HEALTH PLAN COMMUNITY

Certificate of Coverage

Individual HMO Plan

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INTRODUCTION

McLaren Health Plan Community (MHP Community) is a health maintenance organization operating under a certificate of authority issued by the state of Michigan. Your Certificate is issued by MHP Community and is an agreement between you, as an enrolled Member, and MHP Community.

The Certificate includes: this document, the Schedule of Cost Sharing, the Member's Identification Card, the Application and any amendments, Riders or endorsements to this Certificate.

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

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

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

By enrolling with MHP Community, accepting this Certificate and using the MHP Community ID Card, Members agree to be bound by the terms and conditions of this Certificate. Except for emergency and urgent care health services, only those health care services provided by your Primary Care Physician (PCP) or arranged or approved by MHP Community are a Benefit under this Certificate. Members are entitled to the services and Benefits described in this Certificate in exchange for the Premium paid to MHP Community.

IMPORTANT INFORMATION

- MHP Community is an HMO that operates on a direct service basis. It is not an insurance company.
- We Cover the Benefits listed in this Certificate only when they are:
    - provided in accordance with this Certificate;
    - provided by a Participating Provider (except for emergency care, or when Preauthorized by MHP Community); and
    - otherwise Preauthorized or approved by MHP Community, when required.
- All Benefits are subject to the limitations and exclusions listed in this Certificate.
- The Benefits listed in this Certificate are Covered only when they are Medically Necessary. Medical Necessity is determined by MHP Community. If a service or item is determined to be not Medically Necessary, even if this determination is made after the service is provided to you, it may be a Non-Covered Service and you may be required to pay the provider for the Non-Covered Service.
- You are responsible for Copayments, Coinsurance and Deductibles for many of the Benefits listed. (See Section 8.1 and the Schedule of Cost Sharing.) Copayments, Coinsurance and Deductibles do not apply to Preventive Services provided in accordance with this Certificate (see Section 8.3 of this Certificate).

- MHP Community does not limit Coverage based on genetic information, and it will not adjust Premiums based on genetic information, request/require genetic testing or any collected or acquired genetic information from an individual at any time for underwriting purposes.
- This Certificate does *not provide* Coverage for pediatric dental services. Please note, however, that "pediatric dental services" are an Essential Health Benefit and are therefore required to be covered. If you purchase this MHP Community Coverage on the Michigan Marketplace, you may purchase pediatric dental coverage from a stand-alone dental carrier offering coverage on the Michigan Marketplace. If you purchase this MHP Community Coverage off of the Michigan Marketplace, you must provide us with reasonable assurance that you have purchased a stand-alone dental plan with pediatric dental coverage as a condition of MHP Community agreeing to provide this MHP Community Coverage.
- If you enrolled in an MHP Community Rewards Plan, Rewards Providers are limited to those listed in the MHP Community Provider Directory. Note that in no case will you be entitled to receive reduced or eliminated cost sharing for providers that are not Rewards Providers. (This includes, but is not limited to, situations where: 1) you receive services at a Rewards Provider facility, but are treated by a non-Rewards Provider (e.g. an ER physician, anesthesiologist, etc.), 2) you are referred by a Rewards Provider to a non-Rewards Provider, 3) when there are no Rewards Providers available to perform your requested service, or 4) your Rewards Provider sent labs, pathology or any other services to a non-Rewards Provider. Note – there is no coverage for prescription drugs through a Rewards Provider.
- This Coverage is Guaranteed Renewable unless Terminated under Part 5.
- The following only applies if you are enrolled in a High Deductible Health Plan (as identified in your Application and on the Schedule of Cost Sharing). This Plan is intended to meet the "High Deductible Health Plan" requirements set forth in Section 223 of the Internal Revenue Code ("**IRC**") and its subsequent notices, revenue rules, revenue procedures and amendments, if any. If any part of this Certificate, including the Schedule Cost Sharing or any Riders does not conform to the IRC High Deductible Health Plan requirements, we will interpret it to conform to the IRC High Deductible Health Plan requirements and amend the Certificate accordingly. Members enrolled in a Zero Cost Sharing or Limited Cost Sharing plan are not eligible for a High Deductible Health Plan because the plans do not conform to the IRC rules.
- Balance Billing may also occur if you receive Covered Services at a Participating Provider facility but see a Non-Participating Provider in the facility and an Applicable Surprise Billing Law does not apply or you agree to the charges. Applicable Surprise Billing Laws do not cover all services and in some cases you could consent to Balance Billing. For Non-Emergency Covered Services provided at a Participating Provider facility, you can contact MHP Community in advance to ask whether Balance Billing could occur at that facility.
- You could be billed by a provider for Non-Covered services. Please ensure that your services are Medically Necessary *before* receiving the services. See Section 3.8 below for more information on how we determine Medical Necessity. You can view the medical necessity criteria in our member portal and you can contact Customer Service at (888) 327-0671 if you have any questions.
- Your Network provides comprehensive coverage. Review the Provider Directory for your Network and contact Customer Service for details on where to obtain Covered Services by Participating Providers. In most cases, there is no need for you to obtain services by a Non-Participating Provider. Except for Emergency Services (see Section 8.6 for details) or if services are specifically Preauthorized (see Section 8.2.1 for details), MHP Community does not provide Coverage for Non-Participating Providers.

- You should always request to have your labs, pathology and other services sent to a Participating Provider in order to avoid Balance Billing. Except if required by applicable law, we will not pay for labs, pathology and other services sent to a Non-Participating Provider, even if they were sent by a Participating Provider and may not be Covered Services or Balance Billing could apply because the services are not covered by Applicable Surprise Billing Laws or you consented to be Balance Billed.
- As it relates to MHP Community, MHP Community complies with Applicable Surprise Billing Laws.

ANTI-DISCRIMINATION

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

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

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

If you believe that MHP Community has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a Grievance with MHP Community's Compliance Officer, G-3245 Beecher Rd., Flint, MI 48532, call: (866) 866-2135, TTY 711, Fax: (877) 733-5788, or Email mhpcompliance@mclaren.org.

You can file a Grievance in person or by mail, fax, or email. If you need help filing a Grievance, MHP Community's Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

Syriac/Assyrian:

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܡܦܠܚܝܬܘܢ ܡܢ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-888-327-0671 (TTY: 711)

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

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

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

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

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-327-0671 (TTY: 711)।

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

Adverse Benefit Determination means any of the following:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigation or not Medically Necessary or appropriate; or
- A Rescission of Coverage determination

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

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

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

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

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

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

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

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

Calendar Year is a period of time beginning January 1 and ending December 31 of the same year.

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

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

Child, for purposes of Child Only Coverage, is an individual under 21 years of age.

Child Only Coverage means Coverage under this Certificate where all Members are under 21 years of age.

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

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

Coinsurance is a percentage of MHP Community's Reimbursement Amount that the Member is responsible to pay for certain Benefits. The Coinsurance applies to the Out-of-Pocket Maximum. Refer to the Schedule of Cost Sharing and applicable Rider(s) to verify which Benefits have a Coinsurance requirement.

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

Cost-Sharing is the Copayment, Coinsurance and/or Deductible that is the Member's responsibility as outlined in the Schedule of Cost-Sharing.

Covered Services, Coverage, Cover or Covered means those Benefits that the Member is entitled to under this Certificate, if they are Medically Necessary and have met all other requirements of this

Certificate. This Certificate (including the Schedule of Cost Sharing and applicable Riders) describes what MHP Community will pay for some services and supplies.

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

Deductible is the annual amount of money payable by you or Member for Covered Services. A Member's Deductible(s) is/are included in the Schedule of Cost Sharing and any applicable Rider(s). If you have multiple Deductibles, that will be outlined in your Schedule of Cost Sharing. The Deductible(s) applies/apply to your Out-of-Pocket Maximum. You have a combined pharmacy and medical services Deductible unless the Schedule of Cost Sharing provides for a separate Pharmacy Deductible. The annual Deductible(s) resets on January 1 of each year.

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

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

Effective Date means the date Coverage under this Certificate begins.

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

Enrollment is the process of submitting a completed enrollment form and paying the necessary Premium to MHP Community to receive Coverage.

Family Dependent or Dependent means one of the following:

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

Grievance means a formal complaint on behalf of a Member concerning any of the following:

- The availability, delivery, or quality of health care services, including a complaint regarding an Adverse Benefit Determination made pursuant to utilization review;
- Benefits or claims payment, handling, or reimbursement for health care services;
- Matters pertaining to the contractual relationship between a Member and MHP Community; or
- Other expressions of dissatisfaction not related to an Adverse Benefit Determination.

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

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

Infertility means a disease, condition, or status characterized by:

- a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility;
- a Member's inability to reproduce either as a single individual or with a partner without medical intervention; or
- a licensed physician's findings based on a Member's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

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

Legal Representative, for purposes of Child Only Coverage, is the (i) parent of eligible individuals, whether by birth, legal adoption or placement; or (ii) the court-appointed Guardian of the eligible individual.

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

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

Member is the Subscriber, an eligible Dependent, or an eligible Child covered by and entitled to Benefits under this Certificate.

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

Michigan Health Insurance Marketplace or Michigan Marketplace is the program through which an individual may purchase health coverage for him or herself and eligible dependents. For more information, visit HealthCare.gov.

Native American or **Indian** is any person who is a member or any Indian Tribe, Band, Nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, and as defined by the Indian Health Care Improvement Act (IHCIA) or Section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA).

Network is the network of Participating Providers that have contracted with MHP Community to provide Covered Services under this Agreement for your Plan. The Network for your Agreement may be different than the Networks for our other plans. Contact Customer Service at (888) 327-0671 or go to our website at www.McLarenHealthPlan.org to find the Provider Directory for your Network. Participating Providers are limited to those in your Network.

Newborn is a child 30 days old or younger.

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

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

Open Enrollment Period is a period of time each year when an Eligible person may enroll in or disenroll from MHP Community.

Out-of-Pocket Maximum is the most you have to pay for certain expenses related to Covered Services during a Calendar Year. The Out-of-Pocket Maximum includes your medical and pharmacy Deductible, Copayment and Coinsurance. This limit never includes your Premium, Balance Billed charges or health care services or supplies that are not Covered Services.

Participating Provider is a provider or licensed facility directly contracted with MHP Community to provide services to MHP Community Members in your Network. For Members who are Native American (as defined above), Participating Providers include Indian Health Service/Tribal/Urban Indian Health (I/T/U) providers. Note, however, that if an I/T/U provider has not directly contracted with MHP Community, the Member may be responsible for Balance Billing. Members who utilize a Participating Provider in their Network (with any required Preauthorizations) will avoid significant out-of-pocket

expenses. Participating Provider agreed not to seek payment from you for Covered Services except for permissible Deductible, Copayment and Coinsurance.

Plan Year is the 12-consecutive-month period determined by the Group during which Coverage is provided per the Group's plan documents.

Preauthorized Service, **Preauthorization, Preauthorize, Prior Authorized or Prior Authorization** relates to a Benefit that is required to be authorized or approved by MHP Community prior to obtaining the care or service. If such a service is not authorized or approved, it is not a payable Benefit unless provided as an emergency or urgent care service. See Section 8.2 for more information about when and how to obtain a Preauthorization. Note that references to "Prior Authorized" or "Prior Authorization" are specific to pharmacy Benefits. Unless specifically stated otherwise in this Certificate, the requirements related to "pre" authorized services apply to "prior" authorized services.

Premium is the amount prepaid monthly for MHP Community Coverage.

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

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

Qualifying Events are events that qualify an individual to enroll in this plan outside of the Open Enrollment Period. Circumstances that may be considered as a Qualifying Event include, but are not limited to, marriage, birth, adoption, and other circumstances required under state or federal law.

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

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

Reimbursement Amount is the maximum amount MHP Community will pay for a Benefit. MHP Community's payment methodology is available upon request. Contact Customer Service at (888) 327-0671 for more information.

Rewards Providers are a subset of MHP Community Participating Providers. If you enrolled in an MHP Community Rewards Plan, when you receive services from Rewards Providers, your standard Copayments, Coinsurance and Deductible may be reduced or eliminated. Please review the Schedule of

Cost Sharing for information specific to each Covered Service. “Rewards Providers” are identified in the MHP Community Provider Directory. **NOTE:** In no case will you be entitled to receive reduced or eliminated cost sharing for providers that are not Rewards Providers. (This includes, but is not limited to, situations where: 1) you receive services at a Rewards Provider facility, but are treated by a non-Rewards Provider, 2) you are referred by a Rewards Provider to a non-Rewards Provider, 3) when there are no Rewards Providers available to perform your requested service) or 4) your Rewards Provider sent labs, pathology or any other services to a non-Rewards Provider.

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

Schedule of Cost Sharing means the document included as a part of this Certificate that details any Copayment, Coinsurance and/or Deductible that is the Member’s responsibility. Although a service is listed in the Schedule of Cost Sharing, it may require MHP Community Preauthorization in order to be a payable Benefit. Benefits are subject to all conditions, exclusions and/or limitations contained in this Certificate.

Service Area is the geographic area made up of counties or parts of counties, where MHP Community has been authorized by the state of Michigan to market and sell our health plans and where the majority of our Participating Providers are located. Your Service Area may be smaller than MHP Community’s entire Service Area depending on the Network covering your Agreement. Contact Customer Service at (888) 327-0671 for more information about your Service Area.

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

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

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

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

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

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

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

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

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

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

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

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

Virtual PCP Plan means a plan that a member enrolls in that provides Virtual Visits at reduced cost-sharing. If you have questions about whether you enrolled in a Virtual PCP Plan, please check your application materials or contact Customer Service at (888) 327-0671.

Virtual Visit means, for only those enrolled in a Virtual PCP Plan, a secure real-time health care service, delivered by a McLarenNow provider or a mental health or behavioral health Participating Provider

using secure video on a smartphone, tablet, or computer with a webcam. Virtual Visits are available for the purpose of diagnosing, treating, or providing other medical treatment for Covered Services. Contact for these services must be initiated by you or your Participating Provider and must be within your Participating Provider's scope of practice. Virtual Visits are subject to the same Preauthorization requirements as services rendered in an in-office setting.

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

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

MHP Community Subscribers and Members must meet Eligibility requirements established by MHP Community and, as applicable, the Michigan Marketplace. Members enrolling through the Michigan Marketplace must also meet Marketplace eligibility requirements. Certain requirements depend on whether the individual is:

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

Note: If you are a minor Child, you are eligible for Child Only Coverage.

1.1 ELIGIBILITY

1.1.A Subscriber

1.1.A.1. Non-Native American Subscriber

A Subscriber must meet all of the following:

- Be an adult age 21 or over, or be under 21 years of age for Child Only Coverage as allowed by the Marketplace;
- Be a citizen, national or non-citizen lawfully present in the United States, and reasonably expected to remain so for the entire period for which enrollment is sought;
- Live in the MHP Community Service Area at least nine (9) months out of the year;
- Not be enrolled in group coverage;
- Not be enrolled in other health care coverage as a subscriber or dependent, including but not limited to Medicare or Medicaid;
- Not be incarcerated; and
- Submit a completed and signed enrollment form and the required Premium

1.1.A.2. Native American Subscriber

In addition to the eligibility requirements described above in Section A.1. there are special eligibility standards and processes for Native American Subscribers:

- If you are a verified American Indian or Alaskan Native, you are permitted to change your health plan selection a maximum of once every 30 days. The Michigan Marketplace will check your tribal status against available federal data sources or a roster of tribe members from an authorized representative of your federally recognized tribe, if provided. If the Exchange cannot verify your status as a tribe member, you may be required to provide other proof of tribal status. Please note that if you change your plan selection, all of your plan accumulators such as Deductibles and Out-of-Pocket Maximums will be reset under the new plan.
- If you are an American Indian or Alaskan Native, you may be eligible for a plan with no cost sharing requirements; you will not pay Deductibles, Coinsurance, or Copayments. To qualify for these special cost sharing reductions:
    - You must be eligible for advanced premium tax credits (sometimes referred to as subsidies);
    - Your household income must be no more than 300% of the Federal Poverty Level; and
- You must be enrolled in a health plan in the individual market through the Michigan Marketplace.

  If you are an American Indian or Alaskan Native, and your household income exceeds 300% of the Federal Poverty Level, you may be eligible for a Limited Cost Sharing Plan. Any such Plan must be purchased in the individual market through the Michigan Marketplace.

  Further, federal law requires MHP Community to eliminate cost sharing for a Native American Member, regardless of household income, for Covered Services furnished directly by the Indian Health Service, and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services, and prohibits MHP Community from reducing payments to any such entity for such Covered Services. **Note**: Cost Sharing is waived for Covered Services at Participating Providers for certain Native American plans. See your Schedule of Cost Sharing for more information.

1.1.B Family Dependents

A Family Dependent may be:

- The legally married Spouse of the Subscriber; or
- A child of the Subscriber or of the Subscriber's Spouse, by birth, legal adoption, or legal guardianship (see Subsection D below) who has not attained the age of 26 years.

And MUST:

- Be a citizen, national or non-citizen lawfully present in the US and reasonably expected to remain so for the entire period for which enrollment is sought; and
- Not be incarcerated.

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

A Dependent child's Coverage Terminates at the end of the calendar year in which he or she becomes 26 years old.

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

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

The Subscriber must submit to MHP Community the proof of the disability and dependence within 30 days of the child's 26th birthday. MHP Community may require annual proof of continued disability and dependence.

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

1.1.C. Dependent under a Qualified Medical Child Support Order or "QMCSO"

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

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

1.1.D. Court-Appointed Guardianship

A Family Dependent may include a child for whom the Subscriber or the Subscriber's Spouse is the court-appointed permanent or limited guardian. The child may be enrolled from the moment he or she is in your physical custody. We will not Cover any expenses incurred for the child's health care before the child is in your physical custody. "Physical custody" means that the child is legally and physically placed in your home. You must give MHP Community acceptable proof that the child meets the above requirements (for example, the court order) within 31 days of MHP Community's request of proof. The child is eligible for Coverage until the end of the day on which the child turns 18 years of age.

1.1.E. More Than One Child – Child Only Coverage

For more than one child to be eligible to be Covered under the same Child Only contract:

- Each of the individuals must meet the eligibility requirements above and have one common parent and/or one common other Legal Representative; and
- The Legal Representative of the individuals must sign the application and agrees to be responsible for Premiums for Coverage for the eligible individuals.

1.2 ENROLLMENT

To enroll in this MHP Community plan you must complete an enrollment form. On that form you must list each person being enrolled, and give the information asked about for each person.

If you purchase this plan through the Michigan Marketplace, you will complete an enrollment form through the Marketplace website (Healthcare.gov) and provide authorization for Premium payments.

Open Enrollment Period for Subscribers and Family Dependents

You may enroll yourself and your eligible Family Dependents during an annual Open Enrollment Period.

If you are a verified American Indian or Alaskan Native, you are permitted to change your health plan selection a maximum of once every 30 days. The Marketplace will check your tribal status against available federal data sources or a roster of tribe members from an authorized representative of your federally recognized tribe, if provided. If the Michigan Marketplace cannot verify your status as a tribe member, you may be required to provide other proof of tribal status. Please note that if you change your plan selection, all of your plan accumulators such as Deductibles and Out-of-Pocket Maximums will be reset under the new plan.

Special Enrollment of Newly Eligible and Dependents

Certain events may qualify you to enroll in this plan outside of the Open Enrollment Period. These are called Qualifying Events. If you purchased your Coverage off the Michigan Marketplace, you are entitled to a 30-day Special Enrollment Period from the date of the Qualifying Event. If you purchased your Coverage on the Michigan Marketplace, you must check with HealthCare.gov to determine the length of the Special Enrollment Period.

(1) New Family Dependents

If you are already enrolled in this MHP Community plan and you gain a new Dependent as a result of marriage, birth, adoption, placement for adoption or legal guardianship you may add your new Dependent. This plan Covers a Subscriber's Newborn child initial stay in connection with the delivery for up to 48 hours for a vaginal delivery and up to 96 hours following a cesarean section, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. In order to continue coverage for a newborn child beyond the initial 48 hours following a vaginal delivery or the first 96 hours following a cesarean, and you are Covered under a Michigan Marketplace plan, you must add the Newborn at HealthCare.gov within 60 days after the child is born. If you purchased your plan off the Michigan Marketplace, fill out and return a change form to us within 31 days after the child is born.

The Plan covers Hospital and professional inpatient claims for an eligible newborn child's initial stay in connection with the delivery for up to 48 hours for a vaginal delivery and up to 96 hours following a cesarean section. In order to continue coverage for a newborn child beyond the initial 48 hours following a vaginal delivery or the first 96 hours following a cesarean, the baby must be enrolled within the 60-day period following birth if you are Covered under a Michigan Marketplace plan or within 31 days if you purchased your plan off the Michigan Marketplace. Note – additional premiums may apply.

(2) Loss of Other Coverage

If you lost other minimum essential coverage, including Medicaid, you may enroll yourself and/or your Family Dependent if you meet MHP Community or Marketplace requirements.

(3) Other Events and Circumstances

- Change in citizenship, state, national or lawfully present status; or
- You lose eligibility with MHP Community but gain access to another health plan as a result of a permanent move; or
- You meet other exceptional circumstances expressly allowed under state or federal law.

You must submit your request for enrollment or request for change in enrollment within the time periods established by MHP Community (or if applicable, the Marketplace) along with written proof of the event. In most cases this is within 31 days of the date of the qualifying life event. Contact MHP Community for more information.

NOTE: If you do not enroll yourself and/or your eligible Family Dependents during the applicable MHP Community or Michigan Marketplace timeframe, you cannot enroll until the next Open Enrollment Period.

If you lose coverage under another health plan for one of the following reasons, you and your Family Dependents are *not* eligible for Special Open Enrollment:

- You did not pay your share of the Premiums on a timely basis;
- Your coverage was Terminated for cause such as for making a fraudulent claim or giving false information; or
- You voluntarily drop your other coverage mid-year for any reason, including an increase in Premium or change in Benefits.

Notification of Change in Status or Other Changes that Affect Coverage and Eligibility

Notify us or the Marketplace, as applicable, about any changes that affect your Coverage under this Certificate. For example, notify us if any of the following happens to anyone Covered under this Certificate:

- Change of Primary Care Physician (PCP);
- Change of address or state of residence;

- Change in Covered Dependent status;
- Enrolling in coverage under a group health plan;
- Eligibility for federal, state, county or local governmental or quasi-governmental health coverage; or
- Coverage by any other insurance or health plan.

These are examples only. Let us know about any change that, according to the terms of this Certificate, affects your Coverage or Coverage for your Covered Dependents.

1.3 EFFECTIVE DATES AND DURATION OF COVERAGE

Enrollment Effective Dates for Subscribers and eligible Family Dependents follow the rules established by MHP Community or the Michigan Marketplace, and are based on the day you enroll in the plan. The first day of Coverage is either the first of the month following enrollment or the first of the second month following enrollment. There are exceptions for certain Special Enrollment Qualifying Events that allow an individual to make a plan selection or add Family Dependents outside of the annual Open Enrollment Period.

Special Enrollment Period Coverage Effective Dates depend on the type of event, the date of request of the Special Enrollment and the date of plan selection.

Unless this Coverage is Terminated pursuant to Part 5 of the Certificate or renewed at the next Annual Enrollment, this Coverage will end on the last day of the Calendar Year in which it was purchased.

Annual Enrollment

Coverage for you and your Family Dependents begins on the first day of January following enrollment acceptance.

Special Enrollment Period

Enrollment Effective Dates related to a special enrollment period for Subscribers and eligible Family Dependents follow the rules established by MHP Community and the Michigan Marketplace (if applicable).

If enrollment is retroactive, all terms and provisions of this Certificate, such as Preauthorization requirements and the use of Participating Providers, apply for services to be Covered during that time.

NOTE: If you do not enroll yourself and/or your eligible Family Dependents during the applicable MHP Community or Michigan Marketplace timeframe, you cannot enroll until the next Open Enrollment Period.

1.4 ADDITIONAL ELIGIBILITY GUIDELINES

The following guidelines apply to **all** Members:

- Medicare: If a Member is enrolled in Medicare he/she is not eligible to purchase an individual plan;
- Change of Status: You agree to notify MHP Community within 30 days of any change in eligibility status of you or any Family Dependents. When a Member is no longer eligible for Coverage, he or she is responsible for payment for any services or Benefits;
- Members admitted to a Hospital or Skilled Nursing Facility prior to the Effective Date of Coverage will be Covered for Inpatient care on the Effective Date of the Certificate only if the Member has no continuing coverage under any other health Benefits, contract, program or insurance.

PART 2: OTHER PARTY LIABILITY

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

2.1 NON-DUPLICATION

- MHP Community provides each Member with full health care services within the limits of this Certificate.

- MHP Community does not duplicate Benefits or pay more for Covered Services than the actual fees.

- Coverage for Member's Benefits will be reduced to the extent that the Benefits are available or payable under any other certificate or policy covering the Member, whether or not a claim for the Benefits is made.

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

2.2 AUTO POLICY AND WORKERS' COMPENSATION CLAIMS

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

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

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

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

2.3 COORDINATION OF BENEFITS (COB) AND SUBROGATION

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

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

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

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

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

Coordination of Benefits or COB means determining which Certificate or policy is responsible for paying Benefits for Covered services first (primary carrier) when a member has dual coverage. Benefit payments are coordinated between the two (2) carriers to provide 100% coverage whenever possible for services Covered in whole or in part under either plan, but not to pay in excess of 100% of the total amounts to which providers or Members are entitled. Except as otherwise stated in this Certificate, MHP Community will coordinate Benefits in accordance with Michigan law, and specifically PA 275 of 2016; MCL 550.251, *et seq.*

If the carriers that issued plans cannot agree on the order of Benefits within 30 days after the carriers have received all of the information needed to pay the claim, the carriers shall immediately pay the

claim in equal shares and determine their relative liabilities following payment. A carrier is not required to pay more than it would have paid had the plan it issued been the primary plan.

COB WITH MEDICARE

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

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

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

COB ADMINISTRATION

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

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

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

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

SUBROGATION

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

- When you accept an MHP Community ID card, you agree that, as a condition of receiving Benefits and services under this Certificate, you will make every effort to recover funds from the liable party. If you recover any funds for Benefits paid by MHP Community, you will reimburse MHP Community. MHP Community shall have a lien against any such recoveries of funds whether by judgment, settlement, compromise or reimbursement. This applies no matter how the recovered funds are designed, i.e., economic or non-economic damages.
- When you accept an MHP Community ID card, it is understood that you acknowledge MHP Community's right of subrogation. If MHP Community requests, you will authorize this action through a subrogation agreement. If a subrogation lawsuit by you or by MHP Community results in a financial recovery greater than the services and Benefits provided by MHP Community, MHP Community has the right to recover its legal fees and costs out of the excess.
- By accepting Benefits, you and your covered dependents assign to MHP Community any rights you or they may have to recover all or part of the same covered expenses from another source, including another group health plan, insurer or individual, limited, however, to the amount of covered expenses MHP Community has paid on behalf of you and/or your covered dependents. This assignment also grants MHP Community a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage. By virtue of the assignment, MHP Community is entitled to recover 100 percent of the covered expenses it has paid on behalf of you or your covered dependents from all recoveries from a third party (whether by lawsuit, settlement or otherwise). This assignment allows MHP Community to pursue any claim that you may have against a third party, or its insurer, whether or not you choose to pursue that claim.
- This assignment entitles MHP Community to be reimbursed on a first-dollar basis (that means that MHP Community will have a first priority claim to the recovered funds), whether the funds paid to or for the benefit of you and/or your covered dependents amounts to a full or partial recovery, or whether the funds paid are designated for non-medical charges, attorney fees, pain and suffering, or other costs and expenses. MHP Community's share of the recovery will not be reduced because you or your covered dependent has not received the full damages claimed, unless MHP Community agrees in writing to a reduction.

- MHP Community has an equitable lien against any money or property you or your Covered Dependents recover from any party, including an insurer, another group health plan or individual, but only to the extent of the covered expenses that MHP Community has paid.
- This and any other provisions of the Certificate concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under applicable law and relevant case law. MHP Community's provisions concerning subrogation, equitable liens, and other equitable remedies are also intended to supersede the applicability of the common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.
- You or your representative will do whatever is necessary to enable MHP Community to implement the provisions of this Section. If you hire a lawyer to pursue a claim, you must inform the lawyer of MHP Community's rights under this Certificate. When reasonable collection costs and legal expenses are incurred in recovering amounts that benefit both you and MHP Community, the costs and legal expenses will be divided equitably.
- You agree not to compromise or settle a claim or take any action that would prejudice the rights and interests of MHP Community without getting MHP Community's prior written consent.
- If you refuse or do not cooperate with MHP Community regarding subrogation, it will be grounds for terminating Membership in MHP Community or the reduction of future benefits under the Plan by an amount up to the aggregate amount paid by MHP Community that was subject to MHP Community's equitable lien, but for which MHP Community was not reimbursed.

PART 3: MEMBER RIGHTS AND RESPONSIBILITIES

3.1 CONFIDENTIALITY OF HEALTH CARE RECORDS

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

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

3.2 INSPECTION OF MEDICAL RECORDS

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

3.3 PRIMARY CARE PHYSICIAN (PCP)

You must select a PCP from the list of MHP Community Participating Providers. You may select any available PCP. We recommend that you choose a PCP that is located in your geographic area. (You

have the option of choosing an MHP Community pediatrician as the Primary Care Physician for a child under the age of 18 years.) MHP Community will make every attempt to honor your choice.

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

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

3.4 REFUSAL TO ACCEPT TREATMENT

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

If you refuse the treatment recommended, and the physician believes that no other medically acceptable treatment is appropriate, the physician will notify you. If you still refuse the treatment or request procedures or treatment that MHP Community regards as medically or professionally inappropriate, MHP Community is no longer financially or professionally responsible for providing Coverage for the condition or resulting complications.

3.5 COMPLAINT, GRIEVANCE AND APPEALS PROCEDURES

MEMBER COMPLAINTS

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

STANDARD GRIEVANCES

Members are encouraged to call Customer Service at (888) 327-0671 if they have questions or concerns. MHP Community staff will try to resolve your concerns during the initial contact. If you are still dissatisfied with MHP Community's response, you may file a formal Grievance. Customer Service staff are available to assist you with filing a Grievance. Customer Service will assist you in documenting your Grievance. The Grievance process will be completed within 30 days. MHP Community will acknowledge receipt of your Grievance in writing within five (5) days of receipt. MHP Community will investigate your

Grievance and provide you with a written determination within 15 days of receipt of your Grievance. If you are not happy with our decision you may appeal to MHP Community in writing or by phone, so long as your appeal is received within five (5) days of our written determination. MHP Community will review your Grievance appeal and provide you with a written determination within 30 days from the initial date of your Grievance.

EXPEDITED GRIEVANCES

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

STANDARD INTERNAL APPEALS

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

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

Email: MHPAppeals@mclaren.org

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

You may request copies of information relevant to your appeal, free of charge, by contacting Customer Service at (888) 327-0671.

MHP Community will provide you with any additional evidence considered, relied upon or generated by MHP Community in connection with your appeal, as soon as possible and sufficiently in advance of the date on which the decision is required to be made, so that you have a reasonable opportunity to respond.

We will provide you with any new or additional rationale for a denial of your claim or appeal as soon as possible and sufficiently in advance of the date on which the decision is required to be made, so that you have a reasonable opportunity to respond.

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

Members have the right to ask MHP Community to arrange a meeting with the appeal review committee. Members or an authorized representative may attend the meeting in person or by telephone. A person not involved in the initial decision will review the appeal. If the Appeal is based in whole or in part on medical judgment, the person who reviews the appeal will be of the same or similar specialty as would typically manage the care.

MHP Community has 30 days to complete the internal appeal process for a pre-service appeal request, and 60 days for a post-service appeal request. These time periods may be extended if requested by the Member. MHP Community may also extend the time period for up to 10 business days if it has requested information from a health care facility or health professional and has not received it. You will receive written notification of the final determination within three (3) days after the decision is made. In addition, we may also notify you orally.

EXPEDITED INTERNAL APPEALS

Members or their authorized representatives may request an expedited appeal either orally or in writing. For expedited appeals, a Member's health care practitioner, with knowledge of the Member's condition, will be allowed to act as the members authorized representative. Where time is of the essence and when the practitioner represents that he/she has the member's permission to act as the Member's representative for the expedited internal appeal, the practitioner may act as the Member's representative for purposes of the expedited internal appeal without written or oral Member authorization.

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

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

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

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

EXTERNAL REVIEW

If after your appeal we continue to deny payment, Coverage, or the service requested, or you do not receive a timely decision, you can ask for an external review with the State of Michigan, Department of Insurance and Financial Services (DIFS). You must do this within 127 days of receiving MHP Community's appeal decision. If you are not required to exhaust MHP Community's appeals process, you must do this within 127 days from receiving MHP Community's appeal decision. MHP Community will provide the form required to file an external appeal. **Note** – External review may be available related to MHP Community's compliance with Applicable Surprise Billing Laws. Requests should be sent to DIFS in one of the following ways:

Mail:
DIFS – Office of General Counsel – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Courier/Delivery service:
DIFS – Office of General Counsel – Appeals Section
530 W. Allegan St., 7th Floor

Lansing, MI 48933-1521

Toll Free Telephone: 1 (877) 999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

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

EXPEDITED EXTERNAL APPEALS

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

Mail:
DIFS – Office of General Counsel – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Courier/Delivery service:
DIFS – Office of General Counsel – Appeals Section
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521

Toll Free Telephone: 1 (877) 999-6442
Fax: 517-284-8838

Email: DIFS-HealthAppeal@michigan.gov

Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx
When appropriate, DIFS will request a recommendation by an Independent Review Organization ("**IRO**"). The IRO is not contracted with or related to MHP Community. DIFS will issue a final order.

3.6 FORMULARY EXCEPTION REQUESTS – PRESCRIPTION DRUGS

Definitions:

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

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

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

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

Process:

Standard Formulary Exception Requests.

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

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

If MHP Community grants the Formulary Exception, Coverage of the Non-Formulary Drug will be provided for the until MHP Community Coverage Terminates or through the time period required by applicable law, whichever occurs first. Cost-sharing of an approved Formulary Exception Drug will be at the Tier 3 or Tier 4 level (as determined by MHP Community). See your Schedule of Cost Sharing.

Expedited Formulary Exception Requests.

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

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

If MHP Community grants the Formulary Exception based on Exigent Circumstances, Coverage of the Non-Formulary Drug will be provided until MHP Community Coverage Terminates or through the time period required by applicable law ends, whichever occurs first. Cost-sharing of an approved Formulary Exception Drug will be at the Tier 3 or Tier 4 level (as determined by MHP Community). See your Schedule of Cost Sharing.

External Exception Request Review.

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

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

If MHP Community grants the Formulary Exception, Coverage of the Non-Formulary Drug will be provided for the until MHP Community Coverage Terminates or through the time period required by applicable law, whichever occurs first. Cost-sharing of an approved Formulary Exception Drug will be at the Tier 3 level or Tier 4 level (as determined by MHP Community). See your Schedule of Cost Sharing.

3.7 CONTINUING CARE AS A RESULT OF TERMINATION OF A PARTICIPATING PROVIDER'S CONTRACT WITH MHP COMMUNITY

Definitions:

<u>Continuing Care Patient</u>

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

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

<u>Serious and Complex Condition</u>

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

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

Process:

A Participating Provider may choose to terminate his/her contract or arrangement with MHP Community. Therefore, MHP Community cannot guarantee that a given Participating Provider will be available to treat a Member during the entire time the Member Is Covered by MHP Community. If a Participating Provider informs a Member that the Provider will no longer be contracting with MHP Community, the Member should contact MHP Community's Customer Service Department at (888) 327-0671 as soon as possible.

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

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

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

- Notify Members who are Continuing Care Patients of the termination and of their right to elect transitional care from Participating Provider,

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

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

3.8 INFORMATION USED TO DETERMINE MEDICAL NECESSITY

You have the right to request and ask for and be given, without cost, a copy of the actual benefit provisions, guidelines, protocol, clinical review criteria or other information used to determine Medical Necessity. All requests must be sent in writing to MHP Community Customer Service Department, G-3245 Beecher Road, Flint, MI 48532. MHP Community's Medical Necessity criteria is available for your review in our portal (McLaren CONNECT) on our website at www.mclarenhealthplan.org.

PART 4: FORMS, IDENTIFICATION CARDS, RECORDS AND CLAIMS

4.1 FORMS AND APPLICATIONS

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

4.2 IDENTIFICATION CARD

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

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

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

4.3 MISUSE OF IDENTIFICATION CARD

If any MHP Community Member does any of the following:

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

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

4.4 MEMBERSHIP RECORDS

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

4.5 FILING A CLAIM

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

You are responsible for the costs of any services you receive from a Non-Participating Provider, unless MHP Community Preauthorizes the services in advance, or for certain Covered Services related to a Medical Emergency. See Section 8.6 for details on when Emergency Coverage by a Non-Participating Provider.

4.6 MEMBER REIMBURSEMENT

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

PART 5: TERMINATION OF COVERAGE

5.1 TERMINATION FOR NONPAYMENT OF PREMIUM

If you, the Subscriber, fail to pay the Premium – whether in whole or in part, by the due date, the contract is in default.

If you have outstanding Premium payments, you still owe the money and must pay it to MHP Community.

5.1.1 MEMBERS WHO RECEIVE ADVANCED PREMIUM TAX CREDITS (APTC):

If you purchased your Coverage on the Michigan Marketplace and receive APTC *and* you have paid at least one full month of Premium during the current benefit year, you will be given a three-month grace period during which the Premiums must be brought up to date. If you need health care services at any time during the second and third months of the grace period, MHP Community will hold payment for claims beginning on the first day of the second month of the grace period and notify the Participating Provider that we are not paying these claims during this time. If Premiums are not brought up to date within the three-month grace period, your Coverage will be cancelled. Your last day of Coverage will be the last day of the first month of the three-month grace period. All claims for any health services that were provided after the last day of Coverage will be denied, and any Benefits incurred by a Member and paid by MHP Community after the Termination effective date may be charged to the Subscriber or the Member who received the Benefit.

5.1.2 MEMBERS WHO DO NOT RECEIVE ADVANCED PREMIUM TAX CREDITS (APTC):

If you purchased your Coverage on or off the Michigan Marketplace, you do *not* receive APTC *and* you have paid at least one full month of Premium during the current benefit year, a grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the policy shall continue in force. If Premiums are not brought up to date within the one-month grace period, your Coverage will be cancelled. Your last day of Coverage will be the last day of the last month in which a full monthly Premium was received by MHP Community. All claims for any health services that were provided after the last day of Coverage will be denied, and any Benefits incurred by a Member and paid by MHP Community after the Termination effective date may be charged to the Subscriber or the Member who received the Benefit.

5.2 TERMINATION OR NON-RENEWAL OF A MEMBER'S COVERAGE – ADDITIONAL CAUSES

Termination of Coverage means the Member's Coverage will end following notice from MHP Community.

Non-Renewal of Coverage means a Member's Coverage will end at the end of the Calendar Year and may not be continued into the subsequent Calendar Year.

Coverage for a Member may also be Terminated or Non-Renewed for any of the reasons listed below. Such Termination or MHP's decision to Non-Renew Coverage is subject to 30 days' notice (including the reason for the Termination or Non-Renewal) and, if applicable, Grievance rights, and is effective on the date specified by MHP Community or the Michigan Marketplace.

- The Member enrolled in a Michigan Marketplace plan is no longer eligible for Coverage through the Michigan Marketplace;
- The Member enrolled with MHP Community off the Michigan Marketplace no longer meets MHP Community eligibility requirements;

- The MHP Community Michigan Marketplace plan is terminated or decertified by state or federal regulators;
- The MHP Community plan is withdrawn from the marketplace by MHP Community in accordance with state and federal laws;
- A contract is cancelled for nonpayment of Premium (see Section 5.1);
- The Member changes products;
- The Member moves out of the MHP Community Service Area;
- The Member enrolled with MHP Community off the Michigan Marketplace ceases to be a member of an association through which the Member has achieved eligibility; or
- The Member commits fraud against MHP Community or a provider of Benefits.

A Member wishing to Terminate Coverage must provide at least 14 days' notice to MHP Community or the Michigan Marketplace (as applicable) of his or her wish to Terminate. Termination by a Member is only permitted in accordance with MHP Community's requirements and as otherwise required by applicable law.

5.3 RESCISSION OF MEMBER'S COVERAGE

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

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

NOTE: Any amounts paid by MHP Community after the event are due and owing from the Member.

5.4 TIME LIMIT ON CERTAIN DEFENSES

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

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

5.5 EFFECT OF TERMINATION OR RESCISSION

If this Certificate is Terminated or Rescinded by MHP Community, neither the Subscriber nor the affected Member(s) will have Coverage under this Certificate as of the effective date of Termination or

Rescission specified by MHP Community. If a Member disagrees with MHP Community's decision to Terminate or Rescind the Member's Coverage, the Member may appeal the decision following the MHP Community Member Appeals Procedure or, as applicable, the Marketplace appeal process. Members will have Coverage under this Certificate until the effective date of Termination or Rescission.

PART 6: LOSS OF COVERAGE BY DEPENDENT

If a Family Dependent ceases to be Eligible for Coverage because of:

- The death of the Subscriber;
- Divorce from the Subscriber; or
- Loss of Dependent status,

the Dependent may apply for separate individual MHP Community coverage. A minor or totally disabled Dependent child that is 26 years or older may be included as a Dependent on a parent's replacement individual MHP Community contract. Under some circumstances, MHP Community child-only individual coverage or MHP Community catastrophic (for individuals ages 21 to 30) is available.

PART 7: GENERAL PROVISIONS

7.1 NOTICE

Any notice that MHP Community is required to give its Members will be:

- In writing;
- Delivered personally or sent by US Mail; and
- Addressed to the Subscriber's last address on record.

7.2 CHANGE OF ADDRESS

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

7.3 HEADINGS

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

7.4 GOVERNING LAW

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

7.5 FILING A LAWSUIT AGAINST MHP COMMUNITY

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

7.6 EXECUTION OF CONTRACT OF COVERAGE

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

7.7 ASSIGNMENT

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

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

7.8 MHP COMMUNITY POLICIES

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

7.9 CONTRACT

Your Contract with MHP Community consists of all of the following:

- This Certificate;
- Any applicable Riders;
- The application signed by the Subscriber;

- The MHP Community identification card; and
- The Schedule of Cost Sharing.

7.10 WAIVER BY AGENTS

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

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

7.11 INFORMATION RECEIVED FROM MHP COMMUNITY CUSTOMER SERVICE

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

7.12 AMENDMENTS

- This Certificate is subject to amendment, modification, or Termination.
- Such changes must be made in accordance with the terms of this Certificate with regulatory approval, if required.

7.13 MAJOR DISASTERS

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

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

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

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

7.14 OBTAINING ADDITIONAL INFORMATION

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

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

7.15 CLERICAL ERRORS

Clerical errors, including but not limited to, an incorrect transcription of Effective dates, typographical errors, Termination dates, or mailings with incorrect information will not change the rights or obligations of you and MHP Community under this Certificate. These errors will not operate to grant additional Benefits, Terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise Terminate. If we identify an error, we may notify you in writing and provide you with the correct document.

7.16 WAIVER

If you or MHP Community waive any provision of this Certificate, you or MHP Community will not be considered to have waived that provision at any other time or to have waived any other provision. Failure to exercise any right under this Certificate does not act as a waiver of that right.

7.17 INFORMATION ABOUT YOUR PREMIUM

Each Premium for a regular billing cycle covers a one-month period.

If you purchased this Coverage on the Michigan Marketplace ("Marketplace") and are eligible for Advanced Premium Tax Credits (APTC's):

- The Marketplace will determine if you are eligible for APTC's;
- You are responsible only for your portion of the Premium, not the APTC; and
- You will receive APTC's only if this Coverage is available on the Marketplace and you purchase this Coverage from the Marketplace.

You will be given a three-consecutive month grace period before we will cancel your Coverage for not paying your Premium when due. If you have health care services at any time during the second and third months of the grace period, we will hold payment for claims for these services beginning on the first day of the second month of the grace period. We will notify your providers that we are not paying these claims during this time.

If we do not receive your payment in full for all Premiums due before the grace period ends, your Coverage will be cancelled. Your last day of Coverage will be the last day of the first month of the three-month grace period. All claims for any health services that were provided after that last day of Coverage will be denied.

If you purchased this Coverage either off the Marketplace or on the Marketplace and are not eligible for Advanced Premium Tax Credits (APTC's):

- You are responsible for the entire Premium amount.
- You must pay your Premium by the due date printed on your bill or coupon. When we receive your payment we will continue your Coverage through the period for which you have paid.
- If any renewal Premium is not paid by the due date, a grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the policy shall continue in force. If Premiums are not brought up to date within the one-month grace period, your Coverage will be cancelled. Your last day of Coverage will be the last day of the last month in which a full monthly Premium was received by MHP Community. All claims for any health services that were provided after the last day of Coverage will be denied, and any Benefits incurred by a Member and paid by MHP Community after the Termination effective date may be charged to the Subscriber or the Member who received the Benefit.
- If any renewal Premium is not paid within the time granted the Member for payment, a subsequent acceptance of Premium by MHP Community or by any agent duly authorized by MHP Community to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Coverage: Provided, however, that if MHP Community or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Coverage will be reinstated upon approval of such application by MHP Community or, lacking such approval, upon the 45th day following the date of such conditional receipt unless MHP Community has previously notified the Member in writing of its disapproval of such application. The reinstated Coverage shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects MHP Community and the Member shall have the same rights thereunder as they had under the Certificate immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Change in Amount of Premium

By giving you 30 days written notice, we may change the Premium mid-year following a change in law or regulation that directly impacts the cost of providing Coverage under this Certificate such as an increase in premium tax or additional mandated coverage to be Covered under this Certificate. Additionally, if there is a change in law or regulation that directly impacts the cost of providing Coverage under this Certificate; we may change the Premium before the renewal of this Certificate.

If there is a Benefit or Premium change, you may Terminate this Certificate by providing at least 14 days written notice. The Termination will be effective on the date of renewal or the date the Premiums change mid-year or as a result of change in law or regulation.

7.18 INDEPENDENT CONTRACTORS

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

7.19 COMPLIANCE WITH LAW

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

7.20 SURPRISE BILLING

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

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

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

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

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

Note: Please review Section 8.6 for more information regarding Emergency Services.

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

PART 8: YOUR BENEFITS

8.1 COPAYMENTS, COINSURANCE AND DEDUCTIBLES

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

8.2 PREAUTHORIZATION AND UTILIZATION REVIEW

8.2.1 Preauthorization

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

Covered Services you receive from a Non-Participating Provider must be Preauthorized in advance by MHP Community in order to be Covered. A referral from your PCP or another Participating Provider is not enough if you want the services to be Covered. A request for Preauthorization for Covered Services from a Non-Participating Provider must be provided to MHP Community prior to receiving services. MHP Community will review the clinical indications and factors of the case and will determine whether the services are available from a Participating Provider. If MHP Community determines the services are not available from a Participating Provider, MHP Community will direct you to the provider deemed to be the most appropriate to address your medical needs and your cost sharing will be no greater than if the services were provided by a Participating Provider. If MHP Community determines that the requested services can be provided by a Participating Provider, you will be responsible for the full costs of services obtained from a Non-Participating Provider. If you do not receive approval from MHP Community prior to seeking Covered Services from a Non-Participating Provider, you will be responsible for the full cost. In no case will MHP Community authorize services from a Non-Participating Provider if the services can be obtained by a Participating Provider, as determined by MHP Community.

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

The complete and detailed list of services requiring Preauthorization is available by calling our Customer Service Department or visiting our website at www.McLarenHealthPlan.org. The list may change throughout the Plan Year in MHP Community's discretion. For benefits that do not involve coverage of a prescription drug, we will provide notification of at least 60 days on our website of a change in a prior authorization requirement. For coverage of a prescription drug, we will provide no less than 45 days notification on our website of a change to a prior authorization requirement. Preauthorizations submitted by a provider must be in compliance with MCL 500.2212e. Providers who are unable to use the standardized process due to a temporary technological or electrical failure may be able to use an alternative process. See our website for details. Also refer to the specific Benefits in Part 8 of this Certificate to see if a Preauthorization is required. Below are the general categories of services and supplies that require Preauthorization by MHP Community:

- Inpatient and long term acute Hospital services, including inpatient mental health or substance abuse treatment;
- Skilled nursing home;
- Outpatient Hospital and clinic services for dorsal spinal stimulators;
- Oral surgery, TMJ treatments and orthognathic surgery;
- Special surgical procedures (see Section 8.12);
- Durable medical equipment (DME) costing more than $3,000;
- Prosthetics, orthotics and corrective appliances costing more than $3,000;
- Insulin pumps and continuous glucose monitors (CGMs);
- Genetic testing (including BRCA testing Covered under Section 8.3);
- Autism services and Applied Behavioral Analysis (ABA Therapy);
- Electroconvulsive therapy (ECT);
- Contact lenses as a part of Pediatric Vision Coverage;
- Routine Patient Costs provided as a part of an Approved Clinical Trial;
- Nuclear medicine testing, MRI, CT and PET scans;
- Non-emergency ground ambulance services;
- Residential Mental Health services;
- Residential Substance Abuse services;
- Partial Hospitalization for Mental Health services;
- Partial Hospitalization for Substance Abuse services;
- Organ and tissue transplants;
- Habilitative services, including Habilitative services for treatment of Autism Spectrum Disorder;
- Outpatient Rehabilitation services;
- Infertility treatment;
- Voluntary sterilization procedures;
- Termination of pregnancy;
- Proton beam radiation;
- Photo chemotherapy;

- Home health care;
- Hospice;
- Gender reassignment surgery;
- Select injectable and infusion medications provided in the office setting or in an infusion center;
- Pain management services;
- Non-emergent or non-urgent services provided by a Non-Participating Provider;
- Inpatient hospice care;
- Gene Therapy - Cellular and Gene therapy, intended to restore defective or insufficient structural or functional proteins (treatment is limited to once per lifetime as indicated in Plan's medical necessity criteria);
- Certain Prescription Drugs.

Timing of Request and MHP Community Response

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

- Except for Urgent Preauthorization Requests, if Preauthorization is required for a service, Preauthorization must be requested at least five (5) business days prior to obtaining the services.
- If the requested service is an Urgent Preauthorization Request, the request for Preauthorization should be submitted to MHP Community by the treating Provider as early in advance of the service as possible. Requests for Urgent Preauthorizations may be made by telephone.

For most non-Urgent Preauthorization Requests, MHP Community or its designee will make a decision within 9 days after receiving the request. After May 31, 2024, for most non-Urgent Preauthorization Requests, MHP Community or its designee will make a decision within 7 days after receiving the request. For Urgent Preauthorization Requests, MHP Community or its designee will make a decision as expeditiously as possible considering the medical condition of the Member, but no later than within 72 hours after receiving the request. MHP Community may extend the 72-hour maximum response time if the Member fails to provide MHP Community with necessary information.

Denial of Request for Preauthorization: If a Member disagrees with a decision regarding a Preauthorization request, the Member or his/her treating practitioner or designee may contact MHP Community to request a re-evaluation of the decision or utilize the appeal process described in Section 3.5 under the heading, **Standard Internal Appeals**.

A Member may request an expedited appeal for denials of Urgent Preauthorization Requests. See Section 3.5, under the heading, **Expedited Appeals.**

8.2.2 Utilization Review

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

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

8.3 PREVENTIVE SERVICES

Generally, Preventive Services are screenings, immunizations, lab tests and other services that help prevent illness or help find diseases or medical conditions before you experience symptoms. Some services are Preventive Services only for specified age groups or genders.

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

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

MHP Community Covers the following general categories of Preventive Services:

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

The following provides more detail about the categories of Preventive Services that are Covered. More detailed information about Covered Preventive Services is available on MHP Community's website at www.McLarenHealthPlan.org. You can also visit the USPSTF website at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ or www.HealthCare.gov. You can also call Customer Service at (888) 327-0671.

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

Physical Exams

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

Immunizations

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

Assessments and screenings Newborn to age 21

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

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

Preventive services for women

Service	Who	Frequency
Obesity prevention in midlife women	Women ages 40 to 60 with normal or overweight body mass index	As needed
Well-woman visits (includes pre-pregnancy, prenatal, postpartum and interpregnancy visits)	Adult women	Annually and/or as needed
Screening for Diabetes in Pregnancy	Women after 24 weeks of gestation (preferably between 24-28 weeks)	Once per pregnancy

Screening for Diabetes after Pregnancy	Women with a history of gestational diabetes mellitus who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.	Initial testing should occur within the first year postpartum. Women not screened in the first year postpartum or those with a negative initial postpartum screening should be screened at least every 3 years for a minimum of 10- years after pregnancy. Those with a positive screening in the early postpartum period, testing should be repeated at least 6 months to confirm. Repeat testing is also indicated for women screened with hemoglobin A1c in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A1c test is less accurate during the first 6 months postpartum.
Breast Cancer Screening (mammography only)	Women aged 40 to at least age 74	Annually or every 2 years
Cervical Cancer Screening (Pap test)	Women aged 21 to 30 years	Every 3 years
Cervical Cancer Screen (Pap test and Co-Testing for (HPV))	Women aged 30 to 65 years	Every 3 years for Pap Test alone or Co-testing for HPV every 5 years
Sexually transmitted infection (STI) counseling	Sexually active women	Annually
HIV screening and counseling	• Women aged 15 and older • Sexually-active women	• At least once during their lifetime • Annually, or as appropriate

Risk Assessment and Prevention Education for HIB Infection	Women aged 13 and older	As needed
Contraceptive methods*, sterilization procedures and patient education and counseling (including instruction in fertility awareness-based methods, including lactation amenorrhea)	Sexually active women	As needed
Breastfeeding support, supplies (including a double electric breast pump and breast milk storage supplies) and counseling	Pregnant and postpartum women	Per pregnancy
Interpersonal and domestic violence screening and counseling	All adolescent and adult women	At least annually and as needed

NOTE:

- "Contraceptive methods" include Coverage for designated contraceptive medications, devices and appliances when prescribed by an MHP Community Participating Provider. Coverage for contraceptives includes Coverage at no cost for at least one drug/device in each of the FDA's categories. Additional terms and conditions of Coverage for most contraceptive medications are found in Section 8.34 Prescription Drug Coverage. Some devices and appliances (e.g., IUD's) are Covered under your medical Benefits and are subject to the medical conditions of Coverage.
- MHP Community also covers, without cost sharing, contraceptive services and FDA approved, cleared, or granted contraceptive products that your attending provider, who is a Participating Provider, and has determined to be medically appropriate for you, even if the contraceptives are not in the categories listed in the then applicable HRSA-Supported Guidelines ("HRSA Guidelines"). This can include contraceptive products more recently approved, cleared, or granted by FDA. Contraceptives must be prescribed and administered by an MHP Community Participating Provider. When obtained through the pharmacy benefit, contraceptives must be ordered by an MHP Community Participating Provider and delivered through a Participating Pharmacy.
- Coverage for contraceptives is subject to reasonable medical management techniques.
    - *HRSA Guidelines* – MHP Community covers at least one contraceptive in each HRSA Guidelines category at no cost sharing. See your Formulary for Covered contraceptives within the HRSA Guidelines.
    - *Outside HRSA Guidelines* - For contraceptives not included in the HRSA Guidelines, MHP Community will use reasonable medical management techniques to determine which products to cover without cost sharing, when multiple, substantially similar services or products that are not included in a category in the HRSA Guidelines are available and are medically appropriate for you.
- If your Participating Provider determines a contraceptive not listed in MHP Community's Formulary is medically necessary (regardless of whether it is in the HRSA Guidelines), you or your Participating Provider may submit an exception to MHP Community in accordance with MHP Community's exceptions process. MHP Community's exceptions process is easily accessible, transparent and when appropriate, expeditious. Please contact Customer Service at (888) 327-0671 for more information on the exception process.

- To the extent required by law, MHP Community will defer to the determination of your attending provider, who is a Participating Provider, that coverage is medically necessary, so you can obtain Coverage for the medically necessary contraceptive service or product without cost sharing.
- Please contact Customer Service at (888) 327-0671 for additional information, and review your drug Formulary at www.mclarenhealthplan.org.

Assessments and Screening for Adults

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

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

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

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

Educational Services

These services include:

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

Tobacco Use Counseling and Interventions for Adults

These services include:

- Screening for tobacco use.
- For those who use tobacco products, MHP Community's Tobacco Cessation Counseling program. (Call Customer Service to request enrollment in the Tobacco Cessation Counseling program.)
- Tobacco cessation Prescription Drugs. (See Section 8.34, Prescription Drug Coverage.)

Drugs Other Than Contraceptive or Tobacco Cessation Medications (Prescription Required)

Recommended ages and who should have these services vary and include, but are not limited to:
- Oral fluoride supplements
- Folic acid supplements
- Iron supplements

Refer to Section 8.34, Prescription Drug Coverage, for Coverage information.

General Limitations:

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

8.4 DIABETIC SERVICES AND SUPPLIES

The following equipment, supplies, related to the treatment of diabetes are Covered if determined to be Medically Necessary and prescribed by the Member's treating Provider:

- Blood glucose monitors;
- Test strips for glucose monitors, visual reading and urine reading strips, and lancets ;
- Insulin pumps and medical supplies required for the use of an insulin pump*;
- Insulin syringes;
- Medications used in the treatment of foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes if prescribed by an allopathic, osteopathic or podiatric physician; and
- Diabetes self-management training is Covered under Educational Services (see Section 8.31).

*** Note**: Insulin pumps and continuous glucose monitors require Preauthorization.

**Certain diabetic supplies, such as syringes, needles, lancets, and blood glucose test strips, may be Covered at a Participating Provider for DME. Your DME Cost Sharing will apply. These supplies may also be Covered at a Participating pharmacy to the extent Covered under Section 8.33 and this Certificate, your Prescription Drug Cost Sharing will apply.

Limitations:

- Alcohol swabs are limited to one box of 100 injection alcohol swabs per 30 day time period

Exclusions:

- Gauze pads
- Items that are for the convenience of the Member or a care giver.

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

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

8.5.1 PHYSICIAN OFFICE VISITS

Includes:
- Allergy test
- Allergy injections
- Hearing exams
- Diabetes education (see Section 8.4)
- Home visits
- Specialist visits
- Emergency care
- Non-hospital facility services
- Consultations
- OB/GYN services (Female Members have the right to obtain routine OB/GYN services without a referral if the OB/GYN is a Participating Provider.)
- General pediatric care

Note: If you receive a Covered physician office visit in an Inpatient or Outpatient Facility setting, the Inpatient or Outpatient Cost Sharing, as applicable, will apply (not the Primary Care Physician (PCP) Office Visit or Specialist Office Visit Cost-Sharing).

8.5.2 IMMUNIZATIONS

Immunizations that are included as Preventive Services are Covered pursuant to Section 8.3. Please also refer to the complete list of Preventive Services at www.McLarenHealthPlan.org or call Customer Service at (888) 327-0671.

All other immunizations are Covered with applicable Copayments, Coinsurance and/or Deductibles. No Preauthorization is required when provided by a Participating Provider.

8.5.3 MATERNITY CARE AND NEWBORN CARE

Covered Services:

- Hospital and physician care: Services and supplies furnished by a Participating Hospital or other Participating Provider, including a licensed nurse midwife, for prenatal care, including genetic testing, postnatal care, Hospital delivery and care for the complications of pregnancy are Covered.

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

Note: Some prenatal care and postnatal services are Covered under Preventive Services. However, cost-sharing will apply to non-routine (non-preventive) high risk visits.

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

- Newborn child care: MHP Community will Cover a Member's Newborn child (including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities) for as part of the Member mother's Coverage through the earlier of up to 48 hours following a normal vaginal delivery or up to 96 hours following a cesarean section or the date of discharge of the Member mother or the newborn, whichever occurs first.. If you want the Newborn's Coverage to continue beyond this period, and you are Covered under a Michigan Marketplace plan, you must add the Newborn at HealthCare.gov within 60 days after the child is born. If you purchased your plan off the Michigan Marketplace, fill out and return a change form to us within 31 days after the child is born.

Exclusions:

- Unless specifically Preauthorized by MHP Community, no maternity care, including prenatal services, delivery services and postpartum care, provided while you are outside of the Service Area for your Plan are Covered. MHP Community does not consider a routine delivery to be a Medical Emergency.
- Services and supplies received in connection with an obstetrical delivery, including but not limited to those provided by a lay-midwife, in the home or free-standing birthing center are not Covered.
- We do not Cover parenting classes or other maternity classes (e.g. Lamaze)
- Services provided to surrogate parents who are not Members under this Plan are not Covered.

8.5.4 INJECTABLE DRUGS PROVIDED IN THE OFFICE

The following drugs are covered as medical Benefits:

- Injectable and infusible drugs administered in a facility setting (e.g., inpatient or emergency)

- Injectable and infusible drugs requiring administration by a health professional in a medical office, home or Outpatient Facility

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

Note: Allergy injections (including serum) are covered under this Benefit. See your Schedule of Cost Sharing for allergy injection Cost Sharing.

Limitations:

- We may require selected Drugs be obtained through a MHP Community designated supplier. MHP Community will manage the treatment setting for infusible drug services and may direct you to an infusion center or home setting.
- Self-administered drugs are only Covered, if applicable, under your prescription drug benefit.

Exclusions

- Drugs not approved by the FDA are not Covered.
- Select injectable drugs in certain categories and drugs that are not primarily intended to be administered by a health professional are only Covered under your prescription drug benefit
- Self-administered drugs as defined by the FDA and provided by a pharmacy (retail, mail order, specialty, etc.) are not Covered under your medical benefit and are only Covered under your prescription drug benefit

8.5.5 HOME VISITS

Covered Services:

- Home visits provided by a physician in the home or temporary residence.
- For home health care services other than physician visits please see the Home Care Services, Section 8.16

8.5.6 INPATIENT PROFESSIONAL SERVICES

Covered Services:

Inpatient Professional Services provided while the Member is in an Inpatient Hospital or Skilled Nursing Facility or Inpatient rehabilitation center and billed by a physician are covered when Preauthorized by MHP Community. These services are included as "Inpatient Hospital Services" in the Schedule of Cost Sharing.

8.6 EMERGENCY AND URGENT CARE

Definitions:

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

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

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

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

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

Covered Services:

- Items and Services for a **medical emergency or accidental injury**, including mental health or substance abuse-related medical emergencies, are Covered up to the point of stabilization when they are Medically Necessary and needed immediately to treat a medical emergency as defined above. Preauthorization is not required. NOTE – some post-stabilization services are subject to and may be subject to Applicable Surprise Billing Laws

- Items and Services for **medical emergency or accidental injury**, including mental health or substance abuse-related medical emergencies, are Covered when provided by a Participating Provider or Non-Participating Provider. A Member's Cost Sharing (Copayment, Coinsurance or Deductible) is the same whether the services are provided by a Participating or Non-Participating Provider. However, unless an Applicable Surprise Billing Law applies, when services are provided by a Non-Participating Provider, the Member will be responsible for any Balance Bill (the difference between the Reimbursement Amount paid by MHP Community and the amount of the Non-Participating Provider's charges). Your Cost Sharing (Copayment, Coinsurance, or Deductible) will apply even if you are directed or otherwise referred to the emergency room by your physician. Emergency Service are Covered without regard to any other term or condition of coverage other than as provided in under 45 CFR 149.110(b)(5).

- Items and Services for treatment of an illness or injury that needs immediate attention, such as cuts or sprains, that is not as serious as a medical emergency, are Covered under **urgent care**. You should call your PCP before you seek urgent care. Your PCP will help you determine the best place to go for care. If you are out of your Service Area at that time, your PCP will determine if you can wait for those services and supplies until you could reasonably return to receive them from a Participating Provider. If you cannot reach your PCP's office and your illness or injury needs urgent care, go to an urgent care center or Hospital emergency room. Present your ID

Card and be prepared to pay the required Copayment, Coinsurance or Deductible. Preauthorization is usually not required.

Limitations:

- In case of a **medical emergency or accidental injury**, you should seek treatment at once. We urge you, the Hospital, or someone acting for you to notify MHP Community within 24 hours, or as soon as medically reasonable.

- **Emergency services** are no longer payable as emergency services at the point of the patient's stabilization as defined above.

- **Urgent care** services received from a Non-Participating Provider who is located in your Service Area are not Covered. **Urgent care** services received from a Non-Participating Provider who is located outside of your Service Area are Covered.

- If you receive urgent care services from a Non-Participating Provider, contact your PCP's office as soon as possible so your PCP can arrange follow-up treatment. Do not return to the urgent care center or emergency room for follow-up care unless it is an urgent situation or medical emergency. Any follow-up care that is provided by a Non-Participating Provider must be Preauthorized by MHP Community in order to be Covered.

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

8.7 AMBULANCE

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

The following ambulance services are Covered:

- Non-emergency Medically Necessary ground ambulance services when Preauthorized by MHP Community to transport a Member from one facility to another.

- Emergency ground ambulance services when:
  - You are admitted as an inpatient to the Hospital immediately following emergency room treatment.
  - The services are necessary for management of shock, unconsciousness, heart attack or other condition requiring active medical management.
  - The services are needed for emergency delivery and care of a Newborn and mother. See Exclusions below.
  - The ambulance is ordered by an employer, school, fire, or public safety official and you are not in a position to refuse.

- Air ambulance for emergency transport is Covered to the nearest Hospital equipped to treat your condition only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Your symptoms at the time of transport must meet these requirements and the additional requirements for a ground ambulance Coverage and must be verified by the records of the physician who treats you and by the ambulance company.

- For Covered emergency air ambulance transportation, MHP Community complies with Applicable Surprise Billing Laws. Those laws generally include the following requirements:
    - Cost-Sharing requirements must be the same as in-network requirements (see your Schedule of Cost Sharing);
    - Cost-Sharing requirements are calculated based on the rates required by Applicable Surprise Billing Laws;
    - Cost-Sharing must be applied to in-network Deductible and Out-of-Pocket Maximums; and
    - Payment to providers is made in accordance with applicable laws

Exclusions:

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

8.8 INPATIENT AND LONG TERM ACUTE HOSPITAL SERVICES

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

- Semi-private room and board, general nursing services, and special diets. Note: A private room is Covered only when Medically Necessary and Preauthorized by MHP Community;
- Operating and other surgical treatment rooms, delivery rooms, and special care units;
- Surgery;
- Professional services, including surgical services;

- Anesthesia, laboratory, radiology and pathology services;
- Chemotherapy, inhalation therapy and hemodialysis;
- Infusion therapy;
- Physical, speech and occupational therapies;
- Other Inpatient Services and medical supplies necessary for the treatment of the Member;
- Maternity care and routine nursery care of Newborn (see Sections 8.5 "Maternity Care and Newborn Care" and 9.11 for limitations); and
- Non-emergency ground transport between facilities.

Exclusions:

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

Limitations:

MHP Community will manage the treatment setting for infusible drug services and may direct you to an infusion center or home setting.

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

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

8.9 OUTPATIENT SERVICES

Covered Services:
Facility and professional (physician) therapeutic and non-preventive diagnostic laboratory, pathology and radiology services and other procedures when performed in a Participating provider setting, including outpatient Hospital setting, physician office, free standing center, or dialysis center for the diagnosis or treatment of a disease, injury or other medical condition when Medically Necessary and, where required, Preauthorized by MHP Community. See Section 8.2 for Preauthorization requirements. Outpatient Hospital services include the following:

- Outpatient surgery;
- Outpatient CT scans, PET scans, MRI and nuclear medicine;
- Colonoscopy (**Note:** Preventive Colonoscopies are Covered under Section 8.3);
- Outpatient procedures for treatment of breast cancer, including outpatient surgery, chemotherapy and radiation treatment;
- Outpatient hemodialysis;

- Professional Services including physician surgical services; also see Professional Physician Services section; and
- Outpatient infusion therapy.

Note – Observation Care received after an emergency room visit is considered to be outpatient care under this Certificate. Your Outpatient Services cost-sharing will apply.

8.10 DIAGNOSTIC AND THERAPEUTIC SERVICES AND TESTS

MHP Community Covers Medically Necessary and, as applicable, Preauthorized therapeutic and diagnostic laboratory, pathology and radiology services, and other procedures for the diagnosis or treatment of a disease, injury or medical condition. See Section 8.2 for Preauthorization requirements.

Diagnostic and therapeutic services and tests that are included as Preventive Services are Covered in Section 8.3. Please also refer to the complete list of Preventive Services at www.McLarenHealthPlan.org or call Customer Service at (888) 327-0671. All other diagnostic and therapeutic services and tests may be subject to Copayments, Coinsurance and/or Deductibles. Please refer to your Schedule of Cost Sharing.

Diagnostic and therapeutic services and tests include the following:

- Diagnostic laboratory tests, X-rays, high-tech radiology exams and pathology services;
- X-rays and other Diagnostic imaging procedures.

Note – Diagnostic and therapeutic services and tests performed in a facility, (inpatient or an outpatient), are subject to the inpatient or outpatient cost-sharing (as applicable), even if the service or test was ordered and partially performed in a Provider's office.

Exclusions:

- Laboratory, pathology and radiology services and other procedures performed more frequently than medically advised

8.11 ORGAN AND TISSUE TRANSPLANTS

An organ or body tissue transplant is Covered when:

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

Coverage is provided for related drugs for treatment of cancer pursuant to Section 8.29 of this Certificate.

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

Exclusions:

- Services provided at a non-MHP Community designated Participating facility.
- Community wide searches for a donor.
- Donor expenses, even those of Members, for transplant recipients who are not Members.
- Experimental/investigational or unproven treatments and services. (See Part 9 for additional Exclusions).

8.12 SPECIAL SURGICAL PROCEDURES

MHP Community Covers surgical procedures typically considered cosmetic in nature only when they are provided by a Participating Provider, are Medically Necessary and are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. In order for these services to be Covered, you must meet MHP Community's Medical Necessity criteria, and must be Preauthorized by MHP Community. These services may include, but are not limited to:

- Reduction mammoplasty;
- Reconstructive services to correct physical impairments;
- Blepharoplasty of upper eyelids;
- Rhinoplasty;
- Septorhinoplasty;
- Panniculectomy;
- Surgical treatment of male gynecomastia; and
- Procedures to correct obstructive sleep apnea.

8.13 WEIGHT LOSS PROCEDURES

MHP Community Covers surgery and procedures for weight reduction that are not considered cosmetic in nature **only** when they are provided by a Participating Provider, and are Medically Necessary. This includes Medically Necessary morbid obesity weight loss surgery. In order for these services to be Covered, you must meet MHP Community's Medical Necessity criteria and must be Preauthorized by MHP Community.

MHP Community also Covers weight loss and nutrition educational programs (including morbid obesity weight management programs) that MHP Community has reviewed and approved.

Limitations:

- Surgical treatment of obesity is limited to once per lifetime unless medically necessary as determined by MHP Community

Exclusions:

- Food, food supplements, gastric balloons, certain weight loss surgeries, jaw wiring, liposuction, physical fitness or exercise programs.

8.14 BREAST RECONSTRUCTION FOLLOWING A MASTECTOMY

Coverage is available for breast reconstruction in connection with a mastectomy. Covered Benefits include:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthetics (see Section 8.22); and
- Care for physical complications from all stages of the mastectomy including lymph edemas.

8.15 SKILLED NURSING FACILITY SERVICES

Up to 45 days skilled nursing care in any Calendar Year in a Skilled Nursing Facility are Covered when Medically Necessary for recovery from surgery, disease or injury.

Exclusions:

- MHP Community does not cover basic custodial care.
- Leaves of absence (e.g., bed-hold charges when you are on an overnight or weekend pass during an inpatient stay).

8.16 HOME CARE SERVICES

Home care services include skilled nursing care, medical supplies and other health care services approved by MHP Community when they are performed in the Member's home. Medically Necessary home care services are Covered.

Exclusions:

- Habilitative Services or Rehabilitative Services. Habilitative Services and Rehabilitative Services provided in the home are subject to the Coverage provisions and limitations described in Sections 8.19 and 8.20 of this Certificate;
- Housekeeping services; and
- Services that are primarily for the purpose of providing long-term custodial care.

8.17 HOSPICE CARE

The following Hospice Care services, provided as part of an established hospice program are Covered when your physician informs MHP Community that you have an Advanced Illness and Hospice Care would be appropriate:

(a) **Inpatient Hospice Care.** Up to 45 days per Calendar Year of inpatient care is Covered when Skilled Nursing Services are required and cannot be provided in other settings. Inpatient Hospice Care requires Preauthorization.

(b) **Home Hospice Care.** Home Hospice Care is Covered when intermittent Skilled Nursing Services by a

registered nurse or a licensed practical nurse are required or when medical social services under the direction of a Participating Provider are required.

Exclusions:

- Housekeeping services
- Financial or legal counseling
- Room and board charges in facilities, including nursing homes and hospice facilities, unless Skilled Nursing Services are required and cannot be provided in other settings.
- These services are not Covered if primarily for the purpose of providing long-term custodial care.
- Hospice Care facility is not Covered if the necessary care or therapies can be provided safely in a less intensive setting, including the home or a Provider office.

8.18 MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES

8.18.1 MENTAL HEALTH SERVICES

Definitions:

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

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

Partial Hospitalization is an intensive, non-residential level of service provided in a structured setting, similar in intensity to Inpatient treatment. A Member is generally in treatment for more than four (4) hours but generally less than eight hours daily. These services are included as “Inpatient Mental Health Services” in the Schedule of Cost Sharing.

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

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

Covered Services:

This plan Covers evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for mental health conditions. Coverage is provided for Medically Necessary Inpatient Mental Health and Outpatient Mental Health Services, Partial Hospitalization and Residential Mental Health Treatment as defined above. Mental Health Emergency Services are Covered pursuant to Emergency and Urgent Care Coverage. (See Section 8.6)

Limitations:

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

Exclusions:

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

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

- See Part 9 for additional Exclusions.

8.18.2 SUBSTANCE ABUSE SERVICES/CHEMICAL DEPENDENCY

Definitions:

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

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

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

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

Intensive Outpatient Programs are outpatient services provided by a variety of health professionals at a frequency of up to four (4) hours daily, and up to five (5) days per week. These services are included as "Outpatient Substance Abuse Services" in the Schedule of Cost Sharing.

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

Covered Services:

Medically Necessary Substance Abuse Services defined above are Covered under this plan. These include counseling, medical testing, diagnostic evaluation and Detoxification. Diagnosis and treatment may include drug therapy, counseling, Detoxification services, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Emergency Substance Abuse Services are Covered pursuant to Emergency and Urgent Care Coverage. (See Section 8.6)

Limitations:

- Medically Monitored Intensive Inpatient Treatment, Partial Hospitalization and Residential Substance Abuse Treatment require Preauthorization by MHP Community.
- Medical Inpatient services required during a period of substance abuse admission must be Preauthorized separately by MHP Community.

Exclusions:

- Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, recreational or wilderness therapy programs, Custodial Care, halfway house services and health care aids.

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

- Also see Part 9 for additional Exclusions.

8.19 OUTPATIENT HABILITATIVE SERVICES

Short term outpatient medical Habilitative services are Covered when they are Medically Necessary for a condition that can be expected to help a Member keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and Applied Behavioral Analysis (ABA) for the Treatment of Autism Spectrum Disorder (see also Section 8.33).

Limitations:

- Physical and Occupational Therapy for Treatment Other than for Autism Spectrum Disorder – Benefit maximum of 30 visits per Calendar Year;
- Speech Therapy for Treatment other than for Autism Spectrum Disorder – Benefit maximum of 30 visits per Calendar Year;
- ABA Services, Physical and Occupational Therapy and Speech Therapy for treatment of Autism Spectrum Disorder – Not subject to annual visit limitation;
- One or more forms of therapy during the same day count as one visit;
- Habilitative Services, including services for treatment of Autism Spectrum Disorder, must be Preauthorized by MHP Community in order to be Covered.
- Physical Therapy requires a prescription from a referring physician.
- Prescription drugs related to Outpatient Habilitative Services, including services for treatment of Autism Spectrum Disorder, are Covered under your Prescription Drug Coverage. See Section 8.34.
- Medically Necessary Pediatric Habilitative Services and devices are Covered until the end of the month in which the Member turns 19 years old.

Exclusions include but are not limited to:

- Vocal habilitation;
- Services provided by any federal or state agency or any local political subdivision, including school districts, are not payable by MHP Community;
- Craniosacral therapy;

- Prolotherapy; and
- Services outside the scope of practice of the servicing provider.

Speech Therapy exclusions also include:

- Deviant swallow or tongue thrust;
- Voice therapy; and
- Vocal cord abuse resulting from life-style activities.

8.20 OUTPATIENT REHABILITATION

Outpatient rehabilitation includes:

- Medical rehabilitation;
- Physical and occupational therapy (including osteopathic and chiropractic manipulation);
- Breast cancer rehabilitation; and
- Speech therapy.

Short-term Rehabilitative Services are Covered if:

- Treatment is provided for an illness, injury or congenital defect, and
- They are provided in an outpatient setting or in the home, and
- They are not services provided by a federal or state agency or any local political subdivision, including school districts, and
- They result in meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 90 days of starting treatment, and
- A Participating Provider refers, directs and monitors the services, and
- They are Preauthorized.

Limitations:

- **Physical and Occupational Therapy for Treatment other than for Autism Spectrum Disorder** – Benefit maximum of 30 visits per Calendar Year (including osteopathic or chiropractic manipulation);
- **Speech Therapy for Treatment other than for Autism Spectrum Disorder** – Benefit maximum of 30 visits per Calendar Year;
- **Cardiac Rehabilitation and Pulmonary Rehabilitation** – Benefit maximum of 30 visits per Calendar Year;
- One or more forms of therapy during the same day counts as one visit.
- Rehabilitative Services must be Preauthorized by MHP Community in order to be Covered;
- Physical Therapy also requires a prescription from a referring physician.

Exclusions include but are not limited to:

- Vocational rehabilitation (including but not limited to work and work related training);

- Services provided by any federal or state agency or any local political subdivision, including school districts, are not payable by MHP Community;
- Therapy that provides no meaningful improvement in a Member's ability to do important day-to-day activities that are necessary in the Member's life roles within 90 days of starting treatment; and
- Services outside the scope of practice of the servicing provider.

Speech Therapy exclusions also include:

- Chronic conditions or congenital speech abnormalities;
- Learning disabilities;
- Deviant swallow or tongue thrust;
- Voice therapy; and
- Vocal cord abuse resulting from life-style activities.

8.21 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

8.21.1 Durable Medical Equipment (DME)

DME is equipment that must be used primarily for medical purposes. It must be intended for repeated use and be useful primarily as a result of illness, injury or congenital defect. It must be Medically Necessary. Coverage is provided for rental or purchase, and is limited to basic equipment. **If the cost of the DME is greater than $3,000, it must be Preauthorized by MHP Community to be Covered**.

In many instances, MHP Community covers the same items covered by Medicare Part B as of the date of the purchase or rental. In some instances, however, MHP Community guidelines may differ from Medicare. For specific Coverage information and to locate an MHP Community designated Participating Provider, contact Customer Service at (888) 327-0671.

Note: All Medically Necessary equipment and supplies for the treatment of diabetes are Covered (Preauthorization required for insulin pumps). See Section 8.4.

Limitations:

- The equipment must be considered DME by MHP Community and be appropriate for home use;
- The equipment is limited to one piece of equipment for the same or similar use;
- Coverage is limited to basic equipment;
- Your Provider must prescribe the equipment, and it must be obtained from MHP Community or an MHP Community-designated Participating Provider;
- If the cost of the DME is greater than $3,000, it must be Preauthorized by MHP Community to be Covered;
- The equipment is the property of MHP Community or the supplier. When it is no longer Medically Necessary, you may be required to return it to the supplier;
- Replacement of DME is Covered only when necessary to accommodate body growth, body change or normal wear; and
- Repair of the item is covered if it does not exceed the cost of replacement.

Exclusions:

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

- Deluxe equipment (such as motor-driven wheelchairs and beds) unless Medically Necessary for the patient and required so the patient can operate the equipment himself;
- Wheelchair seat elevators;
- Wheelchair power/manual standing feature;
- Items that are not considered medical items;
- Duplicate equipment;
- Items for comfort and convenience (such as bed boards, bathtub lifts, over-bed tables, adjustable beds, telephone arms, air conditioners, hot tubs, water beds, tanning beds, etc.);
- Physician's equipment (such as blood pressure cuffs and stethoscopes);
- Disposable supplies (such as sheets, bags, elastic stockings);
- Over the counter supplies (such as disposable dressing and wound care supplies);
- Exercise and hygienic equipment (such as exercycles, bidet toilet seats, bathtub seats, treadmills);
- Self-help devices that are not primarily medical items (such as sauna baths, elevators and ramps, special telephone or communication devices);
- Equipment that is experimental or for research;
- Needles and syringes for purposes other than the treatment of diabetes;
- Repair or replacement due to loss, theft or damage;
- Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers and other equipment not intended for use in the home;
- Modifications to your home, living area, or motorized vehicles - this includes equipment and the cost of installation of equipment, such as central or unit air conditioners, swimming pools and car seats;
- All repairs and maintenance that result from misuse or abuse;
- Any late fees or purchase fees if the rental equipment is not returned within the specified period of time.

8.21.2 FOOD SUPPLEMENTS AND FORMULA

Covered Services:

- Supplemental feedings administered via tube. This type of nutrition therapy is also known as enteral feeding. Formulas intended for this type of feeding as well as supplies, equipment and accessories needed to administer this type of nutrition therapy, are Covered.
- Supplemental feedings administered via an IV. This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies and equipment needed to administer this type of nutrition are Covered.

Exclusions:

Except for formula specifically intended for tube feeding and nutrients necessary for IV feeding, all food, formula and nutritional supplements are not Covered. This includes, but is not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the FDA.

8.22 PROSTHETICS, ORTHOTICS AND CORRECTIVE APPLIANCES

Definitions:

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

PROSTHETICS AND ORTHOTICS:

Coverage for prosthetics and orthotics includes:

- Basic items and any special features that are Medically Necessary and, if the cost of an item exceeds $3,000, is Preauthorized;
- The cost and fitting of a breast prosthetic device following a mastectomy;
- Replacement when necessary because of body growth, change or normal wear.

Limitations:

- The item must meet the MHP Community definition of a prosthetic or orthotic item;
- You must obtain the item from MHP Community or an MHP Community-designated Participating Provider or supplier; and
- **If the cost of a prosthetic or orthotic exceeds $3,000, the item must be Preauthorized by MHP Community to be Covered.**

Exclusions:

- Repair or replacement due to loss, theft, damage or misuse is not Covered.
- Over the counter supplies and disposable supplies, including but not limited to, compression stockings, ace bandages, gauze and dressings, and urinary catheters.
- Duplicate items.
- Items that are for the convenience of the Member or a care giver.
- Experimental, investigational or unproven items are not Covered.

CORRECTIVE APPLIANCES AND ARTIFICIAL AIDS

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

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

Limitations:

- Foot orthotics are not Covered unless Medically Necessary and are limited to 1 per year per foot (e.g., must be related to plantar fasciitis)

Exclusions:

The following are not Covered:

- Sports-related braces;
- Dental appliances;
- Hearing aids and all supplies and services related to hearing care, including ear plugs hearing aids and adjustments and examinations for hearing aids);
- Eyeglasses or contact lenses (except after surgery as listed above);
- Non-rigid appliances and supplies such as (but not limited to) elastic stockings, garter belts, arch supports, corsets, corrective shoes, wigs or hair pieces, shoe or foot orthotics; and
- Devices or appliances that are experimental or for research.

8.23 REPRODUCTIVE CARE AND FAMILY PLANNING SERVICES

8.23.1 INFERTILITY

Coverage is available for Preauthorized services for diagnosis, counseling and treatment of Infertility (including the underlying cause(s) of Infertility) when provided by a Participating Provider, except as specifically excluded below or under Part 9. Following the initial sequence of diagnostic work-up and treatment, additional work-ups and treatment may begin only when MHP Community determines they are in accordance with generally accepted medical practice and meet MHP Community's Medical Necessity criteria. Coverage for pharmaceutical drugs prescribed as a part of this treatment are Covered as part of this medical Benefit.

Artificial insemination for the treatment of Infertility includes:

- Intravaginal insemination (IVI)
- Intracervical insemination (ICI)
- Intrauterine insemination (IUI)

Exclusions:

- In-vitro fertilization procedures, such as GIFT-gamete intrafallopian transfer or ZIFT-zygote intrafallopian transfer, and all related services including prescription drugs;
- Artificial insemination (except for treatment of Infertility);
- Harvesting;

- Storage or manipulation of eggs and sperm;
- Embryo or ovum transfer procedures;
- Services for the partner in a couple who is not enrolled with MHP Community and does not have coverage for Infertility services or has other coverage;
- All services related to surrogate parenting arrangements, including but not limited to, maternity and obstetrical care for non-Member surrogate parents; and
- Reversal procedures and other Infertility services for couples who have undergone a prior voluntary sterilization procedure (e.g. vasectomy or tubal ligation)

8.23.2 GENETIC TESTING

MHP Community Covers medically indicated genetic testing and counseling when they are Preauthorized by MHP Community and provided in accordance with generally accepted medical practice. Certain genetic testing services (e.g., BRCA for women when Medically Necessary) are Covered under Preventive Services Coverage. See Section 8.3.

Exclusion:

There is no Coverage for genetic testing and counseling for non-Members for any purpose.

8.23.3 VASECTOMY

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

8.23.4 ABORTIONS

There is no Coverage under this Certificate for any service or supply relating to elective abortions.

Exclusion: Procedures in jurisdictions where the procedure is prohibited by law.

8.24 PEDIATRIC VISION SERVICES

The following services are Covered for Members who are under the age of 19 years:

Benefit	Limit
Eye Exam	Annually
Eyeglass Frames for Medically Necessary Lenses	Annually
Eyeglass Lenses if Medically Necessary	Annually
Contact Lenses in lieu of frames and lenses if Medically Necessary	Annually

Limitation: Contact lenses require MHP Community Preauthorization.

Coverage for this Benefit ends at the end of the month in which a Member turns 19 years of age.

8.25 ORAL SURGERY

Note: Also see Sections 8.26, 8.27 and 9.13

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

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

***Note**: "Immediately following" means treatment within 24 hours of the injury.

Exclusions:

- Routine dental care;
- Pediatric dental services;
- Implants (we also do not Cover procedures to prepare for implants), and repair/restoration of the teeth;
- Preparation of oral implants;
- Cosmetic services (e.g., rebuilding or repair for cosmetic purposes);
- Orthodontic treatment is not Covered for any purpose;

- Services provided by an individual who is not a licensed, practicing oral surgeon or a licensed medial or osteopathic physician.

8.26 TEMPOROMANDIBULAR JOINT SYNDROME (TMJ) TREATMENT

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

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

Covered Services:

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

Exclusions:

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

8.27 ORTHOGNATHIC SURGERY

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

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

Exclusions:

- Orthodontic treatment is not Covered for any purpose, including orthognathic conditions.
- Prostheses for orthognathic related treatment are not Covered

8.28 PAIN MANAGEMENT

Evaluation and treatment of Chronic and/or acute pain are Covered as Medically Necessary and Preauthorized by MHP Community.

8.29 APPROVED CLINICAL TRIALS

Covered Services:

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

For purposes of this Section, the following definitions apply:

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

- A **Qualified Individual** is a Member who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either (i) the referring health care professional is an MHP Community Participating Provider and has concluded that the Member's participation in such trial would be appropriate, or (ii) the Member provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

- **Routine Patient Costs** include all items and services that would be Covered for a Member outside of participation in an Approved Clinical Trial

Limitations:

- MHP Community does not Cover the costs of the Approved Clinical Trial itself, but rather just the Routine Patient Costs (e.g., laboratory services) associated with the Approved Clinical Trial.
- Routine Patient Costs that otherwise require Preauthorization, also require Preauthorization when provided as part of an Approved Clinical Trial.

Exclusions:

The following are not Covered as Routine Patient Costs:

- The investigational item, device or service itself.
- Items and services that are provided solely to satisfy data collection and analysis needs, and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Drugs or devices not approved by the FDA.
- Drugs, devices or other items that are paid for by the clinical trial sponsor or another entity.

8.30 CANCER DRUG THERAPY (ANTINEOPLASTIC SURGICAL DRUG THERAPY)

Covered Services:

As required by state law, drugs for cancer therapy and the reasonable cost of administering them are Covered. These drugs are Covered regardless of whether the federal Food and Drug Administration

(FDA) has approved the cancer drugs to be used for the type of tumor for which the drugs are being used.

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

Coverage Benefits for drugs for cancer therapy will be payable under your prescription drug Coverage (Section 8.34) before being payable under other sections of this Certificate.

Limitations:

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

Exclusions:

- Drugs not approved by the FDA for use in cancer therapy are not Covered.
- Experimental, investigational or unproven services are not Covered.
- Also, certain drugs for which a majority of experts believe further studies or clinical trials are needed to determine toxicity, safety or efficacy, of the drug are not Covered.

8.31 EDUCATIONAL AND NUTRITIONAL COUNSELING SERVICES

Covered Services:

- Diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management and treatment of their condition;
- Dietician services (limited to 6 visits per contract year, upon referral from your PCP, unless Covered as a Preventive Service (see Section 8.3); and
- Certain Maternity education services through MHP Community are Covered under your Preventive Benefit. (See Section 8.3.) For more information about these services call Customer Service at (888) 327-0671.

Limitations:

- Covered dietician services are limited to 6 visits per contract year, upon referral from your PCP, unless Covered as a Preventive Service (see Section 8.3)

Coverage for diabetes self-management training is available if the following conditions apply:

- It is limited to completion of a certified diabetes education program if:
  - Considered Medically Necessary upon the diagnosis of diabetes by the Provider who is managing the Member’s diabetic condition and if the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or
  - The Member’s treating Provider diagnoses a significant change with long-term implications in the Member’s symptoms or conditions that requires changes in the Member’s self-management or a significant change in medical protocol or treatment modality.

- It is provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Michigan Department of Health and Human Services. This training must be conducted in group settings whenever available.

Exclusions:

- Services for remedial education, including school-based services;
- Services, treatment or diagnostic testing related to learning disabilities, cognitive disorders and developmental delays;
- Education testing or training, including intelligence testing; and
- Classes covering such subjects as stress management, parenting and lifestyle changes.

8.32 VISION EXAM

Vision screening exams are Covered in a provider's office as part of a physician exam to determine vision loss. Only one screening exam is allowed each Calendar Year to detect vision impairment. Vision exams performed by an MHP Community Participating Provider do not require Preauthorization.

Note: Other than as Covered under Pediatric Vision Benefits (Section 8.24), Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses, except as Covered under Section 8.24.

Exclusions:

See Section 9.16 below for exclusions.

8.33 SERVICES FOR TREATMENT OF AUTISM SPECTRUM DISORDERS

Covered Services:

Outpatient Treatment of Autism Spectrum Disorders is Covered when performed by an approved MHP Community Participating Provider. Preauthorization for Applied Behavioral Analysis or ABA services is required by MHP Community.

Coverage includes the following:

- Diagnosis of Autism Spectrum Disorders, including Autism Diagnostic Observation Schedule, when performed by a physician or licensed psychologist;
- Applied Behavioral Analysis or ABA when provided by a board certified health professional who has the appropriate credentials (Preauthorization is required);
- Medication management; and
- Speech therapy.

Note: Autism screening for children ages 18 months and 24 months is Covered as a Preventive Health Service (see Section 8.3).

Limitations:

Covered Services for Autism Spectrum Disorder:

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

Exclusions:

- ABA services not Preauthorized by MHP Community;
- Treatments or services provided by a Non-Participating Provider unless otherwise approved in advance by MHP Community; and
- Treatments for Autism Spectrum Disorder that are in conflict with MHP Community's medical policies.

8.34 PRESCRIPTION DRUG COVERAGE

Definitions:

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

Compounded Drug: A medication that is the result of a combination, mix or alteration of one or more ingredients of a Drug or Drugs.

Covered Drug: A Tier 1, Tier 2, Tier 3, Tier 4 or Preventive Drug that is prescribed by a Participating Provider, included on the MHP Community Formulary and obtained through a Participating Pharmacy, except as excluded or otherwise provided in this Certificate.

DAW (Dispense as Written): A Drug dispensed as written, with no substitutions (for example, "no substitution of a Generic").

Drug: A therapeutic agent; any substance, other than food, used in the prevention, diagnosis, alleviation, treatment or cure of disease.

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

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

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

Non-Preferred Generic and Non-Preferred Brand Name Drugs (Non-Preferred Drugs): Prescription Drugs that are listed on the MHP Community Formulary as "Non-Preferred". These Drugs may require Prior Authorization and will have higher Copayments.

Off-Label: The use of a Drug or device for clinical indications, route of administration, or dosage that exceeds the limitations other than those stated in the manufacturer guidelines approved by the FDA.

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

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

Prior Authorization/Step Therapy Drugs: Drugs listed on MHP Community's Formulary that require MHP Community review of a Member's medical information to ensure clinical criteria have been met regarding the Medical Necessity of the Drug. This review is performed by MHP Community prior to approving Coverage and may involve the need for documentation for use of previous treatment with another Drug or result in the substitution of an alternative Drug. The Member is responsible for the cost of such Drugs unless and until MHP Community approves a Prior Authorization of the Drug.

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

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

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

Preventive Drugs: Preventive Drugs are Prescription Drugs that have been recommended by the United States Preventive Service Task Force that help prevent illness. Some Preventive Drugs are Preventive Drugs only for specified age groups or genders. For more information, see Section 8.3, Preventive Services.

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

Tier 1 Drugs: An MHP Community Formulary Drug available with the lowest Copayment. This Tier includes Preferred Generic Drugs.

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

Tier 3 Drugs: This Tier includes Non-Preferred Generic and Non-Preferred Brand Name Drugs.

Tier 4 Drugs: This Tier includes Specialty Drugs.

Coverage:

Coverage is provided, except when excluded, for:

1. Tier 1, Tier 2, Tier 3 and Preventive Drugs when prescribed by a Participating Provider, obtained through a Participating Pharmacy, and, where required, Prior Authorized by MHP Community;
2. Disposable insulin needles and/or syringes when prescribed with injectable insulin and prescribed by a Participating Provider and obtained through a Participating Pharmacy;
3. Tier 4 Specialty Drugs when prescribed by a Participating Provider and when Prior Authorized by MHP Community and obtained through an MHP Community Preferred Specialty Pharmacy;
4. Tier 1 Drugs, Tier 2 Drugs or Tier 3 Drugs and Preventive Drugs by Mail Order;
5. Compounded Drugs that are Prior Authorized by MHP Community and obtained through a Participating Pharmacy; and
6. A limited number of Over-the-Counter Medications when prescribed by a Participating Provider, obtained through a Participating Pharmacy and on the Formulary.

Note:

- Coverage is provided for internasal spray opioid reversal agent when prescription of opioids are dosages of 50MME or higher. Please check the formulary for specific details.
- There are no Prior Authorization requirements for prescriptions for medication-assisted treatment of opioid use disorder. Please check the formulary for specific details.

Copayments:

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

<u>Retail Pharmacy</u>

-- Tier 1 Drugs
-- Tier 2 Drugs
-- Tier 3 Drugs
-- Preventive Drugs

NOTE:

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

- **DAW:** If a Drug is prescribed as DAW when a Generic is available, the Copayment will be affected unless the DAW is Prior Authorized by MHP Community.

Mail-Order Pharmacy

-- Tier 1 Drugs
-- Tier 2 Drugs
-- Tier 3 Drugs
-- Preventive Drugs

Specialty Drugs

Must be filled at an MHP Community Preferred Specialty Pharmacy. Specialty Drugs are limited to a 30-day supply.

Limitations:

1. Prescriptions Covered under this Certificate are limited to a 30-day supply except that MHP Community, in its discretion, may recognize for Benefit purposes the provision of the specific Prescription Drugs in quantities exceeding a 30-day supply. MHP Community reserves the right to place a maximum supply limit on certain Covered Prescription Drugs. MHP Community does not Cover any prescription refill in excess of the number specified by the physician or any prescription or refill dispensed after one year from the date of the physician's order. Notwithstanding the foregoing, for controlled substances, MHP Community does not Cover any prescription refill in excess of the number permitted or in excess of the time periods required by applicable law or regulation.

2. A 90-day supply of Generic Drugs may be dispensed from a Retail Pharmacy if a Member successfully completes a 30-day trial of the Drug. The 90-day supply may be obtained with two Copayments.

3. A 90 day supply of Brand Name Drugs or Generic Drugs may be dispensed from a Mail Order Pharmacy if a Member successfully completes a 30-day trial of the Drug. The 90-day supply may be obtained with two Copayments.

4. If a Member obtains Covered Prescription Drugs, needles or syringes, or insulin from a Non-Participating Pharmacy in urgent situations, MHP Community will reimburse the Member MHP Community's Reimbursement Amount, or the actual charge to the Member, whichever is less, minus the applicable Copayment.

5. Specialty Pharmacy Drugs must be Prior Authorized and obtained through an MHP Community Preferred Specialty Pharmacy, and cannot be dispensed in a quantity greater than a 30-day supply.

6. If a Brand Name Drug is dispensed when a Generic Drug equivalent is on the MHP Community Formulary, the Member must pay the difference between the cost of the Brand Named Drug and the price of its Generic Drug equivalent **in addition** to the applicable Copayment.

7. A Compounded Drug requires Prior Authorization by MHP Community and must meet the following additional requirements in order to be Covered:

- FDA-approved for the route of administration and medical condition for which it is prescribed;
- Obtained through a Participating Pharmacy; and
- At least one of the ingredients of the Compound is an FDA-approved Prescription Drug and on MHP Community's Formulary.

8. Any Drug or device prescribed for use or dosage other than those specifically approved by the FDA and the reasonable cost of Medically Necessary supplies administer them are Covered if the prescribing provider can substantiate that the Drug is recognized for treatment of a condition for which it was prescribed and the Drug or device is Preauthorized by MHP Community. As required in MCL 500.3406q, if Preauthorization is requested, the Member or his/her provider must provide MHP Community with all supporting documentation necessary to determine whether the Preauthorization should be granted. Documentation of the following is required:

- The Drug is approved by the FDA;
- The Drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:
  - A life-threatening condition so long as the Drug is Medically Necessary to treat that condition and the Drug is on the MHP Community Formulary or accessible through MHP Community's Formulary procedures;
  - A Chronic and Seriously Debilitating condition so long as the Drug is Medically Necessary to treat that condition and the Drug is on MHP Community's Formulary or accessible through MHP Community's Formulary procedures.
- The Drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:
  - The American Medical Association Drug evaluations;
  - The American hospital formulary service Drug information;
  - The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional";
- Two articles from major peer-reviewed medical journals that present data supporting the proposed Off Label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

For purposes of this Section:

- "Chronic and Seriously Debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration, and that causes significant long-term morbidity.
- "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

9. An Over-the-Counter Medication requires a prescription from a Participating Provider and must be included on the MHP Community Formulary.

Exclusions:

1. There is no Coverage for Drugs, needles and syringes, or insulin provided by any private or public agency that are or may be obtained by the Member without cost to the Member.

2. There is no Coverage for any Drug that is experimental or that is being used for experimental purposes including, but not limited to, those regarded by the FDA as investigational.

3. There is no Coverage for any prescription that is filled prior to the effective date of this Certificate or after the Termination of the Certificate or that is filled prior to Termination of the Certificate but provides more than a 30-day supply beyond the Termination date.

4. There is no Coverage for any cosmetic Drug or Drug used for cosmetic purposes. "Cosmetic Drug" or "cosmetic purpose" means any prescription legend Drug that is intended to be rubbed, poured, sprinkled or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for the purpose of cleaning, beautifying, promoting attractiveness, promoting or reducing hair growth, reducing or eliminating wrinkles or altering the appearance, and any substance intended to be used as a component of the above Drugs.

5. Some Preventive Drugs, such as certain vaccines, are Covered under Section 8.3 of the Certificate, and are subject to the Benefits and limitations of that Section.

6. Certain other Drugs are covered elsewhere in this Certificate as a part of medical Benefits (e.g., serums, Drugs for treatment of Infertility, certain cancer Drugs). They are not Covered under this Section, but are subject to Benefits, limitations, exclusions and Copayment, Coinsurance, Deductible and Preauthorization requirements of the other applicable sections of this Certificate. (See, for example, Sections 8.5.4, 8.23.1 and 8.30).

7. There is no Coverage for any Prescription Drug, insulin, or needles and syringes to the extent that Benefits or coverage are available under Medicare or under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.

8. There is no Coverage for any Drug, needles or insulin that was acquired without cost to the provider, or if the cost is included or includable in the cost of other services or supplies provided to or prescribed for the Member in accordance with generally accepted professional procedures.

9. There is no Coverage for Prescription Drugs for which there is an Over-the-Counter equivalent in both strength and dosage form.

10. There is no Coverage for OTCs without a prescription from a Participating Provider, not listed on the MHP Community Formulary and not provided by a Participating Pharmacy.

11. There is no Coverage for medications that are not regulated by the FDA, such as medical foods or herbal supplements.

12. There is no coverage for multivitamins (except prenatal vitamins) and nutritional supplements, except when these are the only means of nutrition.

13. There is no Coverage for the replacement of Drugs that are lost, stolen or damaged.

14. There is no Coverage for a vacation supply of Drugs. Covered Drugs needed during a vacation may be provided by a Participating Pharmacy, if Covered in accordance with this Certificate.

15. There is no Coverage for Drugs provided by an Out-of-Network Pharmacy.

16. Drugs administered by a health care provider are not Covered under the pharmacy Benefit. They are a medical Benefit only. See the applicable sections of this Certificate for information about Coverage.

17. There is no Coverage of drugs for the treatment of sexual dysfunction, regardless of age, gender or health status. Note drugs may be Covered for the treatment of Infertility under the Medical Benefit.

18. There is no Coverage for male contraceptives.

19. There is no Coverage of drugs used for the purpose appetite suppression or weight loss products.

20. There is no Coverage for a medication which is consumed or administered at the place where it is dispensed.

21. There is no Coverage for any legend drug where an OTC equivalent is available without a prescription.

22. Amounts paid toward cost-sharing using any form of direct support offered by drug manufacturers to Members to reduce or eliminate out-of-pocket costs for Drugs will not be counted toward the annual limit of cost sharing or Deductible. For example, if your cost is reduced by a Copayment assistance card, manufacturer coupon or other drug assistance program (other than those MHP is required to accept by law), only the amount you actually pay will accumulate toward your Deductible or Out of Pocket Maximum.

8.35 VIRTUAL VISITS

This Section 8.35 only applies if you are enrolled in a Virtual PCP Plan. If you are not enrolled in a Virtual PCP Plan, please see Section 8.40 for coverage of Telemedicine and your Schedule of Cost Sharing for more information about Coverage for Telemedicine services.

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

Limitations:

- For Virtual Visits provided through McLarenNow, services must be performed by a McLarenNow Provider through your browser or through the app for iOS or Android;
- Cost Sharing for Virtual Visits only applies to Virtual Services provided through McLarenNow or Virtual Visits by a mental health or behavioral health Participating Provider;
- In-person office visits, including but not limited to PCP visits, specialist visits and mental health or behavioral health visits are not Virtual Visits and are subject to the applicable Cost Sharing in your Schedule of Cost Sharing;
- Any follow-up services, including but not limited to services that cannot be performed during a Virtual Visit, referrals to other providers, labs and other services are not covered under the Virtual Visit Cost Sharing and are subject to the applicable Cost Sharing in your Schedule of Cost Sharing;
- All other Covered Telemedicine Services are not Virtual Visits and are subject to Section 8.40 and the applicable Cost Sharing in your Schedule of Cost Sharing.

Exclusions:

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

8.36 MCLAREN CARE NOW CLINICS

MHP Community Covers Medically Necessary visits provided by a McLaren Care Now Clinic Provider and subject to the terms and conditions of this Certificate. McLaren Care Now Clinics are available at select Walgreens stores. A list of McLaren Care Now Clinics is available on our website at www.McLarenHealthPlan.org. You can also find a McLaren Care Now Clinic at the following website: https://www.mclaren.org/main/mclaren-carenow or by calling Customer Service at (888) 327-0671.

McLaren Care Now Clinic Cost Sharing is equal to the in-person PCP Cost Sharing outlined in your Schedule of Cost Sharing. See your Schedule of Cost Sharing.

Limitations:

- Cost Sharing for a McLaren Care Now Clinic visit only applies to Medically Necessary Covered Services provided through the McLaren Care Now Clinic;
- Any follow-up or other services, including but not limited to: 1) services that cannot be performed during a McLaren Care Now Clinic visit, 2) referrals to other providers, 3) labs, or 4) other services are not covered under the McLaren Care Now Clinic Cost Sharing and are subject to the applicable Cost Sharing in your Schedule of Cost Sharing.

Exclusions:

- Fees imposed by the McLaren Care Now Clinic for a missed appointment.

8.37 SERVICES FOR GENDER TRANSITION

MHP Community Covers Medically Necessary services related to gender dysphoria or gender transition. Such services will be subject to the applicable Member cost sharing and limitations otherwise applicable. (e.g., see Section 8.8 Inpatient hospitalization, Section 8.34 Prescription Drugs, Section 8.18 Mental Health Services, Part 9 Exclusions).

Limitations:

- Gender reassignment surgery must be Preauthorized

Exclusions:

- Reversal of prior gender reassignment surgery;
- Surgery that is considered cosmetic in nature and not Medically Necessary when performed as a component of a gender reassignment;
- Services, treatment and surgeries that are considered Experimental and Investigative; and
- Exclusions under other benefits (e.g., see Section 8.8 Inpatient hospitalization, 8.19 Outpatient Habilitative Services, 8.20, Outpatient Rehabilitative Services, Section 8.23 Reproductive Care and Family Planning Services, Section 8.34 Prescription Drugs, Section 8.18 Mental Health Services, Part 9 Exclusions.

8.38 SERVICES COVERED BY RIDER ONLY

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

8.39 OUT-OF-AREA COVERAGE

You are Covered when traveling outside of your Service Area only for Emergency Services that meet the conditions described in Section 8.6 of this Certificate.

8.40 TELEMEDICINE

Telemedicine Services (including telepsychiatry) are Covered if provided by a Participating Provider and subject to the terms and conditions of this Certificate.

Limitations:

- Services must be performed by a Participating Provider;
- The same Preauthorization requirements apply as if the service was provided in an in-office setting; and
- Telemedicine services are a method of accessing Covered Services, not a separate Benefit and are subject to the applicable Cost Sharing for the service specified in your Schedule of Cost Sharing.

Exclusions:

No Coverage is provided in the following scenarios:

- When you and the treating Participating Provider are in the same location;
- Texting, fax or email only;
- Services related to administration issues, (e.g., registering, appointment scheduling, billing issues); and
- Services provided without a real time interaction

PART 9: EXCLUSIONS AND LIMITATIONS

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

9.1 UNAUTHORIZED SERVICES

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

9.2 SERVICES THAT ARE NOT MEDICALLY NECESSARY

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

9.3 NON-COVERED SERVICES

- Office visits, exams, treatments, test and reports for any of the following are not Covered:
  - Employment
  - Licenses
  - Insurance
  - Travel (only immunizations for purposes of travel are Covered Benefits)
  - School purposes
  - Legal Proceedings, (for example, parole, court and paternity requirements);
- Housekeeping services;
- Court-related services and marital counseling;
- Outpatient rehabilitation services related to vocational rehabilitation;
- Outpatient rehabilitation services for speech therapy related to Chronic conditions or congenital speech abnormalities, learning disabilities, deviant swallow or tongue thrust, and vocal cord abuse resulting from life-style choices;
- Deluxe DME such as motor-driven wheelchairs and beds, unless Preauthorized, Medically Necessary and required so that the patient can operate the equipment himself;
- Items that are not considered medical items;
- Duplicate DME;
- Physician’s equipment such as blood pressure cuffs and stethoscopes;

- Disposable supplies such as sheets, bags and elastic stockings;
- Exercise and hygienic equipment such as exercycles, treadmills, bidet toilet seats and bathtub seats;
- Self-help devices that are not primarily medical items such as sauna baths, elevators and ramps, special telephone or communication devices;
- Needles and syringes for purposes other than the treatment of diabetes;
- Repair or replacement of DME, prosthetics, orthotics, and corrective appliances due to loss, theft or damage;
- Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers and such equipment not intended for use in the home;
- Sports-related braces;
- Dental appliances;
- Hearing aids and offices visits, evaluations or exams related to hearing aids;
- Eyeglasses or contact lenses except after a Preauthorized surgery for eye diseases such as cataracts or to replace an organic lens that is missing from birth (see Section 8.22) or except as Covered as a part of Pediatric Vision services under Section 8.24;
- Non-rigid appliances and supplies such as (but not limited to) elastic stockings, garter belts, arch supports, corsets, corrective shoes, wigs or hair pieces, shoe or foot orthotics;
- Private Duty Nursing;
- Autopsies;
- Costs related to the collection, processing and storage of items or services or bodily parts or fluids unless immediately medically required;
- Travel and lodging expenses;
- Over the counter medical supplies, devices and tests; and
- All other services specifically defined as “not Covered” or a Benefit exclusion in this Certificate.

9.4 COSMETIC SURGERY

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

9.5 MILITARY CARE

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

9.6 CUSTODIAL CARE

We do not Cover any custodial care, i.e. care that is primarily for maintaining the Member’s basic needs for food, shelter and clothing. This means that custodial care is not Covered in settings such as your home, a nursing home, residential institution or any other setting that is not required to support medical and skilled nursing care. Further, we do not Cover Custodial (non-skilled) care when received in a home or facility on a temporary or permanent basis. Examples of such care include three-quarter house or

half-way house placement, room and board, health care aids and personal care designed to help in activities of daily living or to keep from continuing unhealthy activities.

9.7 COMFORT ITEMS

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

9.8 RESEARCH OR EXPERIMENTAL SERVICES

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

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

Covered Services:

Coverage is available for Routine Patient Costs in connection with an Approved Clinical Trial (see Section 8.29). For information about which trials are Covered, a Member's PCP should contact MHP Community.

Exclusions:

Any drug, device, treatment or procedure that is experimental, investigational or unproven. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:

- The drug or device has not been approved by the Food and Drug Administration (FDA) and, therefore, cannot be lawfully marketed in the United States;
- An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy;
- The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy;
- Reliable Evidence shows that the drug, device, treatment or procedure is:
    - Under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or
    - Believed by a majority of experts to require further studies or clinical trials to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis.
- **Reliable Evidence** includes any of the following:

  - Published reports and articles in authoritative medical and scientific literature, or technology assessment and cost effectiveness analysis; or
  - A written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same or a similar drug, device, treatment or procedure; or
  - Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device or procedure.

9.9 NON-MEDICAL SERVICES

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

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

9.10 FOOT CARE

We do not Cover routine foot care unless Medically Necessary. Routine foot care includes, but is not limited to, corn and callous removal, nail trimming and other hygienic or maintenance care.

9.11 COURT-RELATED SERVICES

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

9.12 ELECTIVE PROCEDURES

The following elective procedures are not Covered:

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

9.13 DENTAL SERVICES

MHP Community does not Cover dental services (including pediatric dental services), dental prostheses, replacement of teeth, X-rays, orthodontic treatment, oral surgery or anesthesia for procedures relating to the teeth except as stated in Sections 8.25 - 8.27.

9.14 SERVICES COVERED THROUGH OTHER PROGRAMS AND THE PUBLIC SECTOR

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

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

9.15 ALTERNATIVE SERVICES

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

9.16 VISION SERVICES

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

- Radial keratotomy;
- Laser-Assisted in situ Keratomileusis (LASIK);
- Routine non-Medically Necessary vision and optometric exams;
- Refractions;
- Eyeglasses and eyeglass frames;
- Contact lenses in lieu of eyeglass frames and eyeglass lenses
- Dilation;
- Visual training, eye exercises, orthoptics or sensory integration therapy; and
- Dyslexia treatment.

9.17 ILLEGAL OCCUPATION OR CRIMINAL ACTIVITY

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

9.18 CARE RENDERED WHILE IN POLICE CUSTODY

Services provided to a Member while in police custody are not Covered. This includes, but is not limited to, services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment.

9.19 SERVICES PROVIDED BY FAMILY OR HOUSEHOLD MEMBER(S)

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

9.20 HEALTH EDUCATION OR HEALTH COUNSELING

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

- Services for remedial education, including school-based services;
- Services, treatment or diagnostic testing related to learning disabilities, cognitive disorders and developmental delays;
- Education testing or training, including intelligence testing; and
- Classes covering such subjects as stress management, parenting and lifestyle changes.

9.21 NO SHOW CHARGES

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

9.22 SERVICES PROVIDED BY A NON-PARTICIPATING PROVIDER

You are responsible for the full costs of any services you receive from a Non-Participating Provider, unless MHP Community Preauthorizes the Non-Participating Provider's services in advance of you receiving the services, or for certain Covered Services related to a Medical Emergency. See Section 8.6 for details on Emergency Coverage by a Non-Participating Provider. The following includes, but is not limited to, additional scenarios where MHP Community will not pay for services you receive from a Non-Participating Provider: 1) when a Participating Provider sends labs, pathology or other services to a Non-Participating Provider, 2) you are referred to a Non-Participating Provider by a Participating Provider, 3) services are delivered by a Non-Participating Provider at a Participating Provider facility, 4) when the Participating Provider (e.g., physician) uses a Non-Participating Provider Facility, 5) if you fail to obtain

preauthorization in advance to see a Non-Participating Provider, even if MHP Community does not have the services available in-network.

9.23 SERVICES PROVIDED BY AN UNLICENSED OR UNAUTHORIZED PROVIDER

You are responsible for the full costs of any services you receive from a Provider who is not appropriately credentialed or privileged as determined by MHP Community or who is not legally authorized or licensed to provide the services. We do not Cover items or services furnished, ordered or prescribed by any Provider listed or identified in a database for exclusion (e.g., the U.S. Department of Health & Human Services Office of Inspector List of Excluded Individuals and Entities (LEIE), the U.S. General Services Administration (GSA), or a Medicaid OIG exclusion list).

9.24 CLINICAL ECOLOGY AND ENVIRONMENTAL MEDICINE

Clinical Ecology and Environmental Medicine. Services and supplies provided to effect changes in or treatment to you and/or your physical environment. When we say “clinical ecology” and “environmental medicine” we mean medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems.

9.25 SERVICES PROVIDED OUTSIDE THE UNITED STATES

Except for Covered Emergency services, we do not provide Coverage for services outside the United States. Covered Emergency Services provided outside the United States will be paid in accordance with the Reimbursement Amount. See Section 4.6 for more information on the requirements and how to submit documentation for reimbursement. Note, services provided outside the United States may not be covered under Applicable Surprise Billing Laws and may be subject to Balance Billing.