal. You must first appeal to Molina before you can request an External Appeal.

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

- You have 60 calendar days from the original adverse benefit determination date to file an appeal.
- You have the right to appeal by phone or in writing to the Designated Appeals Reviewer for Molina Healthcare. Molina Healthcare's AnG Specialist can help you write your appeal. If you would like to file an appeal, please call our Member Services Department at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

  You may also send in Appeals to fax number (248) 925-1799 or in writing to:
  Molina Healthcare of Michigan Attention: Appeals and Grievance Department
  880 West Long Lake Road, Suite 600
  Troy, MI 48098-4504

  Your written request must include:
  • Your name
  • Address
  • Member number
  • Reasons for appealing
  • Any evidence you want reviewed, such as medical records, doctors' letters, or other information that explains why you need the item or service. Please call your doctor if you need this information.

- You have the right to include an Authorized Representative (anyone you choose, including an attorney) during the appeals process and to attend the Appeals hearing. You must inform us of your Authorized Representative in writing by completing the Authorized Representative Designation form. If your appeal is sent in by a representative, but we haven't received your written approval for the representative, we will not begin the appeal until after we receive it.
- Molina will provide the Member and/or Member's representative the Member's case file upon request, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Molina in connection with the appeal of the adverse benefit determination. This information will be provided free of charge and well in advance of the resolution timeframe for appeals.
- You can bring any information that you feel will help the Designated Appeals Reviewer make a better decision.
- The AnG Specialist will tell you the time and place the appeal will be held.
- Molina Healthcare will use a Designated Appeals Reviewer who was not involved in the initial decision to review. The Designated Appeals Reviewer is a health care professional who has the appropriate clinical expertise in treating your condition or disease. A decision will be mailed to you in 30 calendar days from the date that Molina Healthcare received your appeal. Molina Healthcare will communicate to you in a way you will understand.
- An additional 14 calendar days are allowed to obtain medical records or other important medical information if you request more time, or if the Plan can prove that the delay is in your best interest. You will receive written notification of this extension.
- The Member Appeals Associate Specialist will help you file your appeal, including interpreter services if required. Interpretation by phone is available for all languages. Hearing-impaired members are instructed to use the MI Relay line at (800) 649-3777 and "non-English" speaking members are helped by our Bi-Lingual Representatives and Language Line services for all languages. Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711) for assistance.
- You may also call the Health Insurance Consumer Assistance Program (HICAP) for

help. They offer free help with questions, concerns, disputes and complaints.
Health Insurance Consumer Assistance Program (HICAP)
P.O. Box 30220
Lansing, MI 48909
Phone: (877) 999-6442
Web: Michigan/HICAP
Email: DIFS-HICAP@Michigan.gov

- Molina Healthcare will continue your benefits if all of the following conditions apply:
  - The appeal is filed timely. The appeal must be filed:
    *Within 10 calendar days of Molina Healthcare's original adverse benefit determination
    *On or before the intended effective date of the action
  - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
  - The services were ordered by an authorized doctor
  - The authorization period has not expired
  - You request continued benefits
- If Molina Healthcare continues or reinstates your benefits while the appeal is pending, the benefits will continue until one of the following occurs:
  - You cancel the appeal
  - You do not request a State Fair Hearing within 10 calendar days from when Molina Healthcare mails an adverse benefit determination
  - A State Fair Hearing decision adverse to you is made
  - The authorization expires or authorization limits are met
- If Molina Healthcare reverses the adverse action decision or the decision is reversed by the State Fair Hearing, Molina Healthcare must pay for services given while the appeal is pending and authorize or give disputed services as quickly as your health condition requires.
- You may be required to pay the cost of the services if the denial is supported.
- Molina Healthcare will let you know of our decision in writing.

Expedited (Fast) Appeal

If you or your doctor believes that the usual 30 calendar day time frame for appeals will cause harm to your health, or affect your normal body functions, your appeal may be expedited (fast). You, your Provider or an Authorized Representative may file a fast appeal within 10 calendar days of the date the adverse benefit

determination was received. We will give you a verbal decision on a fast appeal within 72 hours. We will follow up in writing in 2 days. You have the right to ask for a copy of the benefit guidelines used to make this decision. You may request a fast appeal with Department of Insurance and Financial Services (DIFS) after you have filed a fast appeal with Molina Healthcare. If Molina Healthcare denies your request for a fast appeal, you may request a fast external review with DIFS within 10 calendar days of the denial.

External Appeals

There are two kinds of External Appeals after your appeal is denied by Molina. You may file an External Review with DIFS and/or a Medicaid State Fair Hearing with MDHHS.

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. You can also ask for an external review 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)
Healthcare Appeals Section Office of General Counsel
P.O. Box 30220
Lansing, MI 48909-7720
(877) 999-6442
Fax Number: (517) 284-8848
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want reviewed, such as medical records, doctors' letters, or other information that explains why you need the item or service. Please call your doctor if you need this information.

You must appeal in writing to DIFS within 127 calendar days after you receive the final answer from Molina Healthcare. Molina Healthcare can explain the external review process to you. We 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 a fast appeal decision from DIFS at the same address above within 10 calendar days after receiving a final determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

State Fair Hearing Process with MDHHS

If you have any problems about the care you are getting, you must first request an appeal to Molina. If you are unhappy with Molina's decision, you may directly appeal to the Michigan Department of Health and Human Services (MDHHS) through the State's Fair Hearing process. This must be done within 120 calendar days of the final determination. Molina Healthcare will include a State hearing request form with a self-addressed stamped envelope with our decision. Below are the steps for the State's Medicaid Fair Hearing process.

Step 1 Please call Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711); or Michigan ENROLLS at (888) 367-6557 (TTY: (888) 263-5897); or Michigan Office of Administrative Hearings and Rules at (800) 648-3397 to have a Hearing Request form sent to you. You may also call to ask questions about the hearing process.

Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want reviewed, such as medical records, doctors' letters, or other information that explains why you need the item or service. Please call your doctor if you need this information.

Step 2 Fill out the request form and mail it to the address listed on the form. Molina will help you complete and send in the request form.

Step 3 A hearing will be scheduled. The State will hold a hearing. You may attend the hearing in person or by phone. You will be asked to tell the state why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you.

Step 4 The results will be mailed to you from Michigan Department of Health and Human Services after the hearing is held. The written decision will explain if you have additional appeal rights. If your complaint is taken care of before your hearing date, you must call to ask for a Hearing Request Withdrawal Form. You can call (800) 648-3397 to request this form. The address to request this Hearing Request Withdrawal form is:

Michigan Department of Health and Human Services
Michigan Office of Administrative Hearings and Rules
P.O. Box 30763
Lansing, MI 48909
Attn: Hearings/Appeals
(800) 648-3397
https://courts.michigan.gov/self-help/mahs/pages/default.aspx

Rights and Responsibilities

These right and responsibilities are posted in doctors' offices. They are also posted at **MolinaHealthcare.com.** Molina Healthcare staff and providers will comply with all requirements concerning your rights.

Molina Healthcare members have the right to:

- Get information on the structure and operation of the health plan, its services, its practitioners and providers and member rights and responsibilities
- To receive notice of any significant changes in the Benefits Package at least thirty (30) days before the intended effective date of the change
- Choose your Primary Care Provider
- Know if a co-payment or contribution is required
- Know the names, education, and experience of your health care providers
- Be treated with respect with recognition of your dignity and your right to privacy
- Direct access to network women health specialists and pediatric providers for covered services necessary to provide routine and preventive health care services without a referral

- Receive Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services
- Take part in decision making with your doctor about your health care, including the right to refuse treatment and openly discuss appropriate or medically necessary treatment choices of your health problems, regardless of cost or coverage
- Get a fair and timely reply to requests for service
- Voice complaints or appeals about the organization and the care it provides
- 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 be able to file an appeal, a grievance (complaint) or request a State Fair Hearing (after Molina has made a decision and you aren't happy with that decision)
- To get help with filing an appeal, grievance (complaint) or request a State Fair Hearing (after Molina has made a decision and you aren't happy with that decision)
- To receive information and timeframes for filing an appeal, a grievance or a State Fair Hearing
- To make recommendations regarding the Plan's member rights and responsibility policy
- To use any hospital or other setting for emergency care
- To receive detailed information on emergency and after-hours coverage
- To receive all information, including but not limited to, enrollment notices, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood
- Be free from any form of restraint or seclusion used as means of pressure, discipline, convenience or retaliation
- Request and receive a copy of your medical records at no cost to you, and request that they be corrected
- Be provided culturally and linguistically appropriate healthcare services (CLAS)
- Be provided covered healthcare services
- Be free to exercise your rights without negatively affecting the way Molina, our providers or the State treat you.
- Be free from other discrimination prohibited by State and Federal regulations

- Request clinical practice guidelines upon request
- Get a second medical opinion
- Get help with any special language needs
- To receive interpretation by phone services free of charge for all non-English languages, not just those identified as prevalent

Molina Healthcare members have the responsibility to:

- Provide Molina Healthcare, its practitioners and providers with the necessary information needed to care for you
- Know, understand, and follow the terms and conditions of the health plan
- Follow plans and instructions for care that they have agreed to with their practitioners
- Seek out information in order to make use of the services
- Take part in decision-making about your healthcare. Understand your health problems and participate in developing mutually agreed-upon treatment goals
- Report other insurance benefits, when you are eligible, to your Department of Health and Human Services Specialist and the Beneficiary Help Line at (800) 642-3195, TTY (866) 501-5656
- Show your Molina Healthcare ID card, Medicaid mihealth card and valid ID to all providers before receiving services
- Never let anyone use your Molina Healthcare ID card or Medicaid mihealth card
- Choose a primary provider, schedule an appointment within 60 days of enrollment and build a relationship with the provider you have chosen
- Make appointments for routine checkups and immunizations (shots)
- Keep your scheduled appointments and be on time
- Provide complete information about your past medical history
- Provide complete information about current medical problems
- Ask questions about your care
- Follow your provider's medical advice
- Respect the rights of other patients and healthcare workers
- Use emergency room services only when you believe an injury or illness could result in death or lasting injury
- Notify your primary provider if emergency treatment was necessary and follow-up care is needed

- Report changes that may affect your coverage to your Department of Health and Human Services specialist. This could be an address change, birth of a child, death, marriage or divorce, or change in income
- Promptly apply for Medicare or other insurance when you are eligible

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 Health and Human Services (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

If you find that your wishes are not followed by a health care provider, or they do not comply with your DPAHC you may file a complaint with:
Department of Licensing and Regulatory Affairs
BPL/Investigations & Inspections Division
PO Box 30670
Lansing, MI 48909-8170
(517) 373-9196 or bhpinfo@michigan.gov

The Bureau of Health Professions (BHP) Grievance & Allegation website is **www.michigan.gov/healthlicense** (click on Professional Licensing and "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 (877) 999-6442 or michigan.gov/difs.

Five Wishes

Five Wishes is the first living will that talks about your personal, emotional and spiritual needs as well as your medical wishes. It lets you choose the person you want to make health care decision for you if you are not able to make them for yourself. Five Wishes lets you say exactly how you wish to be treated if you get seriously ill.

Five Wishes is for anyone 18 or older – married, single, parents, adult children, and friends.

You may already have a living will or a durable power of attorney for health care. If you wish to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will or durable power of attorney for health care. Or you can write "revoked" in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you.
- Tell your health care agent, family members and doctor that you have filled out a new Five Wishes. Make sure they know about your new wishes.

To order a copy of Five Wishes, please contact:
Aging with Dignity
P.O. Box 1661
Tallahassee, Florida 32302-1661
(850) 681-2010
Monday – Friday, 9 a.m. to 5 p.m. EST
info@fivewishes.org
https://fivewishes.org

There is no cost to you to register your Advance Directive. There is no cost to health care providers to have access to your Advance Directive.

If you register your Advance Directive, you always have the right to revoke it.

Fraud, Waste and Abuse

Molina Healthcare's Fraud, Waste and Abuse Plan benefits Molina, its employees, members, providers, payers 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 to government agencies when appropriate. Molina Healthcare takes the appropriate disciplinary action, including but not limited to, termination of employment, termination of provider status, and/or termination of membership.

Definition:

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid 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 Medicaid program. (42 CFR §455.2)

Here are some examples of abuse:

- Using the emergency room for non-emergent healthcare reasons
- Going to more than one doctor to get the same prescription
- Threatening or offensive behavior at a doctor's office, hospital or pharmacy
- Receiving services that are not medically necessary

Definition:

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

Here are some examples of fraud:

- Using someone else's member ID card
- Changing a prescription written by a doctor
- Billing for services that were not provided
- Billing for the same service more than once

Here are some ways you can help stop fraud:

- Don't give your Molina Healthcare ID card, Medical 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

Definition:

"Waste" means health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process

complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid/ Medicare programs.

If you think fraud, waste and abuse has taken place, you can report it without giving your name to:
Online: www.MolinaHealthcare.alertline.com
Email: MHMCompliance@MolinaHealthcare.com
Phone: (866) 606-3889
Fax: (248) 925-1797
Regular Mail:
Molina Healthcare of Michigan
Attention: Compliance Director
880 West Long Lake Road, Suite 600
Troy, MI 48098-4504
Or you can contact:
Online: www.michigan.gov/fraud
Phone: 1-855-MI-FRAUD (1-855-643-7283)
Regular Mail:
Michigan Department of Health and Human Services (MDHHS) Office of Inspector General
P. O. Box 30062
Lansing, MI 48909

Member Privacy

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared.

Your Protected Health Information (PHI)
PHI stands for Protected Health Information. PHI 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 use or share your Protected Health Information (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 share PHI 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?

- Please call or write Molina Healthcare and 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 Practices is included below. It is also available on our website at **MolinaHealthcare.com.** You also may get a copy of our Notice of Privacy Practices by calling Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

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" or "we") uses and shares Protected Health Information about you to provide your health benefits. We use and share to carry out treatment, payment and health care operations. We also use and share for other reasons as allowed and required by law. We have the duty to keep your health information private. We have policies in place to obey the law. The effective date of this notice is March 1, 2007.

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 health care 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 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?
In addition to treatment, payment and health care operations, the law allows or requires Molina Healthcare to use and share your PHI for several other purposes, including the following:

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either orally agreed to the disclosure or have been given an opportunity to object and have not objected

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).

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, when approved by a privacy or institutional review board.

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, such as national security activities.

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. 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 to fill out a 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 fill out a 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 fill out a 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.
- **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 fill out a 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;
  - as part of a limited data set for research or public health activities;
  - PHI released in the interest of national security or for intelligence purposes;
  - to correctional institutions having custody of an inmate; or
  - shared prior to April 14, 2003

  We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You must fill out a form to request a list of PHI disclosures.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Manager of Member Services at (888) 898-7969, Monday - Friday, 8 a.m. to 5 p.m. (TTY: 711).

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 will not change in any way.
You may complain to us at:

Molina Healthcare of Michigan
Attention: Compliance Director
880 West Long Lake Road, Suite 600
Troy, MI 48098-4504
Phone: (888) 898-7969
(TTY: 711)

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) 886-1019 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
- 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, a new notice will be sent to you by US Mail.
Contact Information
If you have any questions, please contact the following office:

Molina Healthcare of Michigan
Member Engagement
880 West Long Lake Road, Suite 600
Troy, MI 48098
Phone: (888) 898-7969
(TTY: 711)

Definitions

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Enrollee practices that result in unnecessary cost.

The Act - The Social Security Act

Advance Directive - A written legal instruction, such as a living will, personal directive, advance decision, durable power of attorney or health care proxy, where a person specifies what actions should be taken relating to the provision of health care when the individual is incapacitated.

Adverse Action Notice - A notice sent to members that involves service authorization decisions that deny or limit services following Molina Healthcare's policy timeframes for standard and expedited authorization decisions.

Adverse Benefit Determination - An action or inaction by the Contractor including any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the MDHHS.
5. The failure of the Contractor to act within the timeframes provided in § 438.408(b)(1) and (b)(2) regarding the standard resolution of Grievances and Appeals.
6. For a resident of a Rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
7. The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Advisory Committee on Immunization Practices (ACIP) - A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health & Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.

Agent (of the entity) - Any person who has express or implied authority to obligate or act on behalf of the State, Contractor, Subcontractor, or Network Provider. Alternative Formats - Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Examples of Alternative Formats shall include, but not be limited to, Braille, large font, audio tape, video tape,

and Enrollee Information read aloud to an Enrollee by an Enrollee services representative.

Appeal - An appeal is the action you can take if you disagree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:

- Denies your request for a health care or dental service, supply, item, dental appliance or device or prescription drug that you think you should be able to get.
- Reduces, limits or denies coverage of a health care or dental service, supply, item, dental appliance or device or prescription drug you already got.
- Your plan stops providing or paying for all or part of a health care or dental service, supply, item, dental appliance or device or prescription drug you think you still need.
- Does not provide timely health or dental services.

Appeal Coordinator - Supervises the Appeals Associate Specialist and the coordination, management, and adjudication of Member and Provider Grievances

Appeal and Grievance Specialist - Receives, documents, investigates and communicates the resolution of an appeal or grievance to the Member or their representative

Authorization - An approval for a service

Authorized Representative - An "authorized representative" can be the subscriber, the parent of a minor covered under the MHM contract, a person with legal guardianship, a medical durable power of attorney, rights to representation via court order, an estate representative of a deceased member or an appointed individual as designated on a signed and dated statement by the member that clearly identifies the scope of the representation, including, if so specified, representation in an external review. An authorized representative may act on behalf of a member at any point in the appeals process, as designated in the statement of presentation. If a member is unable to provide consent, a family member of the member may act as their authorized representative.

Beneficiary - Any person determined eligible for the Michigan Medical Assistance Program

Business Day - Monday through Friday, 8:00 AM through 5:00 PM EST (unless otherwise stated) not including State or federal holidays.

CAHPS® - Consumer Assessment of Healthcare Providers and Systems

Centers for Medicare and Medicaid (CMS) - The federal agency (and its designated agents) within the United States' Department of Health and Human Services responsible for federal oversight

Children's Special Healthcare Services (CSHCS) - Eligibility is authorized by Title V of the Social Security Act. Individuals eligible for both CSHCS and Medicaid are mandatorily enrolled into a MHP

Clean Claim - All claims as defined in 42 CFR §447.45 and MCL 400.111i

Clinical Advisory Committee (CAC) - Clinical Advisory Committee appointed by MDHHS.

Code of Federal Regulations - The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States

Collaboration - A process of working with others to achieve shared goals.

Community Collaboration - A plan for developing policies and defining actions to improve Population Health.

Community Health Needs Assessment (CHNA) - A systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.

Community Health Workers (CHWs) or Peer-Support Specialists - Frontline public health workers who are trusted members of and /or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/ link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Community-based health - A strong focus on the Social Determinants of Health, creating Health Equity, and supporting efforts to build more resilient communities by coordinating Population Health improvement strategies

Complaint - A communication by a Beneficiary or a Beneficiary's representative to the Contractor expressing a concern about care or service provided by the Contractor, dental provider or Transportation Subcontractor; presenting an issue with a request for remedy that can be resolved informally. Complaints may be oral or written.

Contractor - A health plan (Molina Healthcare) who was awarded a Medicaid contract

Co-payment - An amount you are required to pay as your share of the cost for a medical service or supply, like a doctor's visit, dental visit, hospital outpatient visit, prescription drug or dental

appliance or device. A copayment is usually a set amount. For example, you might pay $2 or $4 for a doctor's visit, dental visit or prescription drug

Covered Services - All services provided under Medicaid, as defined in the Contract that the

Contractor has agreed to provide or arrange to be provided to Enrollees

Culturally and Linguistically Appropriate Services (CLAS) - Health Care goal to reduce Health Disparities and to provide optimal care to patients regardless of their race, ethnic background, native languages spoken, and religious or cultural beliefs

Days - Calendar days unless otherwise specified

Dental Insurance - Dental insurance is a type of coverage that pays for dental costs for people. It can pay the person back for costs from dental injury or treatment. It can also pay the provider directly. Dental insurance requires the payment of premiums (see premium) by the person getting the insurance.

Dental Plan - A plan that offers health care services to members who meet State eligibility rules. The State contracts with certain dental organizations to provide dental services for those who are eligible. The State pays the premium on behalf of the member.

Dental Services - Oral health services provided by a person licensed under state law to practice dentistry

Department of Insurance and Financial Services (DIFS) - Responsible for oversight of insurers, Health Maintenance Organizations (HMOs), and financial entities doing business in the State

Designated Appeals Reviewer - Makes decisions on Appeals. The Designated Appeals Reviewer is not involved in any previous level of review or decision-making, nor a subordinate of any such individual. The Designated Appeals Reviewer is a health care professional who has the appropriate clinical expertise in treating the Member's condition or disease when the Appeal involves a clinical issue.

Durable Medical Equipment (DME) - Equipment and supplies ordered by a health care provider for everyday or extended use. For example: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - Benefits defined in section 1905(r) of the Act including: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions

discovered by the screening services, whether or not such services are covered under the state plan.

Emergency Dental Condition - A dental injury or condition so serious that you would seek care right away to avoid harm.

Emergency Dental Services - Care for an acute disorder of oral health that requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket

Emergency Medical Condition - An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm

Emergency Medical Services (EMS) - Those services necessary to treat an Emergency Medical Condition

Emergency Medical Transportation - Ambulance services for an emergency medical condition

Emergency Room Care - Care given for a medical emergency or dental emergency when you believe that your health is in serious danger or you need dental treatment right away

Emergency Services - Evaluation of an emergency medical condition or emergency dental condition and treatment to keep the condition from getting worse

Emergency Treatment and Active Labor Act (EMTALA) - Enrollees must be screened and stabilized without prior authorization

Enrollee - Any Medicaid Beneficiary who is currently enrolled in Medicaid managed care in the Contractor's Medicaid Health Plan

Excluded services - Health care or dental services that your plan doesn't pay for or cover

Expedited Appeal - An Appeal conducted when the Contractor determines (based on the Enrollee request) or the Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Contractor decision must be made within 72 hours of receipt of an Expedited Appeal.

Expedited Authorization Decision - An authorization decision required to be expedited due to a request by the Provider or determination by the Contractor that following the standard timeframe could seriously

jeopardize the Enrollee's life or health. Contractor's decision must be made in 3 working days from the date of receipt.

Experimental/Investigational - Drugs, biological agents procedures, devices or equipment determined by the Medical Services Administration, that have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used

Explanation of Benefits (EOB) - Statement to covered individuals explaining the medical care or services that were paid for on their behalf

External appeal - A request for an independent, external review of the final adverse determination made by the Plan through its internal appeal process

Federally Qualified Health Center (FQHC) - Community-based organizations that provide comprehensive health care services to persons of all ages, regardless of their ability to pay or health insurance status with no authorization required

Fee-for-Service (FFS) - A reimbursement methodology that provides a payment amount for each individual service delivered

Fraud - 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)

Fraud, Waste and Abuse - Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care

Freedom of Information Act (FOIA) - Allows access by the general public to data held by national governments

Grievance - A complaint that you communicate to your plan. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person or doctor treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Habilitation services and devices - Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people

with disabilities in a variety of inpatient and/or outpatient settings

Health Disparities - A particular type of health difference that is closely linked with social or economic disadvantage

Health Equity - When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance

Health Insurance - Health insurance is a type of insurance coverage that pays for medical and/or drug expenses for people. Health insurance can pay the person back for expenses from illness or injury, or pay the provider directly. Health insurance requires the payment of premiums (see premium) by the person receiving the insurance.

Health Insurance Portability and Accountability Act (HIPAA) - The protection of medical records and information insuring any individual's information is secure and only shared with others through their consent

Health Maintenance Organization (HMO) - An entity that has received and maintains a State certificate of authority to operate as a Health Maintenance Organization as defined in MCL 500.3501

Healthcare Effectiveness Data and Information Set (HEDIS®) - The result of a coordinated development effort by the National Committee for Quality Assurance (NCQA) to provide a widely used set of performance measures that provides some objective information with which to evaluate health plans and hold them accountable

Home Health Care - A wide range of health care services a health care provider decides you need in your home for treatment of an illness or injury. Home health care helps you get better, regain independence, and become as self-sufficient as possible.

Hospice Services - Hospice is a special way of caring for people who are terminally ill, and provides support to the person's family.

Hospitalization - Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital outpatient-care - Care in a hospital that usually doesn't require an overnight stay

Indian Health Care Provider (IHCP) - A healthcare program operated by the Indian Health Service (HIS) or by an Indian Tribe, Tribal Organization (otherwise known as I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)

Indian Health Services/Tribal Health Centers/Urban Indian Organizations (I/T/U) - Health care providers specifically for American Indian/Alaska Native.

Initial Appointment - The first scheduled examination by Provider for a new patient admitted into the practice

Initial Enrollment - First enrollment in Medicaid Health Plan following determination of eligibility; re-enrollment in a Medicaid Health Plan following a gap in eligibility of less than two months is not considered Initial Enrollment

Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID) - Care facilities specifically for persons with Intellectual Disabilities

LARA - Michigan Department of Licensing and Regulatory Affairs

List of Excluded Individuals/Entities (LEIE) - List of Excluded Individuals/Entities. List of people/entities who have been debarred or otherwise excluded under the Federal Acquisition Regulations and are not allowed to be in the Contractor's Provider Network

Medicaid - A federal/state program authorized under Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being 400.105 of the Michigan Compiled Laws; which provides federal matching funds for a Medical Assistance Program. Specified medical and financial eligibility requirements must be met

Medicaid Health Plan (MHP) - A plan that offers health care services to members that are verified as eligible by the State. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The government pays the premium on behalf of the member.

Medical Assistance Program - The Michigan Medicaid program authorized under Title XIX of the Social Security Act

Medically Necessary - Health care or dental services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine or dental practices needed to diagnose or treat oral health.

Medical Necessity Denial - A denial of covered medical benefits as defined by Molina Healthcare, including hospitalization and emergency services, as listed in the Evidence of Coverage-Summary of Benefits, or care or service that could be considered a covered benefit depending on the circumstances

Member - May mean a member of the Plan or a member's representative, including, but not limited to: provider, family member or other member designee. A member may authorize in writing, any person, including, but not limited to, a physician, to act on his or her behalf at any stage in an appeal proceeding by signing the "Authorization of Representative Form."

National Committee for Quality Assurance (NCQA) - A private, 501©(3) not-for-profit organization dedicated to improving health care quality

Network - A group of doctors, dental providers, hospitals, pharmacies, and other health care experts contracted by your plan to provide health or dental services. This includes dentists and dental specialists.

Network Provider/Participating Provider - A healthcare or dental provider that has a contract with the Plan and dental Plan as a provider of care

Non-Participating Provider/Out-of-Network Provider - A healthcare or dental provider that doesn't have a contract with the Medicaid health plan and dental Plan as a provider of care.

Non-Urgent Symptomatic Care - An Enrollee encounter with a Provider that is associated with presenting medical signs and symptoms, but that does not require urgent or immediate medical attention

Out-of-Network - Covered Services rendered to a beneficiary by a provider who is not part of the Contractor's Provider Network

Persons with Special Health Care Needs (PSHCN) - Enrollees with special needs including persons with physical, mental and/or behavioral health care disabilities or impairments, Enrollees with autism, children in foster care, children who have lost eligibility for the Children's Special Health Care Services (CSHCS) program and those who have lost CSHCS eligibility due to the program's age requirements

Physician Services - Healthcare services provided by a person licensed under state law to practice medicine

Plan - A plan that offers health care or oral health services to members that pay a premium

Population Health - Management to prevent chronic disease and coordinate care along the continuum of health and well-being. Effective utilization of these principles will maintain or improve the oral and physical health and psychosocial well-being of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum

Potential Enrollee - Medicaid Beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an Enrollee of the Contractor's MHP

Preauthorization - Approval from a Plan that is required before you get a health service, dental service, appliance or device, medical equipment or fill a prescription in order for the service, medical equipment or prescription to be paid for by your plan. Sometimes called prior authorization, prior approval or precertification. Your plan may require preauthorization for certain services before you receive them, except in an emergency.

Premium - The amount paid for health care or dental benefits every month. Medicaid Health Plan premiums are paid by the government on behalf of eligible members. Dental Plan premiums are paid by the State on behalf of eligible members.

Prepaid Inpatient Health Plan (PIHP) - Provides behavioral health services to Enrollees excluding the outpatient behavioral health services for Enrollees

Prescription Drug Coverage - Drugs and medications that, by law, require a prescription by a licensed physician

Prescription Drugs - Drugs and medications that, by law, require a prescription by a licensed physician

Preventive Health Care - Health care focused on finding and treating health problems and to prevent disease or illness

Prevalent Language - Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's Enrollees

Preventive Services (Dental) - Preventive dental services include services such as oral evaluations, routine cleanings, x-rays, sealants and fluoride treatments

Primary Care Physician - A licensed physician who provides and coordinates your health care services. Your primary care physician is the person you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Primary Care Provider (PCP) - A licensed physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides and coordinates your health care services. Your primary care provider is the person you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Prior Authorization - The process for any service that needs approval from Molina Healthcare before it can take place

Provider - A person, facility or organization that's licensed to provide health care or dental services. Doctors, dentists, nurses, and hospitals are examples of health care or dental providers.

Provider Directory - A list of all providers contracted with Molina Healthcare

Provider Network - The collective group of Network Providers who have entered into Provider Contracts with the Contractor for the delivery of MCO Covered Services. This includes, but is not limited to, physical, behavioral, pharmacy, and ancillary service providers

Referral - A request from a PCP for his or her patient to see another provider for care

Region - Groupings of contiguous counties defined and numbered as follows:

1. Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft
2. Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford
3. Alcona, Alpena, Cheboygan, Crawford, Iosco, Ogemaw, Oscoda, Otsego, Presque Isle, Montmorency, Roscommon
4. Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newago, Oceana, Osceola, Ottawa
5. Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw
6. Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola
7. Clinton, Eaton, Ingham
8. Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
9. Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw
10. Macomb, Oakland, Wayne

Rehabilitation Services and Devices - Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings

Routine Care (Dental) - Dental services that include the diagnosis and treatment of oral health conditions to prevent deterioration to a more severe level or minimize/reduce the risk of development of

dental disease or the need for more complex dental treatment. Examples include but are not limited to services such as fillings and space maintainers

Routine Care (Medical) - An Enrollee encounter with a Provider that is not associated with any presenting medical signs. Examples include well-child visits and annual adult physical examinations

Rural - Rural is defined as any county not designated as metropolitan or outlying metropolitan by the 2000 U. S. Census Office of Management and Budget

Rural Health Clinic (RHC) - Public, non-profit or for-profit healthcare facility located in rural medically underserved area. In Michigan, RHCs are certified by the Department of Licensing and Regulatory Affairs (LARA) to participate in Medicare and Medicaid programs under an agreement with CMS. The current RHCs in Michigan are listed as the following website: http://www.michigan.gov/documents/lara/MI_Rural_Health_Clinic_Directory_2-2016_515599_7.pdf

Service Area - The geographic area where Molina Healthcare provides services

Service Authorization Decision - Contractor's written response to Enrollee's service authorization request provided as expeditiously as the Enrollee's condition requires and with State establish timeframes that may not exceed 14 calendar days following the receipt of the request for service, with a possible extension of up to 14 additional calendar days if---(i) The Enrollee, or the Provider requests an extension; or (ii) Contractor justifies a need for additional information and how the extension is in the Enrollee's best interest

Service Authorization Request - A managed care Enrollee's request for the provision of a service

Services - Any function performed for the benefit of the State

Sexually-Transmitted Infection (STI) - Serious infections that can be screened for and may be treated with early identification

Skilled Nursing Care - Services from licensed nurses, technicians and/or therapists in your own home or in a nursing home

Social Determinants of Health - The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social Determinants of Health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Specialist - A licensed physician or dental specialist focuses on a specific area of medicine or dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of medical or dental symptoms and conditions.

State - The State of Michigan, including any departments, divisions, agencies, offices, commissions, officers, employees and agents. Michigan, the Michigan Department of Health and Human Services, or its Agent

State Fair Hearing - An impartial review by MDHHS of a decision made by the Contractor that the Enrollee believes is inappropriate

Urgent Care - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care

Urgent Care (Dental) - Care for a dental injury or condition bad enough to seek care soon but not bad enough that it needs emergency room care. Urgent dental care can be treated with a quick dental appointment.

Urgent Care (Medical) - Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

Utilization Management (UM) - Medical decisions relating to an individual's care

Vaccines for Children program (VFC) - A federal program which makes vaccine available free to immunize children age 18 and under who are Medicaid eligible

Women Infants and Children (WIC) - A supplemental Food and Nutrition Program

Certificate of Coverage

Article I. General Conditions

1.1 Certificate. This Certificate of Coverage is issued to Medicaid 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 to any other person or entity, 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 means 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 Michigan Department of Health and Human Services or its successor agency which administers the Medicaid Program in the State of Michigan.

2.6 Michigan Department of Health and Human Services (MDHHS) is the State agency responsible for Medicaid eligibility determinations and enrollment.

2.7 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 or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

2.8 Emergency Services means the services which are Medically Necessary to treat an emergency.

2.9 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 Michigan Department of Health and Human Services (MDHHS) 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 Section 21054b of the Public Health Code.

2.10 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.

2.11 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.

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

2.13 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.

2.14 Hospital Services mean those Covered Services which are provided by a Hospital.

2.15 Medicaid Contract is the contract between the State and the Plan under which the Plan agrees to provide or arrange for Covered Services for Members.

2.16 Medicaid Program means the Michigan Department of Health and Human Services' program for Medical Assistance under Section 105 of Act No. 280 of The Public Acts of 1939, as amended, MCL 400.105, and Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq.

2.17 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.

2.18 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.

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

2.20 Member means a Medicaid Program beneficiary enrolled in the Plan and on whose behalf the Michigan Department of Health and Human Services has paid a Premium in accordance with the Medicaid Contract.

2.21 Member Agreement means this Certificate, the Plan's member handbook, the Medicaid mihealth card and Molina Healthcare ID card, including any amendments, addenda and appendices to any of the foregoing.

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

2.23 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.

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

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

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

2.27 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.

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

2.29 Plan means the Medicaid Program under Molina Healthcare of Michigan, a Michigan for Profit Corporation and a licensed health maintenance organization.

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

2.31 Premium means the amount prepaid by the Michigan Department of Health and Human Services on behalf of the Member to secure Covered Services.

2.32 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.

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

2.34 Service Area means the geographic area in which the Plan has been authorized by the Michigan Department of Health and Human Services and the DIFS to operate as a health maintenance organization.

2.35 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.

2.36 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 Medicaid Program as determined by the Michigan Department of Health and Human Services and must reside within the Service Area. The Michigan Department of Health and Human Services is solely responsible for determining the eligibility of individuals for the Medicaid Program. Eligible individuals may choose a health plan, or the Michigan Department of Health and Human Services may choose a health plan for the eligible individuals within the health plan's service area.

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 Michigan Department of Health and Human Services notifies the Plan in writing of the assignment of the individual to the Plan. However, if the Member is an inpatient at a Hospital on this date, the Plan is not responsible for payment for the inpatient Hospital stay or any charges connected with that stay, but is responsible for any ancillary or other Covered Services. From the time of discharge forward, then the Plan becomes entirely responsible for all Covered Services. The Plan will not be responsible for paying for Covered Services during a period of retroactive eligibility and prior to the date of enrollment in the Plan, except for newborns as set forth below. The Plan will notify the Member of the effective date of enrollment in the Plan and coverage under this Certificate.

3.3 Newborns. The Member's newborn child is automatically enrolled in the Plan as a Member for the month of birth, and may be eligible for enrollment for additional time periods. The newborn is entitled to Covered Services retroactive from the date of birth. The Member shall notify the Plan as soon as possible of the birth of a newborn. The Plan will notify the Michigan Department of Health and Human Services of the birth in accordance with Michigan Department of Health and Human Services procedures. The Michigan Department of Health and Human Services is solely responsible for determining the continued eligibility and the enrollment of a newborn.

3.4 Change of Residency. The Member shall notify the Michigan Department of Health and Human Services 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.

3.5 Final Determination. In all cases, the Michigan Department of Health and Human Services 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, the Member should select a Primary Care Provider. 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. The Plan may select a Primary Care Provider for a Member in the event that a Primary Care Provider is not selected by or for the 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.

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 in-network Specialist Physician Services. In some circumstances, certain medical services, equipment and supplies are not covered or may require Prior Authorization by the Plan. Prior Authorization is required for most services provided out of the Plan's provider network. The Member may contact the Plan to obtain a list of services requiring Prior Authorization. If the Member does not obtain the necessary authorization from the Plan, the Member may be financially responsible for payment of medical services, equipment or supplies if notified by the provider prior to the service. A female Member may receive an annual well-woman examination and routine obstetrical and routine gynecological services from an obstetrician-gynecologist or women's health specialist who is a Participating Provider without Prior Authorization 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.

4.5 Non-Participating Providers. The Member may occasionally require Covered Services from Non-Participating Providers. On these occasions, the Member must obtain Prior Authorization as required by the Plan in order to receive Covered Services from Non-Participating Providers. If the Member does not obtain the necessary authorization from the Plan, the Member is financially responsible for payment for all medical services, equipment and supplies furnished by Non-Participating Providers if notified by the provider prior to the service. However, Prior Authorization is not required for Emergency Services, Family Planning Services, immunizations or treatment of Communicable Diseases at the Member's local health department, services from child and adolescent health centers and programs, and Federally Qualified Health Centers.

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 Medicaid 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. The Plan shall permit the Member to continue an ongoing course of treatment with the Primary Care Provider as required by MCL 500.2212b. 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 Services

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 Medicaid 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 Michigan Department of Health and Human Services, or their designees on request, and also authorizes the Plan, DIFS and Michigan Department of Health and Human Services, 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, DIFS and the Michigan Department of Health and Human Services, 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 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 90 calendar 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 benefit determination. The Member has 60 calendar days from the original adverse benefit determination date to file an appeal. The Member has the right to appeal in person, in writing, or by telephone to the Designated Appeals Reviewer. The Plan's Appeal and Grievance Specialist can help assist with filing the appeal.

The appeal request should be sent to Molina Healthcare of Michigan, 880 W. Long Lake Rd., Suite 600, Troy, MI 48098. The Member may also send in appeals to fax number (248) 925-1799. The Member has the right to include an Authorized Representative throughout the appeals process and to attend the Appeals hearing. The Member must inform the Plan of the Authorized Representative in writing by completing the Authorized Representative Designation form. The Plan will use reviewers who were not involved in the adverse benefit determination. **The reviewers are health care professionals who have the appropriate clinical expertise in treating your condition or disease.** A decision will be mailed to the Member in 30 calendar days from the date that the Plan received the appeal.

An additional 14 calendar days are allowed to obtain medical records or other pertinent medical information if the Member requests the extension, or if the Plan can demonstrate that the delay is in the member's interest. Members will receive a written notification of this extension.

5.2.3 Expedited Appeal Process. An expedited (fast) appeal process is available if the Member or the Member's physician believes that the usual 30 calendar day time frame for appeals will cause harm to the Member's health, or affect the Member's normal body functions. Fast appeals are decided in 72 hours. The Member may request a fast appeal with DIFS after a fast appeal is filed with Molina Healthcare. If the Plan denies the Member's request for a fast appeal, the Member may request a fast external review with the Department of Insurance and Financial Services (DIFS) within 10 calendar days of the denial.

5.2.4 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 calendar days from the Plan or is not satisfied with the result of the appeal. Members have 127 calendar days to file an external appeal with DIFS. The appeal request should be sent to Department of Insurance and Financial Services (DIFS), Healthcare Appeals Section, Office of General Counsel, P.O. Box 30220, Lansing, MI 48909-7720. The appeal request can also be sent via fax to (517) 284-8848 or online at https://difs.state.mi.us/Complaints/ExternalReview.aspx.

The Plan's Appeal and Grievance Specialist will mail the external review forms to the Member. DIFS will send the appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to the member in 14 calendars days of accepting the appeal. The Member, Authorized Representative, or Doctor can also request an expedited (fast) appeal from DIFS at the same address above within 10 calendar days after receiving a final determination. DIFS will send the appeal to an IRO for review. A decision will be mailed to the member within 72 hours. During this time, benefits will continue.

5.2.5 State Fair Hearing Process. A Member has the right to a Medicaid fair hearing on any decision made by the Plan that the Member believes is inappropriate by contacting the Michigan Department of Health and Human Services, Michigan Office of Administrative Hearings and Rules by calling (800) 648-3397. The fax number is (517) 763-0146. The address is Michigan Department of Health and Human Services, Michigan Office of Administrative Hearings and Rules, P.O. Box 30763, Lansing, MI 48909 or online at https://courts.michigan.gov/self-help/mahs/pages/default.aspx. If the

member has any problems about the care they are getting, they must first submit an appeal to Molina. If they are unhappy with Molina's decision, they may directly appeal to the Michigan Department of Health and Human Services (MDHHS) through the State's Fair Hearing process. This must be done within 120 calendar days of the final determination. Molina Healthcare will include a State hearing request form along with a self-addressed stamped envelope with our decision.

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 **MolinaHealthcare.com.**

5.4 Membership Cards.

5.4.1 The Plan will issue a Molina Healthcare ID card to each Member. The Member must present both the Medicaid mihealth card and Molina Healthcare ID card to Participating Providers each time the Member obtains Covered Services.

5.4.2 If the Member permits the use of the Molina Healthcare ID card by any other person, the Plan may immediately reclaim the card. Permitting the use of the Medicaid mihealth card and Molina Healthcare ID 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 Medicaid mihealth card and Molina Healthcare ID card are 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 are 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 Periodic Premium Payments. The Michigan Department of Health and Human Services or its remitting agent will pay directly to the Plan, on behalf

of the Member, the Premium specified in the Medicaid Contract. The Michigan Department of Health and Human Services or its remitting agent will pay the Premium on or before the due date specified in the Medicaid Contract. The Member understands that the Premium to be paid on behalf of the Member by the Michigan Department of Health and Human Services in return for Covered Services will be remitted in accordance with the Medicaid Contract.

6.2 Members Covered. Each Member for whom a Premium has been received by the Plan is entitled to Covered Services under this Certificate for the period to which the Premium applies.

6.3 Claims.

6.3.1 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. If the Member pays a bill for Covered Services, the Plan will require the Participating Provider to reimburse the Member.

6.3.2 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 to the Plan. 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.

6.3.3 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.

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

6.4 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 at the Member's local health department, immunizations at the Member's local health department, services from a child and adolescent health centers and programs and federally qualified health centers.

6.5 Non-Covered Services. The Member may be financially responsible for payment for any Non-Covered Services received by the Member if the Member knew or reasonably should have known 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 Medicaid Contract at the time that the services are rendered. The details of all Medicaid covered services are contained in Medicaid Program policy manuals and publications.

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 Medicaid 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. 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 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 C are Non-Covered Services.

8.2 Limitations.

8.2.1 Covered Services are subject to the limitations and restrictions described in Medicaid Program policy manuals and publications 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 Medicaid 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 Medicaid 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 Medicaid 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 Medicaid Agreement.

9.2.3 The Michigan Department of Health and Human Services 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 Michigan Department of Health and Human Services 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 Michigan Department of Health and Human Services:

a. The Member moves out of the Service Area.
b. The Member ceases to be eligible for the Medicaid Program or the Plan as determined by the Michigan Department of Health and Human Services.
c. The Member dies.
d. The Member is admitted to a skilled nursing facility for custodial care, or for restorative health services that exceed 45 days, unless the Member is a hospice patient.
e. The Member is incarcerated in a correctional facility.

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

a. The Member is unable to establish or maintain a satisfactory physician-patient relationship with available participating providers.
b. Violent/life-threatening situations involving physical acts of violence; physical or verbal threats of violence made against the Plan's providers, staff, or the public at the Plan's locations; or stalking situations.

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 Michigan Department of Health and Human Services 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 Michigan Department of Health and Human Services will make the final decision concerning termination of a Member's enrollment under this Section 9.3. The Michigan Department of Health and Human Services 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 Michigan Department of Health and Human Services may require an annual open enrollment period in accordance with the Medicaid Contract. After the annual open enrollment period, the Member may disenroll from the Plan for 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 Michigan Department of Health and Human Services Enrollment Broker.

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 Michigan Department of Health and Human Services.

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, Medicaid Contract and Medicaid Provider Manual.

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 Michigan Department of Health and Human Services 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 Michigan Department of Health and Human Services 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 Michigan Department of Health and Human Services.

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 Michigan Department of Health and Human Services 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 Determine whether and to what extent the Member has health insurance or other health benefit coverage for Covered Services; and

10.6.2 Establish, in accordance with this Article, priorities for determining primary responsibility among the Payers obligated to provide health care services or health insurance; and

10.6.3 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

10.6.4 Recover from the Member, 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.

10.7 Construction. Nothing in this Article shall be construed to require the Plan to make a payment until it determines whether it is the primary Payer or the secondary Payer and the benefits that are payable

by the primary Payer, if any. The Plan must follow the Medicaid Contract and Medicaid Provider Manual requirements related to coordination of benefits.

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 Pay or 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 Medicaid 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
880 West Long Lake Road, Suite 600
Troy, Michigan 48098-4504

Appendix A - Benefit Detail of 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. **Allergy testing, evaluations and injections, including serum costs.**
2. **Ambulatory Surgical Services and Supplies.** Outpatient services and supplies furnished by a surgery center for a covered surgical procedure.
3. **Ambulance Services.** Professional ambulance services including air ambulance for the following situations or conditions:
   - **a.** Ambulance transportation to the emergency department of a Hospital due to an Emergency;
   - **b.** Ambulance transportation from a hospital to another facility, including a skilled nursing facility (participating or non-participating;
   - **c.** Transportation from a non-participating hospital to a Participating Hospital; and provided at the facility in which the patient is confined.
   - **d.** Round trip ambulance transportation from the Hospital or facility of the patient's confinement to another facility for tests or other medically necessary services that cannot be provided at the facility in which the patient is confined.
4. **Antineoplastic Drug Therapy.** Antineoplastic drugs are covered in accordance with Section 21054b of the Public Health Code.
5. **Blood Lead Screening and Follow-Up.** Blood lead screening and follow-up services are covered for Member's under age 21.
6. **Breast pumps; personal use, double electric**
7. **Cardiac Rehabilitation** Therapy. Cardiac rehabilitation therapy is not covered. No PA is required, except for Non-Par.
8. **Chiropractic Care.** Up to 18 visits per calendar year limited to specific diagnosis and procedures.
9. **Contraceptive Medications and Devices.** Contraceptive medications, supplies and devices are covered. Over-the-counter family planning drugs and supplies are covered without a prescription.

10. **Diabetes Treatment Services.** In accordance with MCLA 500.3406(p), the following equipment, supplies and educational training for the treatment of diabetes, if determined to be Medically Necessary and prescribed by Participating Provider is a Covered Service:
    1. Blood glucose monitors and blood glucose monitors for the legally blind.
    2. Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
    3. Syringes.
    4. Insulin pumps and medical supplies required for the use of an insulin pump.
    5. Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition; subject to completion of a certified diabetes education program and if services are needed under the comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.
    6. The following medications are Covered Services for the treatment of diabetes when ordered by a Participating Provider and deemed to be Medically Necessary:
        1. Insulin.
        2. Non-experimental medication for controlling blood sugar.
        3. Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes.
11. **Disposable Items and Other Medical Supplies:**
    l. Disposable items are covered when replacing a normal body function (e.g., ostomy and urology supplies).
    m. The following diabetic supplies are covered: insulin, syringes, reagents, standard glucometers and lancets. Insulin pumps may be covered for Type I uncontrolled insulin dependent diabetes.
12. **Durable Medical Equipment and Supplies.** Durable medical equipment is covered in accordance with Department guidelines.
13. **Emergency Services.**
14. **End Stage Renal Disease Services.**
15. **Family Planning.** Family planning such as contraception counseling and associated physical exams and procedures, and limited infertility screening and diagnosis are covered. The following are covered services even if they are not provided in connection with the diagnosis and treatment of an illness or injury:
    a. Voluntary Sterilizations. Tubal ligations and vasectomies are covered for Members

21 years and older. Vasectomies are only covered when performed in a Physician's office. Any time a sterilization procedure is performed a consent form must be signed 30 days in advance of the procedure and submitted to the Plan. Sterilization reversals are excluded.
Diaphragms and Intrauterine Devices (IUDs).

b. Advice on Contraception and Family Planning.
c. Abortion. Abortion is covered in the case of rape, incest; when medically necessary to save the life of the mother; treatment is for medical complications occurring as a result of an elective abortion; or treatment is for a spontaneous, incomplete, or threatened abortion or for ectopic abortion pregnancy.

16. **Hearing Care.** Hearing exams and supplies are covered. Hearing aid batteries and maintenance and repair of hearing aids are covered. Hearing aid batteries are distributed 36 disposable every 6 months. Hearing aids are covered for all ages.
17. **Health Education.**
18. **Home Health Care.** Home health care visits are covered. Covered Services include home care nursing visits by a registered professional or licensed practical nurse and home health aides under certain circumstances.
19. **Hospice Services.**
20. **Hospital Services.**
    a. Inpatient Services. Hospital inpatient services and supplies including professional services, semi-private room and board, general nursing care and related services.
    b. Outpatient Services. Facility and professional services and supplies which are furnished on an outpatient basis.
    c. Diagnostic and Therapeutic Services. Services and supplies for laboratory, radiologic and other diagnostic tests and therapeutic treatments.
21. **Infusion Therapy.**
22. **Maternal and Infant Health Program.**
23. **Maternity Care.**
    a. **Hospital and Physician.** Services and supplies furnished by a Participating Hospital or Participating Physician for prenatal care, genetic testing, delivery and postnatal care.
    b. **Certified Nurse Midwife Services.**
    c. **Newborn Child Care.** A newborn child of a Member is eligible for Covered Services for the month of birth.

d. **Home Care Services.** One routine home health postnatal visit for mother and baby.
e. **Length of Stay.** The Member and newborn child shall be entitled to a minimum of 48 hours of inpatient Hospital Services following a vaginal delivery and a minimum of 96 hours of inpatient Hospital Services following a Caesarian section.
f. **Parenting and Birthing Classes.**
g. **Special conditions for new Members in the Plan who are pregnant at the time of enrollment.** These Members may select or remain with the Medicaid obstetrician of choice and shall be entitled to receive all medically necessary obstetrical and prenatal care without Prior Authorization from the Plan. The services may be provided without Prior Authorization regardless of whether the provider is a Plan participating provider.

24. **Medically Necessary Weight Reduction Services.** Medically necessary weight reduction services are covered for members with life endangering medical conditions. Prior Authorization is required.
25. **Mental Health Services.** Short-term outpatient therapy is covered. The outpatient mental health benefit is not meant to cover severe and/or persistent mental disease or illness of children or adolescents with severe emotional disturbances.
26. **Non-Emergent Transportation.** Non-Emergent transportation to covered services is provided. Covered services include doctor appointments, x-rays, lab tests, pharmacy, medical supplies or other medical care.
27. **Oral and Maxillofacial Surgery.**
    a. **Oral and maxillofacial surgery and related x-rays** are a Covered Service when performed by a Participating Provider, in accordance with the Plan's Prior Authorization policies, for the following conditions:
        ii. Emergency repair and treatment of fractures of the jaw and facial dislocation of the jaw.
        iii. Emergency repair of traumatic injury resulting from a non-occupational injury to sound natural teeth, provided treatment occurs within 24 hours of the initial injury (only the initial visit for treatment will be covered).
    b. **Orthognathic Surgery.** Orthognathic surgery (surgery to correct the relationship or positions of the bones and soft tissues of the jaw) for congenital syndromes which directly affect the growth, development and function of the jaw and surrounding structures is covered.

3. **Organ and Tissue Transplants.** Cornea and kidney transplants are covered benefits. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologous, and peripheral stem cell harvesting, and small bowel) are covered on a Member specific basis when determined medically necessary according to currently accepted standards of care. The Plan has a policy to evaluate, document and act upon a Member's request for an extrarenal transplant. A Member may obtain a copy of the policy upon request to the Plan. Antineoplastic drugs are covered in accordance with Section 21054b of the Public Health Code.
4. **Out-of-Network Services.** Services provided by out-of- network providers are covered if medically necessary, authorized by the Plan, and could not reasonably be obtained by a network provider, inside or outside of the State of Michigan, on a timely basis.
5. **Plastic and Reconstructive Surgery.** Plastic and reconstructive surgery to improve function or to approximate a normal appearance is covered when the surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery of the breast on which a mastectomy for cancer was performed is covered. Some plastic and reconstructive surgery must meet specific criteria before being covered.
6. **Podiatry Services. Podiatry services are covered.**
7. **Prescription Drugs.**
    a. Formulary drugs are covered every 30 days.
    b. Condoms are covered, limited to 36 condoms every 30 days.
    c. Over-the-counter drugs and medical supplies must have a prescription to be covered.
    d. Infertility drugs are not covered.
    e. Off-label use of a federal food and drug administration approved drug and reasonable cost of supplies medically necessary for administrator the drug as required under MCL 500.3406q.

33. **Professional Care Services by Physicians and Other Health Care Professionals.** Coverage is provided for the Member for office visits to Physicians, Certified Pediatrics and Nurse Practitioners and other Health Care Professionals. Covered Services include:
ah. Preventive health services, office visits for

sickness and injury, consultations, well-child care, allergy care and routine and periodic age/sex-specific exams.

ai. Routine pediatric and adult immunizations as recommended by the U.S. Public Health Services guidelines.

aj. Health education.

34. **Prosthetic Devices and Orthotics.** Standard prosthetic and orthotic supports and devices are covered in accordance with Department guidelines. Prosthetic devices are custom made artificial devices used to replace all or a portion of a part of the body (e.g. artificial limb). Breast prosthesis after mastectomy is covered.

35. **Radiology Examinations and Laboratory Procedures.** Diagnostic and therapeutic radiology services and laboratory tests if not excluded elsewhere in the Certificate.

36. **Rehabilitative Nursing Care.** Intermittent or short-term restorative or rehabilitative services (in a nursing facility) up to 45 days is covered.

37. **Restorative or Rehabilitative Services (in a place of service other than a nursing facility).**

38. **Screening Mammography and Breast** Cancer Services. Breast cancer screening mammography, diagnostic services, outpatient treatment services and rehabilitative services are covered in accordance with Section 500.3406d of the Insurance Code.

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

40. **Skilled Nursing Facility.** Certain skilled nursing facility services are covered in accordance with Department guidelines.

41. **Therapy.** Short-term, restorative physical, occupational and speech therapy is covered. Short-term therapy is treatment that is expected to significantly improve the Member's condition within 60 days from the date therapy begins. Coverage is as follows:

    a. **Physical Therapy.** Physical therapy in a Participating Hospital outpatient department, a Participating Physician's office, or the Member's home is covered.

    b. **Occupational** Therapy. Occupational therapy provided in a Participating Hospital outpatient department or a Participating Physician's office, or the Member's home is covered.

    c. **Speech Therapy.** Speech therapy provided in a Participating Hospital outpatient

department or a Participating Physician's office is covered. Speech therapy is not covered to treat developmental delays in speech. Speech therapy is not covered in the home.

d. **Tobacco Cessation Treatment.** Tobacco cessation treatment including pharmaceutical and behavioral support is covered.

42. **Treatment of Communicable Diseases.** Treatment for communicable disease require no Prior Authorization when received from a local health department or other clinic.

43. **Vision Services.** Eye exams, prescription lenses and frames are covered. Benefit includes one eye exam and one pair of eyeglasses every twenty-four months. Replacement eyeglasses (if originals are lost, broken or stolen), are covered. Replacements are limited to two pairs of eyeglasses per year for Members under age 21 and to one pair of replacement eyeglasses for Members age 21 and over. Contact lenses are covered only if the Member has a vision problem that cannot be adequately corrected with eyeglasses.

44. **Well-Child/EPSDT.** Well-child and EPSDT services for Members under the age of 21 is covered.

Appendix B - Coordination of Care Services

The following services are the coordination of care services provided by Plan to Members under the Member Agreement:

a. **Dental Services.** Dental services are available for pregnant women. Diagnostic, preventive, restorative, prosthetic and medically/clinically necessary oral surgery services, including extractions, are covered. It is important that pregnant women receive proper dental care during their pregnancy for the health and wellbeing of the mother and infant. The Plan will provide Members with the names of participating dentists in their area who are available to provide dental services. The Plan provides unlimited round-trip or one-way trips for covered, medically necessary services each calendar year. Members can use this benefit to visit any Molina Healthcare provider.

b. **Developmental Disability Services.** Developmental disability services are not covered by the Member Agreement. Members may be eligible to receive developmental disability services through coordinating agencies in their area. The Plan will provide Members with information regarding these services upon request, may refer Members

for these services and will coordinate the Member's services with the coordinating agency as appropriate.

c. **Substance Abuse Services.** Substance abuse services are not covered by the Member Agreement. Members may be eligible to receive substance abuse services through coordinating agencies in their area. The Plan will provide Members with information regarding these services upon request, may refer Members for these services and will coordinate the Member's services with the coordinating agency as appropriate.

d. **Coordination with Local Health Department.** The Plan will coordinate certain services with the Member's local health department and will make certain referrals as appropriate.

e. **Nursing Facility Services.** Intermittent or short-term restorative rehabilitative services in a nursing facility after 45 days and custodial care provided in a nursing facility.

f. **School Based Services.** Services provided by a school district and billed through the Intermediate School Districts.

g. **Developmental Disability Services.** Services, including therapies (speech, language, physical, occupational) provided to persons with developmental disabilities which are billed through the Community Mental Health Service Program providers or Intermediate School Districts.

h. **Transportation Services.** Transportation for services not covered by the Plan to include therapies (speech, language, physical, occupational) provided to persons with developmental disabilities which are billed through the Community Mental Health Program.

Appendix C - Excluded Services & Limitations

Any services, equipment or supplies excluded or limited under the Medicaid Contract are excluded or limited under the Member Agreement, even when recommended by a Primary Care Provider or Participating Provider and/or written on a Plan referral form. Exclusions and limitations include, but are not limited to, the following:

1. **Abortions.** Elective therapeutic abortions and related services.
2. **Acupuncture.** Acupuncture services are not covered.
3. **Alternative Procedures and Treatments.** Alternative procedures and treatments which are not generally recognized or accepted by the medical community are excluded. Also excluded are procedures and treatments which are primarily educational in nature.

4. **All Services or Supplies that are not medically necessary are not covered.**
5. **Ambulance Services.** Use of an ambulance for transportation for any reason other than an Emergency or because the Member's medical condition necessitates use of an ambulance is not a Covered Service.
6. **Autopsy. Autopsy services are not covered.**
7. **Biofeedback.** Biofeedback services are not covered.
8. **Cognitive Evaluation and/or Retraining and Related Services.** Cognitive services, training and/or retraining, and any related care, supplies or procedures, are excluded regardless of who provides them.
9. **Cosmetic Surgery/Procedures.** Surgery, medications, injections, procedures and related services performed to reshape normal structures of the body in order to improve or alter the Member's appearance or self-esteem are excluded. Examples include, but are not limited to, elective rhinoplasty, spider/varicose vein removal and elective breast reduction. Cosmetic alteration done simultaneous to surgery for a medical condition is not covered. Wigs, prosthetic hair or hair transplants are not covered. As provided in Appendix A, breast reconstructive surgery following a mastectomy is covered.
10. **Court-Ordered Services.** Charges for services ordered by a court of law will not be covered unless they are otherwise Medically Necessary and all Plan requirements are met.
11. **Custodial or Domiciliary Care.** Custodial or domiciliary care, including such care in a nursing home, is excluded.
12. **Dental Services.** Routine dental services, including tooth repair/restoration/extraction, dental x-rays, wisdom teeth extractions, root canals and gingivectomies are excluded. Orthodontia, supplies and appliances including splints and braces are not covered. Also excluded are services and supplies due to damage of any tooth due to the natural act of chewing. Dental implants/mandibular bone staples are not covered. Dental services are available for pregnant women.
13. **Developmental Disability Services.** Services provided to a Member with a developmental disability and billed through Community Mental Health Services Program providers are not covered. Members may be eligible to receive developmental disability services through providers or agencies in their areas as indicated in Appendix B of the Certificate.
14. **Experimental, Investigational or Research Drugs, Biological Agents Devices, Supplies, Treatments, Procedures or Equipment.** These services are not covered.

15. **Forms.** Charges for time involved in completing necessary forms, claims or reports are not covered.
16. **Government-Provided Medical Care.** Medical expenses incurred in any government hospital or for services of a government physician or other health professional are excluded.
17. **Hair Analysis.**
18. **Home and Community Based Waiver Program Services.**
19. **Hospital Confinement.** Days of confinement for non-medical reasons are not covered.
20. **Long-Term Therapies.** Long-term therapies which exceed the defined benefit are not covered.
21. **Medical Equipment and Supplies.** Excluded from coverage are: replacement and/or repair of most covered items due to misuse, loss or abuse as defined by the Medicaid Provider Manual; experimental items; batteries (except hearing aid batteries); and comfort and convenience items such as over-bed tables, heating pads, protective helmets, adjusta-beds, telephone arms, air conditioners, sauna baths, whirlpool baths, hot tubs and elevators.
22. **Non-Medical Services.** Non-medical services such as on-site vocational rehabilitation and training or work evaluations, school, home or work site environmental evaluations, or related employee counseling are excluded.
23. **Obstetrical Delivery in the Home.** Services and supplies related to obstetrical delivery in the home are not covered.
24. **Oral Splints and Appliances.** Oral splints and appliances associated with TMJ, orthognathic, and oral and maxillofacial surgeries are excluded.
25. **Other Coverage.** The Plan is a payer of last resort under the Medicaid Contract. Coverage is excluded for health care service, equipment or supply to the extent any third-party is liable for payment of benefits under a state or federal law or a private or governmental health insurance plan or health benefit program, including, but not limited to, Medicare. Benefits by any third-party payer and the Plan will be coordinated in accordance with Article 10 of the Certificate.
26. **Personal and Convenience Items.** Personal and convenience items, including but not limited to, household fixtures and equipment, are excluded.
27. **Personal Care and Home Help Services.**
28. **Prescription Drugs.** The following prescription drugs are excluded from coverage:
    a. Medications prescribed for cosmetic purposes;
    b. Experimental, investigational or research drugs;
    c. Drugs prescribed to treat infertility;

d. Vitamin and mineral combination drugs (only selected prenatal, end-stage renal disease vitamins, and pediatric fluoride preparations are covered);
e. Drugs prescribed for weight loss are excluded unless medically necessary; and
f. Anti-psychotic classes and H7Z class psychotropic drugs as listed under the category "Classes for Psychotropic and HIV/AIDS carveout at Michigan.fhsc.com; drugs in the anti-retroviral classes including protease inhibitors and reverse transcriptease inhibitors; substance abuse treatment drugs as listed under the category Classes for Psychotropic and HIV/AIDS carveout at Michigan.fhsc.com.

29. **Private Duty Nursing Services.** Private duty inpatient and outpatient nursing services are excluded.
30. **Reproductive Services.** Reversal of elective sterilization is excluded. In vitro fertilization, GIFT, artificial insemination, ZIFT, intrauterine insemination (IUI), surrogate parenthood, and any infertility treatments are excluded.
31. **School District Services.** Services provided by a school district and billed through the Intermediate School District are excluded.
32. **Services Rendered by a Member or a Family Member.** Services, care, or treatment rendered by the Member or by the Member's family, including, but not limited to, spouse, mother, father, grandmother, grandfather, aunt, uncle, cousin, brother, sister, son, daughter, niece, nephew, grandson, granddaughter or any person who resides with the Member.
33. **Services Required by Third-Parties.** Services required by third-parties are excluded, including: physical examinations, diagnostic services, prescriptions and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state or federal government, obtaining or continuing insurance coverage, securing school admission or attendance, or participating in athletics. Medical and/or psychiatric evaluations for any legal determinations with the exception of foster care placement are excluded.
34. **Special Food and Nutritional Supplements.** Food and food supplements are not covered, except for enteral and parenteral feedings when they are the only means of nutrition.
35. **Speech Therapy.** Speech therapy is covered, excluding services provided to person with developmental disabilities which are billed through Community Mental Health services Program providers or Intermediate School Districts.

36. **Substance Abuse.** Substance abuse services including screening and assessment, detoxification, intensive outpatient counseling, other outpatient services and methadone treatment are excluded. Members may be eligible to receive substance abuse services through providers or agencies in their areas as indicated in Appendix B of the Certificate.
37. **Temporomandibular Joint Syndrome (TMJ).** TMJ surgery is not covered.
38. **Transportation Services which are not covered benefits under the Medicaid Contract are excluded.**

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