

**MIDWEST HEALTH PLAN  
MICHild Program**

**Certificate of Coverage**

Midwest Health Plan  
(A State Licensured For-Profit Health Maintenance Organization)  
4700 Schaefer Rd. Ste 340  
Dearborn Michigan 48126  
313-581-3700  
888-654-2200

**This page intentionally left blank.**

**TABLE OF CONTENTS**

**SECTION I. INTRODUCTION.....4**

**SECTION II. DEFINITION OF TERMS .....5**

**SECTION III. ELIGIBILITY AND ENROLLMENT .....8**

**SECTION IV. DISENROLLMENT.....8**

**SECTION V. FORMS, IDENTIFICATION CARDS, RECORDS.....9**

**SECTION VI. COORDINATION OF BENEFITS AND SUBROGATION.....10**

**SECTION VII. GRIEVANCES AND APPEALS .....12**

**SECTION VIII. GENERAL PROVISIONS .....14**

**APPENDIX I SCHEDULE OF COVERED SERVICES.....17**

**APPENDIX II SCHEDULE OF EXCLUSIONS AND LIMITATIONS .....26**

## **WE WANT TO BE SURE YOU ARE HAPPY WITH MHP**

MHP cares about its Members and wants to know what they like and don't like about its services. Also, MHP appreciates feed back about the information it sends its Members and how it can better serve its Member's needs. Please let MHP know how it can better serve its Members by calling Customer Services at 1-888-654-2200

### **SECTION I. INTRODUCTION**

Midwest Health Plan ("MHP") is a for-profit, State licensed Health Maintenance Organization based in Dearborn, Michigan. MHP is accredited by the National Committee on Quality Assurance. MHP has a contract with the Michigan Department of Community Health ("MDCH") to provide health care services to Michigan MICHild participants. **The Plan** is the name of the health care plan offered by MHP to Michigan MICHild participants that is described in this Certificate.

The eligibility for, and Covered Services provided under, the Plan are funded by MDCH and are governed by the terms and conditions of the MICHild program, as may be changed from time to time. MHP is a contractor with MDCH and can provide Covered Services only to eligible MICHild participants while it remains a contractor.

This Certificate of Coverage ("Certificate") describes MHP's responsibilities to its Members and its Member's rights and responsibilities. This Certificate is effective on the date set forth on the Member's Identification Card ("Effective Date") and it is the Member's responsibility to understand the terms and conditions of this Certificate. Of course, MHP's Customer Service Department is available to answer Member questions regarding this Certificate and the Covered Services provided hereunder.

MHP reserves the right to change or end the Plan and the Covered Services provided under this Certificate at any time, in its sole discretion, subject to the terms of its participation in the MICHild program as a contractor with MDCH. If the Plan or a Member's eligibility ends, only claims incurred before the date of termination will be paid through the Plan. MHP will coordinate care and pay for the care of members whose eligibility ends while inpatient.

MHP's Customer Services staff is available to answer questions and assist Members in obtaining services and filing claims under the Plan. Customer Service staff can be contacted by calling toll-free at 1-888-654-2200 or at 1-313-581-3700. Additionally, Members can contact the MDCH MICHild program directly at 1-888-988-6300.

## SECTION II. DEFINITION OF TERMS

- 2.1 “**Abuse**” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Plan or the MICHild 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 beneficiary practices that result in unnecessary cost to the Plan or the MICHild program.
- 2.2 **Advisory Committee on Immunization Practices (ACIP)**. A federal advisory committee convened by the Centers for Disease Control, Public Health Service, and Health and Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.
- 2.3 “**Administrative Contractor**” means the qualified contractor providing MDCH with administrative support for the MICHild program.
- 2.4 “**Affiliated Physician**” means an individual licensed to practice medicine or osteopathy (MD or DO) and who has a contract with MHP or an Individual Practice Association (IPA) to provide services to Members.
- 2.5 “**Affiliated Provider**” means a health professional, a Hospital, licensed pharmacy, or any other institution, organization, or person who has a contract with MHP or an Individual Practice Association (IPA) to render one or more health maintenance services to Members.
- 2.6 “**Appeal**” means a request for review of a Contractor’s decision that results in any of the following actions:
- The denial or limited authorization of a requested service, including the type or level of service;
  - The reduction, suspension, or termination of a previously authorized service;
  - The denial, in whole or in part, of payment for a properly authorized and covered service;
  - The failure to provide services in a timely manner, as defined by the State;
  - The failure of a Contractor to act within the established timeframes for grievance and appeal disposition.
- 2.7 “**Covered Services**” means all services provided under the Plan, as specifically set forth in Appendix I of this Certificate, which MHP has agreed to provide or arrange to be provided under the terms of the Service Agreement.
- 2.8 “**CMHSP**” means Community Mental Health Services Program.
- 2.9 “**CHSCS**” means Children’s Special Health Care Services.

- 2.10 **"Emergency Health Service(s)"** means Medically Necessary services that are provided to Members for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- 2.11 **"Enrollee"** means an Eligible Child enrolled with a *MIC* Child Contractor.
- 2.12 **"Expedited Appeal"** means an appeal conducted when the Contractor determines (based on the Enrollee request) or the provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function
- 2.13 **"FQHC"** means Federally Qualified Health Centers
- 2.14 **"Fraud"** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law (*e.g.*, 42 CFR 455.2).
- 2.15 **"Grievance"** means an expression of dissatisfaction about any matter other than an action subject to appeal.
- 2.16 **"HMO"** means An entity that has received and maintains a State certificate of authority to operate as a Health Maintenance Organization as defined in MCL 555.3501
- 2.17 **"Hospice"** means a licensed health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.
- 2.18 **"Hospital"** means a facility licensed, accredited, or approved under the laws of any state or by the United States government that offers outpatient and inpatient services, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, psychiatric, or rehabilitative condition requiring the daily direction or supervision of a physician.
- 2.19 **"Identification Card"** shall have the meaning set forth in Section 5.2.
- 2.20 **"Medically Necessary"** means services and supplies furnished to a Member when and to the extent the Plan Medical Director determines that they satisfy all of the following criteria:
- They are medically required and medically appropriate for the diagnosis and treatment of the Member's illness or injury;

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25"

- They are consistent with professionally-recognized standards of health care; and
- They do not involve costs that are excessive in comparison with alternative services that would be effective for the diagnosis and treatment of the Member's illness or injury.

The fact that a physician may have prescribed, ordered, recommended, or approved the provision of certain services to the Member does not necessarily mean that such services satisfy the above criteria.

- 2.21** “**Medical Director**” is a Michigan licensed physician designated by MHP to provide medical management and related services on behalf of the Plan. As used in this Certificate, the term shall include any individual designated by the Medical Director to act on his or her behalf.
- 2.22** “**MDCH**” means the Michigan Department of Community Health.
- 2.23** “**Member**” means an individual enrolled in MICHild and entitled to receive Covered Services under this Certificate.
- 2.24** “**MICHild**” means a health coverage and dental program using funds authorized under Title XXI of the Social Security Act to furnish health coverage to low-income, uninsured individuals who meet eligibility criteria.
- 2.25** “**Network Providers**” means those providers contracted with MHP that are responsible for providing health care for Members.
- 2.26** “**Plan**” means the MICHild program administered by MHP.
- 2.27** “**Primary Care Provider**” or “**Primary Care Physician**” or “**PCP(s)**” means those providers within the Plan who are designated as responsible for providing, or arranging for the provision of, health care for specified Members. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist or pediatric physician when appropriate for a Member. Other physician specialists may be designated by MHP when appropriate for a Member's health condition.
- 2.28** “**Service Agreement**” is the contract between MHP and MDCH that establishes the scope of Covered Services being purchased, the criteria for eligibility, as well as the underwriting and administrative agreements between MHP and MDCH.
- 2.29** “**Service Area**” means the geographic area in which MHP is authorized by regulating agencies to provide the Plan's health care services to Members.

## SECTION III. ELIGIBILITY AND ENROLLMENT

### 3.1 Eligibility Criteria

To be eligible to enroll in MICHild, an individual must:

1. Be eligible for MICHild as determined by MDCH; and
2. Reside within the Plan's Service Area.
3. Pay \$10.00 monthly premium per family to MDCH

In all cases, MDCH makes the final determination regarding an individual's eligibility for MICHild.

### 3.2 Enrollment

MDCH contracts with an Administrative Contractor to provide enrollment and disenrollment services. It is the Administrative Contractor's responsibility to educate individuals about how to enroll, disenroll, and change their enrollment status in a MICHild participating health plan. The Administrative Contractor will provide Members with their choice of MICHild health plans in their area and enroll them in the plan of their choice. If an eligible individual does not voluntarily choose a health plan, the Administrative Contractor will automatically assign them to a health plan within their county of residence. Accordingly, Administrative Contractor is responsible for enrolling eligible participants in the Plan.

The combined Healthy Kids/MICHild application may be obtained by going to the Michigan Department of Community Health website, [www.michigan.gov/MICHild](http://www.michigan.gov/MICHild) or calling the MICHild toll-free number at 1-888-988-6300.

## SECTION IV. DISENROLLMENT

### 4.1 Disenrollment Generally

It is the Administrative Contractor's responsibility to disenroll a Member from the Plan. MHP is responsible for the Member's medical care until the Administrative Contractor notifies MHP that its responsibility to the Member has ended. Disenrollment will occur consistent with the rules and regulations of MDCH.

### 4.2 Disenrollment by Member

If a Member wants to disenroll from the Plan, the Member must follow the procedures issued by MDCH. Disenrollment information is available upon request from MDCH.

### 4.3 Member Moves from Service Area

A Member will be disenrolled from the Plan if he/she or his/her family moves from the Plan's Service Area. The Member shall be disenrolled from the Plan effective the first day of the month following the month in which the Administrative Contractor notifies MHP of the change of address.

#### **4.4 Termination of Service Agreement**

Members will be disenrolled from the Plan if the Service Agreement is terminated for any reason. The effective date of the disenrollment is the date the Service Agreement is terminated.

#### **4.5 Non-Eligibility by Member**

A Member will be disenrolled from the Plan if MDCH or its Administrative Contractor determines the Member is not eligible for MICHild.

#### **4.6 Disenrollment by Plan**

With the consent of DCH, MHP may request disenrollment of any Member from the Plan due to improper actions on the part of the Member/parent/guardian that are inconsistent with the Plan membership, including, without limitation, Fraud, Abuse of the Plan, or other intentional misconduct, or if, in the opinion of MHP, the Member's/parent's/guardian's behavior is such as to make it medically infeasible for the provider to safely or prudently render Covered Services to the Member. Such termination is subject to the grievance procedures set forth in Exhibit 1 to this Certificate, except that notice of termination shall be immediately communicated to the Member/parent/guardian, along with the procedures for expeditious review. MHP may also request disenrollment of a Member as provided by Section 6.3 of this Certificate.

#### **4.7 Effective Date of Disenrollment**

MHP is liable for payment for all Covered Services set forth in this Certificate until the date of disenrollment becomes effective and notification of termination is received by MHP. All rights to Covered Services cease as of the effective date of disenrollment without prejudice to any pending claims for Covered Services furnished prior to the effective date of disenrollment. The foregoing notwithstanding, if a Member is disenrolled from the Plan and is in the inpatient hospital setting on the date of disenrollment from the Plan, MHP shall be responsible for all covered inpatient hospital-related charges incurred until the date of discharge.

### **SECTION V. FORMS, IDENTIFICATION CARDS, RECORDS**

#### **5.1 Forms and Questionnaires**

Members shall complete and submit to MHP or Network Providers, medical questionnaires and other forms as are reasonably requested and shall assure that all

information contained in such applications, questionnaires and forms is true, correct and complete.

#### Member Identification Cards

- MHP will issue an Identification Card to each Member. Identification Cards must be presented whenever services are sought. To be eligible for coverage under this Certificate, the holder of the Identification Card must be the Member designated on the card and be eligible for services through the Plan. The Identification Card may not be used by and provides no rights to Covered Services for anyone other than the Member designated on the Identification Card, and it does not provide Covered Services to any person who is no longer eligible for coverage. Persons receiving services through the Plan to which they are not entitled under this Certificate shall be charged for the services. The Identification Card is the property of MHP and shall be returned by Member upon request by MHP.
- Member agrees that any misuse of the Identification Card or allowing its use by any other person, or otherwise attempting to or defrauding MHP or the Plan, shall be cause to request disenrollment of the member subject to approval of MDCH.
- Member must promptly notify MHP of any change of his/her address and the loss of theft of any Identification Card. Notification to MHP may be done either in writing or by telephone to the Customer Services Department toll-free at 1-888-654-2200 or at 1-313-581-3700.

**Formatted:** Outline numbered + Level: 4 + Numbering Style: Bullet + Aligned at: 0.5" + Tab after: 0.75" + Indent at: 0.75"

**Formatted:** Outline numbered + Level: 4 + Numbering Style: Bullet + Aligned at: 0.5" + Tab after: 0.75" + Indent at: 0.75"

**Formatted:** Outline numbered + Level: 4 + Numbering Style: Bullet + Aligned at: 0.5" + Tab after: 0.75" + Indent at: 0.75"

### 5.2 Authorization to Receive Information

Member agrees to authorize MHP to receive from any provider of services to Members, information reasonably necessary in connection with the administration of this Certificate. By accepting Covered Services as provided under this Certificate, Member authorizes the disclosure of information concerning the care, treatment and physical condition of the Member to MHP and to permit copying of records by MHP.

### 5.3 Confidentiality of Member's Personal Health Information

Members should refer to MHP's Privacy Notice (available in the MHP Member Handbook and on MHP's web site [www.midwesthealthplan.com](http://www.midwesthealthplan.com)) for a description of how personal and medical information about Members may be used and disclosed and how Members can get access to this information.

## SECTION VI. COORDINATION OF BENEFITS AND SUBROGATION

### 6.1 General Provision

It is MHP's intention to provide its Members with Covered Services to which Members are entitled under this Certificate. A Member is not entitled, however, to receive duplicate

benefits or benefits greater than the actual expenses incurred or the amount MHP pays to Affiliated Providers for Covered Services under this Certificate, whichever is less.

Covered Services are not provided under this Certificate to the extent that any amounts are paid or payable for expenses to or on behalf of the Member under the provisions of any insurance, service benefit or reimbursement plan providing similar direct benefits without regard to fault, including, without limitation, Medicare, Worker's Compensation, Employer's Liability Law, or No Fault Automobile Insurance.

## 6.2 Coordination of Benefits

In establishing the order of carrier responsibility applicable to health plans covering Members, MHP will follow the coordination of benefits guidelines of MDCH and the State of Michigan. Accordingly, all medical bills must first be submitted to the primary insurance carrier as determined by such guidelines. MHP will generally be the payer of last resort.

## 6.3 Subrogation

If the Member has a right of recovery from person or organization for any Covered Services or supplies covered under this Certificate (except from a Member's health insurance coverage, subject to the coordination of benefits provisions), the Member, as a condition of receiving Covered Services under this Contract, will either:

- Pay MHP all sums recovered by suit, settlement, or otherwise, to the extent of Covered Services provided by the Plan and in an amount equal to the Plan payment for those Covered Services, but not in excess of monetary damages collected; or
- Authorize MHP to be subrogated to the Member's rights of recovery, to the extent only of the Covered Services provided including the right to bring suit in the Member's name at the sole cost and expense of MHP.

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

In the event a suit instituted by MHP on behalf of the Member results in monetary damages awarded in excess of the cash value of actual Covered Services provided by MHP, MHP shall have the right to recover costs of suit and attorney fees out of the excess, to the extent of the cost of such fees.

If a Member or its legal representative refuses to cooperate with MHP in its filing of a claim for reimbursement, MHP shall have the right to request disenrollment of a Member upon consent of DCH.

## 6.4 Right of Recovery

To the extent Covered Services have been provided by MHP under this Certificate and the responsibility for payment is with another health plan, MHP shall have the right to deny payment or recover from the other health plan the reasonable cash value of each

service provided under the Plan in an amount necessary to satisfy the intent of this Section 6.

## SECTION VII. GRIEVANCES AND APPEALS

### 7.1 General Information Concerning Grievances and Appeals

To promote Member service and satisfaction, and in accordance with the applicable state and federal law, MHP has a formal grievance and appeal procedure to address, resolve and track all Member grievances and appeals. Specifically, MHP has established and maintains a system that affords procedures for the expeditious resolution of grievances and appeals initiated by Members concerning any matter relating to the provision of services under this Certificate. Members may utilize these procedures to pursue the resolution of claims for reimbursement, denials, cancellations, or non-renewals of certificates, and complaints regarding the quality of the services delivered by Affiliated Physicians and Providers.

#### GRIEVANCE AND APPEAL PROCESS

If you need to file a grievance or appeal with MHP, our Grievance Coordinator is available to help you at any step in the process by calling 888-654-2200.

- A grievance is when you are not happy about anything other than a denied, reduced, or terminated service.
- Grievances can be taken over the phone, in writing, or in person. The Grievance Coordinator is available to help you in writing a grievance. Your doctor or an authorized person may file a grievance for you in writing.
- A letter of receipt of acknowledgement will be sent to you within 5 days of the grievance. All grievances are thoroughly investigated.
- You will receive a response in writing within 15 days of the date of the grievance.

If you are not happy with MHP's decision, you or an authorized person may appeal the grievance in writing, by phone, or in person.

- The Customer Service Supervisor investigates all level 2 grievances.
- You have a right to appear before the board of directors or designated committee, or the right to a managerial-level conference to present your appeal.
- If you are not happy with the decision by MHP, you can request an appeal.
- This appeal is reviewed by the Board of Directors at MHP.
- You can do this by calling, writing or appearing in person at:

Midwest Health Plan  
4700 Schaefer Suite 340  
Dearborn, MI 48126  
888-654-2200

If you are not happy with MHP's decision, or MHP does not respond with a decision within 35 days, you may request an external review from the Office of Financial and Insurance Regulation.

Formatted: Bulleted + Level: 1 + Aligned at: 0.5" + Tab after: 0.75" + Indent at: 0.75"

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

APPEAL PROCESS:

You can file an appeal if a covered health care service has been denied, suspended, terminated, or reduced.

- You have 90 calendar days from receiving the denial to file an appeal.
- You have the right to appeal in person, in writing, or by telephone. The Appeal Coordinator can help you write your appeal.
- You have the right to include an authorized representative throughout the appeals process.
- A decision will be mailed to you in 35 calendar days from the day that MHP receives your appeal.
- An additional 10 calendar days are allowed to obtain medical records or other pertinent medical information if the member requests the extension, or if MHP can demonstrate that the delay is in the member's interest.

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

EXPEDITED APPEAL

- If a doctor believes that the 35 calendar day decision timeframe will cause harm to your health, or affect your normal body functions, MHP will handle your appeal as expedited.
- Expedited appeals are handled in 72 hours.
- You may file an expedited appeal with the Office of Financial and Insurance Regulation (OFIR) at the same time.

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

EXTERNAL REVIEW BY THE OFFICE OF FINANCIAL AND INSURANCE REGULATION

You can ask for an external review if you do not get an answer within 30 calendar days from MHP or if you are not happy with the decision MHP has made. Write to OFIR at:

Office of Financial and Insurance Regulation

Health Plans Division

P.O. Box 30220

Lansing, MI 48909-7720

- You must appeal in writing to the OFIR within 60 calendar days after you receive the final decision from MHP.
- You must complete the grievance/appeal process within the health plan before requesting a review from the OFIR.
- The Appeal Coordinator will explain the external review process to you. We can also mail the external review forms to you.
- The OFIR will send your appeal to an Independent Review Organization (IRO) for consideration if appropriate.
- A decision will be mailed to you in 14 calendar days of accepting your appeal.

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

## SECTION VIII. GENERAL PROVISIONS

### 8.1 Selection of a Primary Care Physician (PCP)

Each Member will have the opportunity to choose a PCP under contract with MHP for the Member's personal care. If a PCP is not selected at the time of enrollment, MHP will assign a PCP based on the geographic location of a Member's address.

PCPs play an important part in a Member's health care and should be thought of as a Member's personal doctor. PCPs will familiarize themselves with their patients' medical history and health needs and are responsible for their patients' health care. A Member's PCP must authorize all referral services (such as, specialty care, out-patient hospitalization, and home health) and all in patient Hospital admissions.

Members should call their PCP for all health care services except Emergency Health Services. Member's requiring Emergency Health Services should go directly to the emergency room.

Members in need of information about selecting a PCP should contact MHP's Customer Service Department toll-free at 1-888-654-2200 or at 1-313-581-3700.

### 8.2 MHP's Right to Transfer a Member

If a PCP is unable, fails, neglects, or refuses to provide Covered Services, MHP can transfer Members assigned to such PCP to another PCP during such inability, failure, neglect and/or refusal to provide Covered Services. MHP's right to transfer Members will be exercised in the best interest of the Member's health care needs and within the contractual limitations regarding the termination of medical care to patients. In the event of such a transfer, MHP does not guarantee that transferred Members will be assigned to the former PCP in the future.

### 8.3 Covered Services are Solely for the Member

As a member of MICHild, you do not have fees or copays for covered services. The Covered Services provided under this Certificate are solely for the individual benefit of the Members and cannot be transferred or assigned. If any Member aids, attempts to aid or knowingly permits any other person not a Member of the Plan to obtain Covered Services from or through the Plan, MHP will report such actions to MDCH for appropriate action. The theft or wrongful use, delivery or circulation of a Member's identification card may constitute a felony under Michigan law.

By enrolling in this Certificate, each Member agrees to be bound by the rules and policies of the Plan described in this Certificate. Each Member agrees that to be a benefit under this Certificate, all health care services must be provided or authorized by MHP except for Emergency Health Services.

## 8.4 Your Rights and Responsibilities

We are committed to providing quality health care to you and your family. A Member of the Plan, has certain rights and responsibilities regarding his/her health care.

### Member has a right to:

- Be treated with respect, dignity, and privacy.
- Have medical care that meets your health needs.
- Receive information about MHP, its services, its doctors (practitioners and providers).
- A list of MHP providers.
- Work with doctors in decision making about your health care.
- Understand how to use MHP health care services.
- Choose a Primary Care Provider.
- Change your Primary Care Provider.
- Ask their doctor about their health problems, and what they can do to help yourself.
- Discuss all treatment options with their doctor. This means an open and honest talk about the right or medically required treatment options for your illness, regardless of cost or benefit coverage.
- Decide what type of care you would want if critically ill. This decision is called an “Advance Directive.” For example, if a member is hurt and needs a machine to keep him/her alive, he/she has a right to decide if he/she wants this treatment. It is important for you to know how you want to be treated if this happens to you.
- Receive medical care through a Federally Qualified Health Center
- Give his/her permission or say no when a doctor wants to give treatment, unless it is a life-threatening emergency. (A legal guardian must give permission to treat someone who is under 18 years old, unless it is a life-threatening emergency and the guardian is not available.)
- Ask for an opinion from another doctor when Member is not sure about the treatment or surgery his/her doctor suggests.
- Read his/her medical records. All information in the medical record is confidential and is kept private. Member must call his/her doctor to see your record.
- Get timely service from the Customer Service department.
- Voice complaints or appeals about MHP or the care MHP provides.
- Call or visit the Customer Service department to file an oral or a written grievance.
- Appeal a decision MHP has made about member’s grievance.

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25"

- Have his/her grievance reviewed by the State Office of Financial and Insurance Regulation if he/she is unhappy with the decision made by MHP.
- Have these rights and responsibilities explained to him/her if they have any questions.
- Receive information about, and suggest changes to MHP's rights and responsibilities policy.
- Expect MHP, its staff and its Affiliated Providers to comply with Member rights.
- Receive a hard copy of information contained on the web site.

**Member has a responsibility to:**

- Practice good health habits.
- Learn how MHP works.
- Follow MHP's rules for getting health care services.
- Pick a Primary Care Provider.
- Show his/her MHP and MIHealth cards when they need care.
- Make sure no one else uses their MHP and MIHealth cards.
- Treat other members, MHP staff, and providers with respect.
- Tell their PCP about their medical history. This will help him or her give better care to them and their family.
- Give correct, honest answers to their health care provider's questions, and on all forms you are required to complete. Providers need this information to make sure the member gets the health care they need.
- Understand his/her health problems and develop treatment goals with his/her doctor.
- Follow instructions that the health care provider gives them. That is how he/she gets well quickly.
- Keep scheduled appointments. Arrive on time. If he/she cannot keep their appointment, call the doctor as soon as possible.
- Report any suspected Fraud and Abuse.
- Know what to do when their PCP's office is closed.
- Contact MICHild and MHP to report changes in the following information: address and phone number and family size, and MICHild status.

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25"

## 8.5 Refusal to Accept Treatment

Member understands that providers are responsible for determining treatment appropriate to the Member's care. A Member, however, may refuse procedures recommended by a provider. If refusal of recommended procedure is related to lack of agreement between

the provider and patient and creates a barrier to the delivery of proper health care, MHP may assist the Member in changing the Primary Care Physician. If the Member refuses to accept recommended treatment or procedures and no alternatives exist, the Member shall be so advised. If the Member still refuses the recommended care, MHP may request disenrollment from the Plan, subject to the approval of MDCH.

## 8.6 Entire Contract

This Certificate constitutes the entire understanding between MHP and Members, and, as of the effective date of coverage, supersedes all other like agreements. This Certificate may be amended only in writing as authorized by MHP in accordance with applicable law.

## APPENDIX I SCHEDULE OF COVERED SERVICES

The Covered Services described in this Appendix I are consistent with the Michigan MICHild program and the Service Agreement. Except for Emergency Health Services and as otherwise provided below, coverage under this Certificate is only available for those Covered Services authorized in advance by the Member's PCP and/or MHP in accordance with all MHP policies and procedures. Only services that are Medically Necessary according to generally accepted standards of practice as determined by an MHP Medical Director are Covered Services under this Certificate.

Subject to the Schedule of Limitations and Exclusions set forth in Appendix II, Covered Services include, but are not limited to the following:

1. **Second Surgical Opinion** consultations are covered when recommended by a physician or desired by the enrolled child or child's representative.
2. **Home Health Care** is covered up to 120 days per calendar year for services provided through a Medicare-certified home health agency when:
  - The Member is confined to home,
  - The Member's physician orders home health care, and
  - The Member's physician prepares a treatment plan.

Home health care visits do not reduce the available benefit for hospital days.

### Covered home health care benefits include the following:

- Nursing care by a Registered Nurse (RN), or a Licensed Practical Nurse (LPN) if the services of an RN are not available,

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25"

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25"

- Home health aide services, such as meal preparation, bathing and feeding (with a 4 hour visit being defined as a “day”),
- Nutritional guidance and social services,
- Physical, speech and occupational therapy
- Wound care, including medical and surgical supplies.
- Oxygen, laboratory services, and drugs

3. **Hospice Care** is covered when all of the following conditions are met:

A physician certifies that the Member is terminally ill (that is, the Member has been diagnosed as having six months or less to live),

The Member/Member’s representative chooses to receive care from a Hospice instead of standard benefits for the terminal illness, and

Care is provided by a certified hospice program

The Contract will cover up to 210 days--two periods of 90 days each, and one period of 30 days--during the patient's lifetime.

**Covered hospice care benefits include the following:**

- Nursing care by, or under the supervision of, a Registered Nurse,
- Home health aide and homemaker services,
- Short-term inpatient care
- Medical supplies and drugs,
- Medical social services (including needs assessment, psychological and dietary counseling), and
- Bereavement counseling for the family for up to 30 days following the patient's death
- Physical, speech, occupational therapy.

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25"

4. **Inpatient Hospital** admissions are covered up to 365 days per benefit year including the following services and supplies:

- General medical care days,
- Semi-private rooms and intensive care units,
- Meals and special diets,
- General nursing services,
- Use of operating and other treatment rooms,
- Use of delivery room and birthing center services,
- Anesthesia when administered by an employee or agent of the Hospital,
- Laboratory and pathology examinations,
- Chemotherapy for the treatment of malignant and non malignant disease,
- Oxygen and other gas therapy,

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25"

- Drugs, biologicals, and solutions,
- Diagnostic and therapeutic x-rays, EKGs, cobalt, isotopes, radiation therapy, CAT, MRI, MRA, and PET scans,
- Routine nursery care of the newborn when the mother is eligible for maternity care,
- Dental surgery, including removal of impacted teeth or multiple extractions, and related anesthesia and facility expenses in a Hospital only when a concurrent hazardous health condition, diagnosed by a physician, exists,
- Cosmetic surgery or reconstructive surgery only for the correction of birth defects, conditions resulting from accidental injuries, deformities resulting from certain surgeries, such as breast reconstruction following mastectomies (cosmetic surgery that is not reconstructive in nature and is performed solely to improve appearance is not covered), and
- Hospital-billed ambulance service

5. **Outpatient Hospital** is covered for the following services:

- Emergency room services for accidental injuries treated within 48 hours of the injury,
- Emergency room services for an illness or disease if the condition is life-threatening (emergency room services are covered for emergencies only),
- Surgery,
- Hemodialysis,
- Chemotherapy,
- Diagnostic laboratory, x-ray, and EKG services, cobalt, isotopes, radiation therapy, CAT, MRI, MRA, and PET scans,
- Preadmission testing within 72 hours of inpatient admission,
- Termination of pregnancy when determined Medically Necessary to save the life of the mother, or in cases of rape and/or incest, and
- Special Hospital programs including hemophilia services and hemodialysis services.

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25"

6. **Emergency Health Services**, as well as medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act, are covered. Heart attacks, hemorrhaging, poisonings, loss of consciousness or respiration, trauma and convulsions are some examples of medical conditions that would require Emergency Health Services. Transportation for all Emergency Health Services, as well as all Medically Necessary and appropriate transportation, is covered by the Plan.

MHP ensures that Emergency Health Services are available 24 hours a day and 7 days a week. MHP is responsible for payment of all out-of-plan or out-of-area Emergency Health Services and medical screening and stabilization services provided in an

emergency department of a Hospital consistent with the legal obligation of the emergency department to provide such services. Emergency Health Services are covered without prior authorization when Medically Necessary. MHP will not be responsible for paying for non-emergency treatment services that are not authorized by MHP.

MHP provides professional services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard. MHP acknowledges that Hospitals that offer Emergency Health Services are required to perform a medical screening examination on emergency room clients leading to a clinical determination by the examining physician that an emergency medical condition does or does not exist. MHP further acknowledges that if an emergency medical condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the enrollee.

MHP ensures that Emergency Health Services continue until the Member is stabilized and can be safely discharged or transferred. If a Member requires hospitalization or other health care services that arise out of the screening assessment provided by the emergency department, then MHP may require prior authorization for such services. However, such services shall be deemed prior authorized if MHP cannot be contacted for authorization or if MHP does not respond within one hour to a request for authorization being made by the emergency department.

**Follow-up services necessary for the continued treatment of an Emergency Health Service must be coordinated by the Member's PCP.**

7. **Pediatric Well Child Care** is covered for the following services:

- Physician office visits for well baby care from a child's birth to age 24 months,
- Physician office visits for physician examinations for a child 24 months to age 19 years,
- Immunizations from a child's birth to age 19 per AICP/AAP guidelines
- Blood lead screening in accordance with the protocols recommended by the American Academy of Pediatrics and the Centers for Disease Control.
- Children (under 18 years old) may see any MHP participating Pediatrician for well child visits with no referral.
- MHP shall provide or arrange for outreach services to Members who are due or overdue for well-child visits. Outreach contacts may be by phone, home visit, or mail.

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

8. **Skilled Nursing Facility** benefits are covered up to 120 days per admission for skilled care in a skilled nursing facility including:

- Semi-private room,
- Meals and special diets,
- Nursing services,
- Use of special treatment rooms, x-ray, and laboratory examinations,
- Physical, speech, and occupational therapy,

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

- Oxygen and other gas therapy,
- Drugs, biologicals, and solutions, and
- Materials used in wound care dressings and casts

After all benefit days have been exhausted, they are renewed when there has been a lapse of at least 90 days from discharge date until the next admission date.

9. **Physician and Other Professional Provider Services and Medical/Surgical Supplies and Services** including the following:

- Physicians' charges for office, nursing home, and clinic visits and consultations for the diagnosis or treatment of an injury, illness, or disease,
- Surgery,
- Blood and blood storage when the Member donates in preparation for scheduled surgery,
- Cataract surgery and first intraocular lens implant(s),
- Technical surgical assistance when an intern, resident, or house officer is not available or qualified,
- Inpatient and outpatient medical care,
- Anesthesia and oxygen,
- Treatment of accidental injuries if treated within 48 hours of injury,
- Emergency medical treatment,
- Family planning services,
- Termination of pregnancy when determined Medically Necessary to save the life of the mother, or in cases of rape and/or incest,
- Inpatient consultations and outpatient consultations,
- Diagnostic and therapeutic EKG, x-ray, radium, isotope and radiation therapy,
- Diagnostic laboratory and x-ray examinations including CAT, MRI, MRA, and PET scans,
- Allergy testing,
- Allergy extract and extract injection,
- Dermatology,
- Hemodialysis,
- Chemotherapy and Antineoplastic drugs
- Professional ambulance service for a trip to or from the Hospital, skilled nursing facility, or home,
- Private duty skilled care nursing charges, except such care if provided by a person who ordinarily resides in your home or who is a member of your family or the family of your spouse,
- Papanicolaou (PAP) test once every 12 consecutive months,
- Physical, occupational, and speech therapy,
- Prenatal and postnatal care visits,
- Contraceptive devices requiring a prescription or physician insertion/removal,
- First contact lens obtained within one year of cataract surgery,
- Chelation therapy for certain diagnosis,

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5"

- Eye and ear examinations for the diagnosis of an illness or injury,
- Pain management,
- Hypodermic syringes or needles prescribed by an attending physician, and
- Blood lead testing.
- Breast Cancer screening and treatment
- MHP has “open access” policy for women seeking ON/GYN care from MHP’s network providers.
- Nurse Midwife services are available in MHP’s network.
- Oxygen, laboratory services, and drug prescribed by an attending physician(s),

10. **Chiropractic Care** benefits are as follows:

- Manipulations,
- An initial office examination,
- X-rays relating to back and spine once per year
- First aid treatment of musculoskeletal injury, and
- 24 visits per calendar year

11. **Acupuncture Therapy** treatments are covered up to a maximum of twenty (20) in a calendar year when performed by (not just under the direction of) a physician (M.D. or D.O.) for the treatment of any one of the following illnesses:

- Sciatica
- Neuritis
- Post herpetic neuralgia
- Tic douloureux
- Chronic headaches, e.g., migraine
- Osteoarthritis
- Rheumatoid arthritis
- Myofascial complaints, e.g., neck and lower back

12. **Therapeutic Services** are covered at home or in an outpatient setting to restore or improve a functional loss caused by injury, illness, disease or congenital anomaly. The following therapies are limited to a combined maximum of sixty (60) visits per calendar year:

- Physical therapy,
- Speech therapy, and
- Occupational therapy.

13. **Durable Medical Equipment** is covered on a rental or purchase basis when:

- It is reasonably and Medically Necessary for the treatment of illness, injury or disease, prescribed by a physician, used in the course of

medical treatment, and obtained from a professional supplier approved by MHP.

- Repair of purchased durable medical equipment is covered due to normal wear and tear.
- Replacement of purchased durable medical equipment is covered due to the following:
  - The loss or irreparable damage of equipment
  - A change in patient's condition or size
  - Medical and surgical supplies, such as catheters, colostomy supplies, and hypodermic needles

14. **Prosthetic and Orthotic Appliances** are covered when prescribed by a physician as Medically Necessary. Prosthetics are defined as artificial and/or mechanical appliances (such as arms, legs, eyes, etc.) that replace all or part of the functions of a permanently inoperative or real functioning body organ. Orthotics are defined as appliances that support or straighten a deformed body part. Coverage includes:

- Prosthetic and orthotic appliances that are pre-fabricated or custom-fitted,
- The repair, fitting, and/or adjustment of a covered prosthetic or orthotic appliance,
- The replacement of appliances when they are damaged beyond repair or worn out, or because of a change in the child's condition or size, and
- Orthopedic shoe inserts are covered when prescribed by a physician.
- Prosthetic for mastectomy

15. **Organ and Tissue Transplants** are covered including the Hospital and professional medical services required to receive a non experimental transplant of a human organ or body tissue as defined by, and according to, established utilization guidelines used by the Plan. Transplants of artificial organs are not covered. MICHild will pay for the Covered Services for donors if the donor does not have transplant benefits under any other health care plan. The total payment for all services combined for each specified organ transplant type is limited to a one million dollar (\$1,000,000) lifetime maximum.

16. **Hearing Care** is covered for the following services and supplies payable once in every 36 consecutive months:

- Audiometric examination to measure hearing ability, including tests for air conduction, bone conduction, speech reception, and speech discrimination,
- Hearing aid evaluation tests to determine what type of hearing aid(s) should be prescribed to compensate for loss of hearing,
- Hearing aids including in-the-ear, behind-the-ear, and on-the-body designs, and binaural aids purchased together,
- Dispensing fees for the normal services required in the fitting of a hearing aid, and
- Hearing aid conformity tests to evaluate the performance of a hearing aid and its conformity to the original prescription after the aid has been fitted.

Hearing care benefits are not payable for hearing aid repairs or for the replacement of parts (including batteries and ear molds). Benefits are also not payable for the replacement of lost or broken hearing aids unless the 36 month coverage limitation does not apply.

17. **Vision Care** is covered for the following services:

- Annual vision exam,
- Annual glaucoma testing,
- Eye glasses once every 24 months or once every 12 months with a prescription change, and
- Contact lenses when Medically Necessary or therapeutic, to correct visual impairment when glasses are insufficient to correct a visual impairment

18. **Pharmacy** is covered for each prescription drug or refill purchased up to a 34-day supply. Certain medications can be covered in a 100 unit dosage or 34-day supply (whichever is greater) or a 200 unit dosage or 34-day supply (whichever is greater).

Prescriptions are to be filled with a generic medication unless the prescribing physician has indicated “dispense as written” (DAW) on the prescription.

Benefits cover the following:

- A drug, biological, or compounded medication which, by federal law, may be dispensed only by prescription and is required to be labeled “Caution: Federal Law Prohibits Dispensing without a Prescription”,
- Injectable insulin, needles and syringes,
- Hypodermic syringes or needles prescribed by an attending physician,
- Birth control prescriptions, and
- Covered prescriptions written by a participating MICHild provider.
- Off-label drugs are available with prior authorization

19. **Diabetes Patient Education:**

Diabetes patient education when ordered by the PCP and provided by diabetes educators (e.g. nurse, dietitian) in a certified outpatient hospital or a Michigan Department of Public Health – certified public health department or public funded clinic (as defined by the Michigan Department of Public Health or under Section 330 or 329 of the Public Health Services Act.) Only one diabetes patient education training program will be covered in a six month period.

20. **Diabetic Supplies and equipment**

- Blood glucose monitors and blood glucose monitors for the legally blind
- Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
- Syringes
- Insulin pumps and medical supplies required for the use of an insulin pump
- Diabetes self management training to ensure that persons with diabetes are trained as to the proper self management and treatment of their diabetic condition.

21. **Weight Loss Clinic** counseling is covered for morbid obesity when prescribed by a physician.

22. **Ambulance Services** are covered as follows:

- Hospital-billed ambulance service for a trip to or from the Hospital, a skilled nursing facility, or Member's home, and
- Professional ambulance service when used to transport the Member from the place where injured or emergency occurred to the first Member where treatment is given.

23. **Dental Work** and/or **Oral Surgery**, limited to the following:

- The excision of teeth partly or completely impacted in the bone of the jaw,
- The excision of teeth that will not erupt through the gum,
- The excision of other teeth that cannot be removed without cutting into bone,
- The excision of a tooth root without extracting the entire tooth, but not including root canal therapy,
- The treatment of a jaw fracture, dislocation, or wound,

- The treatment of cysts, tumors, or other disease tissues,
- Apicoectomy,
- Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction,
- The alteration of the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement, and
- Charges for dental services, office consultations and appliance therapy related to the above procedures.

24. **Out of Network – Out of Area Services.** If Medically Necessary, MHP may authorize services either out-of-network or out-of-area. Unless otherwise noted in this Certificate, MHP is responsible for coverage and payment of all Emergency Health Services and authorized Covered Services provided outside of the established network

If services are rendered to a Member by a provider who does not participate in the Plan, MHP may deny payment if the Plan's authorization requirements are not followed for non-emergent services. Plan's authorization requirements are listed on MHP MICHild's web site of [www.midwesthealthplan.com](http://www.midwesthealthplan.com).

25. **Enhanced Services.** In conjunction with the provision of Covered Services, MHP places strong emphasis on programs to enhance the general health and well-being of Members. MHP has health promotion programs and health education classes available to Members. For persons with, or at risk for, a specific disability, the Network Providers and staff are available to provide education to the Member, Member's family, and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities.
26. **Indian and Adolescent Health Centers.** MHP will cover Covered Services rendered at Indian and Adolescent Health Centers as required by the MICHild program.

## Appendix II Schedule of Exclusions and Limitations

Coverage for services and products not specifically listed in this Certificate are not Covered Services, including, but not limited to:

- Medical, surgical, Hospital, and related services (except for Emergency Health Services) obtained by a Member from providers other than Affiliated Providers, are not covered unless they are authorized in writing by the Plan's Medical Director before the services are rendered, unless otherwise stated in this Certificate.

- Services which are not Medically Necessary are not covered. The final determination of medical necessity is made by the Plan's Medical Director.
- Services ordered by a court of competent jurisdiction are not covered, unless they are otherwise Covered Services.
- Services provided during police (county or state) custody are not covered, unless they are otherwise Covered Services.
- Surgery and other services for cosmetic purposes, consistent with MICHild's policies and procedures, are not covered.
- Medical, surgical, and other health care procedures deemed to be experimental (including research studies) consistent with MICHild's policies and procedures are not covered.
- Services of private duty nurses are not covered unless they are authorized by the Plan's Medical Director before services are rendered, or unless otherwise stated in this Certificate.
- Personal care services to provide assistance with daily living activities are not Covered Services, unless otherwise stated in the Certificate. Examples of personal care include assistance in bathing, dressing, eating, walking, getting in and out of bed and taking medicine,.
- General housekeeping services and personal convenience items, including, but not limited to, television and telephone services, are not covered.
- Reversal of voluntary, surgically induced sterilization is not covered.
- Hospital, medical and surgical services for the primary purpose of sex transformation are not covered.
- Services for treatment of infertility are not covered.
- MICHild funds cannot be used to pay for elective abortions (and related services) to terminate pregnancy. Limited exceptions apply when a physician certifies that the abortion is Medically Necessary to save the life of the mother within the limits of the law. Elective abortions are also covered if the pregnancy is a result of rape or incest within the limits of the law. Treatment for medical complications occurring as a result of an elective abortion are covered. Treatment for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies are covered
- Dental services, except as listed under Section 21 of Appendix I.

- Services provided by a school district and billed through the Intermediate School District.
- Mental Health Services are covered benefit via local Community Mental Health agencies. Call the local community mental health agency, MICHild, or MHP for information or assistance in finding a provider.
- Substance abuse services are not covered by MHP, but are covered by accredited providers including: (i) Screening and assessment, (ii) Detoxification, (iii) Intensive outpatient counseling and other outpatient services, and (iv) Methadone treatment. Call the local coordinating agency, MICHild or MHP for information or assistance in finding a provider.

18. The following pharmacy drugs are not covered benefits:

- Any drug entirely consumed at the time and place it is prescribed
- The administration or injection of any drug
- Any refill of a drug if it is more than the number of refills specified by the prescription
- Any refill of a drug dispensed more than one year after the latest prescription for that drug
- Any drug that is provided while the Enrollee is an inpatient in a facility
- Any drug provided on an outpatient basis in any facility if benefits are paid under any other part of the plan
- Over-the-counter drugs available without a prescription

