



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 Copayments and Deductibles, the Member's Identification Card, the Application and any amendments, Riders or endorsements to this Certificate.

This Certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of Coverage. No change in this Certificate shall be valid until approved by an executive officer of MHP Community and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Certificate or to waive any of its provisions.

Note: The Schedule of Copayments and Deductibles 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 Identification 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 a Member's 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.

Change of beneficiary: Unless the Member makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Member and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Physical examinations and autopsies: MHP Community, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death where it is not forbidden by law.

Proof of loss: Written proof of loss must be furnished to MHP Community at its offices in case of claim for loss for which this Certificate provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which MHP Community is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

Time of payment of claims: Indemnities payable under this Certificate for any loss other than loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which

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this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

IMPORTANT INFORMATION

- 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 and, when required, Preauthorized by MHP Community); and
 - otherwise Preauthorized or approved by MHP Community, when required.
- MHP Community is an HMO that operates on a direct service basis. It is not an insurance company.
- 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 as determined by MHP Community.
- You are responsible for Copayments, Coinsurance and Deductibles for many of the Benefits listed. (See Section 8.01 and the Schedule of Copayments and Deductibles.) Copayments, Coinsurance and Deductibles do not apply to Preventive Services (see Section 8.03 of your Certificate).
- **Genetic Testing:** 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 such 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.
- This Coverage is Guaranteed Renewable unless Terminated under Part 5.

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:

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- 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 48507, 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 888-327-0671-1 (رقم هاتف الصم والبكم: 711).

Syriac/Assyrian:

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

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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 ১-৮৮৮-৩২৭-০৬৭১ (TTY: ৭১১)।

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).

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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.

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.

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.

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.

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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.

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 and the Member that describes Member's Benefits, the Schedule of Copayments and Deductibles, the application for Coverage and any Riders we issue that change Benefits.

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.

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 Copayments and Deductibles 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. Refer to the Schedule of Copayments and Deductibles and applicable Rider(s) to verify which Benefits have a Copayment requirement. Copayments apply to the Out-of-Pocket Maximum.

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 Copayments and Deductibles and applicable Riders) describes what MHP Community will pay for some services and supplies.

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 Copayments and Deductibles and any applicable Rider(s). The Deductible(s) applies/apply to your Out-of-Pocket Maximum. You have a

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combined pharmacy and medical services Deductible unless the Schedule of Copayments and Deductibles provides for a separate Pharmacy Deductible.

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.

Inpatient Service is a service provided during the time a patient is admitted to a hospital or skilled nursing facility.

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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.

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

Mental Health Provider is a psychiatrist, licensed consulting psychologist, social worker, hospital or other facility duly licensed and qualified to provide mental health services under the law or jurisdiction in which treatment is received.

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

Michigan Health Insurance 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 (IHCA) or Section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA).

Newborn is a child 30 days old or younger.

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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 each year 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 that MHP Community does not Cover.

Participating Provider is a provider directly contracted with MHP Community to provide services to MHP Community Members. 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.

Preauthorized Service, Preauthorization or Preauthorize 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 7.02 for more information about when and how to obtain Preauthorization.

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 the MHP Community Network. You may call our Customer Service Department to obtain a list of Providers in your area, or you can go to our website at www.McLarenHealthPlan.org.

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, change in citizenship, state, national or lawfully present status, and loss of other minimum essential coverage.

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.

Referral is a document issued by MHP Community that your PCP completes before you receive certain services. See also **Preauthorization**.

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“Rewards Providers” are a subset of MHP Community Participating Providers for some Individual MHP Community Coverage plans. If you are a Member of a Rewards plan, your standard Copayments, Coinsurance and Deductible may be reduced or eliminated when you receive services from a Rewards Provider. Please review the Schedule of Copayments and Deductibles for information specific to each Covered Service. “Rewards Providers” are identified in the MHP Community Provider Directory. **NOTE:** Only Members of MHP Community Rewards plans have a Rewards benefit. Please review your Schedule of Copayments and Deductibles or call Customer Service at (888) 327-0671 if you are unsure if Rewards Benefits are a part of your plan.

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 outlines 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 Copayments and Deductibles 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 Copayments and Deductibles, 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.

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 (Qualifying Events) 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.

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.

Treatment Plan for Treatment of Autism Spectrum Disorder means a written, comprehensive and individualized intervention plan that incorporates specific treatment goals and objectives. The plan is (i) developed by a health professional who has the appropriate behavioral health credentials and who is operating within his or her scope of practice when the treatment of an Autism Spectrum Disorder is first prescribed; or (ii) ordered by a physician or licensed psychologist.

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.

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 Health Insurance Marketplace (“**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; or
- A Principally Supported Child.

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

1.01 ELIGIBILITY

1.01.A Subscriber

1.01.A.1. Non-Native American Subscriber

A Subscriber must meet all of the following:

- Be over 18 years of age and under 65 years of age for standard Individual Coverage **or** be under 21 years of age for Child Only Coverage;
- Be a citizen, national or non-citizen lawfully present in the U.S., 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 Medicare or Medicaid;
- Not be incarcerated;
- Not have been Terminated from MHP Community or its affiliates within the past two (2) years for non-payment of a premium; and
- Submit a completed and signed enrollment form and the required Premium

1.01.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.

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- 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:** If the I/T/U provider is not directly contracted with MHP Community, Covered Services will be paid at the lesser of (a) the Provider's usual charge for furnishing the service; or (b) MHP Community's Reimbursement Amount. The Member will be responsible for any Balance Bill of the Provider.

1.01.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 retardation or physical handicap;
- 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; and
- The Dependent child is unmarried.

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The Subscriber must submit to MHP Community the proof of this 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.

1.01.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 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.

1.01.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.

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

For more than one (1) 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 (1) common parent and/or one (1) 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.

1.02 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 referred to as 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, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, for the first 30 days from birth even if you do not submit a change form. If you want the Newborn's Coverage to continue beyond the first 30-day period and you are Covered under a Michigan Marketplace plan, you must add the Newborn at HealthCare.gov within sixty (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 thirty (30) days after the child is born.

(2) Loss of Other Coverage

If you lost other minimum essential coverage, including Medicaid, you may enroll yourself

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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 as the Michigan Marketplace may provide.

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 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; or
- 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;
- 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.

1.03 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

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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

- The first of the month following the date of marriage
- The date of a Dependent’s birth, adoption or placement for adoption
- The first of the month following the date of plan selection on the Michigan Marketplace for loss of other coverage
- Change in citizenship – If you select your plan between the 1st and the 15th day of the month, your effective date is the first day of the following month. If you select your plan between the 16th of the month and the last day of the month, your effective date is the first day of the 2nd following month.
- Other circumstances for plans on the Michigan Marketplace – effective dates of coverage will be determined by the Marketplace.

1.04 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.

2.01 NONDUPLICATION

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.

2.02 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” whereby 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.

2.03 COORDINATION OF BENEFITS (COB) AND SUBROGATION

Note: For purposes of this Section, “certificate” and “policy” include a certificate, contract, or policy issued by:

- A health or medical care corporation;
- A hospital service corporation;
- A HMO;
- A dental care corporation;
- An insurance company;
- A labor-management trustee plan;
- A union welfare plan;
- An employer organization plan; or
- An employer self-insurance plan

in connection with a disability benefit plan under which health, hospital, medical, surgical, or sick care benefits are provided to members.

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Member Responsibility: At the time of enrollment and if requested by MHP Community thereafter, 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 thirty (30) calendar 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

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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.

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 obtain the information from a third party.

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.

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- 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. MHP Community will have the right to recover from you the value of services and Benefits provided to you.

PART 3: MEMBER RIGHTS & RESPONSIBILITIES

3.01 CONFIDENTIALITY OF HEALTH CARE RECORDS

Your health care records will be kept confidential by MHP Community in accordance with all 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.

3.02 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.

3.03 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 and verify that the PCP you have chosen is accepting new patients. You

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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.

3.04 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.

3.05 COMPLAINT, GRIEVANCE AND APPEALS PROCEDURES

MEMBER COMPLAINTS

At MHP Community, 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 attempt to resolve your concerns during the initial contact. If you continue to be 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 thirty (30) calendar days. MHP Community will acknowledge receipt of your Grievance in writing within five (5) calendar days of receipt. MHP Community will investigate your Grievance and provide you with a written determination within fifteen (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 thirty (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 thirty (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

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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 seventy-two (72) hours after receipt of an expedited Grievance. Written notification of the determination is sent within two (2) calendar 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 Determination in the Definitions Section of this Certificate, and also note that an untimely response to a request may become an Adverse Benefit Determination. Members or their authorized representative have one hundred eighty (**180**) days from the date of the notification letter to file a written appeal of an Adverse Benefit Determination. You can send your appeal request along with any additional information to:

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

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 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, sufficiently in advance of the date on which the decision is required to be made, 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 thirty (30) calendar days to complete the internal appeal process for a pre-service appeal request, and sixty (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 ten (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

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determination within three (3) calendar days after the decision is made. In addition, we may also notify you orally.

EXPEDITED INTERNAL APPEALS

If your treating physician advises us that he or she believes that due to your medical status, resolution of your appeal within MHP Community's normal time frames would seriously jeopardize your life or health or ability to regain maximum function, the expedited complaint/grievance or appeals process may be utilized.

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 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 (2) 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 seventy-two (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. If so, you and your physician will be provided with written confirmation of this decision within two (2) calendar 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 one hundred twenty (120) days of receiving MHP Community's final adverse determination. If you are not required to exhaust MHP Community's appeals process, you must do this within one hundred twenty (120) days from receiving MHP Community's Adverse Benefit Determination. . MHP

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Community will provide the form required to file an external appeal. Requests should be mailed or faxed to:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

Courier/Delivery service:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan Ste., 7th Floor
Lansing, MI 48933-1521

Toll Free Telephone: 1 (877) 999-6442
FAX: 517-284-8838
www.michigan.gov/difs

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 Complaint/Grievance and 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 appeal with the State of Michigan, Department of Insurance and Financial Services (DIFS). You must do this within ten (10) days of receiving MHP Community’s appeal decision. MHP Community will provide the form required to file an expedited external appeal. These requests should be mailed or faxed to:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

Courier/Delivery service:

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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.

3.06 EXPEDITED 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 Preauthorization of a Non-Formulary Drug and, in appropriate circumstances, Coverage of the Non-Formulary Drug at the Generic Drug Copayment.

Non-Formulary Drug: A Prescription Drug that is listed on the MHP Community Formulary as “Non-Formulary”. These drugs require Preauthorization and have higher Copayments.

Process:

When a Member 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, the Member’s designee 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 shall 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.

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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 the Exigency ends, whichever occurs first.

3.07 TERMINATION OF A PARTICIPATING PROVIDER'S CONTRACT WITH MHP COMMUNITY

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 1-888-327-0671) as soon as possible.

If a Participating Provider terminates his/her contract or arrangement with MHP Community, 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.

This continuation of treatment with the Provider may be continued, as applicable:

- For up to 90 days after the Member receives notice that the Provider is leaving MHP Community's Participating Provider network;
- Through the second and third trimester of a pregnancy (in the case of a pregnant woman) and through the completion of post-partum care directly related to the pregnancy; or
- In the case of a Member with an Advanced Illness, through the remainder of the Member's life for treatment related to the Advanced Illness if the physician was treating the Advanced Illness before the date of termination or knowledge of the termination.

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

3.08 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 Services Department, G-3245 Beecher Road, Flint, MI 48532.

PART 4: FORMS, IDENTIFICATION CARDS, RECORDS AND CLAIMS

4.01 FORMS AND APPLICATIONS

Applicants and MHP Community 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.

4.02 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, report it to MHP Community immediately.

4.03 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 and other 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.

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4.04 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 mistakenly paid by MHP Community as a result of the incorrect information.

4.05 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.

Written notice of claim must be given to MHP Community within 20 days after the date of service or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member or the beneficiary to MHP Community at G-3245 Beecher Road, Flint, MI 48532, or to any authorized agent of MHP Community, with information sufficient to identify the Member, shall be deemed notice to MHP Community.

MHP Community, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting, within 12 months after the date of service, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Member. Any other accrued indemnities unpaid at the Member's death may, at the option of the Member, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Member.

PART 5: TERMINATION OF COVERAGE

5.01 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.

5.01.01 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 (3) 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.

5.01.02 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.

5.02 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 thirty 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;

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- 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 5.01);
- 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 fourteen (14) days' notice to MHP Community or the Michigan Marketplace (as applicable) of his or her wish to Terminate.

5.03 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 Complaint and 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.

5.04 TIME LIMIT ON CERTAIN DEFENSES

A. After three (3) years from the date of 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 (3) year period.

B. No claim for loss incurred or disability (as defined in the Certificate) commencing after 3 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.

5.05 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

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Community's decision to Terminate or Rescind the Member's Coverage, the Member may appeal the decision following the 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

7.01 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.

7.02 CHANGE OF ADDRESS

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

7.03 HEADINGS

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

7.04 GOVERNING LAW AND LEGAL ACTIONS

This Certificate is made and will be interpreted under the laws of the state of Michigan.

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the

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requirements of this Certificate. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

7.05 EXECUTION OF CONTRACT OF COVERAGE

When you, the Subscriber, sign the MHP Community application form, you are agreeing to all terms, conditions and provisions of this Certificate.

7.06 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, provider, or other insurance company. MHP Community will not pay any provider except under the provisions of this Certificate.

7.07 MHP COMMUNITY POLICIES

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

7.08 CONTRACT

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

- This booklet;
- Any applicable Riders;
- The Schedule of Copayments and Deductibles;
- The application signed by the Subscriber; and
- The MHP Community identification card.

7.09 WAIVER BY AGENTS

No agent or any other person, except an executive officer 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.

7.10 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.

7.11 MAJOR DISASTERS

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

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

Such circumstances include:

- 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.

7.12 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 professional credentials of the Participating Providers;
- The names of Participating Hospitals where individual Participating physicians have privileges for treatment; and
- How to contact the appropriate Michigan agency to obtain information about complaints or disciplinary actions against a health care provider.

7.13 CLERICAL ERRORS

Clerical errors, such as an incorrect transcription of Effective dates, 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.

7.14 WAIVER

In the event that 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.

7.15 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.

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- 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 forty-fifth 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 thirty (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 fourteen (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.

PART 8: YOUR BENEFITS

8.01 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 Copayments and Deductibles.

8.02 PREAUTHORIZATION AND UTILIZATION REVIEW

8.02.01 Preauthorization

Preauthorization Requirements: Certain services and supplies require Preauthorization by MHP Community before they will be Covered. Part 8, the Schedule of Copayments, Coinsurance and Deductibles 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. If MHP Community Preauthorizes a service, we will notify your PCP or the provider who makes the request.

All Covered Services you receive from a Non-Participating Provider must be Preauthorized by MHP Community in order to be Covered. A Referral from your PCP or another provider is not enough if you want the services to be Covered.

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;
- Outpatient Hospital and clinic services for dorsal spinal stimulators;
- Oral surgery, TMJ treatments and orthognathic surgery;
- Special surgical procedures (see Section 8.13);
- Durable medical equipment (DME) costing more than \$3,000.00;
- Prosthetics, orthotics and corrective appliances costing more than \$3,000.00;
- Insulin pumps;
- Genetic testing (including BRCA testing Covered under Section 8.03);
- Contact lenses as a part of Pediatric Vision Coverage;
- 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;
- 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
- 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 14 calendar 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 3.05 under the heading, **Standard Internal Appeals**.

A Member may request an expedited appeal for denials of Urgent Preauthorization Requests. See Section 3.05, under the heading, **Expedited Appeal**.

8.02.02 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

8.03 PREVENTIVE SERVICES

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 without application of a 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.

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 and adolescents, 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 is more detail about the categories of Preventive Services that are Covered. More detailed information is available on MHP Community's website at www.McLarenHealthPlan.org, or visit the USPSTF website at <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/> or www.HealthCare.gov. This information may also be obtained by calling Customer Service at (888) 327-0671.

Physical Exams

Age	Frequency
Newborns	1 exam, 2 – 3 days after discharge.
0 to 2 years	Well-child visits at 2, 4, 6, 9, 12, 18 and 24 months.
3 to 6 years	Routine visit at 30 months. One visit every 12 months for ages 3 to 6 years.
7 to 10 years	One visit every 12 to 24 months.
19 to 21 years	One visit every 2 to 3 years; annually, if desired.
22 to 64 years	One visit every 24 months, annually, if desired.
65 and older	One visit every year.

Immunization vaccines for newborns to age 18

Doses, recommended ages and who should have these immunizations vary, and include but are not limited to:

- Diphtheria, tetanus, pertussis;
- Measles, mumps, rubella;
- Influenza

Assessments and screenings Newborn to age 18

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.

Immunization vaccines for adults

Doses, recommended ages and who should have these immunizations vary, and include but are not limited to:

Vaccine	Preventive Service
Hepatitis A	2 doses for high risk groups.
Hepatitis B	3 doses for high risk groups.
Herpes Zoster	1 dose at age 60 and older.
Influenza	Every year.
Pneumococcal	1 does after age 65. If high risk, 1 dose before age 65 followed by booster dose after age 65.

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Preventive services for women

Service	Who	Frequency
Well-woman visits	Adult women	Annually and as needed
Gestational diabetes screening	Women 24-28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
Sexually transmitted infection (STI) counseling	Sexually active women	Annually
HIV screening and counseling	Sexually active women	Annually
Contraceptive methods, sterilization procedures and patient education and counseling	Sexually active women	As needed
Breast feeding support, 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 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. 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

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- HIV screening
- Sexually transmitted infection (STI) screening
- Screening and counseling for obesity
- Screening for tobacco use
- Counseling regarding use of aspirin to prevent cardiovascular disease
- Diet counseling – adults at 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;
- Maternity education programs. These programs are available through MHP Community. For more information regarding 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 MHP Community Customer Service to request enrollment in the Tobacco Cessation Counseling program.) Preauthorization is required.
- 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 benefit year and/or done before 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 likewise not Preventive Services, and the Member will be responsible for paying any applicable Copayment, Coinsurance or Deductible for such services.

8.04 DIABETIC SERVICES

The following equipment, supplies, drugs and educational training 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 and blood glucose monitors for the legally blind;
- Test strips for glucose monitors, visual reading and urine reading strips, lancets and spring-powered lancet devices;
- Insulin pumps and medical supplies required for the use of an insulin pump*;
- Insulin syringes;
- Insulin;
- Non-experimental medication for controlling blood sugar;
- 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 to ensure that Members with diabetes are trained as to the proper self-management and treatment of their condition.

* **Note:** Insulin pumps require Preauthorization.

Limitations:

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 Community Health. This training shall be conducted in group settings whenever available.

8.05 PROFESSIONAL PHYSICIAN SERVICES (OTHER THAN 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.

8.05.01 PHYSICIAN OFFICE VISITS

Includes:

- Allergy test and serum
- Allergy injections
- Hearing exams
- Diabetes education (see Section 8.04)
- 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

8.05.02 IMMUNIZATIONS

Immunizations that are included as Preventive Services are Covered pursuant to Section 8.03. 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.

8.05.03 MATERNITY CARE AND NEWBORN CARE

Covered Services:

- Hospital and physician care: Services and supplies furnished by a Participating Hospital or other Participating Provider 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 minimum hospital stay described below. 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.

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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 the first **30 days** from birth. If you want the Newborn's Coverage to continue beyond the first 30-day period, and you are Covered under a Michigan Marketplace plan, you must add the Newborn at HealthCare.gov within sixty (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 thirty (30) 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, is Covered. MHP Community does not consider a routine delivery to be a Medical Emergency.
- Services and supplies received in connection with an obstetrical delivery in the home or free-standing birthing center are not Covered.

8.05.04 INJECTABLE DRUGS PROVIDED IN THE OFFICE

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.

8.05.05 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.

8.05.06 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.

8.06 SPINAL TREATMENT

Covered Services:

- Detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects.
- Other services related to treatment, including diagnosis and x-rays.

Limitations:

- The interference, as stated above, must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.
- Treatment must be provided by a Spinal Treatment provider in the provider's office.
- Spinal Treatment benefits are limited to one (1) visit and treatment per day; 20 visits maximum, annually.

8.07 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.

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 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:

- 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.

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- 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, 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).
- 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 the 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. Subject to the limitations below, Preauthorization is usually not required.

Limitations:

- In case of such 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 our Service Area are not Covered. **Urgent care** services received from a Non-Participating Provider who is located outside of our 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.

8.08 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.

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The following ambulance services are Covered:

- Non-emergency ground ambulance services when Preauthorized by MHP Community.
- 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. The services are not Covered for normal or false labor.
 - 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.

8.09 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: 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 8.05.3 and 9.11 for limitations); and
- Non-emergency transport between facilities.

Exclusions:

Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.

8.10 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 8.02 for Preauthorization requirements. Outpatient services include the following:

- Outpatient surgery;
- Outpatient CT scans, PET scans, MRI and nuclear medicine;
- 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
- Outpatient infusion therapy.

8.11 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 8.02 for Preauthorization requirements.

Diagnostic and therapeutic services and tests that are included as Preventive Services are Covered pursuant to Section 8.03. Please also refer to the complete list of Preventive Services at www.McLarenHealthPlan.org or call Customer Service at (888) 327-0671. All other such services may be subject to Copayments, Coinsurance and/or Deductibles. Diagnostic and therapeutic services and tests include the following:

- Pathology services and laboratory tests; and
- Diagnostic procedures.

8.12 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 a designated MHP Community Participating Provider facility.

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Coverage is provided for related drugs for treatment of cancer pursuant to Section 8.30 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.

Exclusion: Services provided at a non-MHP Community designated Participating facility.

8.13 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 nationally recognized medical necessity criteria, and MHP Community must Preauthorize the services. These services may include:

- Morbid obesity weight loss surgery;
- 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.

8.14 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 60 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.

Exclusion: Basic custodial care.

8.16 HOME CARE SERVICES

Home care services, including skilled nursing care, medical supplies and other health care services, are Covered when they are performed in the patient's home. Medically Necessary home care services are Covered.

Exclusions:

- This Benefit does not include 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;
- This Benefit does not include housekeeping services; and
- These services are not Covered if 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 forty-five (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.

8.18 MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES

8.18.01 MENTAL HEALTH SERVICES

Definitions:

Inpatient Mental Health Service is the service provided during the time a Member is admitted to a 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 (8) hours daily. These services are included as “Inpatient Mental Health Services” in the Schedule of Copayments and Deductibles.

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 Copayments and Deductibles. 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 8.07)

Limitations:

- Inpatient Mental Health Services, Partial Hospitalization and Residential Mental Health Treatment each require Preauthorization by MHP Community.

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- Medical services required during a period of mental health admission must be Preauthorized separately by MHP Community if Preauthorization is otherwise required.
- Coverage is limited to solution-focused treatment and crisis interventions. Solution-focused treatment includes both individual and group sessions.
- Only treatments that are expected to result in measurable, substantial and functional improvement are Covered.
- Coverage is limited to the least restrictive and most cost-effective treatment necessary for restoring reasonable function.

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;
 - Foster care facilities;
 - Therapeutic boarding schools;
 - Recreational or wilderness therapy programs;
 - Custodial Care;
 - Halfway 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.
- Also see Part 9 for additional Exclusions.

8.18.02 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 Copayments and Deductibles.

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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 Copayments and Deductibles.

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 Copayments and Deductibles.

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 Copayments and Deductibles.

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 Copayments and Deductibles.

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 8.07)

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.
- Coverage is limited to solution-focused treatment and crisis intervention. Solution-focused treatment includes both individual and group sessions.
- Only treatments that are expected to result in measurable, substantial and functional improvement are Covered.
- Coverage is limited to the least restrictive and most cost-effective treatment necessary for restoring reasonable function.

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;
 - Foster care facilities;
 - Therapeutic boarding schools;
 - Recreational or wilderness therapy programs;
 - Custodial care;
 - Halfway house services.
- Also see Part 9 for Exclusions.

8.19 OUTPATIENT HABILITATIVE SERVICES

MHP Community Covers Habilitative Services that 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 (including osteopathic and chiropractic manipulation), speech-language pathology, Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (see also Section 8.33) and other services for people with disabilities.

Limitations:

- Physical and Occupational Therapy (including osteopathic and chiropractic manipulation) 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 counts as 1 visit;
- Habilitative Services, including services for treatment of Autism Spectrum Disorder, must be Preauthorized by MHP Community in order to be Covered.
- Physical Therapy also 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 nineteen (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; and;
- Services outside the scope of practice of the servicing provider.

Speech Therapy exclusions also include:

- Deviant swallow or tongue thrust; 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 (including osteopathic and chiropractic manipulation) 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;
- **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 (1) visit.
- Rehabilitative Services must be Preauthorized by MHP Community in order to be Covered;
- Physical Therapy also requires a prescription from a referring physician.

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Exclusions:

- Vocational rehabilitation;
- 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; and
- Vocal cord abuse resulting from life-style activities.

8.21 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

8.21.01 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. Coverage is provided for rental or purchase, and is limited to basic equipment. **If the cost of the DME is greater than \$3,000.00, it must be Preauthorized by MHP Community to be Covered.**

Note: All Medically Necessary equipment and supplies for the treatment of diabetes are Covered (Preauthorization required for insulin pumps). See Section 8.04.

Limitations:

- The equipment must be considered DME by MHP Community and be appropriate for home use;
- 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 \$3,000.00, 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; and
- Replacement of DME is Covered only when necessary to accommodate body growth, body change or normal wear.

Exclusions:

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

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- 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;
- 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);
- Physician’s equipment (such as blood pressure cuffs and stethoscopes);
- Disposable supplies (such as sheets, bags, elastic stockings);
- 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.

8.21.02 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 \$3,000.00, 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 \$3,000.00, the item must be Preauthorized by MHP Community to be Covered.**

Exclusions:

- Repair or replacement due to loss, theft or damage is 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

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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.

Exclusions:

The following are not Covered:

- Sports-related braces;
- Dental appliances;
- 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

8.23.01 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 nationally recognized criteria. Coverage for pharmaceutical drugs prescribed as a part of this treatment are Covered as part of this medical Benefit.

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); and
- All services related to surrogate parenting arrangements, including but not limited to, maternity and obstetrical care for non-Member surrogate parents.

8.23.02 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

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practice. Certain genetic testing services (e.g., BRCA for women when Medically Necessary) are Covered under Preventive Services Coverage. See Section 8.03.)

8.23.03 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.

8.23.04 ABORTIONS

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

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 Lenses	Annually
Eyeglass Lenses	Annually
Contact Lenses in lieu of frames and lenses	Annually

Limitation: Contact lenses require MHP Community Preauthorization.

Coverage for this Benefit ends on the last day 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 9.12

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;

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- 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 and repair/restoration of the teeth;
- Services provided by an individual who is not a licensed, practicing oral surgeon or a licensed medical 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 include:

- 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; 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.

Exclusion: Orthodontic treatment is not Covered for any purpose, including orthognathic conditions.

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

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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; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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:

Experimental, investigational or unproven services are not Covered. Additionally, 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 SERVICES

Covered Services:

- Weight loss and nutrition educational programs--including morbid obesity weight management programs--that MHP Community has reviewed and approved;
- Dietician services (limited to 6 visits per year unless Covered as a Preventive Service (see Section 8.03); and
- Maternity education services through MHP Community. For more information regarding these services call Customer Service at (888) 327-0671.

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 exams are Covered in a provider's office. Vision exams include one (1) routine exam, including refraction, each calendar year to detect vision impairment. Vision exams performed by an MHP Community Participating Provider do not require Preauthorization.

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

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 is available for Covered dependent children through age 18 and 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 and 24 months is Covered as a Preventive Health Service (see Section 8.03).

Limitations:

Covered Services for Autism Spectrum Disorder:

- Must be Medically Necessary as determined by MHP Community; and
- Must be performed by an approved MHP Community facility or agency and in accordance with nationally recognized medical necessity criteria.

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.

8.34 PRESCRIPTION DRUG COVERAGE

Definitions:

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

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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, Specialty or Preventive Drug that is prescribed by a Participating Provider and obtained through a Participating Pharmacy, except as otherwise provided in this Certificate.

Dispense as Written or DAW: A Drug dispensed as written, with no substitutions (for example, “no substitution of a Tier 2 Drug”). If a Drug is prescribed as DAW when a Tier 1 is available, the Copayment will be affected unless the DAW is Preauthorized by MHP Community.

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 that can be dispensed through a mail-order service for a 90-day supply, and that is Covered with two (2) 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 Preauthorization 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.

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

Preauthorization/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 Preauthorizes 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. Coverage for contraceptives as Preventive drugs includes Coverage at no cost for at least one drug/device in each of the FDA's categories. For more information see Section 8.03, 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 and multiple sclerosis and oral oncology drugs.

Tier 1 Drugs: A MHP Community Formulary Drug available with the lowest Copayment. This Tier includes many commonly prescribed low-cost drugs, including commonly prescribed Generic Drugs and may include other low-cost Drugs.

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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. It also includes Specialty Drugs.

Coverage:

Coverage is provided 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, Preauthorized by MHP Community;
2. Injectable insulin when prescribed by a Participating Provider;
3. Disposable insulin needles and/or syringes;
4. Specialty Drugs when prescribed by a Participating Provider and Preauthorized by MHP Community;
5. Tier 2 or Tier 3 Brand Name Drugs and Preventive Brand Name Drugs by Mail Order;
6. Compounded Drugs that are Preauthorized by MHP Community; and
7. A limited number of Over-the-Counter Medications.

Copayments:

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

- Retail Pharmacy

- 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.

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- **Covered Over-the-Counter Drugs:** Copayments vary by OTC Drug. Refer to your Formulary and the Schedule of Copayments and Deductibles.

- Mail-Order Pharmacy – Available for Brand Name Only
 - Tier 1 Drugs – Not available
 - Tier2 and Tier 3 Drugs – Brand Name Only
 - Preventive Drugs – Brand Name only

- Specialty Drugs

Must be filled at a Participating 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.

2. A ninety (90) day supply of Preventive, Tier 2 or Tier 3 Brand Name Drugs may be dispensed from a Retail Pharmacy if a Member successfully completes a thirty (30) day trial of the Drug. The 90-day supply may be obtained with two (2) Copayments.

3. If a Drug is available through the Mail-Order Pharmacy, a 90-day supply may be dispensed with two (2) Copayments if a Member successfully completes a thirty (30) day trial of the Drug.

4. If a Member obtains Covered Prescription Drugs, needles or syringes, or insulin from a non-Participating Pharmacy when out of area or 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.

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5. Specialty Pharmacy Drugs must be obtained through a MHP Community specially-designated specialty pharmacies, and cannot be dispensed in a quantity greater than a thirty (30) day supply.
6. If a Tier 2 Drug is dispensed when a Tier 1 Drug equivalent is on the MHP Community Formulary, the Member must pay the difference between the cost of the Tier 2 Drug and the price of its Tier 1 Drug equivalent **in addition** to the applicable Copayment.
7. MHP may Preauthorize a Non-formulary Drug on the basis that the Drug is Medically Necessary and an appropriate alternative to a Covered Drug. If Preauthorization is requested, the Member or his/her provider must provide MHP Community with all information necessary to determine whether the Preauthorization should be granted. MHP Community shall provide a decision regarding the request within twenty-four (24) hours after receiving all such information. For urgent situations, see also Section 3.06, Expedited Formulary Exception Requests.
8. A Compounded Drug must meet the following additional requirements in order to be Preauthorized and Covered:
 - FDA-approved for the route of administration and medical condition for which it is prescribed; and
 - At least one of the ingredients of the Compound is an FDA-approved Prescription Drug.
9. 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. In accordance with Michigan law, 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

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- 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.

MHP Community shall provide a decision regarding the request within twenty-four (24) hours after receiving all such information. For urgent situations, see also Section 3.06, Expedited Formulary Exception Requests.

10. 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.

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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 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 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 8.03 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 requirements of the other applicable sections of this Certificate. (See, for example, Sections 8.05.4, 8.23 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.

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10. There is no Coverage for medications that are not regulated by the FDA, such as medical foods or herbal supplements.
11. There is no Coverage for the replacement of Drugs that are lost, stolen or damaged.

8.35 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 8.09 Inpatient Hospitalization, Section 8.34 Prescription Drugs, Section 8.18 Mental Health Services, Part 9 Exclusions).

Limitations:

- Services must be ordered and performed by Participating Provider
- Gender reassignment surgery must be Preauthorized
- Gender reassignment surgery must be performed at a Participating facility with expertise in gender reassignment surgery

Exclusions:

- All fees related to parenting arrangements of any kind, not including maternity care and services;
- Reversal of prior gender reassignment surgery;
- Services related to a host uterus, the collection or storage of sperm or eggs, and donor fees;
- 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;
- Voice therapy;
- Treatment received at a non-Participating facility; and
- Services provided by a non-Participating Provider.

8.36 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 Copayments and Deductibles).

PART 9: EXCLUSIONS AND LIMITATIONS

This section lists exclusions and limitations of your MHP Community 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 NONCOVERED 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, such as parole, court and paternity requirements;
- Housekeeping services;
- Court-related services and marital counseling;
- 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;

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- 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;
- 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; 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.

9.7 COMFORT ITEMS

MHP Community does not Cover any personal or comfort items, such as telephone or television.

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:

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- 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 MENTAL HEALTH/SUBSTANCE ABUSE

Coverage does not include the following services:

- Care provided by a Non-Participating facility except for Emergency admissions to the point of stabilization;
- Psychoanalysis and open-ended psychotherapy;
- 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;
- Transitional living centers such as three-quarter house or one-half way house, therapeutic, boarding schools, domiciliary foster care and milieu therapies such as wilderness programs other supportive housing, and group homes;

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- Maintenance treatments for caffeine and opiate addiction;
- 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;
- Treatment programs that have predetermined or fixed lengths of care are not Covered benefits;
- Court-ordered examination, tests, reports or treatments that do not meet requirements for Mental Health or Substance Abuse Services Coverage;
- Marital counseling services;
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider;
- The costs of a private room or apartment; and
- 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 .

9.10 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 treatment for substance abuse or mental illness except as specified in Section 8.18.

9.11 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;

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- Any service or supply relating to elective abortions; and
- Procedures that are not Preauthorized by MHP Community as required in this Certificate.

9.12 DENTAL SERVICES

MHP Community does not Cover dental services (including pediatric dental services), dental prosthetics, replacement of teeth, X-rays, orthodontic treatment, oral surgery or anesthesia for procedures relating to the teeth except as stated in Sections 8.25, 8.26 and 8.27.

9.13 SERVICES COVERED THROUGH OTHER PROGRAMS

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; and
- 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.

9.14 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, light therapy, therapeutic touch or aromatherapy is not Covered. Evaluations and office visits related to alternative services are also not Covered.

9.15 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;

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- Refractions, unless Medically Necessary;
- Glasses, frame and contact lenses;
- Dilation;
- Visual training; and
- Dyslexia treatment.

9.16 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.

- "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.

9.17 CARE RENDERED WHILE IN POLICE CUSTODY

Services provided to a Member while in police custody are not Covered.

9.18 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.

9.19 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.

9.20 NO SHOW CHARGES

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