# 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 Doula means A non-clinical person who typically provides physical, emotional, and educational support services to pregnant individuals during the prenatal, labor, delivery, and post-partum needs.

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

2.8 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.

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

2.10 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.

2.11 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.

2.12 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.

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

2.14 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.

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

2.16 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.

2.17 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.

2.18 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.

2.19 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.

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

2.21 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.

2.22 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.

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

2.24 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.

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

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

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

2.28 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.

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

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

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

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

2.33 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.

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

2.35 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.

2.36 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.

2.37 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 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 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 bonafide 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 the 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 Certificates 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.

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:

a. Blood glucose monitors and blood glucose monitors for the legally blind.
b. Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
c. Syringes.
d. Insulin pumps and medical supplies required for the use of an insulin pump.
e. 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.

The following medications are Covered Services for the treatment of diabetes when ordered by a Participating Provider and deemed to be Medically Necessary:

a. Insulin.
b. Non-experimental medication for controlling blood sugar.
c. 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:

a. Disposable items are covered when replacing a normal body function (e.g., ostomy and urology supplies).
b. 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.
b. Diaphragms and Intrauterine Devices (IUDs).
c. Advice on Contraception and Family Planning.
d. 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.

h. Doula Services. Six (6) visits during the prenatal and postpartum periods and one (1) visit for attendance at labor and delivery. Doula services must be recommended by a licensed healthcare 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:

    i. Emergency repair and treatment of fractures of the jaw and facial dislocation of the jaw.

    ii. 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.

28. 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.

29. 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.

30. 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.

31. Podiatry Services. Podiatry services are covered.

32. 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:

a. Preventive health services, office visits for sickness and injury, consultations, well-child care, allergy care and routine and periodic age/sex-specific exams.

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

c. 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. Telehealth Services.

42. 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.

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

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

45.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 aged 21 and over. Contact lenses are covered only if the Member has a vision problem that cannot be adequately corrected with eyeglasses.

46.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.

880 West Long Lake Road, Suite 600

Troy, Michigan 48098-4504