Aetna Better Health of Michigan Medicaid

Program Certificate of Coverage

Welcome to Aetna Better Health® of Michigan.

We are extremely pleased to have you as a member in our health plan and look forward to serving you. We have built a strong network of area doctors, hospitals, and other providers to offer abroad range of services for your medical needs.

As an Aetna Better Health of Michigan member, it is important that you understand the way your benefits and coverage works. This Certificate of Coverage contains the information you need to know about your coverage with us. You should also review the enclosed Member Handbook. The Member Handbook contains important information about your coverage with us. The Certificate of Coverage and Member Handbook are also on our website at **AetnaBetterHealth.com/Michigan**.

Please take a few minutes to read these materials. Make sure your covered family members are also aware of the provisions of your coverage. Our Member Service department is available to answer any questions you may have about your coverage. You can reach Member Service at **1-866-316-3784**, Monday through Friday, 8 AM through 5 PM, EST.

We look forward to serving you.

Sincerely,

Teressa D. Smith, MBA
Chief Executive Officer

Aetna Better Health of Michigan Medicaid
Program Certificate of Coverage

The Agreement between Aetna Better Health of Michigan Inc. (hereafter called the "PLAN", "We", "Us", or "Our") and You and, if applicable, Your Dependents as Members of the PLAN (hereafter called "You" or "Member") is made up of this Certificate of Coverage, and any amendments (collectively "this Agreement" or "the Agreement").

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to this Agreement unless approved in writing by an officer of the PLAN, and the resulting waiver, change, or amendment is attached to the Agreement. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the rules and regulations of the PLAN.

THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY. Many of the provisions of this Agreement are related to each other; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement have special meanings. These words will appear capitalized and are defined for You in Section 1 of this Agreement, "Definitions." By using these definitions, You will have a clearer understanding of Your coverage.

From time to time, this Agreement may be amended. When that occurs, We will notify you by U.S. mail. The amended agreement or new Certificate of Coverage will be placed on our website at **AetnaBetterHealth.com/Michigan**. If you would like a copy mailed to you, you may contact Customer Service at **1-866-316-3784**. You should keep this document in a safe place for Your future reference.

This Agreement and all riders attached to it contain the terms and provisions pursuant to which medical and hospital services will be arranged for by the PLAN to Members (as defined below) eligible for such Coverage (as defined below) under the Michigan Medicaid program ("Medicaid program").

SECTION 1.0 – DEFINITIONS

1.1 **ABUSE** means provider 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. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

1.2 **ADVERSE DETERMINATION** means the PLAN'S denial or limited authorization of a requested service, or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Determination also includes (a)the failure to provide services in a timely manner, (b) any entire or partial reduction, suspension, or termination of a

benefit or previously authorized service, or(c) failure to act within specified timeframes when addressing appeals and grievances. An Adverse Determination based, in whole or in part, on medical judgment includes the failure to authorize or cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate.

1.3 **APPEAL** means 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 health care service
  - — A supply or item
  - — A prescription drug that you think you should be able to get
  - — A dental service
  - — A dental appliance or device
- Reduces, limits or denies coverage of:
  - — A health care service
  - — A supply or item
  - — A prescription drug you already got
  - — A dental service
  - — A dental appliance or device
- 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
  - — A dental service

— A dental appliance or device
— Does not provide timely health or dental services.

1.4 **ATTENDING PHYSICIAN** means any Physician responsible for managing the Member's care during a hospitalization or institutionalization.

1.5 **BUSINESS DAY** means Monday through Friday, except those days identified by the state as a holiday.

1.6 **CHRONIC** means a health condition that is prolonged or lingering induration.

1.7 **COPAYMENTS** mean an amount you are required to pay as your share of the cost for a medical service or supply or dental service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug
- A dental visit
- A dental appliance or device

A copayment is usually a set amount. You might pay $2 or $4 for a doctor or dental visit or prescription drug.

1.8 **COSMETIC SERVICES AND SURGERY** means medical or surgical services (i) performed to reshape normal structures of the body in order to improve the Member's appearance and self-esteem; (ii) from which no significant improvements in physiological function could reasonably be expected; (iii)that do not meaningfully promote the proper function of the body (iv) that do not prevent or treat illness or disease; or (v) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

1.9 **COVERAGE** or **COVERED** means the entitlement of a Member to services provided in this Certificate of Coverage, subject to the terms, conditions, limitations, and exclusions herein, including the following: (i) health services must be provided when the Certificate of Coverage is in effect; (ii) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Certificate of Coverage occur;

(iii) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Certificate of Coverage, and (iv)health services must be Medically Necessary and must not be listed in Section 7 as an Exclusion.

1.10 **COVERED SERVICES** means the health care services described at Section 6 of this Agreement and all supplemental benefits described in Attachments to this Agreement, if

any, to the extent such services are required to be provided under policies of the Michigan Medicaid program.

1.11 **DENTAL COVERAGE** means a type of insurance that pays for dental costs for people. It can pay the person back for costs from dental injury or treatment. It can also pay the provider directly.

1.12 **DENTAL SERVICES** means oral health services provided by a person licensed under state law to practice dentistry.

1.13 **DURABLE MEDICAL EQUIPMENT**

Equipment and supplies ordered by a health care provider for everyday or extended use. This may include:

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

1.14 **EFFECTIVE DATE** means the date when the Member is entitled to receive Covered Services under this Agreement, as determined by the Medicaid program.

1.15 **ELECTIVE SURGICAL PROCEDURE** means a treatment technique performed through surgery which is a Covered Service under Section 6.0 of this Certificate of Coverage, and which is one of several optional medical treatments available, relative to the particular condition, which are acceptable under the current standards of Physicians for Health Professionals in the community.

1.16 **ELIGIBILITY APPLICATION** means the form signed by the Member to obtain Medicaid/Public Assistance services under this Agreement for himself or herself and eligible Dependents.

1.17 **EMERGENCY DENTAL CONDITION** means a dental injury or condition so serious that you would seek care right away to avoid harm.

1.18 **EMERGENCY MEDICAL CONDITION** means an illness, injury or condition so serious that you would seek care right away to avoid harm.

1.19 **EMERGENCY MEDICAL TRANSPORTATION** means ambulance services for an emergency medical condition.

1.20 **EMERGENCY ROOM CARE** means care given for a medical emergency when you think that your health is in danger **OR** care given for a dental emergency that requires dental treatment right away.

1.21 **EMERGENCY SERVICES** means review of an emergency medical or dental condition and treatment to keep the condition from getting worse.

1.22 **ENROLLEE** means a Medicaid beneficiary who is currently enrolled in a managed care organization in a given managed care program.

1.23 **EXCLUDED SERVICES** means health care services or dental services that your plan does not pay for or cover.

1.24 **EXPERIMENTAL AND INVESTIGATIONAL** means those health products or services that meet one of the following conditions: (a) any drug or device that is not approved for use by the Food & Drug Administration ("FDA"); any drug classified by the FDA as investigational new drug ("IND"); any drug requiring preauthorization that is proposed for off-label prescribing; (b) any health product or service that is subject to Investigational Review Board ("IRB") review or approval; (c) any health product or service that is

the subject of a clinical trial that meets criteria for Phase I, II, or III, as set forth by FDA regulations; or (d) any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer-reviewed medical literature and generally recognized by academic experts.

1.25 **FORMULARY** means a listing of prescription drugs approved by the PLAN for coverage under this Agreement, dispensed by a pharmacy to Members. This list is subject to periodic review and change by the PLAN. The Formulary is available for review in Participating Providers' offices, on the PLAN'S website, at **AetnaBetterHealth.com/Michigan** or by contacting the PLAN'S Member Service department.

1.26 **FRAUD** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself or some other person.

1.27 **GRIEVANCE** means 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 are 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).

1.28 **GRIEVANCE AND APPEAL PROGRAM** means the procedure under which a Member must file any Appeal or Grievance involving the PLAN, a Participating Provider Center, or any Participating Physician, Participating Health Professional, or other Participating Provider.

1.29 **HABILITATION SERVICES AND DEVICES** mean 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

1.30 **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

1.31 **HEALTH PROFESSIONAL** means a podiatrist, dentist, nurse, optometrist, or other individual licensed or certified to practice a health care profession other than medicine or osteopathy by the state in which he or she is located.

1.32 **HOME HEALTH CARE** means health care services that a health care 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.

1.33 **HOSPICE SERVICES** means a special way of caring for people who are terminally ill and provide support to the person's family.

1.34 **HOSPITAL** means an institution, operated pursuant to law, which(a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic, and surgical techniques by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVII of the Social Security Act (Medicare program). A

facility that is primarily a place for rest, custodial care, or care of the aged, a nursing home, convalescent home, or similar institution is NOT a Hospital.

1.35 **HOSPITALIZATION** means 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.

1.36 **HOSPITAL OUTPATIENT CARE** means care in a hospital that usually does not need an overnight stay.

1.37 **IDENTIFICATION CARD** means the card issued by the PLAN to each Member for purposes of identifying such individuals. The rights and responsibilities attendant to Members issued an Identification Card are set forth in Section 3.3 of this Certificate of Coverage.

1.38 **INDIAN HEALTH CARE PROVIDER** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C.1603).

1.39 **INFERTILITY** means the inability of a woman to conceive a pregnancy after six (6) months of unprotected intercourse with a man, or the inability of a woman to carry a pregnancy to live birth as evidenced by three consecutive miscarriages (spontaneous abortions).

1.40 **MEDICAID HEALTH PLAN** means a plan that offers health care services to members who meet state eligibility rules. The state contracts with certain Health Maintenance Organizations (HMOs) to provide health services for those who are eligible. The state pays the premium on behalf of the member.

1.41 **MEDICALLY NECESSARY** means health care services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- An illness
- Injury
- Condition
- Disease or Symptom

OR

Dental services or supplies that meet accepted standards of dental practices needed to diagnose or treat an oral health:

- Injury
- Condition
- Disease or Symptom

1.42 **MEMBER** means any person entitled to Covered Services under this Agreement in accordance with its terms and conditions.

1.43 **MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES** or **MDHHS** means the administrative agency responsible for administering the Medicaid program in Michigan.

1.44 **NETWORK** means health care providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

OR

Dental providers contracted by your plan to provide dental services. This includes:

- Dentists
- Dental Specialists

1.45 **NETWORK CENTER ASSOCIATION OR CENTER** means a partnership, corporation or association that has entered into a services arrangement or other arrangement with Physicians and Health Professionals (a majority being physicians) and which has additionally contracted with the PLAN to provide or arrange for the provision of Covered Services to Members.

1.46 **NETWORK PROVIDER/PARTICIPATING PROVIDER** means a health care provider or dental provider that has a contract with the plan as a provider of care.

1.47 **NON-PARTICIPATING/OUT-OF-NETWORK PROVIDER** means a health care provider or dental provider that **does not** have a contract with the Medicaid health plan as a provider of care.

1.48 **DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES("DIFS").** The agency

that oversees financial institutions, insurance companies, and securities in the state of Michigan. DIFS can assist Members if they have questions, complaints, or concerns about credit unions, insurance companies, banks, securities, and health maintenance organizations("HMOs").

1.49 **OUT-OF-AREASERVICES** means those Covered Services provided when a Member is temporarily absent from the Service Area that are immediately required as a result of an unforeseen illness, injury, or condition, and it is not reasonable for Member to obtain such Covered Services through the PLAN in the PLAN'S Service Area due to the circumstances.

1.50 **PARTICIPATING**, when used with Physician, Health Professional, Hospital or Skilled Nursing Facility or other individual, facility or health care entity means that the person or entity has entered into a direct or indirect written agreement with the PLAN to provide health services to Members. "Participating" refers only to those Providers included in the network of Providers described in the Provider Directory of Health Care Providers delivered to Members in connection with the Agreement. The participation status of Providers may change from time to time.

1.51 **PHYSICIAN** means any doctor duly licensed and qualified to practice medicine (M.D.) or osteopathy (D.O.) in the state of Michigan.

1.52 **PHYSICIAN SERVICES** means health care services provided by a person licensed under state law to practice medicine

1.53 **PLAN** means Aetna Better Health of Michigan, Inc.

1.54 **PREAUTHORIZATION** means approval from a plan that is required before the plan pays for certain:

- Services
- Medical equipment
- Prescriptions
- Dental services
- Dental appliances or devices

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.

1.55 **PREMIUM** means the amount paid for health care and/or dental benefits every month. Medicaid Health Plan and Dental Plan premiums are paid by the State on behalf of eligible members.

1.56 **PRESCRIPTION DRUG COVERAGE** means a health insurance or plan that helps pay for prescription drugs and medications.

1.57 **PRESCRIPTION DRUGS** means drugs and medications that require a prescription by law by a licensed Provider.

1.58 **PRIMARY CARE PROVIDER** or **PCP** means 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 health care providers about your care and refer you to them.

1.59 **PROVIDER** means a person, place or group that is licensed to provide health care like doctors, nurses and hospitals.

OR

A person, place or group that is licensed to provide dental services like dentists.

1.60 **RECONSTRUCTIVE SURGERY** means surgery that is performed on abnormal structures of the body which are caused by congenital defects, developmental abnormalities, trauma, infection, tumors or diseases and which is performed to improve function or to approximate a normal appearance.

1.61 **REHABILITATION SERVICES AND DEVICES** means 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

1.62 **SERVICE AREA** means the geographic area in which the PLAN has been authorized by the state of Michigan to provide or arrange for the provision of Covered Services to Members. Service Area is subject to change.

1.63 **SKILLED NURSING CARE** means Services in your own home or in a nursing home provided by trained:

- Nurses
- Technicians or,
- Therapists

1.64 **SKILLED NURSING FACILITY** means an institution that is licensed by the state in which it is located to provide skilled nursing services.

1.65 **SPECIALIST or SPECIALITY CARE PROVIDER (SCP)** means 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.

OR

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

1.66 **STATE** means the single state agency for the Medicaid program.

1.67 **TELEHEALTH/TELEMEDICINE** means the use of electronic media to link members with health care professionals in different locations. The health care professional must be able to examine the member under live audio, video or both. The member must be able to interact with the provider at the time services are given.

1.68 **TRANSPLANT NETWORK** means the group of Providers designated by the PLAN to provide transplant services and treatment to Members.

1.69 **URGENT CARE** means care for an illness, injury or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

OR

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

1.70 **URGENT/EXPEDITED GRIEVANCE/APPEAL** means a Grievance/Appeal that requires immediate attention, within seventy-two (72) hours of request because the time frame for the non-Urgent/non-Expedited Appeal process (i) could seriously harm the Member's life or health, or if the Member is pregnant, the life or health of the fetus; (ii) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain or health risk that could not be adequately managed without care or treatment.

SECTION 2.0 – ELIGIBILITY

2.1 **MEMBER ELIGIBILITY**. MDHHS is responsible for making all determinations regarding who is eligible to enroll in Medicaid managed care plans. The Michigan Department of Health and Human Services ("MDHHS") determines Medicaid eligibility. Most changes by MDHHS will be made on a calendar month basis. The PLAN shall be responsible for

Member until the date of disenrollment. To be eligible to enroll as a Member a person must:

2.2 Meet the eligibility criteria established for Medicaid as determined by MDHHS

2.3 Reside within the Service Area; and

2.4 Be determined by MDHHS to be appropriate for enrollment in a managed care plan, such as the PLAN

2.5 **LOSS OF MEDICAID ELIGIBILITY**. Effective on the date a Member covered by this Agreement loses his or her eligibility under the Medicaid Program, coverage under this Agreement shall terminate. In the case of an inpatient hospital admission, payment for services will continue until the Member is discharged from the hospital. If the person regains Medicaid eligibility within ninety (90) days from the date eligibility was terminated, the PLAN will accept automatic-enrollment of the person on a prospective basis as determined by MDHHS.

SECTION 3.0 – ENROLLMENT AND COVERAGE EFFECTIVE DATES

3.1 **ENROLLMENT**. MDHHS is responsible for determining a person's eligibility for enrollment with the PLAN and will provide all enrollment materials to Members. At the time of birth, newborns of women enrolled with the PLAN are automatically enrolled as Members for at least the month in which the birth occurs and may be eligible for a longer period.

3.2 **ENROLLMENT PROCESS AND COLLECTED INFORMATION**. MDHHS contracts with an enrollment services vendor to contact and educate general Medicaid beneficiaries about Medicaid managed care and to enroll and change enrollment for these beneficiaries. The PLAN does not administer the enrollment process, and a beneficiary is not deemed to be enrolled with the PLAN until the PLAN has received information from the enrollment services vendor. All enrollment and disenrollment determinations are made solely by MDHHS. A Member shall complete and provide to the PLAN or its Participating Physicians, Hospitals, Health Professionals or Skilled Nursing Facilities any forms (other than an Eligibility Application) that are reasonably requested, including medical questionnaires, and a Member shall assure that all information in such forms is true, correct and complete. If a Member intentionally submits any false or misleading information or omits any material fact, on such forms about him/herself or his/her family members, the PLAN may ask MDHHS to terminate the Member's enrollment from the PLAN. At all times, the Plan shall ensure that Member's health information is protected pursuant to state and federal law, including but not limited to the Health Insurance Portability and Accountability Act ("HIPAA").

3.3 EFFECTIVE DATE OF COVERAGE

3.4 **MDHHS DETERMINES EFFECTIVE DATE**. Coverage is effective on the first day of the month MDHHS notifies the PLAN of the Member's enrollment. For qualified newborns, coverage will be effective on the first day of the month of their birth.

3.5 **NOTICE OF EFFECTIVE DATE**. The PLAN will notify the Member of the Effective Date in writing.

3.6 **NO COVERAGE PRIOR TO EFFECTIVE DATE**. Consistent with Medicaid requirements, Members are not eligible for Coverage for services provided before the Effective Date. If a Member is an inpatient at a hospital or other health facility on the Effective Date, no Coverage will be provided by the PLAN until the Member is no longer an inpatient in a hospital or facility, except in the case of a qualified newborn.

3.7 **PREGNANT WOMEN COVERAGE.** Effective April 1, 2022, Members whose coverage is based upon their pregnancy will be eligible for benefits for 12 months following the month of delivery.

3.8 **MEMBERS CHANGING COVERAGE**. Members who are changing from Fee-for-Service (FFS) Medicaid or from another health insurance plan to Aetna Better Health of Michigan can continue to receive services covered under their previous plan, in certain circumstances. Members may be able to keep their current providers during this time. For more information, contact Member Services at **1-866-316-3784 (TTY: 711)**.

3.9 **IDENTIFICATION CARDS**. The PLAN will issue Identification Cards to Members, and such Identification Cards are to be used for identification purposes only and must be presented whenever the Member obtains Covered Services. The PLAN'S

non-emergency and emergency contact numbers are on the back of the Identification Card. Only the Member to whom the identification card is issued may use it. A person who is no longer eligible for Coverage or a person who is not designated as the Member on the Identification Card is not entitled to receive Covered Services and has no rights under the Identification Card. The Identification Card shall be returned to the PLAN at its request upon termination of Coverage or misuse.

If a Member misuses, or allows another person to use the Identification Card, or otherwise defrauds or attempts to defraud the PLAN, then the PLAN may request from MDHHS approval to terminate the Member, and Member may be subject to prosecution. The PLAN will report all suspected acts of fraud and abuse to applicable state agencies, including MDHHS's Medicaid Integrity Program Section.

SECTION 4.0 – TERMINATION

4.1 **CANCELLATION OF THE PLAN/MDHHS CONTRACT**. A Member's Coverage shall be subject to a transition plan in the event the contract between the PLAN and the state of Michigan under which this Coverage is provided is cancelled. If the contract between the PLAN and the state of Michigan is cancelled, then MDHHS is responsible for arranging for Members to be reassigned or enrolled in another comparable program. MDHHS is also responsible for setting a cancellation date.

4.2 **DISENROLLMENT BY MEMBER WITHOUT CAUSE**. Disenrollment by a Member is allowed during the initial 90 days of enrollment in the PLAN and during the Member's annual enrollment period. The Member may choose to enroll in another Medicaid health plan. MDHHS will notify the Member of the annual open enrollment period.

4.3 **DISENROLLMENT BY MEMBER FOR CAUSE**. Disenrollment by a Member is only allowed at certain times under MDHHS policy. To request disenrollment, a Member must follow the procedures established by MDHHS and the PLAN'S disenrollment procedures as approved by MDHHS. Member should contact the "Beneficiary Help Line" at **1-800-642-3195** to request the "MSA 176 Special Disenrollment" Form. Michigan Enrolls will mail the form to the Member. Member must show that he or she has contacted the PLAN to resolve the issue of concern. Member must also provide supporting physician documentation of the services that are being requested that the PLAN cannot make arrangements for either within or out of network. Once Member has submitted a request for disenrollment to MDHHS, the Member's access to care and services through the PLAN will continue until he or she is informed in writing of the approval and approval effective date. If the disenrollment request is approved, the Member will be enrolled in another Medicaid health plan or in Medicaid Fee-for- Service as determined by MDHHS. If the request is denied, the Member will remain enrolled in the PLAN until the member's next annual enrollment period. Members may request disenrollment under this Section 4.2 if the Member cannot change health plans because the Member has been enrolled for more than ninety (90) days, or the Member does not meet the timeframe guidelines for a medical exception, AND for any of the following reasons:

4.4 **Medical Reasons**: The Member's Provider must give MDHHS information to show that Member has a serious medical condition, and is under active treatment for that condition, and is receiving active treatment from a provider who no longer participates with the PLAN in which Member is enrolled. The Provider must state that he or she cannot safely transition care to another provider within the PLAN'S network, and that there is a need for the Member to remain with the provider who will not accept an out of network referral from the PLAN. The Provider must indicate the date they terminated their contract with

the PLAN, the last date they treated the Member, and if they accept Michigan Medicaid or participate with any other Medicaid health plans in the Member's county.

4.5 **Lack of Access Reasons**: Member can request disenrollment if the Member experiences a lack of access to Covered Services or Providers. Member must describe the Medically Necessary Covered Services that have been prescribed but that are inaccessible, or Member must describe why he or she believes that the PLAN has not provided the Member with a Provider who is experienced in dealing with Member's health care needs. Member must show that he or she has tried to work with the PLAN on the access to care or specialists' issue and that the PLAN cannot make the necessary arrangements for care either within or out of network. Supporting physician documentation is also required.

4.6 **Quality of Care**: Member must have concerns with the quality of care the PLAN'S Participating Providers have rendered. Member must show that he or she has tried to work with the PLAN on the quality-of-care issue and that the PLAN cannot make the necessary arrangements for care either within or out of network. Supporting physician documentation is also required.

4.7 **Lack of Access to Primary Care**: Member must show that there are no PCPs in the PLAN'S Service Area that are within thirty (30) minutes or thirty (30) miles of where the Member lives, or that the PCPs in the PLAN'S Service Area that are within thirty (30) minutes or thirty (30) miles of where Member lives are not taking new patients or have discharged the Member as a patient. This will not apply, however, if the Member specifically asked to be assigned to a PCP outside of thirty (30) minutes or thirty (30) miles.

4.8 **PLAN-INITIATED DISENROLLMENT**. The PLAN will petition MDHHS for disenrollment of a Member for the below listed reasons. All disenrollments are subject to the prior approval of MDHHS. Before a Member is disenrolled under this section, the PLAN will attempt to resolve the problem with the Member. A Member will have the right to contest through the Grievance and Appeal Program any decision made by the PLAN to request disenrollment of a Member, except when disenrollment is because the Member no longer meets MDHHS enrollment requirements. If the PLAN'S request to disenroll is approved, and Member is disenrolled, the disenrollment will be effective within sixty (60) days from the date MDHHS received the complete request from the PLAN to disenroll the Member. If the Member exercises their appeal right, the date of disenrollment shall be no later than thirty (30) days after resolution of the appeal, or on such other date as set by MDHHS. The Plan will be responsible for the Member until the date of disenrollment:

4.8.1 Fraud, abuse of the PLAN, or other intentional misconduct, including but not limited to, alteration or theft of prescriptions, misrepresentation of membership, or unauthorized use of benefits.

4.8.2 Member's behavior towards either the PLAN or a Provider causes violent or life-threatening situations involving physical acts of violence, physical or verbal threats of violence, or stalking.

4.8.3 A Member misuses the Identification Card as provided in Section 3.3.

4.8.4 Other actions inconsistent with PLAN membership involving the repeated use of Non-Participating Providers when Participating providers are available; discharge from the practices of available Participating Providers; repeated emergency room use for non-emergency services; and other situations that impede care. The PLAN will not request disenrollment based on the physical or mental health status of the Member. If the Member's physical or mental health is a factor in the violent behavior or action inconsistent with PLAN membership, the PLAN must provide proof of the PLAN'S actions to assist the Member in correcting the problem, including appropriate physical and mental health referrals. The PLAN will also document that continued enrollment seriously impairs the PLAN or providers to furnish services to the Member or other members. MDHHS may require additional information from the PLAN to determine the appropriateness of the disenrollment.

4.9 **MOVING OUT OF SERVICE AREA**. If a Member moves out of the Service Area after the Effective Date, the PLAN Coverage will remain in effect until the Member is disenrolled by MDHHS from the PLAN. The Member may be required to return to the PLAN'S Service Area to seek Medically Necessary Covered Services from Participating Providers, or the PLAN may Authorize the Member to seek Medically Necessary Covered Services outside of the PLAN'S Service Area. The PLAN may not pay for otherwise Covered Services provided outside of the Service Area if no Prior Authorization was obtained, except when Covered Services were rendered in response to an Emergency Medical Condition.

4.10 **LONG-TERM CARE FACILITIES**. The PLAN may initiate a disenrollment request if a Member is admitted to a nursing facility for custodial care or remains in a nursing facility for rehabilitative care longer than forty-five (45) days. The PLAN will remain responsible for the Member until the date of disenrollment.

SECTION 5.0 SELECTION OF PARTICIPATING PROVIDERS & FEDERALLY QUALIFIED HEALTH CENTERS ("FQHC")

5.1 **PRIMARY CARE PHYSICIAN & FQHC SELECTION**. Upon enrollment through Michigan Enrolls, the Member shall select a PCP and, as applicable, a FQHC. If the Member fails to select a PCP, within one month of the Member's effective date of enrollment, the PLAN will automatically assign a PCP to the Member until the Member makes an alternate selection. After enrollment, a Member may choose a different PCP from a list provided by the PLAN by contacting the PLAN'S Customer Care Call Center. If the PLAN cannot honor the Member's choice of PCP, the PLAN will contact the Member to assist the Member in making another choice. Member-initiated PCP changes will be permitted at any time; however, the PLAN may limit such changes when they are being requested without cause.

5.2 **PROVIDER DIRECTORY**. Participating Physicians, Health Professionals (including mental health providers) and other providers are subject to change, from time to time, with respect to individual practitioners or institutions. Accordingly, the PLAN neither warrants nor guarantees the length of service of any of its Participating Physicians or other Participating Providers.

5.3 **PHYSICIAN/PATIENT RELATIONSHIP**. When, after reasonable efforts are made, a Member and the Member's PCP are unable to establish or maintain a satisfactory relationship as physician and patient, a Member may be required to choose another PCP with not less than thirty (30) days' notice, subject to the Member's rights under the Grievance and Appeal Program. A PCP must notify a Member of the reason for dismissal by means of a certified letter to the Member's current address of record. A copy must also be sent to the PLAN.

5.4 **CONTINUATION OF CARE FROM A TERMINATED PROVIDER**. In the event Your

Provider's participation with PLAN ends for any reason other than fraud or quality of care issues, you may be able to continue getting care from the Provider in certain circumstances. If You have ongoing treatment with the Provider (a) You can continue care with the Provider for ninety (90) days; or (b) if You are in the second or third trimester of Your pregnancy, You can continue related care through the postpartum period; or (c) if You are terminally ill and were terminally ill before Your Provider knew of their termination, and You were getting treatment for the terminal illness before the Provider's termination, You may continue care with the Provider related to the terminal illness through the remainder of Your life. Your Provider must agree to accept payment from Us in the amount we paid them under their contract with Us. They must also meet our quality standards, provide us with necessary medical record information, and comply with our utilization review, prior authorization, referral, and treatment plan requirements.

SECTION 6.0 – COVERED SERVICES

6.1 **COVERED SERVICES GENERALLY**. Enrollment in the PLAN entitles Members to receive the Covered Services set forth below, so long as such Covered Services are

(a) provided, arranged and/or approved by the PCP or SCP (if required by the PLAN), (b) medically necessary, (c) subject to the limitations and exclusions set forth in this Agreement, and (d) required to be provided under policies of the Medicaid program. The PLAN has the authority to arrange and/or Authorize those services that are Medically Necessary. Members and Providers must comply with the terms and conditions of the PLAN regarding Prior Authorization of services. Failure to secure Prior Authorization may result in the PLAN'S denial of payment for otherwise Covered Services. If a Member needs to see a Specialist, the Member's PCP or Dental Provider will arrange the visit and provide Member with the appropriate documentation to take to the visit. Members are responsible for consulting with their PCP before receiving medical care from another Provider except as otherwise specified in this document. Members may only seek care from Specialists in the PLAN'S network. Visits to Providers who are not in the PLAN'S network must first be approved by the PLAN'S Health Services Department. For example, the PLAN may cover services provided by a Provider outside the PLAN network if no similar Provider is available in network, or the PLAN may cover services outside the network to ensure that a Member's care is not interrupted. Services received outside the network must be approved by the PLAN. Except in the case of emergency, failure to obtain prior authorization of services with a provider that is not in the Plan's network could result in the Member being responsible for payment for the services. Members with serious health conditions may need to see a Specialist to get the care they need. PCPs will refer their Members accordingly for such care.

Some Members with special health conditions need to have a Specialist as their PCP and should contact Customer Service for more information about this option.

6.2 **PHYSICIAN AND HEALTH PROFESSIONAL SERVICES**. Physician services covered by the PLAN shall include:

6.2.1 All office or telehealth visits when deemed appropriate for diagnosis and treatment of illness and injuries provided by a Member's PCP and all related services, supplies and immunizations.

6.2.2 Periodic physical examinations or health assessments as determined by the PCP.

6.2.3 Pediatric care, including well-child care and certified pediatric nurse practitioner services. Prior Authorization is not required for access to a pediatrician who is a Participating Physician for general pediatric services, but Prior Authorization is

required for pediatric services when provided by a Physician who is not a Participating Physician for such services.

6.2.4 Gynecological and maternity care, including prenatal and postnatal care, delivery and other related obstetrical services, and nurse midwife services. Prior Authorization is not required for access to an obstetrician-gynecologist who is a Participating Physician for annual well woman examinations and routine obstetrical and gynecological services, but Prior Authorization is required for the services of a Physician who is not a Participating Physician for such services. Members who qualify for Medicaid due to pregnancy will be allowed access to out of network obstetrical and gynecological services without authorization if the member has an established relationship with that provider. These members will also be allowed access to out of network facilities without authorization for routine obstetrical and gynecological services if referred by the out of network obstetrician-gynecologist.

6.2.5 Necessary outpatient medical consultation and specialist care by a Participating Physician to whom a Member is referred by the PCP.

6.2.6 In-hospital and outpatient physician services, as deemed necessary for the care and treatment of the Member by the Attending Physician, including breast reconstruction surgery following a mastectomy.

6.2.7 Covered Services rendered by a Certified Doula, Nurse, Midwife or Family Nurse Practitioner.

6.3 WELL-CHILD CARE/EARLY & PERIODIC SCREENING. DIAGNOSIS. & TREATMENT PROGRAM ("EPSDT")

TREATMENT PROGRAM ("EPSDT"). These services are available to Members under the age of 21 to ensure access to health resources and assist parents/guardians in appropriately using health resources. No Prior Authorization is required if EPSDT services are rendered by a Participating Provider.

6.3.1 Screening Services shall include periodic well-child examinations, including assessment of health and developmental history; development & behavioral assessments; age appropriate unclothed physical examinations; height/weight/head circumference measurements; blood pressure examination for children aged 3 and over; immunization review and appropriate administration; health education including anticipatory guidance; nutritional assessment; hearing, vision, and dental assessment; blood lead testing for children under age 6; appropriate conference and counseling for parents/guardians; objective testing for developmental behavior, hearing, and vision according to the Medicaid periodicity schedule;

laboratory services for tuberculin, hematocrit, hemoglobin, urinalysis; or other testing as may be ordered by Physician.

6.3.2 Vision Services will include diagnosis and treatment for defective vision and may include eyeglasses as appropriate.

6.3.3 Dental Services shall include relief of pain and infections, restoration of teeth, and maintenance of dental health. The PLAN is responsible for screening and referral only.

6.3.4 Hearing Services shall include diagnosis and treatment for hearing defects, including hearing aids as appropriate.

6.3.5 Referral of children, as appropriate, to hearing and speech clinic; optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services; referral to community mental health services; and if a child is found to have elevated blood lead levels in accordance with MDHHS standards, the PLAN shall refer the child to the local health department for follow-up services that may include a study to determine the source of the lead poisoning.

6.3.6 Outreach Services by home visit, phone, or mail to those Members who are due or overdue for well-child visits.

6.4 **SECOND OPINIONS**. The right of a Member to obtain a second medical opinion from a Participating Physician with respect to a given condition.

6.5 **INPATIENT AND OUTPATIENT HOSPITAL SERVICES**. Inpatient and outpatient hospital care will be provided with no time limit if it is provided and prescribed as Medically Necessary by the PCP or Attending Physician and Authorized as such by the PLAN. Inpatient and Outpatient Hospital Services shall be obtained from a Participating Hospital or other participating facility and subject to the limitations and exclusions set forth in Sections 6.1,7.0 and 8.0 of this Agreement. Inpatient and outpatient hospital services covered by the PLAN shall include:

6.5.1 Semi-private room and board accommodations based upon availability. Such accommodations shall include general duty nursing care.

6.5.2 Private room and board accommodations only with PLAN authorization.

6.5.3 Inpatient therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units.

6.5.4 Use of operating and other surgical treatment rooms and equipment on an inpatient or outpatient Basis.

6.5.5 All laboratory and other diagnostic tests (X-rays, EKGs, nuclear isotopes, ultrasounds, CAT, MRI, MRA, PET) on an inpatient or outpatient basis as described at Section 6.6 below.

6.5.6 Anesthetics, oxygen, drugs and other biologicals.

6.5.7 Radiation therapy, short-term rehabilitation services and other forms of therapy only as described in Section 6.6 below.

6.5.8 Additional services, supplies, equipment and special procedures, on an inpatient or outpatient basis, but excluding convenience items (e.g., telephone, television, etc.).

6.5.9 Skilled nursing care provided in a participating Skilled Nursing Facility to the extent required by MDHHS if the Member requires medical and skilled nursing care (not domiciliary care or custodial care), in the absence of which hospital confinement could be Medically Necessary.

6.6 **DIAGNOSTIC LABORATORY. X-RAY. AND IMAGING TESTS AND THERAPY**

(INPATIENT AND OUTPATIENT). Diagnostic testing and therapy services covered by the PLAN shall include:

6.6.1 X-ray and laboratory tests, electrocardiograms and electroencephalograms.

6.6.2 Radiology services, including diagnostic and therapeutic isotopes and other radioactive materials used for therapeutic purposes.

6.6.3 Short-term physical therapy and medical rehabilitation services, including speech and functional occupational therapy from a Participating Provider, limited to the treatment of conditions that are subject to significant improvement through relatively short-term therapy, to the extent allowed by MDHHS. In order for such services to be covered by the PLAN, Member is required to obtain the prior approval and authorization of a PCP.

6.7 **EMERGENCY MEDICAL SERVICES**. For purposes of this Agreement, Emergency Medical Services means those services that are required as a result of an Emergency Medical Condition as defined in Section 1.13of this Certificate of Coverage.

6.7.1 Emergency Medical Services include inpatient or outpatient services that are:

(a) furnished by a provider qualified to furnish emergency services, including Non-Participating Physicians and Health Professionals in the Service Area or outside of the Service Area; and

(b) necessary to evaluate or stabilize an Emergency Medical Condition found to exist using the prudent layperson standard.

6.7.2 Emergency transportation for Members shall be Covered.

6.7.3 Where it is Medically Necessary that the Member receive medical attention immediately from a Non-Participating Physician or Health Professional, Members receiving Emergency Medical Services are required to have the Provider contact the PLAN by telephone at the number listed on the Identification Card in this Agreement for Prior Authorization for subsequent follow-up care after the Emergency Medical Services have been provided. Treatment following screening and stabilization shall be deemed prior authorized if the PLAN does not respond within one (1) hour for a request for Prior Authorization being made by an emergency department. If the facility does not request prior authorization and the PLAN determines that services, other than those required to evaluate and/or stabilize the Member, were not required as the result of an Emergency Medical Condition, the PLAN will not be responsible for such care, payment or reimbursement for such services.

6.7.4 Accessing Emergency Medical and Urgent Care Services. Members requiring Emergency Medical Services and Urgent Care Services shall have access to such services through one of the following three available emergency service systems in addition to traditional **911** service.

6.7.4.1 Emergency Nurse Line. Information services shall be available and accessible to each Member on a twenty-four (24) hour-a-day, seven (7) day-a-week basis at **1-866-711-6664**. The Emergency Nurse Line is in Contact with Participating Physicians and Health Professionals, hospitals, ambulances and other Participating Providers to facilitate the provision of such services. Any person may contact the Emergency Nurse Line by calling the hot line telephone number listed on the Member Identification Card for purposes of seeking assistance on behalf of a Member in the event of an Emergency.

6.7.4.2 Immediate Emergencies. In cases of an Emergency that requires immediate treatment before the PLAN'S Emergency Triage System can be contacted and/ or before treatment can be secured through the PLAN, the Member may utilize a Non-Participating Physician, Health Professional, or other Provider within or

outside the Service Area. Members are required to comply with the provisions of subsection6.7.3 with respect to notifying the PLAN of such Emergency.

6.7.4.3 Urgent Care Center System. In case of an accident, injury, or illness of a less serious nature in which the Member is not at risk of death or permanent impairment and in instances in which the Member is in the Service Area, the Member shall be required to seek services from a PLAN Urgent Care Center within 24 hours of such accident, injury, or illness. A list of Participating Urgent Care Centers and their locations is provided in the Provider Directory.

6.8 **AMBULANCE/TRANSPORTATION**. The following are Covered Services:

6.8.1 Air and land ambulance services for Emergency Medical Conditions.

6.8.2 Ambulance services for management of shock, unconsciousness, heart attack or other condition requiring active medical management, en route to a Hospital, emergency room, or similar facility.

6.8.3 Ambulance services to transport a Member from one medical facility to another medical facility when necessary to provide medical care or services that the transferring facility cannot provide to the Member, except if Member is in an inpatient facility and is transferred to a substance abuse or psychiatric facility.

6.8.4 Non-emergency transportation may be provided by the PLAN when a Member

(a) has no other means of transportation available to receive Covered Services, (b) when a Member has urgent care needs at the office of the Member's PCP, or (c) when a Member is referred by the Member's PCP to another physician or provider. The transportation benefit does not include transportation to services that are not covered under the Medicaid program such as: services billed through community mental health services program or transportation to substance abuse services.

6.9 **HOSPICE CARESERVICES**.

6.9.1 Hospice care services are available to the extent (a) authorized by the PCP, (b) Authorized by the PLAN and (c) the hospice program is operated under the direction of a Participating Physician and meets the standards of the National Hospice Organization or similar standards.

6.9.2 Covered Hospice Care Services include:

6.9.2.1 Room and board at a hospice Facility or nursing home services and supplies at a Participating Provider or in the Member's home;

6.9.2.2 Part-time home nursing care and home health and services up to a total of eight (8) hours per day;

6.9.2.3 Consultation and case management services by the Member's PCP;

6.9.2.4 Medical supplies and prescription drugs or medicines; and

6.9.2.5 Physical therapy.

6.10 **OUTPATIENT MENTAL HEALTH SERVICES**. Outpatient mental health services are covered by the plan for defined services.

6.11 **PODIATRIC SERVICES**. Services of a Participating podiatrist are covered when referred by the PCP for the diagnosis or treatment of injuries or diseases of the Feet. Limits on these services are consistent with Medicaid Fee-for-Service policy.

6.12 **HOME HEALTH SERVICES**. Services rendered at a Member's home that are Authorized by the PLAN, including:

6.12.1 Professional medical care services deemed necessary for the Member's care and treatment, with the exception of private duty nursing.

6.12.2 Subject to MDHHS limitations, intermittent home care nursing services (other than private duty nursing services) by a registered nurse or a licensed practical nurse, physical therapy services, occupational therapy services, nutrition education and guidance and part-time home health aide services, not including housekeeping or long-term custodial care services.

6.12.3 Home care medical supplies when deemed Medically Necessary by the PCP for the care and treatment of the Member during the Member's home confinement.

6.13 **PREVENTIVE HEALTH SERVICES**. Preventive health services covered by the PLAN shall include:

6.13.1 Periodic health assessment and screening by the PCP at intervals deemed appropriate for the age, sex and medical history of the Member, including well-child care. Well-child care is a clinical assessment of a child in the absence of illness to determine physical status and detect any abnormalities. (See EPSD Tin Section 6.3)

6.13.2 Routine periodic childhood and adult immunizations in accord with the Advisory Committee on Immunization Practices Guidelines for all Members, either from the PCP or, without Prior Authorization from a local health department, excluding immunizations that are required only fortravel.

6.13.3 Voluntary family planning service, including sexually transmitted disease testing and treatment. No Prior Authorization is required for these services.

6.13.4 Vision and hearing screening to determine the need for vision and hearing correction.

6.13.5 Health education and nutrition counseling services. Members may be responsible for a nominal fee for education services beyond what is provided in this Agreement.

6.13.6 Routine pelvic screening for women aged 18 and over.

6.13.7 Routine breast cancer screening mammography exam for women 40 or over.

6.14 ORGAN AND TISSUE TRANSPLANTS.

6.14.1 All organ and tissue transplants must receive Prior Authorization and be performed at a Participating Provider Authorized by the PLAN. The PLAN will pay for transplant-related hospital, surgical, laboratory, and X-ray services. Extrarenal organ transplants, such as heart, lungs, heart-lungs, liver, pancreas, small bowel, and bone marrow including allogeneic, autologous, and peripheral stem cell harvesting, are covered on a patient-specific basis when Medically Necessary according to accepted standards of care.

6.14.2 The PLAN will also pay for hospital, surgical, laboratory and X-ray services incurred by an organ/tissue donor who is not a PLAN Member resulting from the transplant of an organ to a Member by the PCP only to the extent such services are not covered by any other medical plan

6.15 **CHIROPRACTIC SERVICES**. Services of a Participating chiropractor are Covered when referred by the PCP. Limits on these services are consistent with Medicaid fee for service policy.

6.16 **HEARING AND SPEECH SERVICES**. Services for the diagnosis or treatment of diseases or conditions of the ears when Authorized by the PCP, and audiometric examinations and hearing aid evaluation testing by a Participating Provider. The purchase and fitting of a

hearing aid is available to all members. Repairs, maintenance and batteries for hearing aids are covered for all ages.

6.17 **DENTAL SERVICES.** All enrollees ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid, are able to access dental services. Covered services include, but are not limited to; general dentistry, cleaning, check-ups, and other medically necessary services including X-Rays, extractions, fillings, crowns, root canals, dental scaling, dentures and planing services (one (1) per year).

6.18 **VISION SERVICES**. The care and treatment of diseases and conditions of the eye when provided by the PCP or referred by the PCP to a Participating optometrist or ophthalmologist, including:

6.18.1 Complete examination of the eye and refraction; corrective lenses, single vision, multifocal, cataract or contact lenses; and, up to the maximum approved amount, eye glass frames.

6.18.2 Repair or replacement of frames or lenses due to body growth, loss or breakage consistent with MDHHS policies.

6.18.3 Tinted prescription corrective lenses may be Covered if Prior Authorized by the PLAN.

6.19 **REPRODUCTIVE CARE AND FAMILY PLANNING SERVICES**.

Family Planning services, generally, are those medically approved diagnostic evaluations, 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 ("STDs").These services shall be provided confidentially to Members of child- bearing age, including minors who may be sexually active, who voluntarily choose not to risk pregnancy, or wish to limit the number and spacing of their children.

6.19.1 History, physical examination, laboratory testing, advice and supervision related to family planning in accordance with generally accepted medical practices.

6.19.2 All sterilization procedures for Members shall be Authorized by the PLAN.

6.19.3 Contraceptive drugs, devices and supplies. Condoms shall be made available consistent with Medicaid fee-for-service policies.

6.19.4 Terminations of Pregnancy (abortions) and related services are covered only when

(a) a Physician certifies that the abortion is Medically Necessary to save the life of the mother; (b) the pregnancy is a result of rape or incest; (c) treatment is for medical complications occurring as a result of a PLAN approved abortion; or (d) treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy. All terminations of pregnancy must be Prior Authorized by the PLAN.

6.19.5 Family planning services. No prior authorization for family planning services is required at family planning clinics.

6.19.6 Testing for Infertility; however, treatment for Infertility is not a Covered Service.

6.20 **ALLERGY TESTING AND TREATMENT**. Allergy testing and treatment services must be Authorized by the PLAN and are limited to the following:

6.20.1 Routine testing procedures to determine or evaluate the source of an allergy.

6.20.2 Treatment and procedures to contract the allergy or render the Member insensitive to an allergen, including the provision and administration of allergy serum.

6.21 **DURABLE MEDICAL EQUIPMENT**. Durable Medical Equipment is defined as equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of injury; and

(d) is appropriate for use in the home. In order for Durable Medical Equipment

to be covered by the PLAN it must be prescribed by a Participating Physician or Health Professional as Medically Necessary to treat an existing injury or illness, it must be obtained from a supplier approved by the PLAN and the Durable Medical Equipment be Authorized by the PLAN. The PLAN reserves the right to Authorize the least costly Durable Medical Equipment that is medically effective for the injury or illness.

Replacements of such Authorized Durable Medical Equipment due to normal usage is covered, but replacement due to loss; misuse or abuse is not a Covered Service.

See Section 7.1.33for Excluded Durable Medical Equipment.

6.22 **PROSTHETIC AND ORTHOTIC DEVICES**. Coverage is provided for basic Prosthetic Devices and Orthotic Devices and specialized features authorized by the PCP and Authorized by the PLAN. Prosthetic and Orthotic Devices must be ordered by the Attending Physician and obtained from a PLAN-approved supplier. A Prosthetic Device is a device that replaces a missing part of the body or assist in the performance of a natural function of the body without necessarily replacing a missing part. Orthotic Devices are

those external devices that are designed to correct or assist in the prevention of a body defect, either of form or function. Breast prostheses are covered following a mastectomy.

6.22.1 Replacement or repair is covered when due to normal usage or body growth or change but excluded from coverage are replacement and/or repair of Orthotic and Prosthetic Devices due to intentional damage, misuse or abuse and comfort and convenience items.

6.22.2 Corrective Prosthetic Devices such as cardiac pacemakers and joint replacements are covered when surgically attached or implanted during surgery authorized by the PLAN.

6.22.3 Dental appliances or non-rigid appliances including elastic stockings and garter belts.

6.23 **DRUGS AND MEDICAL SUPPLIES**. Covered benefits are listed herein. Members may fill their prescriptions at over 65,000 pharmacies nationwide, and at over 1,900 in Michigan. The PLAN uses a closed Formulary, which means that only drugs listed on the Formulary are covered (except with prior approval in special circumstances). For more facts regarding the Formulary or drugs that require the PLAN'S Prior Authorization, Members can call the PLAN at **1-866-316-3784**. When filling a prescription, Members shall present their Aetna Better Health of Michigan ID and MIHEALTH cards with the prescription at any Participating Pharmacy. The PLAN has contracted with CVS Caremark,

a pharmacy benefit manager, to manage prescription drug coverage for Members. Members should be aware that they will need to use their cards for certain drugs covered by Medicaid, such as anti-psychotic and HIV/AIDS drugs.

6.23.1 Prescription Drugs, which are those medicinal substances which under federal law are required to bear on the package label the statement: "Caution: Federal law prohibits dispensing without a prescription," are Covered.

6.23.2 Selected over-the-counter analgesics, laxatives, antacids, non-supplement and family planning drugs, devices or supplies are covered when prescribed by and Authorized by the PCP.

6.23.3 Insulin, as well as necessary needles and syringes are covered when prescribed or authorized by the PCP.

6.23.4 FDA-approved drugs used in anti-neoplastic therapy and the reasonable cost of administration, whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received FDA-approval if

the following conditions are met: (a) the drug must be ordered by a Physician for treatment of a specific type of neoplasm; (b) the drug must be approved by the FDA for use in anti-neoplastic therapy; (c) the drug is used as part of an antineoplastic drug regimen; (d) current medical literature substantiates the drug's efficacy and recognized oncology organizations generally accept the treatment; and (e) the Physician has obtained informed consent from the Member for the treatment regimen which includes FDA approved drugs for off-label indications.

6.23.5 Coverage for an off-label use of a FDA-approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(1) Coverage for a drug applies if all of the following conditions are met:

(a) The drug is approved by the FDA.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(i) A life-threatening condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(ii) A chronic and seriously debilitating condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(c) The drug has been recognized for treatment for the condition for which it is prescribed by one of the following:

(i) The American medical association drug evaluations.

(ii) The American hospital formulary service drug information.

(iii) The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".

(iv) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

(2) Upon request, the prescribing allopathic or osteopathic physician shall supply to the insurer or health maintenance organization documentation supporting compliance with subsection (1).

(3) This section does not prohibit the use of a copayment, deductible, sanction, or a mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the food and drug administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection shall not be more restrictive than for prescription coverage generally.

(4) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

(b) "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the FDA.

6.23.6 Medically necessary medical supplies such as catheters, test tape, clinic test, and similar supplies; bag frames and supplies for colostomies, ileostomies, and ureterostomies; and dressings and dressing supplies are Covered Services when ordered or authorized by the PCP.

6.24 **RESTORATIVE/REHABILITATIVE NURSING CARE**. Intermittent or short-term restorative or rehabilitative nursing care, in a nursing facility, as Authorized by the PLAN, for a period of up to forty-five (45) days per rolling twelve (12) month period. The PLAN shall also cover restorative or rehabilitative nursing care outside of a nursing facility.

6.25 ESRD. End-Stage Renal Disease Services, consistent with Michigan Medicaid program policies.

6.26 **WEIGHT REDUCTION SERVICES**. Weight reduction services and surgery are Covered to treat morbid obesity subject to Prior Authorization from the PLAN and documentation of compliance with the PLAN criteria from Member's Physician.

6.27 **PUBLIC HEALTH DEPARTMENTS. FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CENTERS**. Members may access covered services provided at public health departments without authorization. Members may also choose a federally qualified health center ("FQHC") or rural health center ("RHC") as their primary care physician.

6.28 **COMMUNICABLE DISEASES**. Members may receive treatment for communicable diseases such as AIDS/HIV, sexually transmitted diseases ("STDs"), tuberculosis, and vaccine-preventable communicable diseases, from local health departments without Prior Authorization from the PLAN.

6.29 **CHILD & ADOLESCENT HEALTH CENTERS & PROGRAMS**. Members may obtain Covered Services from Child & Adolescent Health Centers ("CAHCPs") without Prior Authorization from the PLAN.

6.30 **PERSONS WITH SPECIAL NEEDS**. Members with special healthcare needs are entitled to (a) an assessment to identify any special conditions that require ongoing case management services and (b) direct access to specialists as appropriate for the Member's condition and identified needs.

6.31 **DIABETES EQUIPMENT, SUPPLIES, TRAINING, and SERVICES**.

6.31.1 The PLAN will cover the following equipment, supplies and educational training related to the treatment of diabetes if determined to be Medically Necessary and prescribed by the Member's PCP or a Specialist Physician to whom the Member is Appropriately Referred: (a) blood glucose monitors for the legally blind; (b) continuous glucose monitoring systems (CGMS) for some individuals with Type 1 diabetes, test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices; (c) insulin syringes;

(d) insulin pumps and medical supplies required for the use of an insulin pump; and (e) diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management training of their condition.

6.31.2 Coverage for diabetes self-management training shall be available subject to the following conditions:

(a) training is limited to completion of a certified diabetes education program should either of the following occur:

(i) training is considered Medically Necessary upon the diagnosis of diabetes by the Member's PCP or Specialist Physician to whom the Member is Appropriately Referred who is managing the Member's diabetic condition, and the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or

(ii) the Member's PCP or a Specialist to whom the Member is Appropriately Referred diagnoses a significant change with long term implications in the Member's symptoms or conditions that requires changes in the Member's self-management or a significant change in medical protocol or treatment modality.

(b) training shall be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the MDHHS. This training shall be conducted in a group-setting whenever practicable.

6.32 **TOBACCO CESSATION TREATMENT**. The Plan will cover Tobacco Cessation Treatment including pharmaceutical and behavioral support. The PLAN may place a reasonable limit on the type and frequency of over-the-counter and prescription drugs covered under this benefit. Prior authorization is not required for over-the- counter agents, prescription inhalers, or nasal sprays. Prior authorization is required for prescription drugs other than inhalers and nasal sprays.

6.33 **OUT-OF-STATE SERVICES AUTHORIZED BY THE PLAN**. Prior authorization is required for the services of out-of-state hospitals and physicians, except for Emergency Medical Services necessary to evaluate or stabilize an Emergency Medical Condition found to exist using the prudent layperson standard.

6.34 **CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS).** The state of Michigan program that serves children, and some adults, with special health care needs. Enrollment in Aetna Better Health of Michigan entitles CSHCS Members to receive the Covered Services set forth in Section 6.0, Covered Services. In addition, CSHCS Members are entitled to receive the following Services, which are not covered by Aetna Better Health of Michigan but are covered by the state of Michigan through CSHCS:

6.34.1 Orthodontia services provided for certain qualifying diagnoses, such as Cleft Palate/Cleft Lip (must be medically necessary, related to the condition, and not for cosmetic purposes)"

6.34.2 Respite services (maximum of 180 hours per family during the 12-month eligibility period when a beneficiary requires skilled nursing and a CSHCS nurse consultant determines appropriate)"

6.34.3 Certain over-the-counter medications

6.34.4 Hemophilia drugs

6.34.5 Certain orphan drugs. These services will be coordinated by the local health department.

SECTION 7.0 EXCLUSIONS

7.1 **NON-COVERED SERVICES**. Services not listed in Section 6 are Excluded under the Agreement, unless required to be Covered by Medicaid program or Michigan law. Under the provisions of this Agreement, the following services shall not be Covered by the PLAN:

7.1.1 Services obtained by a member outside the PLAN Service Area and not authorized by the PLAN are not Covered, except for Emergency Medical Services as described in Section 6.7.

7.1.2 Dental for minor members and vision services except as specifically provided in Sections 6.3, 6.8, 6.14,6.17, and6.18. Private duty nursing services in the home.

7.1.3 Non-medical ancillary services such as vocational rehabilitation and employee counseling.

7.1.4 Cosmetic Services and Surgery; including but not limited to breast augmentation, refractive eye surgery, non-Medically necessary reduction mammoplasty, rhinoplasty, spider or varicose vein repair.

7.1.5 Services not required to be provided to Medicaid recipients under the terms of the Comprehensive Health Care Program for Medicaid Beneficiaries.

7.1.6 Weight reduction whether by surgery or commercial or medical programs, except when Medically Necessary to treat morbid obesity, and authorized by the PLAN.

7.1.7 Acupuncture.

7.1.8 Faith healing.

7.1.9 Elective termination of pregnancy (abortion) and related services, except as set forth in Section 6.18.

7.1.10 Personal comfort items such as telephone, television and similar items.

7.1.11 Any and all infertility treatment or related services. This exclusion applies, without limitation, to services performed in connection with any non-coital form of conception such as artificial insemination, intrauterine insemination, in vitro fertilization (IVF), intrafallopian transfers, donor egg/donor sperm programs, pre-implantation genetic testing, embryo transplantation, reversal of voluntary sterilization, and any related diagnostic and therapeutic services unique to these technologies.

7.1.12 Services related in any way to surrogate parenthood, including, but not limited to, otherwise Medically Necessary obstetrical services.

7.1.13 Custodial or basic care (care that is or can be provided by individuals without specific health care skills, training, or licensure and is intended primarily for the purpose of meeting personal needs such as bathing, walking, dressing and eating) and domiciliary services (generally services for the purpose of maintaining or supporting a person's activities of daily living or basic needs for food, shelter, clothing and hygiene), including private duty or hourly nursing services, convalescent care services, and general housekeeping services provided on an inpatient, outpatient or in-home basis.

7.1.14 Food and nutritional supplements available without prescription.

7.1.15 Non-prescribed dietary supplements, vitamins, minerals, and infant formula.

7.1.16 Except as prescribed as treatment for diabetes, routine foot care such as treatment or trimming of corns, calluses, toenails, evaluation and treatment of subluxations of the feet and flat feet, and pedicures.

7.1.17 Home births.

7.1.18 Home health aide services including routine, unskilled care; housekeeping services; private duty or hourly nursing services; home health care services provided by a person who ordinarily resides in the Member's home or is part of the Member's immediate family; and respite care, unless and only to the extent provided as part of covered hospice services.

7.1.19 Long-term rehabilitative treatment.

7.1.20 Fees, costs, and expenses incurred by a person who donates an organ or tissue, unless the recipient is a PLAN Member and the donor's own health benefit plan does not otherwise cover the expenses.

7.1.21 Speech therapy for foreign accent reduction or English as a second language.

7.1.22 Prosthetic hair, hair transplants or other services, procedures or supplies designed to enhance hair growth are excluded, regardless of diagnosis.

7.1.23 Testing to determine parentage or DNA testing.

7.1.24 Services Payable Under Other Programs. Services are excluded from coverage under the Agreement to the extent the services are provided, paid or payable:

7.1.24.1 Under an extended benefit provision of any other health insurance or health benefits plan, policy, program or certificate.

7.1.24.2 Under any policy, program, contract or insurance as provided under Section 8.2 of this certificate.

7.1.24.3 Under any school district and billed through the intermediate school district, veterans or public programs, including but not limited to Home & Community-Based Waiver Program Services.

7.1.24.4 Substance Abuse Services such as screening, detoxification, intensive outpatient counseling, and methadone treatment and other substance abuse pharmaceuticals indicated exclusively for substance abuse treatment and specified on MDHHS's pharmacy vendor's website under the "Classes for Psychotropic and HIV/AIDS Carve Out" at **https://michigan.fhsc.com**. Refer to the Member Handbook for instructions on how to access these services or call Customer Service at **1-866-316-3784**.

7.1.24.5 Mental Health Services for Members identified as being seriously mentally ill and requiring intensive or inpatient services are provided by the local Community Mental Health Service Program. Refer to the Member Handbook for instructions on how to access these services or call the PLAN'S Customer Service at **1-866-316-3784**.

7.1.24.6 Inpatient hospital psychiatric services. The PLAN will not Cover physician costs related to providing psychiatric admission histories and physicals, but if medical services are needed for care other than psychiatric care during a psychiatric inpatient admission, the PLAN will pay for Prior Authorized and Medically Necessary Covered Services.

7.1.24.7 Outpatient Partial Hospitalization Psychiatric Care.

7.1.24.8 Services, including therapies (speech, language, physical, occupational), provided to persons with developmental disabilities and billed through community mental health services program providers or intermediate school districts.

7.1.25 Non-emergent transportation, other than as provided in Section 6.9.

7.1.26 Over-the-counter medicines (other than as provided in Section 6.23.2). Standard "medicine cabinet" items, including but not limited to, first aid supplies.

7.1.27 Disposable medical supplies (other than as provided in Section6.23).

7.1.28 Experimental and investigational services, which include any drug treatment, device, procedure, service or benefit which is experimental or investigational, with the exception of anticancer drugs as defined in Section 6.23.4 of this Agreement. For the purposes of this Agreement, a drug, treatment, device, procedure, service or benefit may be considered to be experimental or investigational if it meets any one of the following criteria: (a) it cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and such approval of the FDA was not granted at the time of the 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 research, investigational or experimental stage or phase of a clinical trial as established, monitored or regulated by any state or federal government or agency; (d) it is being provided pursuant to a written protocol which describes among its objectives, determination of safety, efficacy, efficacy in comparison to conventional alternatives or toxicity; (e) it is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services; (f) the predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings; (g) if the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to

determine safety, toxicity, efficacy, or efficacy in comparison to conventional alternatives; or (h) it is not investigational in itself pursuant to any of the foregoing criteria, and would not be Medically Necessary, but for the provision of a drug, device, treatment, or procedure which is "investigational or experimental." Without limiting the above the following are considered experimental or investigational and therefore are not Covered Services:

1. Fees associated with the care, services, supplies, devices or procedures, which are investigational or are in conjunction with research studies.

2. Medical services which are generally regarded by the medical community to be unusual, infrequently provided, and not necessary for the protection of health.

3. Services associated with organ or tissue transplantation that is considered experimental.

7.1.29 Organ donor-related services, except as stated in Section 6.15.

7.1.30 All health services rendered as a result of a court order, unless otherwise medically necessary, or during Member's incarceration in any jail or prison to extent services are payable by the court or jail or prison authorities.

7.1.31 Health services or prescription drugs not provided by a Participating Provider except approved referrals. Emergencies, and as otherwise stated herein.

7.1.32 Durable Medical Equipment, (a) Deluxe equipment such as motorized wheelchairs and beds, unless Medically Necessary; (b) Items not medical in nature; (c) Physicians 'equipment such as stethoscopes and sphygmomanometers; (d) Comfort and convenience items such as bed boards, over bed tables, telephone arms and air conditioners; (e) Exercise and hygiene equipment such as exercycles, toilet seats and tub or shower seats; (f) Self-help devices not primarily medical in nature such as saunas, elevators, ramps and special telephone or communication devices; (g) Experimental or research equipment. Replacement of Durable Medical Equipment due to intentional damage by any individual is not a Covered Service.

7.1.33 Psychotropic & HIV/AIDS Drugs. The PLAN shall not Cover anti-psychotic classes and the H7Z class psychotropic drugs or drugs in the anti-retroviral classes, including protease inhibitors, and reverse transcriptase inhibitors. These drugs will be available via the Medicaid fee-for-service system and a copayment may be

required. Members are required to use their MI HEALTH card to access these drugs.

7.1.34 Sterilization procedures unless Prior Authorized by the PLAN.

7.1.35 Intermittent or short-term restorative or rehabilitative nursing care, in a nursing facility after a period of forty-five (45) days.

7.1.36 Traumatic Brain Injury Program Services.

7.1.37 Substance abuse treatment drugs as listed under the category "Classes for Psychotropic and HIV/AIDS Carve-Out" at **www.MICHIGAN.fhsc.com**. These medications will be reimbursed by MDHHS's pharmacy TPA through a point-of-service reimbursement system.

7.2 OTHER EXCLUSIONS

7.2.1 Care rendered by Member or a Member's family member or by a business entity that Member or a family member of Member controls.

7.2.2 Any service or supply, or portion of a charge thereof, for which Member has no financial liability, or that was provided free of charge.

7.2.3 Services and/or supplies obtained fraudulently.

7.2.4 Services and/or supplies rendered prior to Member's Effective Date.

7.2.5 Charges resulting from Member failing to appropriately cancel a scheduled appointment.

7.2.6 Services and/or supplies prohibited from being rendered by law or regulation.

7.2.7 Procedures to repair or remove varicose veins unless Medically Necessary.

SECTION 8.0 COORDINATION OF BENEFITSAND SUBROGATION

8.1 **COORDINATION IN GENERAL WITH OTHER INSURANCE**. By federal and state law, the Covered Services provided under this Agreement are secondary to benefits available under any other health benefit plan or plans (such as individual, group, employer- related, self-insured or self-funded plan or commercial carrier) to which a Member is eligible, the PLAN will identify and seek recovery from all other liable third parties.

8.2 **PLAN'S SUBROGATION RIGHTS**. The PLAN shall be subrogated and shall succeed to any Member's rights of recovery from a third party (such as automobile insurance, liability insurance, and worker's compensation insurance) for incurred services provided under this contract. The Member shall reimburse the PLAN to the extent of the amounts recovered by said Member as a result of any lawsuit, settlement, or otherwise, less the PLAN'S pro-rated share of attorney fees and costs sustained by the Member in obtaining such a recovery. If the attorney fees of the Member are to be paid on a contingency basis, the PLAN'S right of subrogation will be reduced by its pro-rata share of attorney fees which do not exceed twenty-five (25) percent of any recovery. The Member shall, upon request by the PLAN, execute and deliver such instruments and papers as may be required to do whatever else may be necessary and reasonable to carry out this Section 8.2.

8.3 **COORDINATION WITH MEDICARE**. Members who become eligible for both Medicaid and Medicare coverage are ineligible for enrollment in the PLAN. The PLAN shall initiate disenrollment with MDHHS. When a Member is also enrolled in Medicare, Medicare will be the primary payer ahead of the PLAN. The PLAN will pay or otherwise coverall cost-sharing amounts incurred by the Member such as coinsurance and deductibles required by Medicare. Members who are eligible for Medicare must apply for Medicare coverage.

SECTION 9.0 MEMBER RIGHTS

9.1 **INSPECTION OF RECORDS**. A Member, parent, guardian or authorized representative of a Member may review the records of the PLAN relating solely to the Member or a minor Dependent of the Member who is also a Member, at the offices of the PLAN during regular business hours and at an appointed hour reasonably granted on request by the Member for that purpose.

9.2 **REFUSAL TO ACCEPT TREATMENT**. A Member may for personal or religious reasons refuse to accept the recommended treatment or procedures recommended by a Participating Physician (or Health Professional). Such refusal to accept treatment may be regarded as incompatible with the physician/patient relationship and as an impediment to the rendering of proper health care. If a Member refuses to accept recommended treatment and no reasonable alternative for treatment exists, the Member shall be so advised. If the Member still refuses recommended treatment, neither the PLAN nor the Physician shall have further responsibility to provide care for the condition being treated. The foregoing is subject to the Member's right to file a grievance in accordance with the Grievance and Appeal Program. The PLAN may request disenrollment when the member

has been discharged from the practices of available PLAN providers due to actions inconsistent with PLAN membership.

9.3 **MEMBER'S RESPONSIBILITY FOR PAYMENT**. If the member receives any services from a Non-Participating hospital, Physician, Health Professional, Skilled Nursing Facility or other entity and is informed of the responsibility to pay prior to receiving services, the member is responsible for payment except in the case of a Medical Emergency or Urgent Care situation. If the services are authorized by the Member's PCP and approved by the Plan, the member is not responsible for payment.

9.4 **NON-PARTICIPATING PROVIDERS**. The PLAN shall reimburse Non-Participating Providers for Covered Services if the services (a) were Medically Necessary, (b) were Authorized by the PLAN, and (c) could not reasonably have been obtained from a Participating Provider, inside or outside of the state of Michigan on a timely basis. This shall be applicable to Non-Participating Providers located in and out of the state of Michigan. The PLAN shall pay claims from Non-Participating Providers at established Michigan Medicaid fees in effect on the date of service for paying Participating Medicaid providers as established by Medicaid policy. If Michigan Medicaid has not established a specific rate for the Covered Service, the PLAN must follow Medicaid policy for the determination of the correct payment amount.

9.5 **NOTICE OF CHANGE OF ADDRESS. OTHER COVERAGE. CHANGE IN ELIGIBILITY.LOSS OR THEFT OF IDENTIFICATION CARD**. Member agrees to notify the PLAN promptly, either in writing or by telephone, of any change in address or if the Identification Card is lost or stolen. Member agrees to give the PLAN notice of any other health benefit coverage under which the Member is covered at the time of enrollment or at any time thereafter while this Coverage is in effect, or any change in eligibility.

9.6 **AUTHORIZED FOR RELEASE AND RECEIPT OF INFORMATION**. Member agrees to allow the PLAN to obtain information from any provider of services that provides Covered Services to Member as may be reasonably necessary to administer Covered Services under this Agreement. By accepting Coverage under this Agreement, Member agrees to authorize such providers to provide reports and information to the PLAN and to other providers in connection with the care, treatment and physical condition of Member. This consent will terminate when Coverage terminates and all claims for Covered Services have been processed. Member agrees to provide a signed authorization to release medical records upon request by the Plan. By signing the application for Medicaid coverage. Member has granted the Plan permission to use Member health information consistent with the HIPAA Privacy Rule.

9.7 **CONFIDENTIALITY**. Confidentiality of Member information maintained by the PLAN will be protected in accordance with applicable state and federal statutes including HIPAA. Please refer to the PLAN'S Notice of Privacy Practices.

SECTION 10.0 GRIEVANCE AND APPEAL PROCEDURES

We take Your concerns seriously and we have procedures for responding to them. You can voice Your concerns, misunderstandings and/or dissatisfaction with any aspect of Our policies and procedures or care rendered by a Participating Provider, or if You are displeased with a decision we made regarding services you requested.

You can file a Grievance at any time. We have ninety (90) days after your Grievance is received to resolve it. If You receive an Adverse Determination in response to your Grievance, you can file an Appeal within sixty (60) days. We have thirty (30) days after your Appeal is received to respond to it. If You receive an Adverse Determination in response to your Appeal, you can request a State Fair hearing from MDHHS. You must request a State Fair hearing within 120 days of the Adverse Determination for your Appeal. If you need help completing the Request for State Fair Hearing form, call Customer Service at **1-866-316-3784**. This request can be submitted during the appeals process.

Submit your requests to:

Michigan Administrative Hearing System for the Michigan Department of Health and Human Services

P.O. Box 30763
Lansing, MI 48909
1-877-833-0870

All Grievance/Appeal information will be provided to You in Your prevalent language. TTY/ TDD (Teletypewriter/Telecommunication Device for the Deaf) and interpretive services will also be made available upon request.

10.1 **GRIEVANCES/APPEALS**. You may file a Grievance if You are upset about the quality of services that You received, or the relationship that You have with Us, or Your Provider, or if You are concerned about Your rights as a Member. You may also file an Appeal due to an Adverse Determination or denial of payment that We made such as when we:

- Deny or limit authorization of a service that You or Your Provider requests.
- Fail to make payment or provide, in whole or in part, a benefit to You.
- Fail to provide services in a timely manner.

- Reduce, either entirely or partially, suspend, or terminate a benefit or previously authorized service (except when reduction, suspension, or termination result from state or federal action).
- Fail to act within specified timeframes when We handle your Grievance/Appeal.
- Fail to authorize or Cover services because We think that the services are experimental, investigational, cosmetic, or not Medically Necessary or appropriate.

By filing a Grievance/Appeal with Us, You are asking Us to reconsider the decision that We made because You, or Your Authorized Representative, think that You are entitled to receive the requested service or have the service paid for, or have us do something differently. Your Provider may also file a Grievance/Appeal on Your behalf, provided that You complete and send to Us an Authorized Representative Form that gives Your permission for Your Provider to act on Your behalf. In the event of an Urgent/ Expedited Grievance/Appeal, Your treating provider can file a Grievance/Appeal on Your behalf without submitting an Authorized Representative Form.

You can file a Grievance/Appeal before You receive the requested service. This is called a Pre-Service Grievance/Appeal. You can also file a Grievance/Appeal after You receive the requested service. This is called a Post-Service Grievance/Appeal. You or Your Provider can also file an Urgent/Expedited Grievance/Appeal if You think that the timeframes of the Grievance/Appeal process could seriously jeopardize Your life or health, or if You are pregnant, the life or health of Your fetus, or Your ability to attain, maintain, or regain maximum function. Please read below for more information about the Grievance and Appeals Process.

If you need help filing a Grievance/Appeal, We are here to help You. Please contact the Appeals Coordinator at **1-866-316-3784 (TTY: 711)**. If You send Your Grievance/Appeal to Us in writing, We will send You a letter acknowledging Our receipt of Your Grievance/Appeal within three (3) days of Our receiving it. We will contact You within ninety (90) days to let You know how Your Grievance was resolved. If you receive an Adverse Benefit Determination after you file a Grievance, you can file an Appeal. If You file an Appeal, we will contact you within 30 days to let you know if Your Appeal was resolved. If You need Your Grievance/Appeal reviewed on an Expedited basis because it involves a medical condition that requires an immediate response from Our Health Services Department, We will respond to Your Grievance/Appeal within seventy-two

(72) hours of receiving it. The PLAN staff reviewing Your Grievance/Appeal will not have been previously involved in any prior decisions about Your Grievance/Appeal. The PLAN will make sure that the staff reviewing Your Grievance/Appeal has the necessary qualifications to review Your Grievance/Appeal.

10.2 THE GRIEVANCE/APPEAL PROCESS

10.2.1 If You receive an Adverse Determination or denial of payment from Us, or if We did something you are dissatisfied with, You can dispute it using the Grievance/Appeal process described below. You can also have Your Provider act on Your behalf. To do that, You must complete an Authorized Representative form, which You can receive by calling Customer Service.

10.2.2 You can file a Grievance at any time. We have ninety (90) days after your Grievance is received to resolve it. If You receive an Adverse Determination in response to your Grievance, you can file an Appeal within sixty (60) days. We have thirty (30) days after your Appeal is received to respond to it. If You receive an Adverse Determination in response to your Appeal, you can request a State Fair hearing from MDHHS. You must request a State Fair hearing within 120 days of the Adverse Determination for your Appeal. At any time, you can contact the Appeals Coordinator at **1-866-316-3784 (TTY: 711)**.

10.2.3 You, or Your Authorized Representative, need to send Us a written request that includes Your name, the name of the treating Provider, the date of service (if it already took place), a description of the service that was requested or received and denied by Us, or the action We took that You are dissatisfied with, Your (or Your representative's) mailing address, an explanation of why We should reverse Our decision, and a copy of any information that will support Your request. You may also provide Us with any additional documents, records or information that is relevant to Your Grievance/Appeal.

10.2.4 If You have an Authorized Representative, You should also send us the completed Authorized Representative form. Such requests should be addressed to: Aetna Better Health of Michigan Attn: Appeals Coordinator PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181 or email **MIAppealsandGrievances@Aetna.com**. If You would like to have an Authorized Representative act on Your behalf, We cannot begin to review Your Grievance/Appeal until We receive the Authorized Representative form. If We receive Your Grievance/Appeal without an Authorized Representative Form, We will not start to process Your Grievance/Appeal until We get this Form. You may submit an Authorized Representative Form at any time before the period in which You are entitled to submit a Grievance/Appeal to Us. Our timeframe to review Your Grievance/Appeal will begin on the day that We receive the Authorized Representative Form from You.

10.2.5 If You or Your representative cannot file a written Grievance/Appeal, You may contact Us so that We can obtain the above information and fill out the necessary documents to start Your Grievance/Appeal. You or your representative may request access to and copies of documents, records and information relevant to the Grievance/Appeal. We will provide

you with that information free of charge. We will also provide You with assistance, if You need it, with completing the paperwork and other steps of Your Grievance/Appeal, for example, if You need an interpreter or a TTY/TTD capability.

10.2.6 Within three (3) working days of Our receipt of Your Grievance/Appeal, the Appeal Coordinator will send a letter to You or Your Authorized Representative confirming receipt of the Grievance/Appeal. The notice will also notify You or Your Authorized Representative of Your rights during the Grievance/Appeal process, including: information on how to contact the Appeal Coordinator who has been appointed to assist in resolving formal Grievances/Appeals; Your right to appear before the Appeal Committee; Your right to request a representative to act on Your behalf;

Your opportunity to participate in the hearing in person, via conference call, or other appropriate technology; and the right of reasonable access before and during the Grievances/Appeals process, upon request and free of charge, to all documents, records and other information considered during the Appeal process. You should contact the Appeal Coordinator if You or Your Authorized Representative would like to participate in the hearing. The Appeal Coordinator may also notify You or Your Authorized Representative of receipt of the Grievance/Appeal via telephone. If You or Your Authorized Representative expresses a desire to participate in the hearing, the Appeal Coordinator will send an additional letter to You or Your Authorized Representative with details about the hearing including the time, date, location and/or conference call telephone number into which You or Your Authorized Representative should dial.

10.2.7 If We determine that We need an extension in order to obtain additional information from your treating Provider, and it is in Your best interest, We will extend Our time period once during the Grievance/Appeal process for up to fourteen (14) calendar days with Your permission.

10.2.8 Depending on whether Your Grievance/Appeal involves a medical or non-medical issue, the Appeal Committee will be made up of the Plan's senior managers and/or the Plan's Medical Director, and other health professionals. No one on the Appeal Committee was involved in making the original decision about Your care, or reports to the person who made the original decision about Your care.

10.2.9 We will render a final decision within five (5) business days of the Appeal Committee meeting and within ninety (90) calendar days after the date the Grievance was received or thirty (30) calendar days after the date the Appeal was received. We will send written notice of Our decision to You or Your Authorized Representative within ninety (90) calendar days after the date the Grievance was received or thirty (30) calendar days after the date the Appeal was received. The notification will include:

- The specific reason(s) for the determination;
- Reference to the specific Coverage provision on which the determination was based (i.e., reference to the specific section in Your Evidence of Coverage);
- Notice if an internal rule, guideline or protocol was utilized in making the determination, and if an internal rule, guideline or protocol was utilized in making the determination, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;
- If the Grievance/Appeal decision is based on Medical Necessity, experimental treatment or a similar exclusion (i.e., investigational, cosmetic, etc.), the specific clinical rationale for the determination;
- Notice of any further Grievance/Appeal rights
- A list of the persons on the Appeal Committee
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to Your Grievance/Appeal;
- A statement of Your rights to request a State Fair Hearing, or appeal to the Michigan Office of Financial and Insurance Regulation, as may be applicable; and
- A statement of Your rights to continuation of health benefits during the time a State Fair Hearing is pending.

10.3 URGENT/EXPEDITED GRIEVANCES/APPEALS

10.3.1 You or Your Authorized Representative (which may include the treating Provider) may file an Urgent/Expedited Grievance/Appeal in writing or orally. The Urgent/Expedited Grievance/Appeal may be submitted verbally or in writing to: Aetna Better Health of Michigan Attn: Appeals Coordinator, PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181 or email **MIAppealsandGrievances@Aetna.com**.Or you can call us at **1-866-316-3784 (TTY: 711)**.

10.3.2 If You would like to have an Authorized Representative, other than Your treating Provider, act on Your behalf during an Urgent/Expedited Grievance/Appeal, and You are unable to submit an Authorized Representative Form to Us because of Your incapacity or an emergency circumstance, We may proceed with Your Grievance/Appeal and communicate with the purported Authorized Representative if it is in Your best interest and if the information disclosed is directly relevant to Your Grievance/Appeal.

10.3.3 To request an Urgent/Expedited Grievance/Appeal, You or Your Authorized Representative must give Us Your name, Your Provider's name, the date of service (if it already took place), a description of the service that was requested or received and denied by Us, or the action We took that You are dissatisfied with, Your (or Your

Authorized Representative's) mailing address and telephone number, an explanation of why We should reverse our decision, and a copy of any information that will support Your request.

10.3.4 If there is insufficient information provided with the Urgent/Expedited Grievance/ Appeal, We will notify You or Your Authorized Representative immediately by telephone of the information needed. If the necessary information is not received, the Appeal committee will make a decision based on the information available.

10.3.5 If a physician with knowledge of Your medical condition determines that a Grievance/ Appeal involves Urgent/Expedited, We will treat your Grievance/Appeal as an Urgent/ Expedited Grievance/Appeal. If You request an Urgent/Expedited Grievance/Appeal, but Your Provider does not also state that Your Grievance/Appeal should be handled on an Urgent/Expedited basis, Our Medical Director will review Your Grievance/Appeal to determine if Your Grievance/Appeal qualifies as an Urgent/Expedited Grievance/ Appeal. If We decide that Your Grievance/Appeal is not an Urgent/Expedited Grievance/ Appeal and that it should be processed as a standard Grievance/Appeal, We will verbally notify You as soon as possible, and send You a letter within two (2) days. You will be able to Appeal Our decision to the Michigan Department of Insurance and Financial Services (DIFS) within ten (10) days.

10.3.6 If We proceed with Your Urgent/Expedited Grievance/Appeal, a hearing will be scheduled with an Appeal Committee to take place within forty-eight (48) hours of Your request, and Your Grievance/Appeal will be resolved within seventy-two (72) hours of Your request. You and/or Your Authorized Representative may participate in the hearing. If You or Your Authorized Representative requests an extension during the Urgent/Expedited Grievance/Appeal, the Grievance/Appeal will have to be moved to the standard timeframe for Us to decide Your Grievance/Appeal. We will provide You with written confirmation of the transfer to the standard Grievance/Appeal timeframes within two (2) days of Your request for extension. If You or Your Authorized Representative chooses to withdraw the request for the extension, We will consider Your Grievance/Appeal on an urgent/expedited basis, within seventy-two (72) hours.

10.3.7 None of the individuals on the Appeal Committee will be someone who was involved in the original Adverse decision or who reports to someone who was involved in the original Adverse decision. You or Your Authorized Representative will be offered the opportunity to attend and participate in the Appeals Committee Meeting when your Appeal is considered by the Committee.

10.3.8 We will render a final decision and provide verbal and written notice of that decision within seventy-two (72) hours after the date the Grievance/Appeal was received. The notification will include:

- The specific reason(s) for the determination;
- Reference to the specific Coverage provision on which the determination was based (i.e., reference to the specific section in Your Evidence of Coverage);
- Notice if an internal rule, guideline or protocol was utilized in making the determination, and if an internal rule, guideline or protocol was utilized in making the determination, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;
- If the Grievance/Appeal decision is based on Medical Necessity, experimental treatment or a similar exclusion (i.e., investigational, cosmetic, etc.), the specific clinical rationale for the determination;
- Notice of any further Grievance/Appeal rights;
- A list of the persons on the Appeal Committee;
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to Your Grievance/Appeal;
- A statement of Your rights to request a State Fair Hearing, or appeal to the Department of Insurance and Financial Services, as may be applicable; and
- A statement of Your rights to continuation of health benefits during the time a State Fair Hearing is pending.

10.4 **CONTINUATION OF BENEFITS**.

During the time that We are processing Your Grievance/Appeal due to an Adverse Determination or while You are waiting for Your State Fair Hearing, You may be entitled to continuation of benefits pursuant to the Following:

10.4.1 As used in this section, "timely" Filing means Filing on or before the later of the Following:

(a) within ten (10) days of Us mailing the Adverse Determination, or (b) the intended effective date of Our proposed Adverse Determination.

10.4.2 We will continue Your benefits during the time of the Grievance/Appeal due to an Adverse Determination process or State Fair Hearing when:

10.4.2.1 You or Your Authorized Representative Files the Grievance/Appeal due to an Adverse Determination on a timely basis;

10.4.2.2 Your Grievance/Appeal due to an Adverse Determination involves the termination, suspension, or reduction of a previously authorized course of treatment;

10.4.2.3 Your services were ordered by an authorized provider;

10.4.2.4 The original period covered by the original authorization has not expired; and

10.4.2.5 You request extension of the benefits.

10.4.3 If, at Your request, We continue or reinstate Your benefits while the Grievance/ Appeal due to an Adverse Determination is pending, the benefits must be continued until one of the Following occurs:

10.4.3.1 You withdraw the Grievance/Appeal.

10.4.3.2 Ten (10) days pass after We mailed the notice providing the resolution of the Grievance/Appeal in Our Favor, unless You, within the ten (10) day timeframe, have requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.

10.4.3.3 A State Fair Hearing officer issues a hearing decision adverse to You.

10.4.3.4 The time period or service limits of a previously authorized service has been met.

10.4.4 IF the Final resolution of the Grievance/Appeal due to an Adverse Determination upholds the original action. We may recover the cost of the services Furnished to You while the Grievance/Appeal was pending, to the extent that such services were Furnished solely because of the requirements of this section.

10.4.5 If We, or the State Fair Hearing officer, decide in Your Favor and reverse a decision to deny, limit, or delay services that were not Furnished while the Grievance/Appeal was pending, We must authorize or provide the disputed services promptly and as expeditiously as Your health condition requires.

10.4.6 If We, or the State Fair Hearing officer, reverse a decision to deny authorization of services, and You received the disputed services while the Grievance/ Appeal was pending. We must pay for those services.

10.5 YOUR RIGHTS UNDER THE PATIENT RIGHT TO INDEPENDENT REVIEW ACT

("PRIRA"). After You have used Our Grievance and Appeal Program for a Non-Urgent/Expedited Grievance/Appeal, and We have issued Our Final decision, You may seek external review through the Michigan Department of Insurance and Financial Services ("DIFS") pursuant to Michigan law within one hundred twenty-seven

(127) days of Your receipt of Our Final decision. In the case of an Urgent/Expedited Grievance/Appeal, You can also File a request for expedited external review with DIFS if You have First sent notice to Us. You should use the "Health Care Request for External Review Form" that We provide to You. This Form can also be Found at **www.michigan.gov/documents/cis_ofis_fis_0018_25078_7.pdf**.

To quality for PRIRA review:

- You must have received an Adverse Determination and a Final decision from Us
- You must have been covered by Us on the date of service in question
- The service You requested must reasonably appear to have been a Covered Service under this Agreement and
- You must have exhausted your Grievance/Appeal rights with Us except in the case of an Urgent/Expedited Grievance/Appeal.

10.5.1 You can request an Expedited PRIRA Review within ten (10) days of receipt of an Adverse Determination when it involved a medical condition for which a physician certifies that the time frame for completing a standard PRIRA review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum Function. if an Expedited PRIRA Review is necessary, it will be completed within seventy-two (72) hours after Your written request was submitted.

10.5.2 Your PRIRA Review request must be sent by fax to **1-517-284-8838** or by UPS or U.S. mail to:

DIFS, Health care Appeals Section Office of General Counsel

P.O. Box 30220

Lansing, Ml 48909-7720

Delivery service to:

Office of General Counsel – Health Care Appeals Section Department of Insurance and Financial Services

530 W. Allegan St., 7th Floor
Lansing, Ml 48933-1521

It must include a copy of the Final Adverse Determination from the Plan, any pertinent documentation about Your case, such as bills, benefits explanations, medical records, correspondence, research materials that support your position, etc.

IT IS YOUR RESPONSIBILITY TO SUBMIT THIS DOCUMENTATION; DIFS DOES NOT CONTACT MEDICAL PROVIDERS FOR THIS INFORMATION. YOU SHOULD ALWAYS SEND COPIES; NOT THE ORIGINALS.

10.5.3 You do not need to hire a lawyer to request a PRIRA Review. You can authorize someone to act on your behalf, such as a clergy, a friend, a family member, your doctor, or a lawyer.

10.5.4 DIFS will notify You within five (5) business days of receiving Your request for PRIRA Review if DIFS can handle Your case. If Your case is accepted by DIFS, DIFS will determine whether it needs to get a recommendation from an Independent Review Organization, which is an entity that can perform an unbiased medical review of Your case. If DIFS does not need to consult with an Independent Review Organization, You can expect to receive a decision from DIFS within fourteen (14) calendar days after Your request was accepted by OFIR for review. If DIFS has to consult with an Independent Review Organization, the Independent Review Organization has fourteen

(14) calendar days after it receives the case from DIFS to make a recommendation to DIFS. DIFS then has seven (7) business days to issue its decision to You.

10.5.5 If You disagree with DIFS' decision, You can appeal to the Circuit Court of the county in which You live, or the Circuit Court of Ingham County.

10.5.6 PRIRA Review cannot be requested for complaints by Providers regarding claims payment or handling of reimbursement for services. PRIRA Review does not apply to issues of termination, cancellation, or the amount You have to pay for Coverage.

10.5.7 If You have questions about PRIRA Reviews, You can call the Appeals Coordinator at

1-866-316-3784, TTY **711**, or DIFS at **1-877-999-6442**.

SECTION 11.0 GENERAL CONDITIONS

11.1 **ASSIGNMENT**. Assignment by a Member is prohibited.

11.2 **CIRCUMSTANCES BEYOND THE PLAN'S CONTROL**. In the event that, due to circumstances not reasonably within the control of the Plan, including but not limited to complete or partial destruction of facilities, a major natural disaster, epidemic, war, riot, civil insurrection, labor dispute, disability of a significant part of a hospital or a disability of the Plan personnel, or similar causes which delay or render impractical the rendition of

services described in this Agreement, neither the Plan nor any Participating Provider shall be liable for such delay or failure to provide services as a result of such circumstances. For purposes of this Section, the term "epidemic" shall mean an outbreak of a contagious disease that spreads rapidly by infection among a population throughout a particular geographic area.

11.3 **NOTICE**. Any notice required or permitted to be given by the Plan here under shall be deemed to have been duly given if in writing and personally delivered, or if in writing and deposited in the United States Mail with postage prepaid, addressed to the Member at the last address of record on file at the principle office of the Plan; such notice by the Member shall be deemed to have been given when so personally delivered or mailed, addressed to the Plan at:

Aetna Better Health of Michigan
28588 Northwestern Hwy, Suite 380B
Southfield, MI 48034

11.4 **HEADINGS**. The catch line headings and captions in no way shall be considered to be a part of this contract but are inserted only for the convenience of reference.

11.5 **GOVERNING LAW**. This contract is made and shall be interpreted under the laws of the state of Michigan and federal law, where applicable.

11.6 **EXECUTION OF CONTRACT**. The parties acknowledge and agree that the Member's signature or execution on a MDHHS Eligibility Application form shall be deemed to be the Member's execution of this Agreement.

11.7 **SEVERABILITY**. If any provision of the Agreement, on its effective date or thereafter, is determined to be in conflict with federal or Michigan law or applicable rules and regulations of the Michigan Office of Financial and Insurance Regulation, such provision shall be fully severable, and the remaining provisions of the Agreement shall continue in full force and effect.

11.8 **WAIVER**. The waiver by either party of any breach of any provision of the Agreement shall be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right under this Agreement shall not operate as a waiver of such right.

11.9 **DISCLAIMER**. The Plan contracts with independent physician groups who provide health care to Members and other patients. The Plan does not directly furnish medical care, make medical judgments, or assume any responsibility for the physician's medical treatment of the Members.

11.10 **AMENDMENTS**. This Agreement may be amended from time to time, in writing in the form of a rider to this Agreement, as required due to changes in Medicaid program policies or coverages, or state and federal regulations.

11.11 **CONFIDENTIALITY AND PRIVACY.**

11.11.1 Medical Records. A Member or Authorized Representative of a Member may review the records of the Plan relating solely to the Member, at the offices of the Plan. This review must be during regular business hours. It must also be at an appointed time agreed to by the Plan and requested by the Member for that purpose. The Plan must reasonably grant such requests.

11.11.2 Your privacy matters. We respect your privacy. As required by the Health Insurance Portability and Accountability Act (HIPAA), Aetna, and each member of the Aetna family of companies (an "Affiliate"), is giving you important information about how your medical and personal information may be used and about how you can access this information. Please review the following Notice of Privacy Practices carefully. If you have any questions, please call Member Services at **1-866-316-3784 (TTY: 711)**.

11.11.3 Notice of privacy practices. 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.

Para recibiresta notificacion en espanol por favor llamaral numero gratuito de Member Services (Servicios a Miembros) que figura en su tarjeta de identificacion.

What do we mean when we use the words "health information"? We use the words "health information" when we mean information that identifies you. Examples include your:

Name.

Date of birth.

Health care you received.

Amounts paid for your care.

How we use and share your health information to help take care of you. We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical

tests. We may also remind you of appointments. We may share your health information with other people who give you care. This could be doctors or drug stores. If you are no longer with our plan, with your approval, we will give your health information to your new doctor.

Family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information, call us at **1-866-316-3784**.

If you are a minor and do not want us to give your health information to your parents or legal guardians, call us at **1-866-316-3784**. We can help in some cases if allowed by state law.

For payment: We may give your health information to others who pay for your care. Your doctor must give us a claim form that includes your health information. We may also use your health information to look at the care your doctor gives you. We can also check your use of health services.

Health care operations: We may use your health information to help us do our job. For example, we may use your health information for:

- Health promotion.
- Case management.
- Quality improvement.
- Fraud prevention.
- Disease prevention.
- Legal matters.

A case manager may work with your doctor. They may tell you about programs or places you can access or enroll in to help you with your health problems. Materials are available to members. When you call us with questions, we need to look at your health information to give you answers.

Sharing with other businesses. We may share your health information with other businesses. We do this for the reasons we explained above. For example, you may have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We will tell them if you are in a motorized wheelchair, so they send a van instead of a car to pick you up.

Other reasons we might share your health information. We also may share your health information for these reasons:

Public safety –To help with things like child abuse. Threats to public health.

Research – To researchers. After care is taken to protect your information.

Business partners – To people that provide services to us. They promise to keep your information safe.

Industry regulation – To state and federal agencies. They check us to make sure we are doing a good job.

Law enforcement – To federal, state and local enforcement people.

Legal actions – To courts for a lawsuit or legal matter.

Reasons that we will need your written okay: Except for what we explained above, we will ask for Your approval before using or sharing your health information. For example, we will get Your approval:

For marketing reasons that have nothing to do with your health plan.

Before sharing any psychotherapy notes.

For the sale of your health information.

For other reasons as required by law.

You can cancel your approval at any time. To cancel Your approval, write to us. We cannot use or share your genetic information when we make the decision to provide you with health care insurance.

What are your rights. You have the right to look at your health information. You can as us for a copy of it. Contact Member Services **1-866-316-3784 (TTY: 711)** or visit our website AetnaBetterHealth.com/Michigan

- You can ask for your medical records. Call your doctor's office or the place where you were treated. You have the right to ask us to change your health information.
- You can ask us to change your health information if you think it is not right. If we do not agree with the change you asked for. Ask us to file a written statement of disagreement.
- You have the right to get a list of people or groups that we have shared your health information with.

- You have the right to ask for a private way to be in touch with you. If you think the way we keep in touch with you is not private enough, call us. We will do our best to be in touch with you in a way that is more private.
- You have the right to ask for special care in how we use or share your health information. We may use or share your health information in the ways we describe in this notice. You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- You have the right to know if your health information was shared without your approval. We will tell you if we do this in a letter.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care. We do not have to agree. But we will think about it carefully.
- You have the right to know if your health information was shared without your approval. We will tell you if we do this in a letter. Call us toll free at **1-866-316-3784 (TTY: 711)**. to: Ask us to do any of the things above. Ask us for a paper copy of this notice. Ask us any questions about the notice.
- You also have the right to send us a complaint. If you think your rights were violated write to us at: Aetna Better Health of Michigan, Member Services department PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181 or email to **MIAppealsandGrievances@Aetna.com**
- You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address. If you are unhappy and tell the Office of Civil Rights, you will not lose plan membership or health care services. We will not use your complaint against you.