Your Member Handbook

Michigan
Medicaid HMP
Last updated 10/2024

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

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

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

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

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

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

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

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

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

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

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

Language	Tag line
English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-898-7969 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-898-7969 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-898-7969 (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 1-888-898-7969（TTY：711）。
Syriac	ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܡܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܫܬܟܚܝ ܠܟ ܚܠܡܬܐ ܕܗܝܪܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-888-898-7969 (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 1-888-898-7969 (TTY: 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-898-7969 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-898-7969 (TTY: 711) 번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-888-898-7969 (TTY: 711)।
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-898-7969 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-898-7969 (TTY: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-898-7969 (TTY: 711).
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。1-888-898-7969（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 1-888-898-7969 (телетайп: 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-898-7969 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-898-7969 (TTY: 711).

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Welcome to Molina Healthcare

Molina Healthcare has a contract with the Michigan Department of Health and Human Services to provide health care services to Medicaid Enrollees. We work with a group of doctors and specialists to help meet your needs.

This handbook is your guide to the services we offer. It will also give you helpful tips about Molina Healthcare. Please read this book and keep it in a safe place in case you need it again. If you need another copy, it is available upon request and free of charge by contacting Member Services. You can also access this handbook on our website at **MolinaHealthcare.com/Medi-Handbook**.

Interpreter Services

We can get an interpreter to help you speak with us or your doctor in any language. We also offer our materials in other languages. Interpreter services and translated materials are free of charge. Call Member Services at **(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m. (TTY: 711) for help getting an interpreter or to ask for our materials in another language or format to meet your needs. Molina Healthcare complies with all applicable federal and state laws with this matter.

¿Habla español? Por favor contacte a al Member Services at **(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m. (TTY: 711).

Hearing and Vision Impairment

TTY/TDD services are available free of charge if you have hearing problems. The TTY/TDD line is open 24/7 by calling 711.

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, transcription services, and assistive listening devices. We offer the Member Handbook and other materials in Braille and large print upon request and free of charge. Call Member Services at **(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m. (TTY: 711). to request materials in a different format to meet your needs.

Molina Healthcare makes sure services are provided in a culturally competent manner to all members:

- With limited English proficiency
- Of diverse cultural and ethnic backgrounds
- With a disability
- Regardless of gender, sexual orientation, or gender identity

Important Numbers and Contact Information

Entity Name	Contact Information
Member Services Toll-Free Help Line	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
Member Services Help Line TTY/TDD	**711**
Website	**MolinaHealthcare.com**
Address	880 W. Long Lake Road, Troy, MI 48098
24 Hour Toll-Free Emergency Line	**(888) 275-8750** (English) **(866) 648-3537** (Spanish) TTY/TDD English: **(866) 735-2929** TTY/TDD Spanish: **(866) 833-4703**
24 Hour Toll-Free Nurse Advice Line	**(888) 275-8750** (English) **(866) 648-3537** (Spanish) TTY/TDD English: **(866) 735-2929** TTY/TDD Spanish: **(866) 833-4703**
Pharmacy Services	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
Transportation Services (non-emergency)	**(888) 898-7969**
Dental Services	**(844) 583-6157,** Monday-Friday, 8 a.m. to 8 p.m.
Vision Services	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
Mental Health Services	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
To file a complaint about a health care facility	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
To file a complaint about Medicaid services	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
To request a Medicaid Fair Hearing	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.

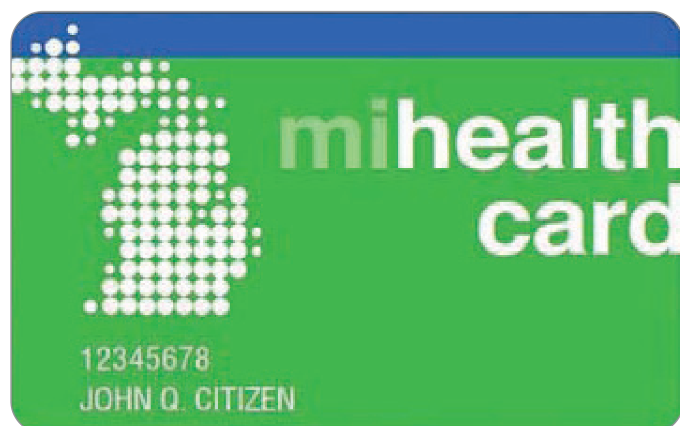
Entity Name	Contact Information
Grievance and Appeals	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
To report Medicaid fraud and/or abuse	Online: **MolinaHealthcare.alertline.com** Email: **MHMCompliance@MolinaHealthcare.com** Phone: **(866) 606-3889** Fax: **(248) 925-1797** Mail: Molina Healthcare of Michigan ATTN: Compliance Officer 880 West Long Lake Rd. Troy, MI 48098
To find out information about domestic violence	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
To find information about urgent care	**(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.
Michigan ENROLLS	**(888) 367-6557**
Michigan Beneficiary Help Line	**(800) 642-3195 or TTY: (866) 501-5656.**
MIChild Program	**(888) 988-6300**
MDHHS office locations and phone numbers	**Michigan.gov/mdhhs/inside-mdhhs/county-offices**
Women, Infants and Children (WIC)	**(800) 942-1636**
Free service to find local resources. Available 24/7	**2-1-1**
Social Security Administration	**(800) 772-1213** TTY/TDD: **(800) 325-0778**
In an emergency	**9-1-1**
Suicide and Crisis Lifeline	**9-8-8**

Your Membership

Identification Cards

Your State Issued Medicaid ID Card

When you have Medicaid, the Michigan Department of Health and Human Services will send you a mihealth card in the mail. The mihealth card does not guarantee you have coverage. Your provider will check that you have coverage at each visit. You may need your mihealth card to get services that Molina Healthcare does not cover. Always keep this card even if your Medicaid coverage ends. You will need this card if you get coverage again.



If you have questions about this coverage or need a new mihealth card, you should call the Beneficiary Help Line at **(800) 642-3195**. This number is located on the back of your mihealth card.

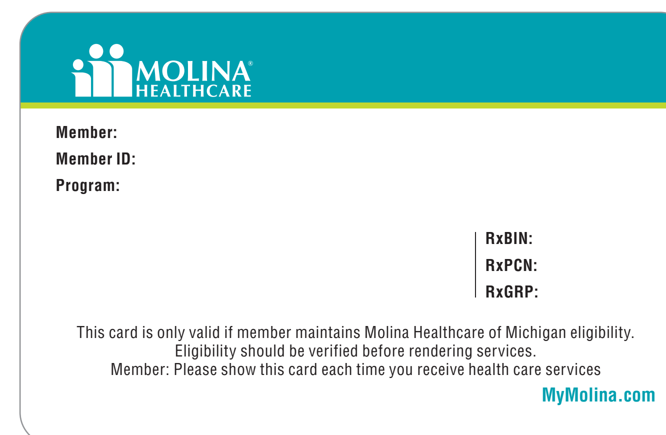
> **It is important to keep your contact information up to date so you don't lose any benefits. Any changes in phone number, email, or address should be reported to MDHHS. You can do this by calling your local MDHHS office or by visiting michigan.gov/mibridges. If you do not have an account, you can create one by selecting "Register". Once in your account, when reporting changes, please make sure you do so in both the profile section and the report changes area.**

Your Molina Healthcare Member ID Card

You should have received your Molina Healthcare ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own Member ID card.

Molina Medicaid Member ID Card

FRONT



BACK

Call **(888) 898-7969:**

BENEFITS: To check your benefits or switch your main doctor, go to MyMolina.com. For help with hearing impairment, call TTY 711 or (866) 735-2929.

TRANSPORTATION: For rides or mileage reimbursement to and from non-emergency medical visits.

DENTAL: For members 21 and older dental benefits. For members under 21, Healthy Kids Dental benefits, call (800) 642-3195, TTY (866) 501-5656.

VISION: For vision benefits.

24-HOUR NURSE ADVICE LINE: For questions about your health, call (888) 275-8750 or (866) 648-3537 (Español). For hearing impaired, call TTY 711 or (866) 735-2929.

PRACTIONERS/PROVIDERS/HOSPITALS: For prior authorizations, eligibility, claims, or benefits, visit the Molina Web Portal at MolinaHealthcare.com or call (855) 322-4077.

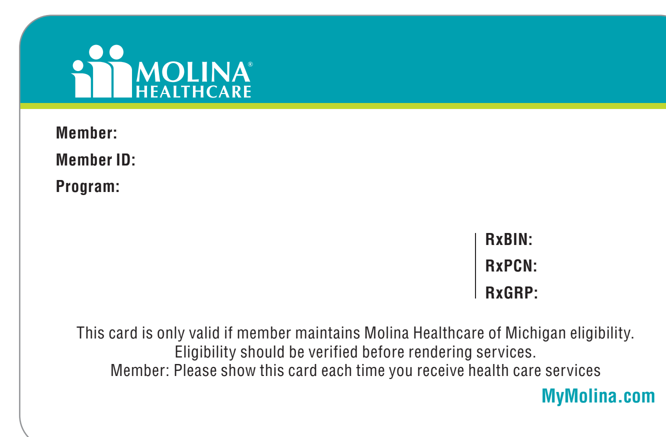
PHARMACISTS: For pharmacy authorization questions, call (855) 322-4077.

Claims Submission: PO BOX 22664 Long Beach, CA 90801

EDI Claims: Endeon Payer ID: 42699 MolinaHealthcare.com

Molina Healthy Michigan Member ID Card

FRONT



BACK

Call **(888) 898-7969:**

BENEFITS: To check your benefits or switch your main doctor, go to MyMolina.com. For help with hearing impairment, call TTY 711 or (866) 735-2929.

TRANSPORTATION: For rides or mileage reimbursement to and from non-emergency medical visits.

DENTAL: To learn more about your dental benefits.

VISION: For vision benefits.

24-HOUR NURSE ADVICE LINE: For questions about your health, call (888) 275-8750 or (866) 648-3537 (Español). For hearing impaired, call TTY 711 or (866) 735-2929.

PRACTIONERS/PROVIDERS/HOSPITALS: For prior authorizations, eligibility, claims, or benefits, visit the Molina Web Portal at MolinaHealthcare.com or call (855) 322-4077.

PHARMACISTS: For pharmacy authorization questions, call (855) 322-4077.

Claims Submission: PO BOX 22664 Long Beach, CA 90801

EDI Claims: Endeon Payer ID: 42699 MolinaHealthcare.com

If you have questions about this coverage or need a new Molina Healthcare Member ID card, you should call Member Services at **(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m. Or view your Member ID Card by visiting **MyMolina.com** or downloading the My Molina Mobile App.

Important ID Card Notes

- Carry both cards with you at all times and show them each time you go for care
- Make sure all of your information is correct on both cards
- Call your local MDHHS office to change your records if your name or address changes
- When getting care you may be asked to show a picture ID. This is to make sure the right person is using the card
- Do not let anyone else use your cards
- **Your PCP will NOT be listed on your ID Card so if you change your PCP, a new ID card is not required**

Getting Help from Member Services

Our Member Services Department can answer all of your questions. We can help you choose or change your doctor, find out if a service is covered, replace a lost ID card, find out how to appeal something we denied, find out how to file a grievance when you are unhappy with your care, help you understand written materials, and more. You can call us anytime.

Contact Us

You may call us at **(888) 898-7969**, or TTY 711, Monday-Friday, 8 a.m. to 5 p.m.

For **urgent** medical concerns regarding you or your child's health after hours, we can connect you to our medical Emergency Help Line for assistance. Call **(888) 275-8750** (English) or **(866) 648-3537** (Spanish) TTY: 711.

Our Website

You can visit our website at **MolinaHealthcare.com** to access online services such as:

- Member Handbook
- Listing of Network Providers
- Services
- The Member Portal at **MyMolina.com**
- My Molina Mobile App
- Annual Member Newsletters

Confidentiality

Your privacy is important to us. You have rights when it comes to protecting your health information. Molina Healthcare recognizes the trust needed between you, your family, and your providers. Molina Healthcare staff have been trained in keeping strict member confidentiality.

Manage Your Digital Health Records with MyMolina.com and My Molina Mobile App

MyMolina.com: Manage your health plan online 24/7

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

YOUR MEMBERSHIP

My Molina Mobile App

Get health plan access with your smart phone anytime, anywhere. With the mobile app, you can easily see your ID card, print it or send it by email to your doctor. Search for new doctors, change your primary care provider (PCP) and much more.

Download the My Molina mobile app today from the Apple App Store or Google Play Store or use the QR Code below.

Transition of Care

If you're new to Molina Healthcare, you may be able to keep your doctors and services for at least 90 days from your enrollment date. Examples include medical, behavioral health, and pharmacy services.

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

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

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

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

Molina Healthcare will help you choose new doctors and help you get services in our network. Your doctor may call Member Services if they want to be in our network.

If you are receiving Children's Special Health Care Services (CSHCS), please contact us for help transitioning your care services. Molina will work with you and your current provider(s) to ensure a smooth transition of care and will provide continuity of care services for services you may be receiving through CSHCS.

Please contact us at (888) 898-7969, Monday-Friday, 8 a.m. to 5 p.m. to request transition of care services or if you have any questions about your care.

Your PCP

Getting Care

Choosing A Primary Care Provider

When you enroll in our plan, you will need to choose a primary care provider (PCP). Your PCP is the health care provider or doctor who takes care of all your health needs. You can choose a different doctor for each family member, or you can choose one doctor for the whole family.

You can choose one of the following provider types as your primary care provider:

- General practice doctor
- Family practice doctor
- Nurse Practitioner
- Internal medicine doctor
- Pediatrician doctor
- OB/GYN doctor

If you do not choose a doctor within 30 days of enrollment, we will select one for you. You can change your doctor anytime.

You do not need a referral to see an in-network pediatrician or OB/GYN provider for routine and preventive health services.

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists addresses, office hours, languages spoken, and information about accessibility. It is located at **MolinaProviderDirectory.com/MI**. You can view or print the provider directory from the website. You can also request a copy of our provider directory, free of charge by calling **(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m. Remember provider information changes often. Visit our website for the most up-to-date information. Call Member Services if you need help finding a doctor.

You can also get medical care from these types of medical providers: **Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable).**

If you have certain health care needs, you may be able to choose a specialist as your primary care provider. Talk to your doctor or call Member Services for more information.

Make sure you ask the provider office if they participate in the Molina Healthcare network.

Getting Care from Your Doctor

Your doctor's office should be your main source for medical health. You should see your doctor for preventive checkups. Call your doctor's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at **(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m.

Your visit is important. Please be on time. Call the office as soon as you can if you cannot make it to your visit. You can set up a new visit when you call to cancel. Some offices will not see you again if you do not call to cancel.

Getting Care from a Specialist

If you need care that your doctor cannot give, they will refer you to a specialist who can. Your doctor works with you to choose a specialist and arrange your care. If you have special health care needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. Talk to your doctor or call Member Services for more information.

Out-of-Network Services

You must get most of your care from providers in our provider network. Member Services can help you find a provider in our network.

If we do not have a doctor or specialist in our provider network in your area who can give you the care you need, or if we do not have a provider that can see you timely, we will get you the care you need from a provider outside our network. This is called an out-of-network referral. We will only cover the services by an out-of-network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure that the cost to you is no greater than it would be if the service was provided in-network.

Out of County Services

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

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

All other services out of the state require prior authorization.

Out of State Services

All services out of the state require prior authorization. If you are out of town and have a medical emergency or need urgent care:

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

All other services out of the state require prior authorization.

Out of Country Services

Health care services provided outside the country are not covered by Molina Healthcare.

Physician Incentive Disclosure

Molina Healthcare does not pay providers to withhold services or reward anyone for denying services. Molina Healthcare does offer providers incentives to ensure members have access to needed care including well care visits, cancer screenings and more. For information on how we pay our providers, you may call Member Services at **(888) 898-7969**.

Prior Authorization

Some services and medications will need to be approved before you or your child can get them. This is called Prior Authorization (PA). Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. We must approve the PA request before you get the care. If we do not approve the service, we will notify the doctor and send you a written notice of the decision.

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

Getting a Second Opinion

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from a Molina Healthcare network provider. Second opinions do not require prior authorization from us. Please call Member Services to learn how to get a second opinion.

Your benefits

Information About Your Covered Services

It is important you understand the benefits covered under your plan. As a Molina Healthcare member you do not have to pay co-pays for covered services under the Medicaid or Healthy Michigan Plan. See Cost Sharing and Copayments section for more information.

If there are any significant changes to the covered services outlined in this handbook, we will notify you in writing at least 30 days before the date the change takes place.

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. Please review the COC included within this handbook.

Make sure a service is covered before the service is done. You may have to pay for services not covered by Molina Healthcare under the Medicaid program.

Molina Healthcare does not deny reimbursement or coverage for services on any moral or religious grounds.

Telehealth/Telemedicine services

Telehealth/Telemedicine care is a convenient way to get care for a variety of common illnesses and mental health needs without having to go to the emergency room or urgent care. For non-emergency issues, including the flu, allergies, rash, upset stomach, other illnesses, and mild to moderate mental health care, you can connect with a provider through your phone or computer to receive care where you are, when you need it. Providers can diagnose, treat, and even prescribe medicine, if needed. Call your provider's office to see if they offer telehealth services. Member Services can also assist you with virtual care options.

Benefits Monitoring Program

We participate in MDHHS' Benefits Monitoring Program. This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper use of medical services and help you get services from appropriate providers. Examples of things that could get you enrolled in this program include:

- Going to the emergency room when it's not an emergency
- Seeing too many different doctors instead of your primary care doctor
- Getting more medicines than may be safe
- Activity that may indicate fraud

Using the right health services in the right amount helps us make sure you're getting the very best care.

Covered services include:

Covered Services (at Participating Providers)	
Ambulance transportation - Emergency	PA (Prior Approval) is not required, except for non-emergency or air ambulance.
Behavioral Health: Mental Health	PAs are required for some outpatient electroconvulsive therapy (ECT) and Transcranial Magnetic Stimulation (TMS). Molina covers outpatient mental health services.
Blood lead testing for members under age 21	PA is not required.
Breast pumps; personal use, double electric	PA is not required.

YOUR BENEFITS

Covered Services (at Participating Providers)	
Certified Nurse Midwife and Doula Services	PA is not required.
Community Health Worker (CHW) / Community Health Representative (CHR) Services	PA is not required.
Certified pediatric and family nurse practitioner services	PA is not required.
Chiropractic (back) services	PA is not required.
Dental services	Routine services do not require PA. Dental services other than routine care may require PA. Coverage for Medicaid members 21 and older and Healthy MI Plan members 19 and over include: • Periodic oral exams • Extractions • Preventative and restorative services • Periodontal Treatment • Dentures and partials
Diagnostic services (x-ray, lab, and prescribed services)	Selected diagnostic services (including CT Scans, MRIs, MRAs, PET Scans, and SPECT) require PA.
Doula Services	Twelve (12) total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery
Durable medical equipment (such as crutches and wheelchairs)	Some durable medical equipment items require PA.
Emergency services	PA is not required.
End stage renal disease services	PA is not required.
Family planning services	PA is not required for family planning services, drugs, supplies and devices. Please note infertility is not covered.

Covered Services (at Participating Providers)	
Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Tribal Health Centers (THC) services	PA is not required. You may choose to get services from a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Tribal Health Center (THC) located in your county. You do not need to ask your PCP to receive FQHC, RHC or THC services. You can also get services from out-of-network FQHCs, RHCs and THCs without prior approval.
Habilitative and Rehabilitative Services	PT/OT/ST evaluation and 12 visits are approved without authorization. 2 evaluations are covered per year with in-network providers.
Health Education	PA is not required.
Hearing Aids for all ages	PA is not required, unless benefit is exceeded. • Hearing Aids – Once every 5 years • Hearing Aid Batteries – 36 disposable every 6 months • Replacement Ear Molds – 1 per 12 months per hearing aid (age 19 and older)
Home health services	Home health evaluation and 6 visits are approved without authorization for in-network providers.
Hospice services	PA is not required.
Inpatient hospital services	Inpatient hospital services (except for emergency admissions), elective admissions, including pregnancy delivery services, and all inpatient surgeries, require PA. Also includes Skilled Nursing Facilities (SNF), Inpatient Rehabilitation and Long Term Acute Care (LTAC) Facility admissions. Notification to Molina Healthcare is required within [24] hours of admission or by the next business day for emergency admissions.

Covered Services (at Participating Providers)	
Interpretative services for non-English speaking members and interpretive services by phone for the hearing impaired	PA is not required.
Maternal and Infant Health Program (MIHP) services	PA is not required. Risk Identifier and up to 9 visits for the mom with a MIHP provider. Risk Identifier and up to 9 visits for the infant with a MIHP provider and an additional nine with a doctor's order. Substance exposed infants may receive up to 18 additional visits.
Medical supplies	Some medical supplies require PA.
Medically necessary weight reduction services	PA is required.
Nursing facility services for an "off and on" or short-term restorative or rehabilitative stay, up to 45 days	Nursing facility services require PA. Nursing facility stays are covered for members. Members in need of nursing services should call Member Services for information on available providers.
Obstetrical (maternity care: prenatal and postpartum including at-risk pregnancy services) and gynecological services	PA is not required.
Office Visits (routine)	PA is not required. You should see your doctor 2 times a year for preventive visits. This includes annual physical exams and screenings, including: • Complete physical exam • Immunization review and update • Age-appropriate heart disease screenings (blood pressure, blood glucose and cholesterol tests) • Cancer risk screenings (pelvic exam, pap smear, prostate and colorectal screenings) • Sexually-transmitted disease testing • Evaluation for signs of depression • Alcohol, depression, obesity and tobacco counseling

Covered Services (at Participating Providers)	
Out of State / Out of Area services (authorized by the Plan)	PA is required. Emergency services do not require a PA.
Outpatient hospital services	Some outpatient services require PA.
Outreach services, including pregnancy and well child care	PA is not required.
Parenting and birthing classes	PA is not required.
Podiatry (foot) services	If the provider is in network, in office procedures and services are covered with no PA required.
Practitioners Services	PA is not required for network providers.
Prescription drugs, including certain prescribed over-the-counter drugs	Selected drugs, including injectables and some over-the-counter drugs, require PA. There is no cost to get these drugs.
Preventive services	PA is not required. There is no cost to get these services.
Primary Care Provider (PCP) services	PA is not required.
Prosthetics and Orthotics	PA is required for some items.
Renal dialysis (kidney disease)	PA is not required.
Restorative or Rehabilitative Services (in a place of service other than a nursing facility)	PA is required.
Screening and counseling for obesity (for bariatric services)	PA is not required. Screening and counseling for obesity requires a referral by a provider.
Shots (immunizations)	PA is not required.
Specialist services	Office visits to see a specialist do not require PA. Some specialist services do require PA.
Telehealth	If your provider offers telehealth services, it is covered.

Covered Services (at Participating Providers)	
Therapies (speech, language, physical and occupational and therapies to support activities of daily living), excluding services provided to persons with developmental disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts	PA is required for: • Occupational Therapy: After initial evaluation plus 12 visits per treatment year for office and outpatient settings. • Physical Therapy: After initial evaluation plus 12 visits per treatment year for office and outpatient settings. • Speech Therapy: After initial evaluation plus 12 visits for office and outpatient settings.
Tobacco cessation program including pharmaceutical and behavioral support	PA is not required.
Transplant Services	PA is required.
Transportation - non-emergent medical	PA is not required, except for non-emergency ambulance.
Treatment for communicable diseases, including sexually transmitted diseases (STD) HIV/AIDS, tuberculosis and vaccine preventable diseases; treatment may be received from a local health department without prior health authorization	PA is not required when services are received at local health department.
Vision services	PA is not required.
Well-child/EPSDT exams for children under the age of 21	PA is not required.
Yearly well-adult exams	PA is not required.

This is not a complete list. All Covered Services received by an out-of-network provider require a Prior Authorization. There may be other limits on Covered Services. Please review the Certificate of Coverage for more detail. If you have a question about if a service is covered, please call Member Services at (888) 898-7969, Monday- Friday, 8 a.m. to 5 p.m. (TTY: 711).

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

Care Coordination

Do you have a chronic health problem or disability? Do you have barriers that are causing you issues with accessing your care? Do you see multiple providers or need special care? It's easy to feel overwhelmed with being in charge of your care if you have many health issues and see many providers. It can add more stress to your daily life. We are here to help you!

Our goal is to offer personalized care coordination services to help guide you through health care. We have nurses, care coordinators, social workers, and other health experts to help you get the best care possible from your care team.

The care coordination program focuses on you and your needs. We help you reduce the barriers you are having accessing your care by linking you to services and resources near you to help improve your health. We also assist you in reducing your barriers by helping to arrange care with your care team and providers. This ensures you are able to better manage your health and improve your quality of life.

How Can Care Coordination Help You?

If you are eligible, you will be assigned your own care coordinator. This person helps you address and eliminate barriers that cause you issues with obtaining care by:

- Completing assessments and reviewing medications
- Making a plan of care to help you identify and meet your health goals
- Linking you with services and community resources near you, including the local health departments
- Helping you better control your healthcare needs
- Collaborating with your providers
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits

Call Member Services for more information about the care coordination program.

Care Management

We offer a care management program for members with chronic and/or complex health conditions. This is a voluntary program that allows you to talk with a care coordinator about your health care. A care coordinator helps you:

- Coordinate care between health care providers
- Set personal goals to manage your medical conditions
- Talk to your doctors or other providers when you need help
- Understand your medical conditions

- Access community-based supports, services, and resources

If you are interested in joining this program, please call Member Services to be connected with a care coordinator.

Children's Health

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a good time for you to ask questions about your child's health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral. Children up to three years old are recommended to have a developmental screening done with their doctor once a year.

Babies from birth through 15 months need at least six well-child visits. These visits often are at these ages:		
3-5 days	2 weeks	1 month
2 months	4 months	6 months
9 months	12 months	15 months

It is important for your child to get a blood lead test once before age one and again before age two. Children who are at risk or who are high risk should be checked more often. These children should be tested at least one time per year. Children who are high risk are those who have had lead poisoning in the past. This includes children who live in old homes or apartments. Lead poisoning can happen even if you do not live in an older home. Lead can be found in paint, soil, ordinary dust, playgrounds, and toys, as well as other places. Have your child tested for lead poisoning so that it may be treated. If untreated, lead poisoning can lead to disabilities and behavioral problems. This simple test will help keep your little one on track!

Teenagers should also receive annual well-child visits. At these visits, teens will have their height, weight and BMI checked. Providers can talk about health, safety and preventive measures that are useful to teens. Required immunizations can also be given at these visits.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a special healthcare program for children under 21 years of age who are covered by Medicaid. Under EPSDT, children and teens enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid. For more information on EPSDT, go to the Bright Futures website **brightfutures.aap.org**.

YOUR BENEFITS

EPSDT checkups include:	
Well-care visits	Physical and mental developmental/ behavioral assessments
Health history and physical exam, including school and sports physicals	Crucial lab tests, including lead screening
Developmental screening	Nutrition assessment
Health education guidance	Immunizations
Hearing, vision, and dental screening assessment	Follow-up services

Children's Special Health Care Services

If your child has a serious, chronic medical condition, they may be eligible for Children's Special Health Care Services (CSHCS).

CSHCS provides extra support for children and some adults who have special health care needs. This is in addition to the medical care coordination from Molina Healthcare.

There is no cost for this program. It doesn't change your child's Molina Healthcare benefits, service, or doctors. CSHCS provides services and resources through the following resources through the following agencies.

MDHHS Family Center for Children and Youth with Special Health Care Needs:

This center provides a parent support network and training programs. It may also provide financial help for conferences about special needs and more. If you have questions about this program, call the CSHCS Family Phone Line at **(800) 359-3722** from 8 a.m. to 5 p.m. Monday through Friday.

Local County Health Department:

Your local county health department can help you find local resources. These may include parent support groups, adult transition help, childcare, vaccines and more. For help finding your local county health department, visit your county's website or **Michigan.gov**. Call Member Services for assistance.

Children's Special Needs Fund:

The Children's Special Needs fund helps families get items not covered by Medicaid or CSHCS. These items promote the health, mobility, and development of your child. They may include wheelchair ramps, van lifts and mobility equipment. To see if you qualify for help from this fund call **(517) 241-7420**.

CSHCS member transitioning to adulthood

We can help members who have special health care needs on how to plan a successful move from pediatric health care to adult health care services.

This is not a complete list. All Covered Services received by an out-of-network provider require a Prior Authorization. There may be other limits on Covered Services. Please review the Certificate of Coverage for more detail. If you have a question about if a service is covered, please call Member Services at **(888) 898-7969**, Monday- Friday, 8 a.m. to 5 p.m. (TTY: 711).

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

Community Health Workers (CHW)

Community Health Workers are the front-line public health workers within the community, assisting members with navigating health care. CHWs serve as a bridge between health care and social services by building trusting relationships. CHWs full range of services include:

- Meeting face to face to improve your access to health care
- Helping others find providers and set up visits
- Finding local support like food and housing
- Teaching ways to live a healthy life
- Helping with provider follow-up visits after going to the hospital or emergency room
- Helping set up rides for medical or pharmacy visits

Contact Member Services for more information.

Dental Services

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above, enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with DentaQuest to provide your dental benefits.

If you have any questions about your dental services, please contact DentaQuest at **(844) 583-6157**, Monday-Friday, 8 a.m. to 8 p.m.

Covered dental services include:

- Fluoride Applications
    - o Fluoride treatments are covered:
        - Up to four times a year for members 0 to 6 years of age

- Twice a year for members ages 6 to 21
- Sealants
  - Sealants are covered once every 3 years
- Crowns
  - Crowns and associated procedures are covered for all beneficiaries once every 5 years per tooth
- Root canal
  - Root canal treatment is a benefit for all members if the tooth and surrounding teeth can be reasonably restored
- Periodontal Treatment
  - Periodontal treatments are covered for all members. Treatments include:
    - Comprehensive Periodontal Evaluation
    - Scaling in the presence of Inflammation
    - Deep Teeth Cleanings, such as Periodontal Scaling and Root Planing
    - Periodontal Maintenance
- Complete and Partial Dentures
  - Complete and Partial dentures are covered once every 5 years per arch

** Prior Authorization (PA) may be required for some procedures. Please check with your dental provider for more details.*

Your Dental Home

As a Molina Healthcare member, you will have a Dental Home. A Dental Home is where you go to see your dentist every six months. This dentist will provide any needed oral health care for you. Your Dental Home will work with you so you can stay healthy. It is important to go back to the same Dental Home for each appointment.

Your Dental Home will provide:

- Complete dental care
- A dental health plan designed for you
- Guidance about diet and growth
- Information on how to correctly care for your teeth

Healthy teeth and gums are an important part of overall health. For a healthier life, be sure to have regular checkups - every six months.

If you have questions about your Dental Home or dental benefits or would like to change your Dental Home, call toll free **(844) 583-6157** or visit our website at **DentaQuest.com**.

Please remember: *It is important to keep all your appointments and arrive on time.*

YOUR BENEFITS

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. The two plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card and Member Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at **(800) 642-3195** for help.

Blue Cross Blue Shield of Michigan
Michigan Health Insurance Plans | BCBSM
Phone: **(800) 936-0935**

Delta Dental of Michigan
Individual Dental Plans | Delta Dental of Michigan (**Deltadentalmi.com**)
Phone: **(866) 696-7441**

Durable medical equipment

Some medical conditions need special equipment. Durable medical equipment we cover includes:

- Equipment such as nebulizers, crutches, wheelchairs, and other devices
- Disposable medical supplies, such as ostomy supplies, catheters, peak flow meters and alcohol pads
- Diabetes supplies, such as lancets, test strips, insulin needles, blood glucose meters and insulin pumps
- Prosthetics and orthotics – Special note: Prosthetics replace a missing body part, such as a hand or leg. They may also help the body function. Orthotics correct, align, or support body parts that may be deformed

To get durable medical equipment, you need a prescription from your doctor. You may also need prior authorization from us. You must get your item from a network provider. To find network durable medical equipment providers, call Member Services.

Emergency Care

Emergency care is for a life-threating medical situation or injury that a reasonable person would seek care right away to avoid severe harm.

Here are some examples of emergencies:	
Convulsions	Broken bones
Uncontrollable bleeding	Loss of consciousness (fainting or blackout)

Chest pain	Jaw fracture or dislocation
High fever	Tooth abscess with severe swelling
Serious breathing problems	Knife or gunshot wounds

If you believe you have an emergency, call 911 or go to the emergency room. You do not need an approval from Molina Healthcare or your doctor before getting emergency care. You can go to any hospital. Be sure to follow up with your doctor to make sure you get the right follow-up care and services.

Healthy Behaviors

You may be eligible to participate in a healthy behavior incentive program. Rewards can be claimed in the Member Portal. Sign up for the Member Portal at **MyMolina.com**. Once registered, visit "My Wellness" and go to "My Healthy Rewards" to view a list of currently available incentive programs. To get more information, call Member Services at **(888) 898-7969** (TTY: 711).

Hearing Services

How well you hear affects your quality of life. We cover services and supplies for the diagnosis and treatment of diseases of the ear, including:

- Hearing exams
- Medically necessary hearing aid evaluations and fittings
- Medically necessary hearing aids

If you need a hearing exam or think you need hearing aids call a provider from our list of hearing providers. To find a list of hearing providers, please visit **MolinaProviderDirectory.com/MI**.

Hepatitis C

Treatment is available for Hepatitis C. Hepatitis C is a liver infection caused by the Hepatitis C virus. It's spread through contact with blood from an infected person, even amounts too small to see. People with Hepatitis C often don't feel sick or show symptoms. When symptoms do appear, they're often a sign of advanced liver disease. It's important to get tested (screened) for Hepatitis C before it becomes severe, when it's easier to treat. All adults should be screened for Hepatitis C at least once. Pregnant beneficiaries should be screened during each pregnancy.

For members under age 21, the screening is covered under the Early and Periodic Screening, Diagnosis and Treatment program, or EPSDT. This includes coverage of any medically necessary follow-up services and referrals.

Home Health Care, Skilled Nursing Services and Hospice Care

Sometimes, you may need long-term care. To help you get the care you need, we may cover:

- Short-term nursing home services up to 45 days in a nursing facility (long-term care is provided by the State of Michigan)
- Home health care services for members who are homebound
- Supplies and equipment related to home health care
- Hospice care

For information on hospice care, please call your PCP or Member Services at **(888) 898-7969**, Monday-Friday, 8 a.m. to 5 p.m. (TTY: 711).

Hospital Care

Hospital care is for care like delivering a baby or taking care of a bad sickness. It also covers care you would get in the hospital, like lab tests or x-rays. Your doctor sets up your hospital care if you need it. A different doctor at the hospital may fill in for your doctor to make sure you get the care you need if an emergency happens.

You should call your doctor as soon as you are admitted (checked in) to the hospital if it was not arranged by your doctor. Ask a family member or friend to call for you if you cannot. It is important to call your doctor right away and set up a visit within seven days of being sent home. You can talk about and arrange your care after you leave the hospital during this follow-up visit.

Mental Health and Substance Abuse Services

We want you to feel your best, including your mental and emotional feelings. To help you, we cover short-term treatment for mental or emotional needs. This applies to members with mild to moderate mental health services. These visits may be with a network therapist, such as a counselor, licensed clinical social worker or psychologist. Telehealth may be an option for you. Talk to your mental health provider to learn more. Treatment for long term, severe mental conditions, or severe emotional disturbances for children, as well as inpatient and intensive outpatient treatment must be arranged through the local Community Mental Health Services Program (CMHSP) agency. CMHSP can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol. If you feel you have a substance abuse problem, we encourage you to seek help. If you need help getting services, call your doctor or Member Services]

Signs and symptoms of substance abuse:

- Failure to finish jobs at work, home, or school
- Being absent often
- Performing poorly at work or school

- Using alcohol or drugs when it is dangerous. This includes while driving or using machines
- Having legal problems because of drinking or drug use
- Needing more of the substance to feel the same effects
- Failing when trying to cut down
- Failing when trying to control the use of the substance
- Spending a lot of time getting the substance
- Spending a lot of time using the substance
- Spending a lot of time recovering from the substance's effects
- Giving up or reducing important social, work, or recreational activities because of substance use
- Continuing to use the substance even though it has negative effects

If you have questions about your mental health or substance abuse benefits call Member Services at **(888) 898-7969**, Monday-Friday 8 a.m. – 5 p.m. You can also call your local CMHSP agency.

If you need emergency care for a life-threatening condition, or if you're having thoughts of suicide or death, go to the nearest emergency room or call 911. You can also call the Suicide and Crisis Lifeline by dialing 988. Help is available for you now.

Obstetrics and Gynecology Care

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network or out of our network. You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN even if they aren't your primary care doctor.

To make sure you get the care you need to be at your best for you and your family, we cover:	
Family Planning	Prenatal and postpartum care
Pregnancy testing	Midwife services in a health care setting
Birth control and birth control counseling	Delivery care
HIV/AIDS testing and treatment of sexually transmitted diseases	Parenting and birthing classes
Pregnancy and maternity care, including the Maternal Infant Health Program	Mammograms and breast cancer services, such as treatment and reconstruction
Doula Services	Pap tests
Depression Screening	

Family Planning Services

Family planning care is covered. Both men and women can get this care. Family planning is an important part of staying healthy. You can get family planning information from your doctor, OB/GYN, or a Family Planning Center. You do not need a referral from your doctor for this care. Please contact Member Services as soon as you discover you are pregnant to help maximize the support and benefits available to you.

Family planning services include:

- Counseling to help you decide when to have children
- Help to decide how many children to have
- Birth control services and supplies
  (It is recommended to get a Pap test and chlamydia test before getting birth control)
- Sexually transmitted disease testing and treatment
- Testicular and prostate cancer screening

Pregnancy Services

If you are pregnant, early and regular checkups can help protect you and your baby's health. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done during pregnancy. Please call Member Services and your local MDHHS office as soon as you find out you are pregnant so we can provide support.

Virtual Prenatal Services with Ouma Health

Ouma is a maternity telehealth service which offers you the ability to get started with your prenatal care anytime, anywhere, and on any device. Complete your early pregnancy visit with Ouma Health and we'll send you a free car seat! To learn more, call, or text Ouma at **(737) 334-3392** or visit **Ouma.me/molina-mi** to schedule your visit today!

Dental Benefits

Taking care of your mouth and teeth while you are pregnant is important for you and your baby. To find a dentist and learn about your benefits call **(844) 583-6157**.

Doula Services

Doulas are trained birth workers who provide emotional, physical, and informational support to pregnant people and their families before, during, and after birth. For more information, visit **michigan.gov/mdhhs/keep-mi-healthy/maternal-and-infant-health/mdhhs-doula-initiative** or call Member Services at **(888) 898-7969**.

- Mae Health provides in-person and virtual doula support specifically to Black pregnant individuals in Metro Detroit, Genesee, and Saginaw counties. For more information, visit **Meetmae.com**.

Centering Pregnancy

Centering Pregnancy programs are a way to get your prenatal care along with other members who are due around the same time. To learn more and find a Centering Pregnancy program in your area, visit Centeringhealthcare.org/what-we-do/centering-pregnancy.

- WIN Network serves Black members in Metro Detroit with nurse midwives and community health workers. To learn more about the WIN Network, call **(313) 847-4581** or contact them at **WINnetworkDetroit@hfhs.org**.

Maternal Mental Health Hotline offered by the Health Resources & Services Administration

This new toll-free hotline is confidential and is designed for expecting and new moms experiencing mental health challenges. The hotline is staffed with counselors available to provide mental health support. Moms can call or text the hotline at **(833) 852-6262** to connect with a counselor at no charge. A range of services are available in English and Spanish.

Michigan Department of Health and Human Services (MDHHS) Resources

Maternal Infant Health Program (MIHP)

When you enroll in the Maternal Infant Health Program (MIHP), you will work with a nurse and a social worker who will help you connect with your doctor, your health plan, and providers in your community. To learn more or enroll with a MIHP call **(833) 644-6447** or visit **www.michigan.gov/mihp**.

Women, Infant, and Children (WIC)

WIC is a nutrition program that helps families by providing nutritious foods, nutrition education, breastfeeding support, and referrals to other community-based programs. Sign up for WIC by calling **(800) 942-1636** or visiting **fns.usda.gov/wic**.

YOUR BENEFITS

You may be eligible to participate in a healthy behavior incentive program. Rewards can be claimed in the Member Portal. Sign up for the Member Portal at MyMolina.com. Once registered, visit “My Wellness” and go to “My Healthy Rewards” to view a list of currently available incentive programs. To get more information, call Member Services at **(888) 898-7969** (TTY: 711).

Postpartum Care

It’s important to take care of yourself after you have a baby. You should have a postpartum checkup 7 to 84 days after your pregnancy. We cover this exam.

The doctor may check your blood pressure and your weight. They may talk to you about birth control, feeding options, and provide other postpartum counseling. You can also talk to your doctor about any new feelings you may have.

When you have your baby, let us know. Call your local MDHHS office so your records can be updated. Also call Member Services to report the change. This starts the process of signing your baby up for health care services. Your baby is covered by your health plan at the time of birth. Make sure you tell us the day you gave birth, your baby’s name, and your baby’s Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Member Services if you need help.

Change in Family Size

When you experience a change in family size, contact Member Services to let us know and we will be able to assist you. A change in family size includes marriage, divorce, childbirth, adoption and/or death. Please reach out to your local MDHHS office if there is a change in family size.

Maternal Infant Health Program (MIHP)

The MIHP is a home visiting program for women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include:

- Prenatal teaching
- Childbirth education classes
- Nutritional support, education, and counseling
- Breastfeeding or formula feeding support
- Help with personal problems that may complicate your pregnancy
- Newborn baby assessments
- Referrals to community resources and help finding baby cribs, car seats, clothing, etc.
- Support to stop smoking
- Help with substance abuse
- Personal care or home help services

Call Member Services for more information on how you can access these services.

Preventive Health Care for Adults

Preventive health care for adults is important to Molina Healthcare. You should have a wellness exam each year to prevent and detect health problems. It is important to find and treat health problems early.

Make sure to schedule an appointment and ask your doctor to check:

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression Screening
- Prostate and Colorectal Screenings

You can also ask your doctor about:

- Immunizations
- HIV/AIDS testing and treatment of sexually transmitted diseases

Preventive health is also about making the right choices for good health habits. Seeing your doctor for routine care is a good preventive health habit that keeps you healthy. We have programs to help you make good preventive health choices for yourself and your family.

You can improve you and your family's health by taking responsibility and following healthy behaviors. Getting needed yearly preventive care is the first step! Some other things you should and should not do to take control of your health are listed below.

Things you should do:	Things you should NOT do:
• Eat healthy • Exercise • Get enough sleep • Manage your stress • Don't smoke or use tobacco • Don't use drugs or drink alcohol • Go to the dentist for regular cleanings and preventive services • Visit your doctor each year for yearly preventive care	• Eat foods high in fat, sugar, and salt • Live an inactive lifestyle • Hold in your feelings or emotions if you're feeling stressed or depressed • Use drugs, alcohol, or tobacco • Forget to set up your dentist visits for regular cleanings and preventive services • Forget to set up a yearly visit to your doctor • Avoid going to the doctor

YOUR BENEFITS

Routine Care

Routine care is for things like:

- Yearly wellness exams
- School physicals
- Health screenings
- Immunizations
- Vision and Hearing Exams
- Lab tests

Your doctor should set up a visit within 30 business days of request.

Transportation Services

Non-Emergency

Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other Medicaid covered services, whether those services are provided by your Medicaid health plan or through MDHHS directly. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.

Please call Transportation Member Services 24 hours a day, 7 days a week at **(888) 898-7969** for more information and to schedule a ride. Please call 3 days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment.

Have this information ready when you call:

- Your name, Medicaid ID number and date of birth
- The address and phone number of where you will be picked up
- The address and phone number of where you are going
- Your appointment date and time
- The name of your provider

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor.

If you are receiving services through the local Community Mental Health Services Program (CMHSP) agency, there may be some transportation services that you will continue to receive through the local CMHSP agency. Contact your local CMHSP agency for questions about this benefit.

Please be sure to call us as soon as possible if you need to cancel.

Emergency

If you need emergency transportation, call 911

Tobacco Cessation

We want to help you quit smoking. If you smoke, talk to your doctor about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor can help you. Molina Healthcare can also help you. To get more information, call Member Services. We cover the following services to help you:

- Therapy and counseling services
- Educational materials
- Prescription inhalers or nasal sprays used to stop smoking
- Non-nicotine drugs
- Over-the-counter items to help you stop smoking
    - Patches
    - Gums
    - Lozenges

Your extras

Urgent Care and after-hours care

Urgent care centers and after-hours clinics are helpful if you need care quickly but can't see your primary care doctor. You don't need a referral or prior authorization to go to an urgent care center or after hours-clinic in our network.

These places can treat illnesses that should be cared for within 48 hours, such as the flu, high fevers, or a sore throat. They can also treat ear infections, eye irritations and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

If you aren't sure if you need urgent care, call your doctor. They may be able to treat you in their office.

Vision Services

Eye care is an important part of your overall health. To make sure your eyes are healthy and help you see the best you can, we cover the following services:

- One eye exam every 24 months
- One pair of glasses every 24 months
- Eye glass frames
- Contact lenses

You do not need a referral to get eye care. If you need glasses or an eye exam, call Member Services at **(888) 898-7969**, Monday Friday, 8 a.m. to 5 p.m. (TTY: 711). You can also call a provider from our list of vision providers. For medical eye problems, talk to your doctor.

Community-Based Supports and Services

We want to provide efficient and appropriate care in a timely manner. We also connect our members to community resources.

- Do you and your family struggle with having enough to eat?
- Do you need help finding a place to stay, or do you need heating assistance?
- Do you need a ride to your doctors' appointments?
- Do you need help with employment?

If you answered yes to any of the above questions, we can help. We know it's difficult to get to your doctor for important health screenings or other care when you're facing these challenges. If you're struggling with a similar problem, or need assistance, reach out to your Care Manager. If you don't have a Care Manager, and need help please call Member Services at **(888) 898-7969**. TTY users should call 711.

You can also access resources at the following:

- Online through our website: MolinaHelpFinder.com
- Online through the State of Michigan portal: **newmibridges.michigan.gov**
- Online through the Michigan 2-1-1 website: **www.mi211.org**

Women, Infants, and Children (WIC) is a free program that provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care. Call **800-262-4784** to find a WIC clinic near you or call Member Services for assistance.

Molina Help Finder

- We are part of your community. And we work hard to make it healthier. Molina Help Finder is your one-stop shop for finding low-and no-cost community resources when you need them. Search for services near you using our online tool at **MolinaHelpFinder.com** and **MyMolina.com**. You can search for help and services to meet basic needs like:
- Food
- Housing
- Transportation
- Health
- Job training
- Childcare
- Education
- Work
- Legal
- And more

Learn more at **MolinaHelpFinder.com**.

Cost Sharing and Copayments

A copayment (sometimes called "co-pay") is a set dollar amount you are required to pay as your share of the cost for a medical service or supply. Molina Healthcare does not require you pay a copayment or other costs for covered services under the Medicaid or Healthy Michigan Plan program.

You must go to a doctor in Molina Healthcare Medicaid network, unless otherwise approved. If you go to a doctor that is not in Molina Healthcare Medicaid network and did not get approval to do so, you may have to pay for those services. You should not receive a bill from your doctor for covered services within the plan's network. If you have questions about how co-pays may apply to you, contact Member Services at **(888) 898-7969** (TTY: 711), Monday – Friday, 8 a.m. to 5 p.m., EST.

Services Covered by Medicaid not Molina Healthcare

Molina Healthcare does not cover all services that you may be eligible for as a member of Medicaid.

Services Covered by State of Michigan Medicaid:

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at **(800) 642-3195**.

- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days)
- Behavioral health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
- Substance Abuse Care including:
  - Screening and assessment
  - Detox
  - Intensive outpatient counseling
  - Other outpatient care
  - Methadone treatment

Non-Covered Services

- Elective abortions and related services
- Experimental/investigational drugs, biological agents, treatments, procedures, devices, or equipment
- Elective cosmetic surgery
- Services for the treatment of infertility

Your policy

Rights and Responsibilities

You have rights and responsibilities as our member. Our staff will respect your rights. We will not discriminate against you for using your rights. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your health care services
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private
- Participate in decisions regarding your health care, including the right to refuse treatment and express preferences about treatment options
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected
- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you
- To file a grievance, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand
- Receive Federally Qualified Health Center and Rural Health Center services
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
- To request information on the structure and operation of Molina Healthcare
- To make suggestions about our services and providers
- To make suggestions about member rights and responsibilities policy
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval

You have the Responsibility to:

- Review this handbook and Molina Healthcare Certificate of Coverage
- Make and keep appointments with your Molina Healthcare doctor
- Treat doctors and their staff with respect
- Protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your Health Plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior
- Apply for Medicare or other insurance when you are eligible
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to **Newmibridges.michigan.gov/**.

Grievances and Appeals

We want you to be happy with the services you get from Molina Healthcare and our providers. If you are not satisfied, you can file a grievance or appeal.

Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as a treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your doctor. Your doctor can often handle the problem. If you have questions or need help, call Molina Healthcare at **(888) 898-7969** (TTY: 711).

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your doctor, you can file a grievance at any time. Molina Healthcare has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits. These are examples of when you might want to file a grievance.

- Your provider or a Molina Healthcare staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a Molina Healthcare staff member was rude to you.
- Your provider or a Molina Healthcare staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Molina Healthcare at **(888) 898-7969** (TTY: 711). You can also file your grievance in writing via mail or fax at:

Mail	Molina Healthcare of Michigan Attention: Appeals and Grievance Department PO Box 182273 Chattanooga, TN 37422
Fax	(248) 925-1799

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling **(888) 898-7969** (TTY: 711). We will let you know when we have received your grievance. We may contact you for more information.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your "representative." If you decide to have someone represent you or act for you, inform Molina Healthcare in writing with the name of your representative and their contact information. Your grievance will be resolved within 90 calendar days of submission. We will send you a letter of our decision.

Appeal Process

An appeal is a way for you to ask for a review of our actions. If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get an "Adverse Benefit Determination" letter from us. This letter will tell you the following:

- The adverse benefit determination the contractor has made or intends to make
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision
- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing/External Review and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not telling you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

You can file your appeal on the phone by calling Molina Healthcare at **(888) 898-7969** (TTY: 711). You can also file your appeal in writing via mail or fax at:

Mail	Molina Healthcare of Michigan Attention: Appeals and Grievance Department PO Box 182273 Chattanooga, TN 37422
Fax	(248) 925-1799

You have several options for assistance. You may:

- Call Member Services and we will assist you in the filing process
- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example
- Choose to be represented by a legal professional

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter their contact information or, 2) fill out the Authorized Representative Designation form. You may call and request the form or find this form on our website at **MolinaHealthcare.com**.

We will send you a notice saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.

Molina Healthcare will send our decision in writing to you within 30 calendar days of the date we received your appeal request. Molina Healthcare may request an extension up to 14 more days in order to get more information before we make a decision. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Notice of Internal Appeal Decision. The Notice of Internal Appeal Decision will tell you what we will do and why.

YOUR POLICY

If Molina Healthcare's decision agrees with the Notice of Adverse Benefit Determination, you may have to pay for the cost of the services you got during the appeal review. If Molina Healthcare's decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed
- You have the option to see your appeal file
- You have the option to be there when Molina Healthcare reviews your appeal

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal. We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision.

How Can You Withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. Molina Healthcare will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Molina Healthcare at **(888) 898-7969** (TTY: 711).

What Happens Next?

After you receive the Notice of Internal Decision in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or asking for an External Review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS). You can choose to ask for both a State Fair Hearing and an External Review or you may choose to ask for only one of them.

State Fair Hearing Process

You, your representative, or your provider can ask for a State Fair Hearing with MOAHR. You must do this within 120 calendar days from the date of your appeal denial notice. A Request for Hearing form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. If you asked for services to continue in your health plan appeal and want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing within 10 calendar days of the date on the decision notice. If you do not win this hearing, you may be responsible for paying for the services provided to you during the hearing process. You can also ask for a State Fair Hearing if you do not receive a decision from us within the required time frame.

Call Molina Healthcare at **(888) 898-7969**, TTY:711 if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited State Fair Hearing. If you qualify for one, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions, you can call MOAHR at **(800) 648-3397**.

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can also request a fast appeal decision from DIFS within 10 calendar days after receiving a final determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Send you request to:

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Or call: **(877) 999-6442**
Fax: (517) 284-8838
Online: **Difs.state.mi.us/Complaints/ExternalReview.aspx**

Make Your Wishes Known: Advance Directives

Molina Healthcare supports your right to file an "Advance Directive" according to Michigan law. This document is a written statement of your wishes for medical care. It explains, in advance, what treatments you want or don't want if you have a serious medical condition that prevents you from telling your provider how you want to be treated.

The state of Michigan only recognizes an advance directive called a durable power of attorney for health care. To create one, you will need to choose a patient advocate.

This person carries out your wishes and makes decisions for you when you cannot. It is important to pick a person that you know and trust to be your advocate. Make sure you talk with the person to let them know what you want.

Talk to your family and primary care physician about your choices. File a copy of your advance directive with your other important papers. Give a copy to the person you designate as your patient advocate. Ask to have a copy placed in your medical record.

Call Member Services for more information and the forms you need to write an advance directive.

If your wishes aren't followed or if you have a complaint about how your provider follows your advance directive, you may file a complaint with:

Department of Licensing & Regulatory Affairs
BPL/Investigations & Inspections Division
P.O. Box 30670 Lansing,
MI 48909-8170
Call: **(517) 373-9196**

Or click below:
Michigan.gov/lara/bureau-list/bpl
Click on File a Complaint

If you have complaints about how Molina Healthcare follows your wishes, you may call the state of Michigan's Department of Insurance and Financial Services. Call toll-free at **(877) 999-6442** or go to **Michigan.gov/difs**.

For those aged 18 or older, you can get a template through Five Wishes that lets you document your wishes and who you want to make health care decisions for you if you are not able to make them for yourself.

To order a copy of Five Wishes, please contact:

Aging with Dignity
P.O. Box 1661
Tallahassee, Florida 32302-1661

Phone: **(850) 681-2010**
Hours: Monday-Friday, 9 a.m. to 5 p.m. EST
Email: info@fivewishes.org
Web: **Fivewishes.org**

To learn more about Five Wishes please visit: **Molinahealthcare.com/members/mi/mem/medicaid/overvw/resources/Five-Wishes.aspx**

Help Identify Health Care Fraud, Waste and Abuse

Medicaid pays doctors, hospitals, pharmacies, clinics, and other health care providers to take care of adults and children who need help getting medical care. Sometimes, providers and patients misuse Medicaid resources. Unfairly taking advantage of Medicaid resources leaves less money to help other people who need care. This is called fraud, waste, and abuse.

Fraud

Fraud is purposefully misrepresenting facts. Here are some examples of fraud:

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

Waste

Waste is carelessly or ineffectively using resources. It is not a violation of the law, but it takes money away from health care for people who need it. Here are some examples of waste:

- Using transportation services for non-medical appointments
- Doctors ordering excessive or unnecessary testing
- Mail order pharmacies sending you prescriptions without confirming you still need them

Abuse

Abuse is excessively or improperly using those resources. Here are some examples of abuse:

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

YOUR POLICY

You can Help

We work to find, investigate, and prevent health care fraud. You can help. Know what to look for when you get health care services. If you get a bill or statement from your doctor or an Explanation of Benefit Payments statement from us, make sure:

- The name of the doctor is the same doctor who treated you
- The type and date of service are the same type and date of service you received
- The diagnosis on your paperwork is the same as what your doctor told you

Health care fraud is a felony in Michigan. Being involved in fraud or abuse can put your benefits at risk or make other legal problems. If you suspect fraud, waste, and abuse has taken place, please report it. You do not have to give your name.

Online: **MolinaHealthcare.alertline.com**
Email: MHMCompliance@MolinaHealthcare.com
Phone: **(866) 606-3889**
Fax: **(248) 925-1797**

Regular Mail:
Molina Healthcare of Michigan
Attention: Compliance Officer
880 West Long Lake Road, Suite 200
Troy, MI 48098-4504

You may also report or get more information about health care fraud by writing:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

Or call toll-free: **1-855-MI-FRAUD** (1-855-643-7283)

Or visit: **Michigan.gov/fraud**
Information may be left anonymously

Helpful Definitions

These managed care definitions will help you better understand certain actions and services throughout this handbook.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Enrollee practices that result in unnecessary cost to the Medicaid Program (42 CFR§ 455.2.)

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

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

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

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

Appeal: An appeal is the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:

Denies your request for:

- A healthcare service
- A supply or item
- A prescription drug that you think you should be able to get

Reduces, limits, or denies coverage of:

- A healthcare service
- A supply or item
- A prescription drug you already got

Your plan stops providing or paying for all or part of:

- A service
- A supply or item
- A prescription drug you think you still need

Does not provide timely medical services

Beneficiary: Any person determined eligible for the Michigan Medical Assistance Program.

Business Day: Monday-Friday, 8 a.m. to 5 p.m. EST (unless otherwise stated) not including State or federal holidays.

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

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

Copayment: A set amount you may be required to pay as your share of the cost for a medical service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug

Covered Services: All services provided under Medicaid, as defined in the Contract that the Contractor has agreed to provide or arrange to be provided to Enrollees.

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

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

YOUR POLICY

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

Durable Medical Equipment: Equipment and supplies ordered by a healthcare provider for everyday or extended use. This may include:

- Oxygen equipment
- Wheelchairs
- Crutches
- Blood testing strips for diabetics

Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Benefits defined in section 1905(r) of the Act including: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.

Electroconvulsive Therapy (ECT): a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure.

Emergency Medical Condition: An illness, injury, or condition so serious that you would seek care right away to avoid harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Care given for a medical emergency when you think that your health is in danger.

Emergency Services: Review of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Medical services that your plan doesn't pay for or cover.

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

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

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

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Grievance: A complaint that you let your plan know about. You may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person or provider treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered or denied (see Appeal).

Habilitation Services and Devices: Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Services for people with disabilities

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

Home Health Care: Healthcare services that a healthcare provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

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

Hospitalization: Care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not need an overnight stay.

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

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

Medical Health Plan: A plan that offers healthcare services to members who meet State eligibility rules. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The State pays the premium on behalf of the member.

Medically Necessary: Healthcare services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- An illness

- Injury
- Condition
- Disease or
- Symptom

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

Network: Health care providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

Network Provider/Participating Provider: A healthcare provider that has a contract with the plan as a provider of care.

Non-Participating Provider/Out-of-Network Provider: A healthcare provider that does not have a contract with the Medicaid Health Plan as a provider of care.

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

Plan: A plan that offers health care services to members that pay a premium.

Preauthorization: Approval from a plan that is required before the plan pays for certain:

- Services
- Medical equipment or
- Prescriptions

This is also called prior authorization, prior approval, or precertification. Your plan may require preauthorization for certain services before you receive them. This excludes an emergency.

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

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that require a prescription by law by a licensed Provider.

Primary Care Provider: A licensed physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides and manages your health care services. This can also be called a Primary Care Physician. Your primary care provider is the person you see first for most health problems. They make sure that you get the care you need to keep you healthy. They also may talk with other doctors and healthcare providers about your care and refer you to them.

Provider: A person, place or group that's licensed to provide health care like doctors, nurses, and hospitals.

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

Rehabilitation Services and Devices: Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Psychiatric rehabilitation services

Skilled Nursing Care: Services in your own home or in a nursing home provided by trained:

- Nurses
- Technicians
- Therapists

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

Transcranial Magnetic Stimulation (TMS): a noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression.

Urgent Care: Care for an illness, injury, or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

Notice of Privacy Practices

MOLINA HEALTHCARE OF MICHIGAN

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

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

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

Why does Molina use or share your PHI?

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

For Treatment

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

For Payment

Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations

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

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

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

We will share your PHI with other companies ("business associates") that perform different kinds of activities for our health plan. We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatment, or other health-related benefits and services.

When can Molina use or share your PHI without getting written authorization (approval) from you?

The law allows or requires Molina to use and share your PHI for several other purposes including the following:

Required by law

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

Public Health

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

Health Care Oversight

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

Research

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

Legal or Administrative Proceedings

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

Law Enforcement

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

Health and Safety

Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions

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

Victims of Abuse, Neglect or Domestic Violence

Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

Workers Compensation

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

Other Disclosures

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

When does Molina need your written authorization (approval) to use or share your PHI?

Molina needs your written approval to use or share your PHI for a purpose other than those listed in this Notice. Molina needs your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written

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approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**

  You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use Molina's form to make your request.

- **Request Confidential Communications of PHI**

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

- **Review and Copy Your PHI**

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

- **Amend Your PHI**

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

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**

  You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

  - o for treatment, payment or health care operations;
  - o to persons about their own PHI;
  - o sharing done with your authorization;
  - o incident to a use or disclosure otherwise permitted or required under applicable law;
  - o PHI released in the interest of national security or for intelligence purposes; or
  - o as part of a limited data set in accordance with applicable law.

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

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

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

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

You may file a complaint with us at:

Molina Healthcare of Michigan
Attention: Compliance Officer
880 West Long Lake Road
Troy, MI 48098-4504
Phone: **(888) 898-7969**

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

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

What are the duties of Molina?

Molina is required to:

- Keep your PHI private;
- Give you written information such as this on our duties and privacy practices about your PHI;
- Provide you with a notice in the event of any breach of your unsecured PHI;
- Not use or disclose your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change

Molina reserves the right to change its information practices and terms of this Notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material

changes, Molina will post the revised Notice on our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by Molina.

Contact Information

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

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

Certificate of Coverage

Article I. General Conditions

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

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

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

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

Article II. Definitions

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

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

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

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

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

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

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

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

2.9 Experimental, Investigational or Research Drug, Device, Supply, Treatment, Procedure or Equipment means a drug, device, supply, treatment, procedure or equipment meeting one or more of the following criteria: (a) it cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use; (b) it is the subject of a current investigational new drug or new device application on file with the FDA;(c) it is being provided pursuant to a Phase I or Phase II clinical trial; (d) it is being provided pursuant to a written protocol which describes among its objectives the determination of safety, efficacy or efficiency in comparison to conventional alternatives; (e) it is described as experimental, investigational or research by informed consent or patient information documents; (f) it is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Michigan Department of Health and Human Services (MDHHS) or successor agencies, or of a human subjects (or comparable) committee; (g) the predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to medical investigational or research settings; (h) the predominant opinion among experts as expressed in the published authoritative medical or scientific literature is that further experiment, investigation or research is necessary in order to define safety, toxicity, effectiveness or efficiency compared with conventional alternatives; (i) at the time of its use or proposed use, it is not routinely or widely employed or is otherwise not generally accepted by the medical community; (j) it is not investigative in itself pursuant to any of the foregoing criteria, and would not be Medically Necessary, but for the provision of a drug, device, treatment, procedure or equipment which meets any of the foregoing criteria; or (k) it is deemed experimental, investigational or research under the Plan's insurance or reinsurance agreements. Experimental, Investigational or Research Drug does not include an antineoplastic drug which is a covered benefit in accordance with Section 21054b of the Public Health Code.

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

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

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

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

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

2.15 Medicaid Contract is the contract between the State and the Plan as described in the Comprehensive Health Care Program agreement under which the Plan agrees to provide or arrange for Covered Services for Members.

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

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

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

a. Services rendered by a Health Professional that do not require the technical skills of such a provider; or
b. Services, equipment and supplies furnished mainly for the personal comfort or convenience of the Member, any individual who cares for the Member, or any individual who is part of the Member's family; or
c. That part of the cost of a service, equipment or supply which exceeds that of any other service, equipment or supply that would have been sufficient to safely and adequately diagnose or treat the Member's physical or mental condition, except when rendered by, or provided upon the referral of, a Primary Care Provider, or otherwise authorized by the Plan, in accordance with the Plan's procedures.

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

2.20 Member means a Medicaid Program beneficiary enrolled in the Plan and on whose behalf the MDHHS has paid a Premium in accordance with the Medicaid Contract.

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

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

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

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

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

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

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

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

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

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

2.31 Premium means the amount prepaid by the MDHHS on behalf of the Member to secure Covered Services.

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

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

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

2.35 Specialist Physician means a Participating Physician, other than a Primary Care Provider, who provides Covered Services to Members upon referral by the Primary Care Provider and, if required, Prior Authorization by the Plan.

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

Article III. Eligibility and Enrollment

3.1 Member Eligibility. To be eligible to enroll in the Plan, an individual must be eligible for the Medicaid Program as determined by the MDHHS and must reside within the Service Area. The MDHHS is solely responsible for determining the eligibility of individuals for the Medicaid Program. Eligible individuals may choose a health plan, or the MDHHS may choose a health plan for eligible individuals within the health plan's service area.

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

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

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

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

Article IV. Relationship with Participating & Non-Participating Providers

4.1 Selecting a Primary Care Provider. By the effective date of enrollment, the Member should select a Primary Care Provider. If the Member is a minor or otherwise incapable of selecting a Primary Care Provider, an authorized person should select a Primary Care Provider on behalf of such Member. An authorized person may select a pediatrician as the Primary Care Provider for a Member who is a minor. The Plan may select a Primary Care Provider for a Member in the event that a Primary Care Provider is not selected by or for the Member. The Plan will use prescribed guidelines to make such a selection.

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

4.3 Changing a Primary Care Provider. The Member may change to another Primary Care Provider through the MyMolina portal, MyMolina app, or contacting Member Services. All PCP changes are effective the day of the change.

4.4 Specialist Physicians and Other Participating Providers. Except as otherwise expressly stated in this Section 4.4 or other sections of this Certificate, the Member may receive Covered Services from Specialist Physicians and other Participating Providers. The Plan does not require authorization for most in-network Specialist Physician Services. In some circumstances, certain medical services, equipment and supplies are not covered or may require Prior Authorization by the Plan. Prior Authorization is required for most services provided out of the Plan's provider network. The Member may contact the Plan to obtain a list of services requiring Prior Authorization. If the Member does not obtain the necessary authorization from the Plan, the Member may be financially responsible for payment of medical services, equipment or supplies if notified by the provider prior to the service. A female Member may receive an annual well-woman

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examination and routine obstetrical and routine gynecological services from an obstetrician-gynecologist specialist who is a Participating Provider without Prior Authorization from the Primary Care Provider or the Plan. A pediatrician may be selected as the Primary Care Provider for a minor Member as indicated in Section 4.1.

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

4.6 Independent Contractors. The Plan and Participating Providers are independent contractors and are not employees, agents, partners or co- venturers of or with one another. The Plan does not itself undertake to directly furnish any health care services under this Certificate. The Plan arranges for the provision of Covered Services to Members through Participating Providers and Non- Participating Providers. Participating Providers and Non- Participating Providers are solely responsible for exercising independent medical judgments. The Plan is responsible for making benefit determinations in accordance with the Member Agreement, the Medicaid Contract and its contracts with Participating Providers, but it expressly disclaims any right or responsibility to make medical treatment decisions. Such decisions may only be made by the Member in consultation with Participating Providers or Non-Participating Providers. A Participating Provider or a Non-Participating Provider and the Member may initiate or continue medical treatments despite the Plan's denial of coverage for such treatments. The Member may appeal any of the Plan's benefit decisions in accordance with the Plan's Grievance and Appeal Policy and Procedure.

4.7 Availability of Participating Providers. The Plan does not represent or promise that a specific Participating Provider will be available to render services throughout the period that the Member is enrolled in the Plan. The Plan or a Participating Provider may terminate a provider contract or limit the number of Members that the Participating Provider will accept as patients. If the Member's Primary Care Provider no longer acts as a Primary Care Provider, the Member must select another Primary Care Provider. The Plan shall permit the Member to continue an ongoing course of treatment with the Primary Care Provider as required by MCL 500.2212b. If a Specialist Physician who is rendering services to the Member ceases to be a Participating Provider, the Member must cooperate with the Primary Care Provider or Plan in selecting another Specialist Physician to render Covered Services.

4.8 Inability to Establish or Maintain a Physician- Patient Relationship. If the Member is unable to establish or maintain a satisfactory relationship with a Primary Care Provider or a Specialist Physician to whom the Member is referred, the Plan may request that the Member select another Primary Care Provider or may arrange to have the Member's Primary Care Provider refer such Member to another Specialist Physician.

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

Article V. Member Services

5.1 Release and Confidentiality of Member Medical Records.

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

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

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

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

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

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

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

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

5.2.1 Grievance Process. The Member may submit a grievance with the Plan either in person, in

writing or by telephone. The Plan's Appeal and Grievance Coordinator may assist the Member filing the grievance. The Plan will make a decision regarding the Member's grievance within 90 calendar days of submission.

5.2.2 Standard Appeal Process. The Member can file an appeal if the Plan denies, suspends, terminates, or reduces a requested service. This is called an adverse benefit determination. The Member has 60 calendar days from the original adverse benefit determination date to file an appeal. The Member has the right to appeal in person, in writing, or by telephone to the Designated Appeals Reviewer. The Plan's Appeal and Grievance Specialist can help assist with filing the appeal. The appeal request should be sent to Molina Healthcare of Michigan, Attention: Appeals and Grievance Department, PO Box 182273, Chattanooga, TN, 37422. The Member may also send in appeals to fax number **(248) 925-1799**. The Member has the right to include an Authorized Representative throughout the appeals process and to attend the Appeals hearing. The Member must inform the Plan of the Authorized Representative in writing by completing the Authorized Representative Designation form. The Plan will use reviewers who were not involved in the adverse benefit determination. The reviewers are health care professionals who have the appropriate clinical expertise in treating your condition or disease. A decision will be mailed to the Member in 30 calendar days from the date that the Plan received the appeal.

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

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

5.2.4 Department of Insurance and Financial Services. The Member may request an external review if the member does not receive a decision from the Plan within 30 calendar days from the Plan or is not satisfied with the result of the appeal. Members have 127 calendar days to file an external appeal with DIFS. The appeal request should be sent to the Department of Insurance and Financial Services (DIFS), Healthcare Appeals Section, Office of General Counsel, P.O. Box 30220, Lansing, MI 48909-7720. The appeal request can also be sent via fax to **(517) 284-8848** or online at **Difs.state.mi.us/Complaints/ExternalReview.aspx**. The Plan's Appeal and Grievance Specialist will mail the external review forms to the Member. DIFS will send the appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to the member in 14 calendars days of accepting the appeal. The Member, Authorized Representative, or Doctor can also request an expedited (fast) appeal from DIFS at the same address above within 10 calendar days after receiving a final determination. DIFS will send the appeal to an IRO for review. A decision will be mailed to the member within 72 hours. During this time, benefits will continue.

5.2.5 State Fair Hearing Process. A Member has the right to a Medicaid fair hearing on any decision made by the Plan that the Member believes is inappropriate by contacting the MDHHS, Michigan Office of Administrative Hearings and Rules by calling **(800) 648-3397**. The fax number is **(517) 763-0146**. The address is Michigan Department of Health and Human Services, Michigan Office of Administrative Hearings and Rules, P.O. Box 30763, Lansing, MI 48909 or online at **Courts.michigan.gov/self-help/mahs/pages/default.aspx**. If the member has any problems about the care they are getting, they must first submit an appeal to Molina. If they are unhappy with Molina's decision, they may directly appeal to the MDHHS through the State's Fair Hearing process. This must be done within 120 calendar days of the final determination. Molina Healthcare will include a State hearing request form along with a self-addressed stamped envelope with our decision.

5.3 Member Handbook. Members can receive a copy of the Member Handbook at any time by telephone request to Member Services. The Member Handbook is also available on the Plan website at **MolinaHealthcare.com**.

5.4 Membership Cards.

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

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

5.4.3 If the Member's Medicaid mihealth card and Molina Healthcare ID card are lost or stolen, the Member must notify Member Services by the end of the next business day following the Member's discovery of the loss or the date of the theft.

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

5.6 Additional Information. The Member may contact the Plan to obtain additional information on any process including how the Plan evaluates new technology for inclusion as a Covered Service.

Article VI. Payment for Covered Services

6.1 Periodic Premium Payments. The MDHHS or its remitting agent will pay directly to the Plan, on behalf of the Member, the Premium specified in the Medicaid Contract. The MDHHS or its remitting agent will pay the Premium on or before the due date specified in the Medicaid Contract. The Member understands that the Premium to be paid on behalf of the Member by the MDHHS in return for Covered Services will be remitted in accordance with the Medicaid Contract.

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

6.3 Claims.

6.3.1 It is the Plan's policy to pay Participating Providers directly for Covered Services furnished to Members in accordance with the contracts between the Plan and Participating Providers. However, if a Participating Provider bills the Member for a Covered Service, the Member should contact Member Services upon receipt of the bill. If the Member pays a bill for Covered Services, the Plan will require the Participating Provider to reimburse the Member.

6.3.2 When the Member receives Emergency Services, or other Covered Services authorized in advance by the Plan, from a Non-Participating Provider, the Member should request that the Non-Participating Provider bill the Plan. If the Non-Participating Provider refuses to bill the Plan but bills the Member, the Member should submit any such bill to the Plan. If the Non-Participating Provider requires the Member to pay for the Covered Services at the time they are rendered, the Member must submit a request for reimbursement for such Covered Services in writing to the Plan within 60 days after the date the Covered Services were rendered.

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

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

6.4 Non-Participating Providers. The Member is financially responsible for payment for all services, supplies and equipment received from Non-Participating Providers unless those services are included as Covered Services on Appendix A of this Certificate and are authorized as required by the Plan. However, Prior Authorization is not required for Emergency Services, Family Planning Services, treatment of communicable diseases at the Member's local health department, immunizations at the Member's local health department, services from a child and adolescent health centers and programs and federally qualified health centers.

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

Article VII. Covered Services & Coordination of Care Services

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

7.1.1 The Covered Services are specified as covered services in the Medicaid Contract at the time that the services are rendered. The details of all Medicaid covered services are contained in Medicaid Program policy manuals and publications.

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

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

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

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

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

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

7.4 Out-of-Area Services.

7.4.1 Covered Services. Emergency Services are covered by the Plan while the Member is temporarily out of the Service Area. The Member or a responsible person must notify the Plan as soon as possible after receiving Emergency Services. Routine medical care while the Member is outside of the Service Area is not a Covered Service unless prior authorized by the Plan.

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

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

Article VIII. Exclusions and Limitations

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

8.2 Limitations.

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

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

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

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

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

Article IX. Term and Termination

9.1 Term.

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

9.2 Termination of Certificate by the Plan or the MDHHS.

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

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

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

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

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

a. The Member moves out of the Service Area

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

c. The Member dies

d. The Member is admitted to a skilled nursing facility for custodial care, or for restorative health services that exceed 45 days, unless the Member is a hospice patient

e. The Member is incarcerated in a correctional facility

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

a. The Member is unable to establish or maintain a satisfactory physician-patient relationship with available participating providers

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

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

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

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

9.4 Disenrollment by Member.

9.4.1 A Member may disenroll from the Plan for any reason during the first 90 days of enrollment. After the 90-day period, the MDHHS may require an annual open enrollment period in accordance with the Medicaid Contract. After the annual open enrollment period, the Member may disenroll from the Plan for cause. In the event that the Member wishes to disenroll from the Plan, the Member, or an authorized person on behalf of the Member, should contact the MDHHS Enrollment Broker.

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

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

Article X. Coordination of Benefits

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

10.2 Assignment.

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

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

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

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

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

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

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

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

10.6.1 Determine whether and to what extent the Member has health insurance or other health benefit coverage for Covered Services; and

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

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

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

10.7 Construction. Nothing in this Article shall be construed to require the Plan to make a payment until it determines whether it is the primary Payer or the secondary Payer and the benefits that are payable by the primary Payer, if any. The Plan must follow the Medicaid Contract and Medicaid Provider Manual requirements related to coordination of benefits.

Article XI. Subrogation

11.1 Assignment; Suit. If the Member has a right of recovery from any person or entity for the Member's injury or illness, except from the Member's health insurance or health benefit plan which is subject to Article 10 of this Certificate, the Member, as a condition to receiving Covered Services under this Certificate, must do the following:

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

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

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

Article XII. Miscellaneous

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

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

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

Molina Healthcare of Michigan
Attn: Member Services
880 West Long Lake Road
Troy, Michigan 48098-4504

Appendix A - Benefit Detail of Covered Services

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

1. Allergy testing, evaluations and injections, including serum costs.
2. Ambulatory Surgical Services and Supplies. Outpatient services and supplies furnished by a surgery center for a covered surgical procedure.
3. Ambulance Services. Professional ambulance services including air ambulance for the following situations or conditions:
    a. Ambulance transportation to the emergency department of a Hospital due to an Emergency;

b. Ambulance transportation from a hospital to another facility, including a skilled nursing facility (participating or non-participating);

c. Transportation from a non-participating hospital to a Participating Hospital; and provided at the facility in which the patient is confined.

d. Round trip ambulance transportation from the Hospital or facility of the patient's confinement to another facility for tests or other medically necessary services that cannot be provided at the facility in which the patient is confined.

4. Antineoplastic Drug Therapy. Antineoplastic drugs are covered in accordance with Section 21054b of the Public Health Code.

5. Blood Lead Screening and Follow-Up. Blood lead screening and follow-up services are covered for Member's under age 21.

6. Breast pumps; personal use, double electric.

7. Cardiac Rehabilitation Therapy.

8. Chiropractic Care. Up to 18 visits per calendar year limited to specific diagnosis and procedures.

9. Contraceptive Medications and Devices. Contraceptive medications, supplies and devices are covered. Over-the-counter family planning drugs and supplies are covered without a prescription.

10. Dental Services. Diagnostic, preventive, restorative, periodontal, prosthetic and medically/clinically necessary oral surgery services, including extractions, are covered for Members 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. Medicaid Members under the age of 21 receive dental coverage through Healthy Kids Dental. The Plan will provide Members with the names of participating dentists in their area who are available to provide dental services. The Plan provides unlimited round- trip or one-way trips for covered, medically necessary services each calendar year. Members can use this benefit to visit any Molina Healthcare dental provider.

11. Diabetes Treatment Services. In accordance with MCLA 500.3406(p), the following equipment, supplies and educational training for the treatment of diabetes, if determined to be Medically Necessary and prescribed by Participating Provider is a Covered Service:

a. Blood glucose monitors and blood glucose monitors for the legally blind.

b. Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.

c. Syringes.

d. Insulin pumps and medical supplies required for the use of an insulin pump.

e. Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self- management and treatment of their diabetic condition; subject to completion of a certified diabetes education program and if services are needed under the comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.

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

1. Insulin.

2. Non-experimental medication for controlling blood sugar.

3. Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes.

12. Disposable Items and Other Medical Supplies:

a. Disposable items are covered when replacing a normal body function (e.g., ostomy and urology supplies).

b. The following diabetic supplies are covered: insulin, syringes, reagents, standard glucometers and lancets. Insulin pumps may be covered for Type I uncontrolled insulin dependent diabetes.

13. Durable Medical Equipment and Supplies. Durable medical equipment is covered in accordance with MDHHS guidelines.

14. Emergency Services.

15. End Stage Renal Disease Services.

16. Family Planning. Family planning such as contraception counseling and associated physical exams and procedures, and limited infertility screening and diagnosis are covered. The following are covered services even if they are not provided in connection with the diagnosis and treatment of an illness or injury:

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

b. Advice on Contraception and Family Planning.

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

17. Hearing Care. Hearing exams and supplies are covered. Hearing aid batteries and maintenance and repair of hearing aids are covered. Hearing aid batteries are distributed 36 disposable every 6 months. Hearing aids are covered for all ages.

18. Health Education.

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19. Home Health Care. Home health care visits are covered. Covered Services include home care nursing visits by a registered professional or licensed practical nurse and home health aides under certain circumstances.

20. Hospice Services.

21. Hospital Services.

    a. Inpatient Services. Hospital inpatient services and supplies including professional services, semi-private room and board, general nursing care and related services.

    b. Outpatient Services. Facility and professional services and supplies which are furnished on an outpatient basis.

    c. Diagnostic and Therapeutic Services. Services and supplies for laboratory, radiologic and other diagnostic tests and therapeutic treatments.

22. Infusion Therapy.

23. Maternal and Infant Health Program.

24. Maternity Care.

    a. Hospital and Physician. Services and supplies furnished by a Participating Hospital or Participating Physician for prenatal care, genetic testing, delivery and postnatal care.

    b. Certified Nurse Midwife Services.

    c. Newborn Child Care. A newborn child of a Member is eligible for Covered Services for the month of birth.

    d. Home Care Services. One routine home health postnatal visit for mother and baby.

    e. Length of Stay. The Member and newborn child shall be entitled to a minimum of 48 hours of inpatient Hospital Services following a vaginal delivery and a minimum of 96 hours of inpatient Hospital Services following a Caesarian section.

    f. Parenting and Birthing Classes.

    g. Special conditions for new Members in the Plan who are pregnant at the time of enrollment. These Members may select or remain with the Medicaid obstetrician of choice and shall be entitled to receive all medically necessary obstetrical and prenatal care without Prior Authorization from the Plan. The services may be provided without Prior Authorization regardless of whether the provider is a Plan participating provider.

    h. Doula Services. Twelve (12) visits during the prenatal and postpartum periods and one (1) visit for attendance at labor and delivery.

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

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26. Mental Health Services. Short-term outpatient therapy is covered. The outpatient mental health benefit is not meant to cover severe and/or persistent mental disease or illness of children or adolescents with severe emotional disturbances.

27. Non-Emergent Transportation. Non- Emergent transportation to covered services is provided. Covered services include doctor appointments, x-rays, lab tests, pharmacy, medical supplies or other medical care.

28. Oral and Maxillofacial Surgery.

    a. Oral and maxillofacial surgery and related x-rays are a Covered Service when performed by a Participating Provider, in accordance with the Plan's Prior Authorization policies, for the following conditions:

        1. ii. Emergency repair and treatment of fractures of the jaw and facial dislocation of the jaw.

        2. iii. Emergency repair of traumatic injury resulting from a non-occupational injury to sound natural teeth, provided treatment occurs within 24 hours of the initial injury (only the initial visit for treatment will be covered).

    b. Orthognathic Surgery. Orthognathic surgery (surgery to correct the relationship or positions of the bones and soft tissues of the jaw) for congenital syndromes which directly affect the growth, development and function of the jaw and surrounding structures is covered.

29. Organ and Tissue Transplants. Cornea and kidney transplants are covered benefits. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologous, and peripheral stem cell harvesting, and small bowel) are covered on a Member specific basis when determined medically necessary according to currently accepted standards of care. The Plan has a policy to evaluate, document and act upon a Member's request for an extrarenal transplant. A Member may obtain a copy of the policy upon request to the Plan. Antineoplastic drugs are covered in accordance with Section 21054b of the Public Health Code.

30. Out-of-Network Services. Services provided by out-of- network providers are covered if medically necessary, authorized by the Plan, and could not reasonably be obtained by a network provider, inside or outside of the State of Michigan, on a timely basis.

31. Plastic and Reconstructive Surgery. Plastic and reconstructive surgery to improve function or to approximate a normal appearance is covered when the surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery of the breast on which a mastectomy for cancer was performed is covered. Some plastic and reconstructive surgery must meet specific criteria before being covered.

32. Podiatry Services. Podiatry services are covered.

33. Prescription Drugs.

    a. Outpatient prescription drugs listed on the Single Preferred Drug List (SPDL) or Michigan's

Common Formulary are covered.

b. Most formulary drugs are covered every 30 days, some drugs are covered up to 102 days.

c. Condoms are covered, limited to 36 condoms every 30 days.

d. Over-the-counter drugs and medical supplies must have a prescription to be covered.

e. Infertility drugs are not covered.

f. Off-label use of a federal food and drug administration approved drug and reasonable cost of supplies medically necessary for administrator the drug as required under MCL 500.3406q.

g. Covered drugs may require prior authorization or be subject to quantity limits, step therapy or other requirements.

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

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

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

 c. Health education.

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

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

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

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

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

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

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

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42. Telehealth Services.

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

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

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

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

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

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

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

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

Additional benefits for Healthy Michigan Plan Enrollees include:

1. Habilitative Services.

Appendix B - Coordination of Care Services

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

1. Developmental Disability Services. Services, including therapies (speech, language, physical, occupational) provided to persons with developmental disabilities which are billed through the Community Mental Health Service Program providers or Intermediate School Districts. The Plan will provide Members with information regarding these services upon request, may refer Members for these services and will coordinate the Member's services with the coordinating agency as appropriate.

2. Substance Abuse Services. Substance abuse services are not covered by the Member Agreement. Members may be eligible to receive substance abuse services through

coordinating agencies in their area. The Plan will provide Members with information regarding these services upon request, may refer Members for these services and will coordinate the Member's services with the coordinating agency as appropriate.

3. Coordination with Local Health Department. The Plan will coordinate certain services with the Member's local health department and will make certain referrals as appropriate.
4. Nursing Facility Services. Intermittent or short-term restorative rehabilitative services in a nursing facility after 45 days and custodial care provided in a nursing facility.
5. School Based Services. Services provided by a school district and billed through the Intermediate School Districts.
6. Transportation Services. Transportation for services not covered by the Plan to include therapies (speech, language, physical, occupational) provided to persons with developmental disabilities which are billed through the Community Mental Health Program.

Appendix C - Excluded Services & Limitations

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

1. Abortions. Elective therapeutic abortions and related services.
2. Acupuncture. Acupuncture services are not covered.
3. Alternative Procedures and Treatments. Alternative procedures and treatments which are not generally recognized or accepted by the medical community are excluded. Also excluded are procedures and treatments which are primarily educational in nature.
4. All Services or Supplies that are not medically necessary are not covered.
5. Ambulance Services. Use of an ambulance for transportation for any reason other than an Emergency or because the Member's medical condition necessitates use of an ambulance is not a Covered Service.
6. Autopsy. Autopsy services are not covered.
7. Biofeedback. Biofeedback services are not covered.
8. Cognitive Evaluation and/or Retraining and Related Services. Cognitive services, training and/or retraining, and any related care, supplies or procedures, are excluded regardless of who provides them.
9. Cosmetic Surgery/Procedures. Surgery, medications, injections, procedures and related services performed to reshape normal structures of the body in order to improve or alter the Member's appearance or self-esteem are excluded. Examples include, but are not limited to, elective rhinoplasty, spider/varicose vein removal and elective breast reduction. Cosmetic alteration done simultaneous to surgery for a medical condition is not covered.

Wigs, prosthetic hair or hair transplants are not covered. As provided in Appendix A, breast reconstructive surgery following a mastectomy is covered.

10. Court-Ordered Services. Charges for services ordered by a court of law will not be covered unless they are otherwise Medically Necessary and all Plan requirements are met.
11. Custodial or Domiciliary Care. Custodial or domiciliary care, including such care in a nursing home, is excluded.
12. Dental Services. Orthodontia, supplies and appliances including splints and braces are not covered. Also excluded are services and supplies due to damage of any tooth due to the natural act of chewing. Dental implants/mandibular bone staples are not covered.
13. Developmental Disability Services. Services provided to a Member with a developmental disability and billed through Community Mental Health Services Program providers are not covered. Members may be eligible to receive developmental disability services through providers or agencies in their areas as indicated in Appendix B of the Certificate.
14. Experimental, Investigational or Research Drugs, Biological Agents Devices, Supplies, Treatments, Procedures or Equipment. These services are not covered.
15. Forms. Charges for time involved in completing necessary forms, claims or reports are not covered.
16. Government-Provided Medical Care. Medical expenses incurred in any government hospital or for services of a government physician or other health professional are excluded.
17. Hair Analysis.
18. Home and Community Based Waiver Program Services.
19. Hospital Confinement. Days of confinement for non-medical reasons are not covered.
20. Long-Term Therapies. Long-term therapies which exceed the defined benefit are not covered.
21. Medical Equipment and Supplies. Excluded from coverage are replacement and/or repair of most covered items due to misuse, loss or abuse as defined by the Medicaid Provider Manual; experimental items; batteries (except hearing aid batteries); and comfort and convenience items such as over-bed tables, heating pads, protective helmets, adjusta-beds, telephone arms, air conditioners, sauna baths, whirlpool baths, hot tubs and elevators.
22. Non-Medical Services. Non-medical services such as on-site vocational rehabilitation and training or work evaluations, school, home or work site environmental evaluations, or related employee counseling are excluded.
23. Obstetrical Delivery in the Home. Services and supplies related to obstetrical delivery in the home are not covered.
24. Oral Splints and Appliances. Oral splints and appliances associated with TMJ, orthognathic, and oral and maxillofacial surgeries are excluded.
25. Other Coverage. The Plan is a payer of last resort under the Medicaid Contract. Coverage is

excluded for health care service, equipment or supply to the extent any third-party is liable for payment of benefits under a state or federal law or a private or governmental health insurance plan or health benefit program, including, but not limited to, Medicare. Benefits by any third-party payer and the Plan will be coordinated in accordance with Article 10 of the Certificate.

26. Personal and Convenience Items. Personal and convenience items, including but not limited to, household fixtures and equipment, are excluded.

27. Personal Care and Home Help Services.

28. Prescription Drugs. The following prescription drugs are excluded from coverage:

    a. Medications prescribed for cosmetic purposes;

    b. Experimental, investigational or research drugs;

    c. Drugs prescribed to treat infertility;

    d. Vitamin and mineral combination drugs (only selected prenatal, end-stage renal disease vitamins, and pediatric fluoride preparations are covered);

    e. Anti-psychotic classes and H7Z class psychotropic drugs as listed under the category "Classes for Psychotropic and HIV/AIDS carveout at **Michigan. fhsc.com**; drugs in the anti-retroviral classes including protease inhibitors and reverse transcriptease inhibitors; substance abuse treatment drugs as listed under the category Classes for Psychotropic and HIV/AIDS carveout at **Michigan.fhsc.com**.

29. Private Duty Nursing Services. Private duty inpatient and outpatient nursing services are excluded.

30. Reproductive Services. Reversal of elective sterilization is excluded. In vitro fertilization, GIFT, artificial insemination, ZIFT, intrauterine insemination (IUI), surrogate parenthood, and any infertility treatments are excluded.

31. School District Services. Services provided by a school district and billed through the Intermediate School District are excluded.

32. Services Rendered by a Member or a Family Member. Services, care, or treatment rendered by the Member or by the Member's family, including, but not limited to, spouse, mother, father, grandmother, grandfather, aunt, uncle, cousin, brother, sister, son, daughter, niece, nephew, grandson, granddaughter or any person who resides with the Member.

33. Services Required by Third-Parties. Services required by third-parties are excluded, including: physical examinations, diagnostic services, prescriptions and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state or federal government, obtaining or continuing insurance coverage, securing school admission or attendance, or participating in athletics. Medical and/or psychiatric evaluations for any legal determinations with the exception of foster care placement are excluded.

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34. Special Food and Nutritional Supplements. Food and food supplements are not covered, except for enteral and parenteral feedings when they are the only means of nutrition.

35. Speech Therapy. Speech therapy is covered, excluding services provided to person with developmental disabilities which are billed through Community Mental Health services Program providers or Intermediate School Districts.

36. Substance Abuse. Substance abuse services including screening and assessment, detoxification, intensive outpatient counseling, other outpatient services and methadone treatment are excluded. Members may be eligible to receive substance abuse services through providers or agencies in their areas as indicated in Appendix B of the Certificate.

37. Temporomandibular Joint Syndrome (TMJ). TMJ surgery is not covered.

38. Transportation Services which are not covered benefits under the Medicaid Contract are excluded.

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