HAP EMPOWERED

A Medicaid health plan offered by HAP Empowered Health Plan, Inc.

Certificate of Coverage
Medicaid
Healthy Michigan Plan
CSHCS

DIFS Approved: June 21, 2023

HAP Empowered Health Plan, Inc.
(A Health Maintenance Organization)
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Medicaid Certificate of Coverage

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HAP EMPOWERED HEALTH PLAN

MEDICAID CERTIFICATE OF COVERAGE

This Certificate of Coverage is given to you who have enrolled in HAP EMPOWERED a Medicaid program offered by HAP Empowered Health Plan Inc. This Certificate only covers Medically Necessary services or supplies that are provided while you are a Member. It replaces any Certificate that have been given to you in the past. This Certificate follows the laws of the state of Michigan. No person has any authority to waive any Agreement provision or to make any changes to this Agreement unless approved in writing by an officer of the HAP Empowered Health Plan Inc.

"MDHHS" will be used to refer to the Michigan Department of Health and Human Services. The terms "we", "us", "our", "PLAN" or "THE PLAN" refer to HAP, HAP EMPOWERED and HAP EMPOWERED HEALTH PLAN INC. The terms "you", "your" or "yourself" refer to the Member.

Please read this entire Certificate carefully as it details the benefits and responsibilities of Members. By following this Certificate, you agree to follow by the rules of THE PLAN as described in this Certificate. It is your responsibility to understand the terms and conditions of this Certificate. This Certificate of Coverage states the terms of THE PLAN for which you, a Medicaid recipient may receive THE PLAN health benefits, and the limitations. Your rights to receive benefits and services are personal, allowed only to you, and may not be given to anyone else. THE PLAN may accept any needed changes to help the supervision of this Certificate.

The groups of Medicaid-eligible persons who may sign up for HMOs are determined by MDHHS. THE PLAN is required to follow the eligibility decision made by MDHHS.

THE PLAN's Customer Service is here to answer your questions. Services provided at (888) 654-2200. The Certificate of Coverage is also located on our website www.hap.org/medicaid. It is also available as a hard copy upon request. We welcome your feedback on how THE PLAN may better serve your health care needs. You are a valued member of THE PLAN family.

SECTION I. DEFINITION OF TERMS

I.1 **"Abuse"** means provider or member practices that are inconsistent with standard accepted fiscal, business, or medical practices, and result in an unnecessary cost to THE PLAN. This includes reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

I.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.

I.3 **"Administrative Contractor"** means the qualified contractor providing MDHHS with administrative support for THE PLAN Medicaid program.

I.4 **"Physician"** means an individual licensed to practice medicine or osteopathy (MD or DO) and who has a contract with THE PLAN or an Individual Practice Association (IPA) to provide services to Members.

I.5 **"Provider"** means a health professional, a Hospital, licensed pharmacy, or any other institution, organization, or person who has a contract with THE PLAN or an Individual Practice Association (IPA) to render one or more health maintenance services to Members.

I.6 **"Appeal"** means a request for review of the plan'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 the plan to act within the established timeframes for grievance and appeal disposition.

I.7 **"Covered Services"** means the health care services THE PLAN has agreed to provide under the Michigan Medicaid program and the terms of the Service Agreement as described in this Certificate of Coverage.

I.8 **"CMHSP"** means Community Mental Health Services Program.

I.9 **"Common Formulary"** means the list of drugs, including drugs on the Single Preferred Drug list, that are covered by THE PLAN.

I.10 **"CSHCS"** means Children's Special Health Care Services.

I.11 **"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.

I.12 **"Enrollee"** ENROLLEE is an individual determined by MDHHS to be entitled to receive health care services under this Certificate of Coverage.

I.13 **"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.

I.14 **"Experimental or Investigational Treatment"** means drugs, biological agents, procedures, devices or equipment determined by the MDHHS, that have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used.

I.15 **"FQHC"** means Federally Qualified Health Centers.

I.16 **"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).

I.17 **"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.

I.18 **"HAP EMPOWERED"** means the Medicaid health plan offered by HAP MHP.

I.19 **"HAP MHP"** means HAP Empowered Health Plan.

I.20 **"HMO"** means an entity that has received and maintains a State certificate of authority to operate as a Health Maintenance Organization as required by MCL 500.3509.

I.21 **"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.

I.22 **"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.

I.23 **"ID card"** shall have the meaning set forth in Section 5.1.

I.24 **"Medically Necessary"** means services and supplies furnished to a Member when and to the extent THE PLAN'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.

I.25 **"MDHHS"** means the Michigan Department of Health and Human Services.

I.26 **"Medical Director"** is a Michigan licensed physician designated by THE PLAN to provide medical management and related services for the 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.

I.27 **"Member"** means an individual enrolled in Medicaid and entitled to receive benefits under this Certificate.

I.28 **"Michigan Pharmaceutical Product List"** or the MPPL is a list of drugs established by the State of Michigan for Fee-for-Service (FFS) Medicaid). THE PLAN must consider this list when reviewing requests for coverage.

I.29 **"Network Providers"** means those providers contracted with THE PLAN that are responsible for providing health care for Members.

I.30 **"The Plan"** means the Medicaid benefit plan offered by HMP and HAP EMPOWERED.

I.31 **"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 including:

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

A physician specialist may be designated as a PCP when appropriate for a Member's health condition and approved by THE PLAN.

I.32 **"Service Agreement"** is the contract between THE PLAN and MDHHS that establishes the scope of Covered Services being purchased, the criteria for eligibility, as well as the underwriting and administrative agreements between THE PLAN and MDHHS.

I.33 **"Service Area"** means the geographic area in which THE PLAN is authorized to provide health care services to Members.

SECTION II. ELIGIBILITY AND ENROLLMENT

II.1 Eligibility Criteria

To be eligible to enroll in THE PLAN, a person must:

- Be eligible for Medicaid as determined by MDHHS; and
- Reside within THE PLAN Service Area.

II.2 Enrollment

THE PLAN contracts with MDHHS to provide enrollment and disenrollment services. MDHHS will assist and educate individuals on how to enroll, disenroll, and change their enrollment status.. MDHHS will provide you with their choice of Medicaid health plans in your area and enroll you in the Medicaid health plan of your choice. If an eligible individual does not choose a health plan by choice, MDHHS will assign them to a health plan within their county of residence. So, MDHHS is responsible for enrolling eligible participants in THE PLAN.

SECTION III. DISENROLLMENT

III.1 Disenrollment Generally

It is the MDHHS's responsibility to disenroll you from the Plan. THE PLAN is responsible for your medical care until MDHHS notifies THE PLAN that this responsibility has ended. Disenrollment will occur per the rules of MDHHS.

III.2 Disenrollment by Member

If you want to disenroll from THE PLAN, you must follow MDHHS procedures of. This information is available upon request from MDHHS.

III.3 Member Moves from Service Area

You will be disenrolled from THE PLAN if you or your family moves from THE PLAN's Service Area. You will be disenrolled from THE PLAN on the first day of the month after the month in which MDHHS notifies THE PLAN of address change.

III.4 Termination of Service Agreement

You will be disenrolled from THE PLAN if THE PLAN's Agreement with the MDHHS is closed for any reason. This starts on the date the Agreement is closed.

III.5 Non-Eligibility by Member

You will be disenrolled from THE PLAN if MDHHS decides you are not eligible for Medicaid.

III.6 Disenrollment by Plan

With the agreement of MDHHS, THE PLAN may ask for your disenrollment from THE PLAN due to improper actions on your part related to THE PLAN membership. These include Fraud, Abuse of the Plan, violence or threats of violence, or other intentional wrongdoing, or if, in the opinion of THE PLAN, your behavior makes it impossible for the provider to safely provide services.

III.7 Effective Date of Disenrollment

THE PLAN is liable for payment for all Covered Services in this Certificate until your disenrollment with the plan. Benefits stop on the date of disenrollment. Any undecided claims for Covered Services for services before the date of disenrollment will be processed by THE PLAN.

If you are disenrolled from THE PLAN and you are in an inpatient hospital on the date of disenrollment from THE PLAN, THE PLAN will be responsible for all covered inpatient hospital- charges until the date of release.

SECTION IV. FORMS, ID CARDS, RECORDS

IV.1 Forms and Questionnaires

Members shall complete and submit to THE PLAN or doctors, any forms as are requested and shall assure that all information contained is true, correct and complete.

IV.2 Member ID cards

- THE PLAN will issue an ID card to each Member. ID cards must be taken with you to the service. The holder of the ID card must be the Member designated on the card and be eligible for Covered Services through THE PLAN. 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. 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 financially responsible for such services.
- Member agrees that any misuse of the ID card or allowing its use by any other person, or otherwise attempting to or defrauding THE PLAN, shall request disenrollment of the member subject to approval of MDHHS.
- Member shall immediately report loss or theft of the ID card to THE PLAN. Member shall promptly notify THE PLAN of any change of his/her address. and the loss or theft of any ID card. Members may contact the Customer Services Department toll-free at (888) 654-2200.

IV.3 Authorization to Receive Information

You give permission, subject to the privacy needs, to doctors to give information about your care, treatment and physical condition to THE PLAN. You also give permission to THE PLAN to copy your records.

IV.4 Confidentiality of Member's Personal Health Information

You should refer to THE PLAN's Privacy Notice (available in THE PLAN Member Handbook and on the HAP Empowered website at www.hap.org/medicaid). For a description of how your personal and medical information about you may be used and how you can get access to this information.

SECTION V. COORDINATION OF BENEFITS AND SUBROGATION

V.1 General Provision

THE PLAN will provide you with Covered Services that you are entitled to under this Certificate. However, you are not allowed to get the duplicate benefits. Or benefits greater than the cost of the Covered Services. Or the amount THE PLAN pays to Providers for those services under this Certificate, whichever is less.

Covered Services are not provided under this Certificate to the degree that any amounts are paid. Or payable for expenses to or on your behalf under the provisions of any other insurance, service benefit or reimbursement plan e.g.: Medicare, Worker's Compensation, Employer's Liability Law, or No-Fault Automobile Insurance.

V.2 Coordination of Benefits

THE PLAN will follow the coordination of benefits guidelines of MDHHS and the state of Michigan. All bills for Covered Services or supplies must be first submitted to the primary insurance carrier. THE PLAN will generally be the payer of last resort. You will provide a statement to THE PLAN, confirming the type of medical coverage carried on your automobile insurance, in the event you are injured in an automobile accident and require care.

V.3 Subrogation

If you have a right of recovery from a person or an organization for any Covered Services under this Certificate. (Except from your health insurance coverage, subject to the coordination of benefits provisions).As a rule of receiving Covered Services under this Contract, you will either:

- Pay THE PLAN all amounts recovered to the extent of Covered Services provided by THE PLAN. And in an amount equal to the THE PLAN payment for those Covered Services, but not in excess of financial damages collected.
- Or Authorize THE PLAN to be subrogated to your rights of recovery. Only for Covered Services provided including the right to bring suit in your name at the sole cost and expense of THE PLAN.

In the event a suit started by THE PLAN on your behalf results in financial damages awarded in additional cash for Covered Services provided by THE PLAN. THE PLAN has the right to take back costs of the suit and attorney fees out of the additional cash.

If you or your legal representative does not agree with THE PLAN in its filing of a claim for reimbursement. THE PLAN has the right to request your disenrollment upon consent of MDHHS.

V.4 Right of Recovery

If THE PLAN provides Covered Services but another health Plan has paid. THE PLAN has the right to deny payment or seek the cash value of each service from the other health Plan.

SECTION VI. GRIEVANCES AND APPEALS

VI.1 General Information Concerning Grievances and Appeals

To ensure your services and satisfaction. THE PLAN has a process to address and fix Member complaints related to the delivery of services under this Certificate. The complaint process, including a time limit on filing a complaint, is described in the THE PLAN, Member Medicaid Handbook, Grievances and Appeals section. The process may be used to fix repayment for

- claims
- denials
- cancellations
- non-renewals of certificates
- and complaints regarding the quality of the services delivered by Providers

You will receive a copy of the THE PLAN Member Medicaid Handbook. Explaining the complaint process when you enroll with the plan. Please call THE PLAN's Customer Service Department, for questions or to request an additional copy of the Handbook, at (888) 654-2200.

SECTION VII. GENERAL PROVISIONS

VII.1 Selection of a Primary Care Physician (PCP)

Upon enrollment, you will select an Affiliated PCP. If a PCP is not selected at the time of enrollment, THE PLAN will assign a PCP to you.

PCPs are in charge of your health care needs. Like review of information about your medical history, concerns and needs. Your PCP must approve all referral services. (Such as, specialty care, out-patient hospitalization, and home health) and all in-patient hospital admissions.

You should call your PCP for all health care services. Except emergency health services. When you need emergency health services should go directly to the emergency room.

Termination of participation between PCP and the Plan

If your PCP is no longer affiliated with the Plan, THE PLAN will notify you and help you to select another PCP

If your PCP leaves THE PLAN network for any reason other than failure to meet THE PLAN's quality standards or fraud. And you are undergoing an ongoing course of treatment you may be eligible to continue treatment. With prior authorization from THE PLAN, for up to 90 calendar days as follows:

- You are in active treatment for an acute condition.
- You are finished with a serious phase of the condition being treated.
- You are finished with the postpartum period of six weeks post-delivery for women in the second and third trimester of pregnancy.
- A terminally ill member for the remainder of your life.

If you need assistance in selecting a PCP. Call THE PLAN's Customer Service Department toll-free at (888) 654-2200.

VII.2 THE PLAN's Right to Transfer a Member

If a PCP is unable, fails, neglects, or refuses to provide Covered Services. THE PLAN may transfer you to another PCP. During such inability, failure, neglect and/or refusal to provide Covered Services. THE PLAN's right to transfer you will be done in the best interest of your health care needs. In the event of such a transfer. THE PLAN does not guarantee that your transfer will be assigned to the former PCP in the future.

VII.3 Covered Services are Solely for the Member

As a Member of THE PLAN. You do not have fees or copays for covered services. The Covered Services provided under this certificate are for your benefit only and cannot be transferred or given to anyone else. If you help, or try to help someone else get services using your ID THE PLAN will report these actions to MDHHS for appropriate action. The theft or wrongful use, delivery or circulation of your ID card may add up to a felony under Michigan law.

By enrolling in THE PLAN, you agree to follow the rules and policies of THE PLAN described in this Certificate. You agree that to be a benefit under this certificate, all health care services must be provided or authorized by THE PLAN. Except for emergency Health Services.

VII.4 Your Rights and Responsibilities

Member rights are important to THE PLAN and will be honored by THE PLAN staff and Providers to ensure quality of care and service to its Members.

Member Rights:

- Confidentiality
- Be treated with respect and dignity
- Get care that meets your health needs
- Get information about THE PLAN services and providers
- Get information about practitioners, rights, and responsibilities
- Work with doctors to make decisions about your health care
- Choose or change your doctor
- Talk about proper or medically necessary treatment for your conditions – regardless of cost or benefit coverage
- Decide what type of care you would like if critically ill
- Get medical care through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)
- Help make decisions about your health care, like asking about treatment options or refusing care
- Ask for advice from another doctor when you are unsure of the care your doctor

suggests

- Ask for a copy of your medical records, including changes or corrections
- Get timely customer service
- Voice complaints about THE PLAN or medical care
- Contact Customer Service to file a grievance
- Ask for an Administrative Fair Hearing with the MDHHS
- Get information about THE PLAN operations
- Make suggestions about our services and providers
- Make suggestions about member rights and responsibilities
- Be free of actions used to pressure, punish, convenience, or retaliate
- Get a second medical opinion from an in-network provider
- Get a second medical opinion from an out-of-network provider. The plan will arrange for an out-of-network provider. Plan approval is required
- Request information regarding doctor incentives, including financial and other types of incentives and whether stop-loss coverage is provided
- Request information on the structure and operation of THE PLAN

- Member Responsibilities:

  - Take good care of your health
  - Talk to your doctors about regular check-ups and screenings
  - Be actively involved in in making decisions about your health care
  - Ask questions about your treatment options including medications
  - Provide your medical information to your doctors
  - Work with your doctor to develop a care plan that you both agree on
  - Follow the plan of care that you and your doctor agree upon
  - Go to appointments and arrive on time. If you cannot keep your appointment, call your doctor to reschedule prior to the appointment
  - Know what to do when your doctor's office is closed
  - Notify THE PLAN and your DHS worker of life changes, for example if you have a baby or your family size changes.
  - Carefully read your Handbook, Certificate and other provided materials to understand your benefits and responsibilities
  - Follow THE PLAN policies for getting health care services
  - Choose an PCP
  - Show your THE PLAN and mihealth cards when you need care
  - Treat other members, staff, and providers with respect
  - Make sure no one else uses your THE PLAN and mihealth cards
  - Report suspected fraud and abuse
  - Notify us of address or phone number changes. If you move or change your phone number, call us at **(888) 654-2200 (TTY: 711)**. You must call your caseworker at your local Department of Human Services (DHS) office

THE PLAN team members, along with our doctors, comply with all requirements concerning your rights.

VII.5 Refusal to Accept Treatment

You understand that doctors are responsible for determining treatment appropriate to your care. You may refuse treatment recommended by a doctor. If refusal of a treatment is related to lack of agreement between the doctor and you. Then THE PLAN may help you in changing the PCP. If you refuse treatment and no alternatives exist. You will be advised. If you still refuse the care. THE PLAN may request your disenrollment, subject to the approval of MDHHS.

VII.6 Entire Contract

This certificate makes up the entire understanding between you and THE PLAN. And, as of the effective date of coverage, replaces all other similar agreements. This certificate may be changed only in writing as authorized by THE PLAN in accordance with the law.

APPENDIX I - SCHEDULE OF COVERED SERVICES

The Covered Services defined in this section is the same as the Michigan Medicaid program and the Service Agreement. Except for Health Services and as items listed below. Coverage under this is only available for those Covered Services authorized in advance by your PCP and/or THE PLAN in line with all THE PLAN policies and procedures. Only services that are Medically Necessary according to standards that are determined by THE PLAN's Medical Director are Covered Services under this certificate. More information can be found out on website at www.hap.org/medicaid.

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 for services provided through a Medicaid-certified home health agency. Services include intermittent nursing care, home health aide services, and therapy provided in the beneficiary's home when the following are met:
   - The Member is unable to access services in an outpatient setting, and
   - The Member's physician orders home health care, and
   - The Member's physician prepares a treatment plan.

2. **Hospice Care** is covered when 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

   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

   Physical, speech, occupational therapy.

3. **Inpatient Hospital** admissions are covered, including the following services and supplies:
    - General medical care days,
    - Meals and special diets,
    - General nursing services,
    - Use of operating and other treatment rooms,
    - Use of delivery room,
    - Laboratory and pathology examinations,
    - Chemotherapy for the treatment of malignant and nonmalignant disease,
    - Oxygen and other gas therapy,
    - Drugs, biologicals, and solutions,
    - Medically necessary radiology services,
    - Routine nursery care of the newborn when the mother is eligible for maternity care,
    - Dental surgery Including:
        - Removal of impacted teeth or multiple extractions,
        - 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:
        - For the correction of birth defects,
        - conditions resulting from accidental injuries,
        - deformities resulting from certain surgeries, such as breast reconstruction following mastectomies
            - NOTE: (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:
    - 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 services.
- Room services for an illness or disease if the condition is life-threatening (room services are covered for emergencies only)

5. **Emergency Health Services**, are covered by THE PLAN:

- Examples, and not limited to:
  Heart attacks Hemorrhaging, poisonings Loss of Consciousness or respiration Trauma and convulsions
- The following are covered by THE PLAN:
  - Transportation for all Emergency Health Services like Ambulances services for an emergency due to a medical condition.
  - Transportation for all medically needed transportation that is not an emergency is provided.
  - Emergency Health Services are available 24 hours a day and 7 days a week.
  - Emergency Health Services are covered without prior authorization when they are medically necessary.
  - Professional services that are needed to evaluate an emergency medical condition that is found using a layperson standard.
- The following is the responsibility of THE PLAN
  - Payment of all out-of-plan or out-of-area Emergency Health Services
  - Medical screening services given in an emergency department of a Hospital.
  - NOTE: THE PLAN will not be responsible for paying for non- treatment services that are not authorized by THE PLAN.

  The following is acknowledged by THE PLAN:

  - Hospitals that offer Emergency Health Services must perform a medical screening examination on room clients. Leading to a decision by the doctor, that an emergency medical condition does or does not exist.
  - If an emergency medical condition is found, the doctor must give whatever treatment is needed to help your condition
  - That Emergency Health Services continue until you can be safely discharged or transferred.
  - If you need hospitalization or other health care services that appear during the screening assessment provided by the emergency department.
  - Then THE PLAN may require prior authorization for such services.

- However, services will be viewed as being prior authorized if THE PLAN cannot be contacted for authorization
- or if THE PLAN does not respond within one hour to a request for authorization being made by the emergency department.

- Follow-up services that are needed for more 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 month to age 19 years,
- Immunizations from a child's birth to age 19 per ACIP and AAP guidelines
- Blood lead screening: blood lead screening and follow-up services are covered for members under the age of 21.
- Children (under 18 years old) may see any Plan Participating Pediatrician for well child visits with no referral. THE PLAN 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 basic and skilled care in a skilled nursing facility including:

- Semi-private room,
- Meals and special diets,
- Nursing services,
- 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

8. **Services**, THE PLAN covers the following services allowed by MDHHS. There are no co-pays for these services (some services are only covered for certain conditions; others may have visit limitations):

- Ambulance and other emergency medical transportation
- Breast Pumps; hospital-grade electric, personal use double electric, and manual breast pumps
- 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 Practitioner Services

- Chiropractic services and spinal X-rays
- Durable medical equipment (DME) and supplies
- Early periodic screening, diagnosis and treatment services (EPSDT) – Well Child Care
- End stage renal disease (ESRD) services
- Family planning services
- Health education and outreach
- Hearing and speech services
- 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 health services,
- Out-of-State services authorized by THE PLAN
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners Services
- Prenatal care
    - Doula Services - up to 6 visits in the prenatal, labor and delivery, and postpartum period - Effective January 1, 2023
- Prosthetics and orthotics
- Preventive care and screenings
- Restorative or rehabilitative 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 except services provided to members with development disabilities
- 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

9. **Chiropractic Care**

Up to 18 visits per calendar year. Limited to specific diagnoses and procedures. Additional visits may be covered if first approved by MHP.

10. **Breast Cancer Diagnostic Services** are covered.

- Breast cancer screening,
- Diagnostic services
- Outpatient treatment services and rehabilitative services are covered
- For women 40 years of age and older, 1 mammogram is covered for every calendar year

11. **Therapeutic Services:** Physical, Speech, and Occupational therapy

12. **Durable Medical Equipment** (DME)

Is covered on a rental or purchase basis. When it is Medically Necessary for the treatment of illness, injury or disease, prescribed by a doctor. For the use in the course of medical treatment. And obtained from a professional supplier approved by THE PLAN.

- Repair of purchased DME is covered if found medically necessary.
- Replacement of purchased DME will be considered when it is more expensive to repair the medical equipment than replace.
    - Or when required due to a change in patient's condition or size
- Items will not be replaced or repaired due to damage to the item. As a result of misuse or abuse. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company
- Medical and surgical supplies are items such as catheters, colostomy supplies, and DME like wheelchairs, beds, and CPAP machines.

13. **Prosthetic and Orthotic Appliances**

Is covered when Medically Necessary. Prosthetics are artificial and/or mechanical appliances. Such as arms, legs, eyes, etc. That replace all or part of the functions of a permanently inoperative body organ. Orthotics support or straighten a malfunctioning body part. Coverage includes:

- Prosthetic and orthotic appliances that are prefabricated 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 in accordance with MDHHS guidelines.
- Prosthetic after a mastectomy
- Items will not be replaced due to damage to the item. As a result of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident. Attempts should be made to collect the full or partial payment from the third party's insurance company

14. Organ and Tissue Transplants

- Hospital and professional medical services required to receive a non-experimental transplant of a human organ or body tissue
- Medicaid will pay for the Covered Services for donor's:
    - organ procurement,
    - donor searching and typing,
    - harvesting of organs,

if the donor does not have transplant benefits under any other health care plan.

15. **Hearing Care.** The following services are covered:

- 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:
    - for the replacement of parts including batteries and ear molds.
- The hearing aid:
    - includes a mandatory hearing aid manufacturer's warranty of 24 months covering parts and labor, and a 12-month warranty covering loss or damage.
- After the 12-month loss and damage warranty has expired:
    - Medicaid will not replace a hearing aid when lost or damaged beyond repair. As a result of misuse or abuse by the beneficiary or caregiver.
    - If loss or damage to a hearing aid is the result of theft or car accident.Attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable.
- 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.

16. **Vision Care** is covered:

Eye exams, prescription lenses and frames. Routine eye exam. One pair of eyeglasses every twenty-four months. Replacement glasses (if originals are lost, broken, or stolen).

- Under 21 years replacements are limited to two pairs of glasses per year
- Over 21 years replacements are limited to one pair of replacement glasses per year
- Contact lenses only if the Member has a vision problem that cannot be corrected with glasses

17. **Pharmacy** covers up to a month supply of most medications. And a 3-month supply of birth control. Prescriptions must be filled at a pharmacy in THE PLAN network. For medication on the Common Formulary whose drug class(es) are not existing on the Single Preferred Drug List, prescriptions are filled with a general medication when a generic option is available; unless the prescribing doctor has indicated "dispense as written" (DAW) on the prescription. And has gotten prior approval based on a medical need.

Benefits cover the following:

- A covered 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"
- Certain medical supply items with a prescription. Some covered products include insulin syringes, alcohol swabs, etc.
- Birth control prescriptions written by a licensed prescriber
- Off-label use drugs are available with prior authorization
- Drugs used in antineoplastic therapy and cost of its administration
- Certain over-the-counter drugs with a written or electronic prescription
- For covered drugs, a formulary drug list applies (the Common Formulary). Drugs on the Common Formulary, including products on the Single Preferred Drug List, are covered. Drugs that are not on the list are covered only if approved. Some drugs on the list require approval or treatment with other drugs first. Some drugs have restrictions or quantity limits.

18. **Diabetes Patient Education:**

- Medicaid covers diabetes self-management education for members diagnosed with diabetes. When ordered by an enrolled doctor or qualified medical practitioner responsible for the member's diabetic care.

Services must be provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid enrolled outpatient hospital. Or LHD that meets Michigan Medicaid DSME program requirements. The doctor or qualified medical practitioner treating the member's diabetes must maintain a documented diabetes diagnosis. And any special needs supported by medical necessity in the medical record.

Diabetic Supplies and equipment include:

- Blood glucose monitors
- Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
- Insulin 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 correct self-management and treatment of their diabetic condition.

19. **Ambulance Services** are covered when medically necessary as follows:

- Ambulance service for a trip to or from the Hospital, a skilled nursing facility, or your home, and
- Professional ambulance service when used to transport you from the place where injured or emergency occurred to the first hospital where treatment is given.

20. **Non-emergency transportation services**, including travel expenses, for transport to and from authorized Covered Services in accordance with THE PLAN's non-emergency transportation policies and procedures.

21. **Dental Services**

Dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older.

- Oral exams (1 in 6 months)
- Comprehensive Periodontal Evaluation (1 in 12 months)

  Note: comprehensive periodontal evaluation is not a covered benefit when billed in conjunction with, or within six months of other oral exams
- Assessment (1 in 6 months)
- X-rays
  - Bitewing X-rays (1 in 12 months)
  - Full mouth or panoramic X-rays (1 in 5 years)

- Teeth cleaning (prophylaxis) (1 in 6 months)
- Scaling in the Presence of Inflammation (1 in 6 months)

  Note: scaling in the presence of inflammation is not covered within 6 months of prophylaxis, scaling and root planing, periodontal maintenance, or debridement procedures
- Periodontal Maintenance (1 in 6 months)

  Note: Any combination of teeth cleanings (prophylaxis, scaling in the presence of inflammation and periodontal maintenance procedures) are covered once per 6 months.

  Scaling and Root Planing (1 in 2 years per quadrant, maximum of 2 quadrants per day)
- Sealants (1 in 3 years for first and second primary (baby) molars and first and second permanent (adult) premolars and molars)
- Fillings
- Sedative filling
- Crowns, including porcelain, metal and resin based (1 in 5 years)
- Crown buildup, including pins
- Re-cement crowns and bridges
- Root canals
- Extractions, simple and surgical
- Limited other oral surgery
- Emergency treatment of dental pain
- IV sedation (when medically necessary)
- Dentures
  - Complete denture (1 in 5 years)
  - Partial denture (1 in 5 years)
  - Denture adjustments and repairs
  - Denture rebase and reline (1 time in 2 years)

22. **Dental services NOT covered**.

- Bite guards
- Removal of healthy third molars (wisdom teeth)
- Bridges and inlays
- Implants
- Braces
- Cosmetic dentistry
- Removable space maintainers
- Services covered under a hospital, surgical/medical, or prescription drug program

- Treatment of TMJ (TMJ is a problem that can cause pain in your jaw joint and can also cause pain in the muscles that control jaw movement.)
- Cone Beams CTs
- Nitrous Oxide

Be sure to ask your dentist if a service is covered before the service is done. You must pay for services that are not covered.

23. **Dental Oral Surgery**-

Dental services that may be provided to all Medicaid members:

- Include emergency, diagnostic, preventive, and therapeutic services for dental disease. Which, if left untreated, would become acute dental problems, or cause irreversible damage to teeth or supportive structures.

Benefits are limited to the following:

The removal of teeth partly or completely impacted in the bone of the jaw,

The removal of teeth that will not erupt through the gum,

The removal of other teeth that cannot be removed without cutting into bone,

The treatment of cysts, tumors, or other diseased tissues, retreatment of

previous root canal therapy

The alteration of the jaw, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement,

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

If services are given to you by a provider who does not participate in the THE PLAN. Payment may be denied if authorization requirements are not followed for non-emergency services. THE PLAN's authorization requirements are listed on THE PLAN's web site at www.hap.org/medicaid.

25. **Enhanced Services.** THE PLAN places importance on programs to improve your general health. THE PLAN has health improvement programs and health education classes available to you. For persons with, or at risk for, a specific disability, the Network Providers and staff are available to provide education to you, your family, and other health care providers about early involvement and management strategies.

26. **Telehealth Services** at Participating Providers

APPENDIX II – COVERED SERVICES FOR CSHCS

Children's 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 Enrollees under this Contract include all of those listed above and the following services:

Case Management Benefit

- Enrollees may be eligible to receive Case Management services if they have a CSHCS medically eligible diagnosis, complex medical care needs and/or complex psychosocial situations which require that intervention and direction be provided by an outside, independent professional

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 tollfree 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 conferences for siblings of children with special needs

Help from the Children with 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
- Therapeutic 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 services:

- 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.

- Dental Services:

  Effective April 1, 2023 additional dental services are now available as outlined in the Dental Services section of this document.

  Additional services if you are 19 - 20, the services listed below are also covered for you:

  - Fluoride Varnish (1 in 6 months)
  - Topical application of Fluoride (1 in 6 months)

    Note: Topical application of fluoride cannot be combined with fluoride varnish within the same six months.
  - Temporary partial denture (only to replace front teeth)
  - Stainless steel crown (prefabricated) (1 in 2 years on same tooth)

- Members may also receive transportation to and from scheduled medical, dental and hearing appointments.

Appendix IIII - Schedule of Exclusions and Limitations

Services and products listed below are not Covered Services. This list is not limited to:

- Medical, surgical, Hospital, and related services (except for Health Services) given to you from providers other than Providers in THE PLAN network, are not covered
    - unless they are authorized in writing by THE PLAN's Medical Director before the services are given, unless otherwise stated.
- Services which are not Medically Necessary are not covered.
    - The final determination of medical need is made by THE PLAN's Medical Director.
- Services ordered by a court of qualified authority 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,
    - similar with Medicaid policies, are not covered.
- Medical, surgical, and other health care procedures thought to be new
    - (this includes research studies) like with Medicaid policies and procedures are not covered.
- Private duty nurses
    - unless they are authorized by THE PLAN's Medical Director before services are given, or if stated in this certificate.
- Personal care services to help with daily activities. Like help with bathing, dressing, eating, walking, getting in and out of bed and taking medicine are not Covered Services, unless stated.
- Housekeeping services and personal 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.
- Elective abortions unless Medically Necessary to save the life of the mother, result of rape or incest within the law. Treatment for medical problems resulting from elective abortion are covered. Treatment for incomplete or threatened abortions are covered
- Dental Services that are provided by a school district.
- Mental Health Services are covered benefit via through Community Mental Health agencies. Call the local community mental health agency or THE PLAN for information help in finding a doctor.
- Substance abuse services are not covered by THE PLAN. But are covered by official providers and include: (i) Screening and assessment, (ii) Detoxification, (iii) Intensive outpatient counseling and other outpatient services, and (iv) treatment. Call the local

coordinating agency, Medicaid or THE PLAN for information or help in finding a doctor.

- Doctor and professional staff charges for completing forms, fees by doctors or other health care providers for missed or no-show appointment, services required by third parties i.e. physical examinations for getting and continuing employment/licensing
- Hair analysis, non-medical services e.g. onsite work rehabilitation personal items; special food and nutritional supplements,
- Long term therapies which go over the defined benefit
- Vision correction procedures
- Weight reduction or weight control procedures and programs are not included unless they are medically needed.

1. The following pharmacy drugs are not covered benefits:
    - Over-the-counter drugs that are not on the Common Formulary drug list (including products on the Single Preferred Drug List) or the Michigan Pharmaceutical Product List
    - Drugs for weight loss
    - Drugs used for cosmetic purposes or hair growth
    - Drugs for the symptomatic relief of cough/cold
    - Experimental/investigational drugs
    - Fertility drugs
    - Lifestyle drugs
    - Drugs uses for treatment of sexual or erectile dysfunction
    - Drugs of Labelers not participating in the Medicaid Drug Rebate Program
    - Drugs not FDA approved or licensed for use in the United States
    - Drugs that are covered directly through the State mihealth card