HAP MIDWEST HEALTH PLAN

Certificate of Coverage
Medicaid
Healthy Michigan Plan
CSHCS

HAP Midwest Health Plan, Inc.
(A Health Maintenance Organization)
21700 Northwestern Hwy.
Southfield MI 48075
(888) 654-2200

DIFS Approved 6.22.2018

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WE WANT TO BE SURE YOU ARE HAPPY WITH HAP MIDWEST HEALTH PLAN

HAP Midwest Health Plan ("HAP MHP") cares about its Members and wants to know what they like and don't like about its services. Also, HAP MHP wants feedback about the information it sends its Members and how it can better serve its Member's needs. Please let HAP MHP know how it can better serve its Members by calling Customer Services at (888)-654-2200.

HAP MHP is a Health Maintenance Organization. "HAP MHP" will be used to refer to HAP Midwest Health Plan. HAP MHP is accredited by the National Committee on Quality Assurance. HAP MHP has a contract with the Michigan Department of Health and Human Services ("MDHHS") to provide health care services to Michigan Medicaid members. The eligibility for, and Covered Services provided under, the HAP MHP Benefit Plan are funded by MDHHS. They are governed by the terms and conditions of the Medicaid program, and may be changed. HAP MHP is a contractor with MDHHS and can provide Covered Services only to eligible Medicaid members while it remains a contractor. "The Plan" will be used to refer to benefit plan(s) administered and offered for sale by HAP MHP.

This Certificate of Coverage ("Certificate") describes HAP 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 (ID) ("Effective Date") and it is the Member's responsibility to understand the terms and conditions of this Certificate. Of course, HAP MHP's Customer Service Department is available to answer Member questions regarding this Certificate and the Covered Services provided. The Certificate of Coverage is also located on our website www.hap.org/midwest and available as a hard copy upon request.

HAP 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 Medicaid program as a contractor with MDHHS. If the Plan or a Member's eligibility ends, only claims incurred before the date of termination will be paid through HAP MHP. HAP MHP will coordinate care and pay for the care of members whose eligibility ends while inpatient.

HAP MHP's Customer Services staff is available to answer questions and assist Members in getting services under the Plan. Customer Service staff can be contacted by calling toll-free at (888) 654-2200. Members can contact the MDHHS Medicaid program at (800) 642-3195**.**

SECTION I. DEFINITION OF TERMS

1.1 **"Abuse"** means provider or member practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to HAP MHP or the Medicaid program. This includes reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

1.2 **"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.

1.3 **"Administrative Contractor"** means the qualified contractor providing MDHHS with administrative support for the Medicaid program.

1.4 **"Affiliated Physician"** means an individual licensed to practice medicine or osteopathy (MD or DO) and who has a contract with HAP MHP or an Individual Practice Association (IPA) to provide services to Members.

1.5 **"Affiliated Provider"** means a health professional, a Hospital, licensed pharmacy, or any other institution, organization, or person who has a contract with HAP MHP or an Individual Practice Association (IPA) to render one or more health maintenance services to Members.

1.6 **"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.

1.7 **"Covered Services"** means all services provided under the Plan, in Appendix I of this Certificate, which HAP MHP has agreed to provide or arrange to be provided under the terms of the Service Agreement.

1.8 **"CMHSP"** means Community Mental Health Services Program.

1.9 **"CHSCS"** means Children's Special Health Care Services.

1.10 **"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. This includes pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

1.11 **"Enrollee"** means an Eligible Member enrolled with a Medicaid Contractor.

1.12 **"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.

1.13 **"FQHC"** means Federally Qualified Health Centers

1.14 **"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).

1.15 **"Grievance"** means **a**n expression of dissatisfaction with the manner in which a health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken.

1.16 **"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.

1.17 **"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.

1.18 **"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.

1.19 **"ID card"** shall have the meaning set forth in Section 5.1.

1.20 **"Medically Necessary"** means services and supplies furnished to a Member when and to the extent HAP MHP's 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;
- 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 certain services to the Member does not mean that such services satisfy the above criteria.

1.21 **"MDHHS"** means the Michigan Department of Health and Human Services.

1.22 **"Medical Director"** is a Michigan licensed physician designated by HAP MHP to provide medical management and related services on behalf of HAP MHP. As used in this Certificate, the term shall include any individual designated by the Medical Director to act on his or her behalf.

1.23 **"Member"** means an individual enrolled in Medicaid and entitled to receive Covered Services under this Certificate.

1.24 **"HAP MHP"** means HAP Midwest Health Plan.

1.25 **"Network Providers"** means those providers contracted with HAP MHP that are responsible for providing health care for Members.

1.26 **"Plan"** means the benefit plan(s) offered by Midwest Health Plan.

1.27 **"Primary Care Provider"** or **"Primary Care Physician"** or **"PCP(s)"** means those providers within HAP MHP who are responsible for providing, or arranging for the provision of, health care for Members. A PCP may be any of the following:

- Family practice physician,
- General practice physician,
- Internal medicine physician,
- OB/GYN specialist or
- Pediatric physician

Other physician specialists may be designated as PCP when appropriate for a Member's health condition.

1.28 **"Service Agreement"** is the contract between HAP MHP and MDHHS that establishes the scope of Covered Services being purchased, the criteria for eligibility, as well as the underwriting and administrative agreements between HAP MHP and MDHHS.

1.29 **"Service Area"** means the geographic area in which HAP MHP is authorized to provide the Plan's health care services to Members.

SECTION II. ELIGIBILITY AND ENROLLMENT

2.1 Eligibility Criteria

To be eligible to enroll in HAP MHP, a person must:

- Be eligible for Medicaid as determined by MDHHS; and
- Reside within the HAP MHP's Service Area.

In all cases, MDHHS makes the final decision regarding an individual's eligibility for Medicaid.

2.2 Enrollment

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

SECTION III. DISENROLLMENT

3.1 Disenrollment Generally

It is the MDHHS's responsibility to disenroll a Member from a plan. HAP MHP is responsible for the Member's medical care until the MDHHS notifies HAP MHP that its

responsibility to the Member has ended. Disenrollment will occur consistent with the rules and regulations of MDHHS.

3.2 Disenrollment by Member

If a Member wants to disenroll from HAP MHP the Member must follow the procedures issued by MDHHS. Disenrollment information is available upon request from MDHHS.

3.3 Member Moves from Service Area

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

3.4 Termination of Service Agreement

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

3.5 Non-Eligibility by Member

A Member will be disenrolled from HAP MHP if MDHHS or its MDHHS determines the Member is not eligible for Medicaid.

3.6 Disenrollment by Plan

With the consent of MDHHS, HAP MHP may request disenrollment of any Member from HAP MHP due to improper actions on the part of the Member/parent/guardian that are inconsistent with HAP MHP membership, including, without limitation, Fraud, Abuse of the Plan, or other intentional misconduct, or if, in the opinion of HAP 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.

3.7 Effective Date of Disenrollment

HAP 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 HAP 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, HAP MHP shall be responsible for all covered inpatient hospital-related charges incurred until the date of discharge.

SECTION IV. FORMS, ID CARDS, RECORDS

4.1 Forms and Questionnaires

Members shall complete and submit to HAP 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 ID cards

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

4.2 Authorization to Receive Information

Member agrees to authorize HAP 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 HAP MHP and to permit copying of records by HAP MHP.

4.3 Confidentiality of Member's Personal Health Information

Members should refer to HAP MHP's Privacy Notice (available in the HAP MHP Member Handbook and on HAP MHP's web site at www.hap.org/midwest.) 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 V. COORDINATION OF BENEFITS AND SUBROGATION

5.1 General Provision

It is HAP 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 HAP 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.

5.2 Coordination of Benefits

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

5.3 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 HAP MHP all sums recovered by suit, settlement, or otherwise, to the extent of Covered Services provided by HAP MHP and in an amount equal to the HAP MHP payment for those Covered Services, but not in excess of monetary damages collected; or Authorize HAP 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 HAP MHP.

In the event a suit instituted by HAP MHP on behalf of the Member results in monetary damages awarded in excess of the cash value of actual Covered Services provided by HAP MHP, HAP MHP has 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 does not cooperate with HAP MHP in its filing of a claim for reimbursement, HAP MHP has the right to request disenrollment of a Member upon consent of MDHHS.

5.4 Right of Recovery

To the extent Covered Services have been provided by HAP MHP under this Certificate and the responsibility for payment is with another health plan, HAP MHP has the right to deny payment. We can also 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.

SECTION VI. GRIEVANCES AND APPEALS

6.1 General Information Concerning Grievances and Appeals

To promote Member service and satisfaction, and in accordance with the state and federal law, HAP MHP has a formal grievance and appeal procedure to address, resolve and track all Member grievances and appeals. HAP MHP maintains a system that has 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 use 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 Providers.

GRIEVANCE AND APPEAL PROCESS

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

- Grievance" means an expression of dissatisfaction with the manner in which a health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. Grievances can be taken over the phone, in writing, or in person. The Grievance Analyst 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 30 days of the date of the grievance.
- You have the right to appear before the board of director's or designated committee or the right to a managerial-level conference to present your appeal.
- You have the right to request a State Fair Hearing only after receiving notice that your pre/post service grievance and/or adverse determination has been upheld.
- You can request a State Fair Hearing within 120 days of the final adverse determination.
- Call HAP MHP at (888) 654-2200 or the State of Michigan at (800) 642-3195 to have a hearing request form sent to you. Fill out the request, and return in address on the form.

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

- The Customer Service Manager investigates all appeals.
- If you are not happy with the decision by HAP MHP, you can request an appeal.
- You can request an appeal by calling, writing or appearing in person at:

HAP Midwest Health Plan
21700 Northwestern Hwy.
Southfield MI 48075

If you are not happy with HAP MHP's decision, or HAP MHP does not respond with a decision within 30 days, you may request an external review from the Department of Insurance and Financial Services (DIFS).

APPEALS

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

- Appeals are resolved within 30 days.

- 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.
- An additional 10 calendar days are allowed to obtain medical records or other medical information if the member requests the extension, or if HAP MHP can show that the delay is in the member's interest.
- You have the right to request a State Fair Hearing only after receiving notice that your pre/post service grievance and/or adverse determination has been upheld.
- You can request a State Fair Hearing within 120 days of the final adverse determination.
- Call HAP MHP at (888) 654-2200 or (800) 645-3195 at the State of Michigan to have a hearing request form sent to you. Fill out the request, and return to the address on the form.
- If you are not happy with HAP MHP's decision, or HAP MHP does not respond with our decision within 30 days, you may request an external review from the DIFS. Your request must be in writing and sent to :

Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Or call toll free (877) 999-6442

EXPEDITED APPEAL

- If a doctor believes that the 30-day calendar day decision timeframe will cause harm to your health, HAP MHP will handle your pre service grievance as expedited.
- Expedited appeals are handled in 72 hours.
- You may file an expedited appeal with the (DIFS) at the same time.

EXTERNAL REVIEW

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

Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Fax: 517-284-8848
Online at: https://difs.state.mi.us/Complaints/ExternalReview.aspx

- You must appeal in writing to the DIFS within 127 calendar days after you receive the final decision from HAP MHP.
- You must complete the grievance/appeal process within the health plan before requesting a review from the DIFS.
- The Appeal Coordinator will explain the external review process to you. We can also mail the external review forms to you.
- The DIFS 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.

SECTION VII. GENERAL PROVISIONS

7.1 Selection of a Primary Care Physician (PCP)

Each Member has to choose a PCP under contract with HAP MHP for the Member's personal care. If a PCP is not chosen at the time of enrollment, HAP MHP will assign a PCP based on the 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 get to know their patients' medical history and health needs. They 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. Member's requiring emergency Health Services should go directly to the emergency room.

Termination of participation between PCP and the Plan

If HAP MHP ends the contract with the PCP, HAP MHP will notify the members of the contract within 30 days and help the members in choosing another PCP. If the PCP ends the contract with HAP MHP, the PCP and HAP MHP will notify the members within days and help the members in choosing a PCP.

If the member is in an ongoing treatment plan with any other provider that is participating with HAP MHP and participation ends, the physician may provide written notice of the termination to the member within 30 days after the physician becomes aware of the termination.

HAP MHP shall permit the member to continue ongoing treatment with the physician as follows:

- For 30 days from the date of notice to the insured by the physician and the physicians termination with HAP MHP.
- If the member is in her 3rd trimester of pregnancy at the time of the termination through postpartum care directly related to the pregnancy.
- If the member is determined to be terminally ill prior to a physician's termination or knowledge of the termination was treating the terminal illness before the date

of termination or knowledge of the termination, for the remainder of the members' life for care directly related to the treatment of the terminal illness.

Members that need help choosing a PCP should contact HAP MHP's Customer Service Department toll-free at (888) 654-2200.

7.2 HAP MHP's Right to Transfer a Member

If a PCP is unable, fails, neglects, or refuses to provide Covered Services, HAP MHP can transfer Members assigned to the PCP to another PCP. During such inability, failure, neglect and/or refusal to provide Covered Services, HAP 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, HAP MHP does not guarantee that transferred Members will be assigned to the former PCP in the future.

7.3 Covered Services are Solely for the Member

As a member of HAP MHP you do not have fees or copays for covered services. The Covered Services provided under this certificate are for the benefit of the Members and cannot be transferred or assigned. If any Member aids, attempts to aid or from or through HAP MHP, will report such actions to MDHHS for appropriate action. The theft or wrongful use, delivery or circulation of a Member's ID card may constitute a felony under Michigan law.

By enrolling in this Plan, 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 HAP MHP except for emergency Health Services.

7.4 Your Rights and Responsibilities

We are committed to providing quality health care to you and your family. A Member of HAP MHP 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 HAP MHP, its services, its doctors (practitioners and providers).
- A list of HAP MHP's providers.
- Work with doctors in decision making about your health care.
- Understand how to use the Plan health care services.
- Choose or change a Primary Care Provider.
- Ask your doctor about your health problems, and what you 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. (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 their record.
- Get timely service from the Customer Service department.
- Voice complaints or appeals about HAP MHP or the Plan, or the care HAP MHP provides.
- Call or visit the Customer Service department to file an oral or a written grievance.
- Appeal a decision HAP MHP has made about member's grievance.
- You have the right to request a State Fair Hearing only after receiving notice that your pre/post service grievance adverse determination has been upheld.
- Have his/her grievance reviewed by the DIFS if he/she is unhappy with the decision made by HAP MHP.
- Have these rights and responsibilities explained to him/her if they have any questions.
- Receive information about, and suggest changes to HAP MHP's rights and responsibilities policy.
- Expect HAP 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 the Plan works.

- Follow HAP MHP's rules for getting health care services.
- Pick a Primary Care Provider.
- Show his/her Plan and MIHealth cards when they need care.
- Make sure no one else uses their HAP MHP and MIHealth cards.
- Treat other members, HAP MHP's 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 your DHHS caseworker and HAP MHP to report changes in the following information: address and phone number and family size, and Medicaid status.

7.5 Refusal to Accept Treatment

Member understands that providers are responsible for determining treatment appropriate to the Member's care. A Member, however, may refuse treatment recommended by a provider. If refusal of a treatment is related to lack of agreement between the provider and patient HAP MHP may assist the Member in changing the PCP. If the Member refuses to accept treatment and no alternatives exist, the Member will be advised. If the Member still refuses the care, HAP MHP may request disenrollment, subject to the approval of MDHHS.

7.6 Entire Contract

This certificate constitutes the entire understanding between HAP 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 HAP 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 Medicaid program and the Service Agreement. Except for Health Services and as otherwise provided below, coverage under this is only available for those Covered Services authorized in advance by the Member's PCP and/or HAP MHP in accordance with all Plan policies and procedures. Only services that are Medically Necessary according to generally accepted standards of practice as determined by HAP MHP's 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. **Home Health Care** is covered up to 120 days 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.

2. **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.

3. **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 nonmalignant disease,
- Oxygen and other gas therapy,
- 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

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

- Room services for accidental injuries treated within 48 hours of the injury,

- Room services for an illness or disease if the condition is life-threatening (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.

5. **Emergency Health Services**, as well as medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act, are covered but not limited to:

- Heart attacks
- Hemorrhaging, poisonings
- Loss of consciousness or respiration
- Trauma and convulsions

These 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 HAP MHP.

HAP MHP ensures that Emergency Health Services are available 24 hours a day and 7 days a week. HAP 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 department to provide such services. Emergency Health Services are covered without prior authorization when medically necessary. HAP MHP will not be responsible for paying for non- treatment services that are not authorized by HAP MHP.

HAP 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. HAP MHP acknowledges that Hospitals that offer Emergency Health Services are required to perform a medical screening examination on room clients leading to a clinical determination by the examining physician that an emergency medical condition does or does not exist. HAP 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.

HAP MHP ensures that Emergency Health Services continue until the Member is stabilized and can be safely discharged or transferred. If a Member needs hospitalization or other health care services that arise out of the screening assessment provided by the

emergency department, then HAP MHP may require prior authorization for such services. However, services shall be deemed prior authorized if HAP MHP cannot be contacted for authorization or if HAP 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.

6. **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 ACIPAAP 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 Plan participating Pediatrician for well child visits with no referral.
- HAP 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.

7. **Skilled Nursing Facility** benefits are covered up to 45 days rolling 12 month period 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,
- Oxygen and other gas therapy,
- Drugs, biologicals, and solutions, and
- Materials used in wound care dressings and casts

The Plan covers the following services allowed by the State of Michigan. There are no co-pays for these services:

- Ambulance and other emergency medical transportation
- Breast Pumps; personal use, double-electric
- Bilateral cochlear implantation,mapping, and calibration (12months –20 years of age)
- Blood lead testing in accordance with EPSDT policy

- Case Management Services
- Certified Nurse Midwife Services
- Certified Pediatric and Family Nurse Practitoner Services
- Chiropractic services Diagnostic lab, x-ray, and other imaging services
- Durable medical equipment (DME) and supplies
- Early periodic screening, diagnosis and treatment services (EPSDT) – Well Child Care
- services
- End stage renal disease (ESRD) services
- Family planning services
- Health education and outreach
- Hearing and speech services (under 21 years of age)
- Home health care services and wound care including medical and surgical supplies
- Hospice services
- Inpatient and outpatient hospital services
- Intermittent, or short-term restorative or rehabilitative nursing care in a nursing facility up to 45 days
- Medical supplies and equipment, wheelchairs, oxygen, laboratory services and drugs
- Medically necessary weight reduction services
- Mental heath servicesOut-of-State services authorized by HAP MHP
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners Services
- Prenatal care
- Prosthetics and orthotics
- Preventive care and screenings
- Restorative or rehabilitave services in a place of service other than a nursing facility
- Services of other doctors when referred by your PCP
- Services provided by local health departments
- Speech, language, physical, and occupational therapy excluding services provided to members with development disabilities which are billed through Community Mental Health Services or Intermediate School Districts
- Transplant services
- Tobacco cessation treatment including prescriptions and support programs
- Treatment for sexual transmitted diseases (STD)
- Transportation for medically necessary covered services, meals and lodging with plan approval
- Vaccines
- Vision Services

1. **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
- 18 visits per calendar year

2. **Breast Cancer Diagnostic Services** are covered for women 35 and older and 40 years of age and under for mammography exam during that year period.

   For women 40 years of age and older, there is 1 mammography exam every calendar year.

3. **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. Physical, Speech, and Occupational therapy

4. **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 HAP 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

5. **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, due to normal wear and tear, or because of a change in the child's condition or size,
   - Orthopedic shoe inserts are covered when prescribed by a physician.
   - Prosthetic for mastectomy

6. **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 HAP MHP. Transplants of artificial organs are not covered. Medicaid will pay for the

Covered Services for donors if the donor does not have transplant benefits under any other health care plan.

7. **Hearing Care** is covered for the following services and supplies payable once in every 36 consecutive months: (under age 21 years)

    - 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).

    Unilateral and bilateral cochlear implantation and associated mapping/calibration are covered with prior authorization for beneficiaries from 12 months through 20 years of age using FDA approved implants.

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

    Ophthalmic Services

    For members under 21 years of age and older:

    Low-Vision Services

    Effective for dates of service on and after October 1, 2010, MDHHS is reinstating coverage of low-vision services. This includes: low-vision eyeglasses, contact lenses, optical devices, and other related low-vision supplies and services for Medicaid beneficiaries age 21 and older.

    Routine eye exams, eyeglasses, contact lenses and other vision supplies and services will not be covered under the Low-Vision benefit (see Examinations below). Vision services relating to eye trauma and eye disease will continue to be covered.

    A $2.00 co-pay may be required for Medicaid beneficiary's age 21 and older for:

    - Each separately reimbursable vision service performed by an optometrist.
    - Each dispensing service for glasses or contact lenses billed by a dispensing Ophthalmologist or Optometrist.

    Examinations:

For members 21 years of age and under:

When performed to determine the need for eyeglasses, one complete eye examination and refraction is covered every two years.

Any eyeglass-related examination performed within this two-year limitation must be medically necessary and appropriate. Evidence of such medical necessity includes: a two or more line reduction in visual acuity; acuity of 20/50 or less with eyeglasses; unusual medical conditions or circumstances.

Vision Hardware: All vision hardware. Specific criteria regarding diopter change must be met for the initial provision of lenses and also subsequent changes. Initial lenses are the first prescription lenses ever worn by a person regardless of how they were obtained. Initial lenses need prior authorization and are a benefit if there is a specific vision correction. These lenses are covered when there is a change in the refractive error of .75D or a change in the annual vision exam.

Eye glasses once every 24 months or once every 12 months with a prescription change. Contact lenses when Medically Necessary or therapeutic, to correct visual impairment when glasses are insufficient to correct a visual impairment.

9. **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 Plan provider.
- Off-label drugs are available with prior authorization
- Coverage for drug used in antineoplastic therapy and cost of its administration

10. 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 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.

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.

11. **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.
12. **Dental Work** and/or **Oral Surgery**, Effective July 1, 2018, members who are or become pregnant are able to access dental services during their pregnancy and postpartum period directly through their Medicaid Health Plan. Pregnant members will be able to see dentists that are contracted as part of the HAP Midwest Health Plan network. Members may also receive transportation to and from scheduled dental appointments.

    Benefits are 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.
13. **Out of Network – Out of Area Services**. If Medically Necessary, HAP MHP may authorize services either out-of-network or out-of-area. Unless otherwise noted in this

certificate, HAP 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, HAP MHP, payment may be denied. HAP MHP's authorization requirements are not followed for non-emergent services. HAP MHP's authorization requirements are listed on HAP MHP's web site at www.hap.org/midwest.

14. **Enhanced Services.** HAP MHP places strong emphasis on programs to enhance the general health and well-being of Members. HAP 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.

APPENDIX II – COVERED SERVICES FOR CSHCS

Childrens Special Health Care Services Program (CSHCS)
CSHCS is a program that services children, and some adults, with special health care needs. The covered services provided to HMP Enrollees under this Contract include all of those listed above and the following serivces:

Additional Benefits for Medicaid Health Plan Enrollees CSHCS members

- Health Plan special consideration and flexibility for transportation, meals and lodging needs
- Help from your Local Health Department for: Community resources- schools, community mental health, respite care, financial support, childcare, Early On, and the WIC program

Help from the Family Center for Children and Youth with Special Health Care Needs

- CSHCS Family Phone Line (800) 359-3722, a toll free phone number available Monday through Friday from 8:00 am to 5:00 pm.
- Parent to parent support network
- Parent/Professional training programs
- Financial help to go to conference about CSHCS medical conditions and "Relatively Speaking" a conference for siblings of children with special needs

Help from the Children's Special Needs Fund (CSN)
The CSN fund helps CSHCS families get items not covered by Medicaid or CSHCS. Examples include:

- Wheelchair ramps
- Van lifts and tie downs
- Theraputic tricycles
- Air conditioners

- Adaptive recreational equipment
- Electrical service upgrades for eligible equipment

APPENDIX III – COVERED SERVICES FOR HMP MEMBERS

Healthy Michigan Plan (HMP) Additional Benefits
The covered services provided to HMP Enrollees under this Contract include all those listed above and the following serivces:
a. Habilitative services (Service that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech, language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
b. Dental Services
c. Hearing aids for persons age 21 and over

Appendix IIII - Schedule of Exclusions and Limitations

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

    - Medical, surgical, Hospital, and related services (except for Health Services) obtained by a Member from providers other than Affiliated Providers, are not covered unless they are authorized in writing by HAP MHP's Medical Director before the services are rendered, unless otherwise stated in this .
    - Services which are not Medically Necessary are not covered. The final determination of medical necessity is made by HAP MHP'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 Medicaid policies and procedures, are not covered.
    - Medical, surgical, and other health care procedures deemed to be experimental (including research studies) consistent with Medicaid policies and procedures are not covered.
    - Services of private duty nurses are not covered unless they are authorized by HAP MHP'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 . 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.
- Services for treatment of infertility are not covered.
- Medicaid 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 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, Medicaid, or HAP MHP for information or assistance in finding a provider.
- Substance abuse services are not covered by HAP 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, Medicaid or HAP MHP for information or assistance in finding a provider.
- Hospital, medical and surgical services for the primary purpose of sex transformation are not covered

2. 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