Welcome to the Molina family.
Welcome and thank you for choosing Molina Healthcare as your health care plan. Molina Healthcare is a State Healthy Michigan Plan. We hold a certificate of authority issued by the State of Michigan as a Health Maintenance Organization (HMO). We know how important your health is to you. We will do all that we can to help you and your family with your health care needs.

This member handbook explains how to get the services that you may need. If you need this book in a language other than English or in a different format because of special needs, please contact our Member Services Department.

Molina Healthcare contracts with independent doctors who will take care of you. You can get a list of Molina Healthcare doctors by going to our website at www.MolinaHealthcare.com. You can contact Molina Healthcare’s Member Services Department to get a paper list of doctors. Your Primary Care Provider (PCP) will also arrange any care you need from other doctors. Please call your PCP to make an appointment as soon as possible.

Just as a reminder, please let us know if you change your telephone number or address. Call Member Services between 8:00 AM and 5:00 PM, Monday through Friday, at 1-888-898-7969 and contact Michigan ENROLLS at 1-888-ENROLLS (1-888-367-6557).

Thank you for choosing Molina Healthcare!
Molina Healthcare Key Contact List

Member Services, Mental Health Services 1-888-898-7969
Non-Emergent Transportation, Dental 1-888-898-7969

March Vision Care 1-844-586-2724
TTY/TDD 1-877-627-2456

Medicaid Hotline 1-800-642-3195

Michigan ENROLLS 1-888-ENROLLS
(1-888-367-6557)

*or if calling from an internet based telephone service* 1-800-975-7630

TTY/Michigan Relay Service 1-800-649-3777

Nurse Advice Line
English 1-888-275-8750
Spanish 1-866-648-3537
TTY/TDD English 1-866-735-2929
TTY/TDD Spanish 1-866-833-4703

MyMolina.Com Support Desk 1-866-449-6848
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Member Services Department

Molina Healthcare provides you with a toll free direct line to Member Services at 1-888-898-7969. Member Services will answer your questions about plan benefits and help you with any concerns you may have about our services, including:

- General Information
- Change of address or phone number
- Changing doctors
- Claim information
- Wellness information
- Requesting an identification (ID) card
- Benefit information
- PCP address and phone number
- Filing a grievance or appeal
- Enrollment or disenrollment questions.

You may contact Member Services by:

- Visiting the Member Services Department at the Molina Healthcare office
- Calling the Member Services Department at 1-888-898-7969 during normal business hours, Monday through Friday, from 8:00 AM to 5:00 PM, or
- Visiting our website at www.MyMolina.com

Oral interpretation services are available if you are non-English speaking, we have Spanish and Arabic speaking Member Service Representatives to serve you. All other languages are assisted by the use of our language line at 1-800-752-6096. If you are hearing impaired, please use Michigan Relay at 1-800-649-3777 to speak with a Member Service Representative. If you need written materials in a language other than English or require materials in a different format because of special needs, please contact Member Services at 1-888-898-7969.

Member Online Self Services

Molina Healthcare offers members help with requests on the MyMolina Web Portal. MyMolina is an easy way to access your personal health information without picking up the phone! By visiting MyMolina, you can change your doctor, request or print an ID card, check your eligibility, view your health record, request materials, and view your benefits. Go to www.MyMolina.com to get started. If you have any problems with MyMolina, call the Help Desk at 1-866-449-6848.

Changing Information

It is important that we are able to get in touch with you. If you change your name, address, telephone number or if your family size changes, please call the Member Services Department at 1-888-898-7969. You can also report these changes at www.MyMolina.com. Also, let your local Department of Human Services (DHS) Worker know of all changes.
Member ID Card

When you become a member of Molina Healthcare, you will get a Member ID card. You will need to carry your Molina Healthy MI card and your MIHealth card with you at all times. You must show your Molina Healthy MI ID card when getting care from your doctor, getting your prescriptions filled or using the hospital emergency room.

Your card will have your name and ID number on it as well as your PCP name and phone number. New ID cards will be mailed to you when you change doctors, or you request a new ID card.

All family members will have their own ID card. Only the person on the ID card may use it for service. You may be asked to show a picture ID when using your Molina Healthy MI ID card. This is to make sure no one else is using your card.

Coverage of Newborns

Once your child is born, your child may become a member of Molina Healthcare, not the Healthy MI Plan. It is important that you tell your DHS worker and Molina Healthcare about your child’s birth as soon as possible.

Please call Member Services at 1-888-898-7969. We will make sure that:

- Your baby gets enrolled into Molina Healthcare
- Your baby’s doctor is listed on the Molina Healthcare ID card

MI Health Account

Individuals with annual incomes between 100% and 133% of the federal poverty level will be required to contribute 2% of income annually for cost sharing purposes. This is your account to assist you with payment of covered health care services you receive. You may be asked to contribute to this account. This account will allow you to save for future health care expenses, which may include copays, deductibles or any other out of pocket expense. You can reduce your annual contribution and co-pays by participating with Molina Healthcare’s healthy behavior activities which may include completing an annual health risk assessment, and changing unhealthy activities. Cost sharing cannot exceed 5% of your income. You will receive quarterly statements on the amounts available, monies used and any monies owed by you for cost sharing. The statement will also show you any services you have received. You will get more information about your MI Health Account and contributions for cost sharing.

Member Out-of-Pocket Cost

CO-PAYS FOR SERVICES

The Molina Healthy MI Plan has co-pays. Most co-pays will be paid to Molina Healthcare through your MI Health Account. Copays will not be collected until after your first 6 months of enrollment with Molina Healthcare. These copays will come from your MI Health Account.

If you improve your health outcomes and show healthy behaviors, you may receive credit to go in your MI Health Account. These credits will be used towards your copays.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits (including Free-Standing Urgent Care Centers)</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Outpatient Hospital Clinic Visit</td>
<td>$1 per visit</td>
</tr>
<tr>
<td>Hospital Emergency Room Visit (Copay only applies to non-emergency services)</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$1 for each generic brand drug</td>
</tr>
<tr>
<td></td>
<td>$3 for each name brand drug</td>
</tr>
<tr>
<td>Chiropractic Visits</td>
<td>1 per visit</td>
</tr>
<tr>
<td>Dental Visits</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$3 per aid</td>
</tr>
<tr>
<td>Podiatric Visits</td>
<td>$2 per aid</td>
</tr>
<tr>
<td>Vision Visits</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Inpatient Hospital Stay (Copay only applies to elective/non-emergent admissions)</td>
<td>$50 for the first day of the hospital stay</td>
</tr>
</tbody>
</table>

If you receive a bill for any covered service, please mail it directly to us:

Molina Healthcare of Michigan  
880 West Long Lake Road, Suite 600  
Troy, MI 48098-4504

**Disenrollment**

Molina Healthcare may ask that you be disenrolled from its membership. You may be disenrolled from Molina Healthcare for:

- Abusive, threatening and/or violent behavior towards doctors and their staff or Molina Healthcare's staff.

**Other Insurance**

Molina Healthcare needs to know if you have any other health insurance in addition to your Molina Healthy MI coverage. Please contact Member Services at 1-888-898-7969 to provide us with your insurance information. This will help us to manage your benefits properly. If Molina Healthcare is not aware of your additional health information, you may experience delays at the pharmacy or at other healthcare provider locations.
Provider Information Section

Your Primary Care Provider (PCP)
To get started, you must choose a PCP. PCPs are doctors, nurse practitioners, or physician assistants who give care in Family Practice, Pediatrics, or Internal Medicine. Your PCP is responsible for providing your day-to-day health care. Your PCP may also send you for care to specialists, other health care providers and hospitals. You will find a list of PCPs for you to choose from on Molina Healthcare’s website at www.MolinaHealthcare.com or visit www.MyMolina.com. You may request a paper copy of our list of PCPs by calling Member Services. If you do not choose a PCP, we will select one for you.

Molina Healthcare and your PCP care about the health of you and your children. Your PCP can help you avoid problems by:

- finding medical, dental and other problems early,
- treating problems before they become serious, and
- providing education about your health.

If you have a chronic health condition like diabetes or end stage renal disease, you may be able to have a specialist take care of you as your PCP. Call us and we will help you.

Changing Your PCP
You may change your PCP. If your health or safety is in danger, you will be given another PCP right away. If you wish to change PCPs, please call Member Services at 1-888-898-7969 and we will help you choose a new PCP or you can locate and change your PCP online at www.MyMolina.com.

You can choose a new PCP at any time. Requests that you make will take effect by the 1st day of the next month.

Nurse Advice Line (NAL)
If you have questions about your health or about getting care during an emergency, Molina Healthcare offers a Nurse Advice Line (NAL) to help you. The Nurse Advice Line is available 24 hours a day, 365 days a year. You can reach the Nurse Advice Line by calling Member Services at 1-888-898-7969, or you can call the line toll free direct at 1-888-275-8750 (English), or 1-866-648-3537 (Spanish).

Questions About Your Health After Hours
For non-emergency care after normal business hours, please call your PCP who will provide instructions for getting the care you need. If you cannot reach your PCP, our Nurse Advice Line can assist you.
Routine and Specialty Care Services

Your PCP will help you get your health care services.

- Call your PCP for an appointment.
- If you cannot keep your appointment, call and cancel the appointment as soon as possible.
- Bring your MIHealth card and your Molina Healthcare ID card with you.
- Please be on time.

You can get specialty care from a Molina Healthcare participating provider including routine and preventive health care services from a OB/GYN, women health specialists and pediatric providers without a referral from your PCP. Tell your PCP when you get care from another doctor.

You can check Molina Healthcare’s website at www.MolinaHealthcare.com for a list of Molina Healthcare specialists and other health care providers. You may request a paper copy of our list of specialists and other health care providers by calling Member Services.

Hospital Services

All hospital services except emergency services must be approved and/or arranged by your PCP or Molina Healthcare except as otherwise stated in this handbook.

REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES

The Healthy MI Plan will cover services ordered by your doctor such as:

- Chiropractic
- Medical equipment
- Medical supplies
- Occupational therapy
- Orthotics
- Physical therapy
- Prosthetics
- Speech therapy

PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT

Preventive care is a key factor in wellness. Beneficiaries must schedule an appointment with their Primary Care Provider within 60 days of choosing or being assigned to a health plan. The Healthy MI Plan covers:

- Yearly Check-ups
- Immunizations (shots)
- Doctor Visits
- Mammograms
- Dentist Visits
- Hearing Check-ups
- Diet
• Lab tests (if needed)
• Eye exams

If you are age 19 or 20, these services are covered through Early, Periodic Screening, Diagnostic and Treatment (EPSDT).

**Dental Services**

Proper dental care has proven to be one of the first lines of defense in identifying health issues. This will assist to detect and identify proper medical treatment before more serious conditions or illnesses present.

Dental services will be provided to adults ages 19 – 64 years of age by a participating dental provider.

The Healthy MI Plan covers:
• Periodic oral exams
• Extractions
• Preventative and restorative services

**Complex Case Management Program**

The Complex Case Management Program is a voluntary program for members with difficult health problems. The program allows you to talk with a nurse about your health problems. The nurse can help you learn more about your health problems and teach you how to better manage them. Our nurses can help with all types of health problems. We also have special programs for conditions such as:
• Asthma
• Chronic Obstructive Lung Disease
• Congestive Heart Failure
• Coronary Artery Disease
• End Stage Renal Disease
• High Risk Obstetrics
• Organ Transplant
• Skilled Nursing Facility and Rehabilitation

Our nurses will work with your doctor to make sure you get the care you need. We also have a Social Worker to help with your medical and mental health needs. If you would like more information about the program, please call us at 1-866-449-6828 Ext. 151317. If you are hearing impaired, please call TTY/Michigan Relay at 1-800-649-3777.

**Provider Information and Payment**

You can request information about our providers, such as license information, how providers are paid by the plan, qualifications, and what services need prior approval. This information will be given upon request. Please call Member Services at 1-888-898-7969 if you have questions.

Molina Healthcare does not prevent our providers from:
• Speaking on behalf of you, the member,
• Discussing treatment and services,
• Discussing payment arrangements between the doctor and the plan.
You may feel free to ask our plan if we have special arrangements with our panel doctors that can affect the use of referrals and other services that you may need. We want you to know that your health is our main concern. We do not pay our providers or encourage them in any way to withhold or deny medical care or services. A decision about your health care is based on medical needs.

Call Member Services at 1-888-898-7969 if you have any questions.

Molina Healthcare and providers cannot refuse to give medical care on the basis of pre-existing health conditions, color, creed, age, national origin, handicap, sex, sexual preference, or cost of medical treatment.

New Medical Technology
Molina Healthcare looks at new services and new uses for benefits you have now. Molina Healthcare reviews all the studies done to see if services should be added to your benefit package. Molina Healthcare reviews the type of services listed below at least once a year:

- Medical services
- Behavioral health services
- Medicines
- Equipment
Emergency & Out of Area Services Section

How to Obtain Emergency Care
Molina Healthcare will cover all emergency services without prior approval in cases where a person, acting reasonably, would believe that they have an emergency.

You should get emergency care when you have severe pain or a serious illness or injury that will cause a lifetime disability or death if not treated at once.

Examples of emergency conditions are:

- Chest pains or heart attack
- Choking or breathing problems
- A lot of bleeding
- Poisoning
- Broken bones

If you can, call your PCP or Member Services at 1-888-898-7969, 24 hours a day. They can help you get the care you need. If you cannot call your PCP or Molina Healthcare, call 911 or go to the nearest hospital emergency room for emergency care.

ALWAYS CARRY YOUR MOLINA HEALTHCARE ID CARD AND MIHEALTH CARD WITH YOU AND SHOW THEM WHEN YOU GO TO THE EMERGENCY ROOM.

NEVER GET ROUTINE CARE THROUGH AN EMERGENCY ROOM.

Out of State / Out of Area
If you are out of town and have a medical emergency or need urgent care, go to the nearest urgent care center or emergency room for care. The hospital or urgent care center may call Molina Healthcare. Remember to follow-up with your PCP after any emergency room or urgent care visits.
Adolescents Services Section

Adolescent Health Care Program Health Centers

As a member of Molina Healthcare, you may choose to get services from an adolescent health care program health center without prior authorization or approval. Molina Healthcare will pay for services you get from these programs. You will need to let the center know that you have Molina Healthcare.

Children’s Special Healthcare Services (CSHCS) Program

CSHCS is a State of Michigan program that serves children, and some adults, with special health care needs. CSHCS covers more than 2,700 medical diagnoses.

Additional Benefits for Medicaid Health Plan Enrollees with Children’s Special Healthcare Services

1. Help from your Local Health Department with:
   - Community resources – schools, community mental health, financial support, childcare, Early On, and the Women Infants and Children (WIC) program
   - Transitioning to adulthood
   - Orthodontia
     - Only for specific CSHCS qualifying diagnosis, such as Cleft Palate/Cleft lip
     - Medically necessary, related to condition
     - Not for cosmetic purposes
   - Respite
     - CSHCS covers 180 hours of respite care annually when a beneficiary requires skilled nursing and a CSHCS nurse consultant determines appropriate

2. Help from the Family Center for Children and Youth with Special Health Care Needs
   - CSHCS Family Phone Line – a toll-free phone number (1-800-359-3722) is 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 conferences about CSHCS medical conditions and “Relatively Speaking,” a conference for siblings of children with special needs

3. Help from the Children’s Special Needs (CSN) Fund
   The CSN Fund helps CSHCS families get items not covered by Medicaid or CSHCS. To see if you qualify for help from the CSN Fund, call 1-517-241-7420.

   Examples include:
   - Wheelchair ramps
   - Van lifts and tie downs
   - Therapeutic tricycles
   - Air conditioners
   - Adaptive recreational equipment
   - Electrical service upgrades for eligible equipment

For more information about CSHCS, please call Member Services at 1-888-898-7969.
**Women’s Health Section**

**Women Preventive Services**

Women may see any Molina Healthcare OB/GYN or women’s health specialist for well woman care without a referral from their PCP.

- Women age 40 or over should have a mammogram to screen for breast cancer once every year.
- Women should have a pap smear every year to screen for cervical cancer.
- Young women, ages 16 – 25, who are sexually active should have a Chlamydia test every year to screen for this sexually transmitted disease (STD).

Women’s Health and Cancer Rights Act – Women’s health benefits include breast reconstruction services if elected after a mastectomy.

**Family Planning Services**

Family Planning Services are covered. These services include:

- Counseling to help you to decide when to have children,
- Helping you decide how many children to have,
- Providing information and prescriptions for birth control. For example, condoms and birth control pills.
- Treatment for sexually transmitted diseases (STD)
- HIV/Aids testing and services.

You do not need a referral to receive family planning services. You can receive family planning services from any doctor, clinic, or Local Health Department.

**Prenatal & Maternity Care**

Early care is important to the health of pregnant women and their babies.

- If you think you are pregnant, please call your doctor for an appointment. It is important to start prenatal care in the first 12 weeks of pregnancy.
- You can get routine maternity care services without a referral from your PCP or OB/GYN doctor.
- If you need help finding a doctor, call Member Services at 1-888-898-7969.
- If you need help making a doctor’s appointment, call the M.O.M. Nurse at 1-888-898-7969 ext. 155428.
- See your doctor throughout your pregnancy.
- Make sure you go to all of your visits when your PCP or OB/GYN tells you to. Do not miss any doctor visits.
- Make sure you go to your doctor right after you have your baby for follow-up care (3-6 weeks after your baby is born).
• Along with prenatal, postpartum and maternity care we offer information on diet, exercise and other important health care services.

• Pregnant women may choose to receive medical services through the Medicaid program; to do so, contact your Department of Human Services specialist to report your pregnancy and due date.

Moms of Molina (M.O.M.) Program

If you are pregnant, Molina Healthcare has a FREE program just for you and your baby. It is called the M.O.M. Program. You and your growing baby are important to us. We want you to have a healthy pregnancy and healthy baby.

Molina Healthcare has a special nurse coordinator to work with you and your doctors to make sure you and your baby get the care you need. All Molina Healthcare mothers-to-be, including teens and high risk, will receive information about the importance of prenatal care and free support services.

We can:
• help you find a doctor for you and your new baby
• help you set up doctor visits during your pregnancy and after your baby is born
• help you get a ride to your doctor visits
• help you stay healthy
• help you with special needs while you are pregnant
• help you find counseling services, and childbirth and parenting classes
• help you find information for getting baby items: food, housing, clothes and give you information about what to expect while you are pregnant
• keep in touch with you and your doctor

It is good to get early and regular prenatal care and to keep all your visits with your doctor even if this is not your first baby. Call the M.O.M. Nurse at 1-888-898-7969 ext. 155428.

Maternal and Infant Health Program (MIHP) Services

The Maternal and Infant Health Program is a covered benefit that helps pregnant members and infants get the proper food, support, and transportation for all health services. It will also help you to understand the importance of getting prenatal care, well childcare, and immunizations when they are scheduled. If you need help to get these support services, please call the M.O.M. Nurse at 1-888-898-7969 ext. 155428.

Women, Infant & Children Services Program (WIC)

Women, Infants and Children (WIC) Program offers pregnant women and young children FREE food and other services. You do not need to ask your PCP to get services from WIC. Call the M.O.M. Nurse at 1-866-449-6828 ext. 155428 or our Member Services Department at 1-888-898-7969 to find out where and how to get WIC Services.
Covered Services Section

Summary of Covered Services

Molina Healthcare will provide or arrange for the following services at no cost to you:

- Blood lead testing for members under age 21,
- Certified nurse midwife services,
- Certified pediatric and family nurse practitioner services,
- Chiropractic services,
- Dental services
- Durable medical equipment,
- Emergency services,
- End stage renal disease services,
- Family planning services,
- Habilitative services
- Health education,
- Hearing aids
- Hearing and speech services,
- Home health services,
- Hospice services,
- Immunizations (shots),
- Inpatient and outpatient hospital services,
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days,
- Interpretive services for non-English speaking members and oral interpretive services for the hearing impaired,
- Laboratory services, x-ray and imaging services,
- Maternal Infant Health Program
- Medically necessary weight reduction services,
- Outpatient mental health services up to 20 visits per calendar year,
- Out of State services (authorized by the Plan),
- Outreach services, including pregnancy and well child care,
- Parenting and birthing classes,
- Pharmacy services,
- Podiatry (foot care) services,
- Preventive services
- Prosthetics and Orthotics,
- Practitioners services,
- Restorative or rehabilitative services (in a place of service other than a nursing facility),
- Services provided in a Rural Health Clinic or Federally Qualified Health Center
- Therapies, (speech, language, physical, occupational) excluding services provided to persons with developmental disabilities which are billed through Community Mental Health Services Program providers or Intermediate School Districts,
- Tobacco cessation program including pharmaceutical and behavioral support,
- Treatment for communicable diseases, including sexually transmitted diseases (STD), HIV/AIDS, tuberculosis and vaccine preventable diseases; treatment may be received from a local health department without prior health authorization,
• Transplant services,
• Transportation, including Ambulance and other emergency medical transportation,
• Vision services,
• Well child/EPSDT/ for members under age 21,
• Women’s health specialist services.

Please call our Member Services Department at 1-888-898-7969 if you have questions about covered or non-covered health care services. You can also call if you have questions on how to get covered services.

Non-Emergency Transportation
Molina Healthcare will provide transportation to covered services. Transportation is provided when you have no other means to get to your doctor appointments, x-rays, lab tests, pharmacy, medical supplies or other medical care.

Call Molina Healthcare at 1-888-898-7969. It is important to call 3 days in advance of your appointment, to schedule transportation. Have your Molina Healthcare ID card handy.

Some services are covered directly by Medicaid, not by Molina Healthcare. These services include substance abuse and some mental health services. If you live in Wayne, Oakland or Macomb County and need a ride to those services, call Logisticare at 1-866-569-1902. Logisticare is open Monday through Friday from 8:00 AM to 5:00 PM. If you live in any other county, you should contact your local DHS office for help with a ride.

Emergency Transportation
Molina Healthcare will also cover emergency transportation to the hospital. You should call 911 when you have an emergency and need immediate transportation.

Prescription Drugs
If you are a new Molina Healthcare member, please call Member Services at 1-888-898-7969 if you need help with any of your medications. Prescriptions are provided at no cost to you when they are filled at approved pharmacies. Covered prescriptions and over-the-counter drugs are listed on the drug list. You may request a drug list by calling Member Services at 1-888-898-7969. The list of pharmacies and approved drug list is on the Molina Healthcare website at www.MolinaHealthcare.com.

Some drugs ordered by your doctor may require prior approval. Prior approval drugs are in gray on the drug list. Sometimes you may experience small delays in getting your prescriptions filled. This is because we have requested additional information from your doctor which we need to approve your medication. Your doctor may request a prescription drug prior approval by faxing a drug prior approval form to 1-888-373-3059. Please remind your doctor when your medication requires a prior approval.

If a drug does not appear in the drug list your doctor may request a review by the Pharmacist, by faxing a drug prior approval form to 1-888-373-3059.
Drugs that are not covered by Molina Healthcare but are covered by Medicaid are subject to Medicaid co-pays.

**Eye Care**
March Vision Care provides routine eye exams and other vision services. Call March Vision at 1-844-586-2724 to make an eye appointment or ask questions about glasses.

**Mental Health**
Molina Healthcare covers 20 outpatient visits for mental health services. You do not need a referral from your PCP to get mental health services. Be sure to go to a Molina Healthcare mental health provider. If you have a serious mental health illness, you may be referred to the Community Mental Health Services Program in your county. You can call Molina Healthcare's Member Services Department at 1-888-898-7969 for help.

**Durable Medical Equipment**
Molina Healthcare covers medically necessary medical equipment. For information, call your PCP or Member Services at 1-888-898-7969.

**Hospice Services**
Hospice is a covered program that provides end of life care. For information on hospice care, call your PCP or Member Services at 1-888-898-7969.

**Federally Qualified Health Centers (FQHCs)**
You may choose to get services from a Federally Qualified Health Centers (FQHC) located in your county. You do not need to ask your PCP to receive FQHC services.

**Healthy Behaviors**
Molina Healthcare encourages a healthy lifestyle by advising members to:

- Increase physical activity, learn more about nutrition and improve diet, and/or weight loss
- Reduce/quit tobacco use
- Receive annual influenza vaccine
- Agree to follow-up appointments for screenings or management (if necessary)
- Reduce/quit alcohol consumption
- Obtain treatment for substance abuse disorder

You can call Molina Healthcare's Member Services Department at 1-888-898-7969 for help.
### Recommended Adult Immunization Schedule, by Vaccine and Age Group

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age Group</th>
<th>19-21 years</th>
<th>22-26 years</th>
<th>27-49 years</th>
<th>50-59 years</th>
<th>60-64 years</th>
<th>≥ 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)</td>
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<tr>
<td>Varicella</td>
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<td>Human papillomavirus (HPV) Female</td>
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<td>Measles, mumps, rubella (MMR)</td>
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<td>1 or 2 doses</td>
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<td>Pneumococcal 13-valent conjugate (PCV13)</td>
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<td>Pneumococcal polysaccharide (PPSV23)</td>
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<td>Haemophilus influenza type b (Hib)</td>
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<td>1 or 3 doses</td>
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*Covered by the Vaccine Injury Compensation Program

*For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of measles

**Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indication)

**No recommendation

### 1. Influenza vaccination
- Annual vaccination against influenza is recommended for all persons aged 6 months or older.
- Persons aged 6 months or older, including pregnant women and persons with hives-only allergy to eggs can receive that inactivated influenza vaccine (IIV.) An age-appropriate IIV formulation should be used.
- Adults aged 18 years or older can receive the recombinant influenza vaccine (RIV) (FluBlok.) RIV does not contain any egg protein and can be given to age-appropriate persons with egg allergy of any severity.
- Healthy, nonpregnant persons aged 2 to 49 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) (FluMist) or IIV.
- Health care personnel who care for severely immunocompromised persons who require care in a protected environment should receive IIV or RIV; health care personnel who receive LAIV should avoid providing care for severely immunosuppressed persons for 7 days after vaccination.
- The intramuscularly or intradermally administered IIV are options for adults aged 18 through 64 years.
- Adults aged 65 years or older can receive the standard-dose IIV or the high-dose IIV (Fluzone High-Dose).

### 2. Tetanus, diphtheria and acellular pertussis (Td/Tdap) vaccination
- Administer 1 dose of Tdap vaccine to pregnant women during each pregnancy (preferably during 27 to 36
weeks’ gestation) regardless of interval since prior Td or Tdap vaccination.

- Persons aged 11 years or older who have not received Tdap vaccine or for whom vaccine status in unknown should receive a dose of Tdap followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-toxoid containing vaccine.

- Adults with an unknown or incomplete history of completing a 3-dose primary vaccination series including a Tdap dose.

- For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6 to 12 months after the second.

- For incompletely vaccinated (i.e. less than 3 doses) adults, administer remaining doses.

- Refer to the ACIP statement for recommendations for administering Td/Tdap as prophylaxis in wound management.

3. Varicella vaccination

- All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have only received 1 dose.

- Vaccination should be emphasized for those who have close contact with persons at high risk for severe disease (e.g. health care personnel and family contacts of persons with immunocompromising conditions) or are at high risk for exposure or transmission (e.g. teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age and international travelers.

- Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health care facility. The second dose should be administered 4 to 8 weeks after the first dose.

- Evidence of immunity to varicella in adults includes any of the following:
  - Documentation of 2 doses of varicella vaccine at least 4 weeks apart;
  - U.S.-born before 1980, except health care personnel and pregnant women;
  - History of varicella based on diagnosis or verification of varicella disease by a health care provider;
  - History of herpes zoster based on diagnosis or verification of herpes zoster disease by a health care provider; or
  - Laboratory evidence of immunity or laboratory confirmation of disease.

4. Human papillomavirus (HPV) vaccination

- Two vaccines are licensed for use in female, bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine for use in males (HPV4.)

- For females, either HPV4 or HPV2 is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 26 years, if not previously vaccinated.

- For males, HPV4 is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 21 years, if not previously vaccinated. Males aged 22 through 26 years may be vaccinated.

- HPV4 is recommended for men who have sex with men age 26 years for those who did not get any or all doses when they were younger.

- Vaccination is recommended for immunocompromised persons (including those with HIV infection) through age 26 years for those who did not get any or all doses when they were younger.

- A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 4 to 8 weeks (minimum interval of 4 weeks) after the first dose; the third dose should be administered 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of at least 12 weeks.)
• HPV vaccines are not recommended for use in pregnant women. However, pregnancy testing is not needed before vaccination. If a woman is found to be pregnant after initiating the vaccination series, no intervention is needed; the remainder of the 3-dose series should be delayed until completion or termination of pregnancy.

5. **Zoster vaccination**

• A single dose of zoster vaccine is recommended for adults aged 60 years or older regardless of whether they report a prior episode of herpes zoster. Although the vaccine is licensed by the U.S. Food and Drug Administration for use among and can be administered to persons aged 50 years or older, ACIP recommends that vaccination begin at age 60 years.

• Persons aged 60 years or older with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency.

6. **Measles, mumps, rubella (MMR) vaccination**

• Adults born before 1957 are generally considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contradiction to the vaccine or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps or rubella.

**Measles component:**

• A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
  - Are students in postsecondary educational institutions,
  - Work in a healthcare facility, or
  - Plan to travel internationally.

• Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type during 1963-1967 should be revaccinated with 2 doses of MMR vaccine.

**Mumps component:**

• A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended by adults who:
  - Are students in a postsecondary educational institution,
  - Work in a healthcare facility, or
  - Plan to travel internationally.

• Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are a high risk for mumps infection (e.g. person who are working in a health care facility) should be considered for revaccination with 2 doses of MMR vaccine.

**Rubella component:**

• For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility.

**Health care personnel born before 1957:**

• For unvaccinated health care personnel born before 1957 who lack laboratory evidence of measles, mumps and/or rubella immunity or laboratory confirmation of disease, health care facilities should
consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.

7. **Pneumococcal (13-valent pneumococcal conjugate vaccine [PCV13] and 23-valent pneumococcal polysaccharide vaccine [PPSV23]) vaccination**
   - General Information
     - When indicated, only a single dose of PCV13 is recommended for adults.
     - No additional dose of PPSV23 is indicated for adults vaccinated with PPSV23 at or after age 65 years.
     - When both PCV13 and PPSV23 are indicated, PCV13 should be administered first; PCV13 and PPSV23 should not be administered during the same visit.
     - When indicated, PCV13 and PPSV23 should be administered to adults whose pneumococcal vaccination history is incomplete or unknown.
   - Adults aged 65 years or older who
     - Have not received PCV13 or PPSV23: Administer PCV13 followed by PPSV23 in 6 to 12 months.
     - Have not received PCV13 but have received a dose of PPSV23 at age 65 years or older: Administer PCV13 at least 1 year after the dose of PPSV23 received at age 65 years or older.
     - Have not received PCV13 but have received 1 or more doses of PPSV23 before age 65: Administer PCV13 at least 1 year after the most recent dose of PPSV23; administer a dose of PPSV23 6 to 12 months after PCV13, or as soon as possible if this time window has passed and at least 5 years after the most recent dose of PPSV23.
     - Have received PCV13 but not PPSV23 before age 65 years: Administer PPSV23 6 to 13 months after PCV13 or as soon as possible if this time window has passed.
     - Have received PCV13 and 1 or more doses of PPSV23 before age 65: Administer PPSV23 6 to 12 months after PCV13, or as soon as possible if this time window has passed, and at least 5 years after the most recent dose of PPSV23.
   - Adults aged 19 through 64 years with immunocompromising conditions or anatomical or functional asplenia (defined below) who
     - Have not received PCV13 or PPSV23: Administer PCV13 followed by PPSV23 at least 8 weeks after PCV13; administer a second dose of PPSV23 at least 5 years after the first dose of PPSV23.
     - Have not received PCV13 but have received 1 dose of PPSV23: Administer PCV13 at least 1 year after the PPSV23, administer a second dose of PPSV23 at least 8 weeks after PCV13 and at least 5 weeks after the first dose of PPSV23.
     - Have not received PCV13 but have received 2 doses of PPSV23: Administer PCV13 at least 1 year after the most recent dose of PPSV23.
     - Have received PCV13 but not PPSV23: Administer PPSV23 at least 8 weeks after PCV13; administer a second dose of PPSV23 at least 5 weeks after the first dose of PPSV23.
     - Have received PCV13 and 1 dose of PPSV23: Administer a second dose of PPSV23 at least 5 years after the first dose of PPSV23.
   - Adults aged 19 through 64 years with cerebrospinal fluid leaks or cochlear implants: Administer PCV13 followed by PPSV23 at least 8 weeks after PCV13.
   - Adults aged 19 through 64 years with chronic heart disease (including congestive heart failure and cardiomyopathies, excluding hypertension), chronic lung disease (including chronic obstructive lung disease, emphysema and asthma), chronic liver disease (including cirrhosis), alcoholism or diabetes mellitus (Administer PPSV23.)
   - Adults aged 19 through 64 years who smoke cigarettes or reside in nursing home or long-term care facilities: Administer PPSV23.
Routine pneumococcal vaccinations is not recommended for American Indian/Alaskan Native or other adults unless they have the indications as above; however, public health authorities may consider recommending the use of pneumococcal vaccines for American Indians / Alaskan Natives or other adults who live in areas with increased risk for invasive pneumococcal disease.

Immunocompromising conditions that are indications for pneumococcal vaccination are: Congenital or acquired immunodeficiency (including B- or T-lymphocyte deficiency, complement deficiencies and phagocytic disorders excluding chronic granulomatous disease), HIV infection, chronic renal failure, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, multiple myeloma, solid organ transplant and iatrogenic immunosuppression (including long-term systemic corticosteroids and radiation therapy.)

Anatomical or functional asplenia that are indications for pneumococcal vaccination are: Sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction and splenectomy. Administer pneumococcal vaccines at least 2 weeks before immunosuppressive therapy or an elective splenectomy and as soon as possible to adults who are newly diagnosed with asymptomatic or symptomatic HIV infection.

8. Meningococcal vaccination

- Administer 2 doses of quadrivalent meningococcal conjugate vaccine (MenACWY [Menactra, Menevo]) at least 2 months apart to adults of all ages with anatomical or functional asplenia or persistent complement component deficiencies. HIV infection is not an indication for routine vaccination with MenACWY. If an HIV-infected person of any age is vaccinated, 2 doses of MenACWY should be administered at least 2 months apart.
- Administer a single dose of meningococcal vaccine to microbiologists routinely exposed to isolates of Neisseria meningitidis, military recruits, persons at risk during an outbreak attributable to a vaccine serogroup and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic.
- First-year college students up through age 21 years who are living in resident halls should be vaccinated if they have not received a dose on or after their 16th birthday.
- MenACWY is preferred for adults with any of the preceding indications who are aged 55 years or younger as well as for adults aged 56 years or older who a) were vaccinated previously with MenACWY and are recommended for revaccination or b) for whom multiple doses are anticipated. Meningococcal polysaccharide vaccine (MPSV4 [Menomune]) is preferred for adults aged 56 years or older who have not received MenACWY previously and who require a single dose only (e.g. travelers).
- Revaccination with MenACWY every 5 years is recommended for adults previously vaccinated with MenACWY or MPSV4 who remain at increased risk for infection (e.g. adults with anatomical or functional asplenia, persistent complement component deficiencies or microbiologists.)

9. Hepatitis A vaccination

- Vaccinate any person seeking protection from hepatitis A virus (HAV) infection and persons with any of the following indications:
  - Men who have sex with men and persons who use injection or noninjection illicit drugs;
  - Persons working with HAV-infected primates or with HAV in a research laboratory setting;
  - Persons with chronic liver disease and persons who receive clotting factor concentrates;
  - Persons traveling to or working in countries that have high or intermediate endemcity of hepatitis A; and
  - Unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemcity. (See footnote 1 for more information on travel.
recommendations.) The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

- Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6 to 12 months (Havrix) or 0 and 6 to 18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1 and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12.

10. Hepatitis B vaccination

- Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:
  - Sexually active persons who are not in a long-term, mutually monogamous relationship (e.g. persons with more than 1 sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection drug users; and men who have sex with men;
  - Health care personnel and public safety workers who are potentially exposed to blood or other infectious body fluids;
  - Persons with diabetes who are younger than age 60 years as soon as feasible after diagnosis; persons with diabetes who are age 60 or older at the discretion of the treating clinician based on the likelihood of acquiring HBV infection, including the risk posed by an increased need for assisted blood glucose monitoring in long-term care facilities, the likelihood of experiencing chronic sequelae if infected with HBV and the likelihood of immune response to vaccination;
  - Persons with end-stage renal disease including patients receiving hemodialysis, persons with HIV infection and persons with chronic liver disease;
  - Household contacts and sex partners of hepatitis B surface antigen-positive persons, clients and staff members of institutions for persons with developmental disabilities and international travelers to countries with high or intermediate prevalence of chronic HBV infection; and
  - All adults in the following settings: STD treatment facilities, HIV testing and treatment facilities, facilities providing drug abuse treatment and prevention services, health care settings targeting services to injection drug users or men who have sex with men, correctional hemodialysis patients, and institutions and nonresidential day care facilities for persons with developmental disabilities.

- Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose.) If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, give 3 doses a 0, 1 and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12 may be used.

- Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 mcg/mL (Recombivax HB) administered on a 3-dose schedule at 0, 1, and 6 months or 2 doses or 20 mcg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.

11. Haemophilus influenzae type b (Hib) vaccination

- One dose of Hib vaccine should be administered to persons who have anatomical or functional asplenia or sickle cell disease or are undergoing elective splenectomy if they have not previously received Hib vaccine. Hib vaccination 14 or more days before splenectomy is suggested.

- Recipients of a hematopoietic stem cell transplant (HSCT) should be vaccinated with a 3-dose regimen 6 to 12 months after a successful transplant, regardless of vaccination history; at least 4 weeks should separate doses.

- Hib vaccine is not recommended for adults with HIV infection since their risk for Hib infection is low.
12. Immunocompromising conditions

- Inactivated vaccines generally are acceptable (e.g. pneumococcal, meningococcal and inactivated influenza vaccine) and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at www.cdc.gov/vaccines/hcp/acip-recs/index.html

You can call Molina Healthcare’s Member Services Department at 1-888-898-7969 for help.

Health Education

Free classes, CDs and written materials are available through our Member Education Programs on subjects such as:

- Asthma
- High blood pressure
- Pre-natal care
- Diabetes
- Birth control
- Immunization shots and well child care
- Diet and weight control

Call Member Services at 1-888-898-7969 for more information.

Tobacco Cessation

Molina Healthcare covers tobacco cessation services for all members, including diagnostic, therapy and counseling services and pharmacotherapy (including coverage of prescription and non-prescription tobacco cessation agents approved by the Federal Drug Administration (FDA). To enroll in the “I Can Quit” program call toll free 1-800-480-7848.
Tobacco use is the largest preventable cause of illness and early death. It doesn’t matter how old you are or how long you’ve smoked or used tobacco, it is important to quit. Quitting smoking reduces your risk of lung cancer, heart disease, stroke and lung diseases. Check out some of the short and long term health benefits when you quit smoking:

– After 20 minutes - blood pressure decreases.
– After 24 hours - the chance of a heart attack is less.
– After 1 year - excess risk of heart disease is decreased.
– After 5 to 15 years - the risk of stroke is reduced.

There are many ways to quit smoking. You may even have to try different ways before you succeed. Don’t get discouraged. The important thing is that you quit. Keep in mind that it’s never too late – especially if you’re living with a chronic disease.

**TIPS TO HELP YOU QUIT:**

1. Admit the problem to yourself and those around you.
2. Keep track of when and why you smoke.
3. Set a quit date.
4. Limit the time you spend with people who smoke.
5. Write down the list of reasons for not smoking. Keep that list with you. Make sure to review those reasons when you feel the urge to smoke.
6. Talk to your doctor about treatment options.
7. Call the “I Can Quit” program at 1-800-480-7848 for information on how Molina Healthcare can help you to quit.

**Substance Abuse**

You may have a substance abuse problem if:

- Anyone has ever told you that you should cut down on your drinking.
- Your drinking or behavior annoys people.
- You feel guilty about drinking or taking drugs.
- You ever had a drink first thing in the morning to steady your nerves or get rid of a hangover.

Please get help, call Molina Healthcare’s Member Services Department at 1-888-898-7969 for more information on how to get these services.
Non-Covered Services Section

Services Not Covered By Molina Healthcare

The following services are not covered by Molina Healthcare, but may be provided by Medicaid or other programs:

- Custodial services in a nursing home,
- Home and Community – Based Waiver Program services,
- Inpatient hospital psychiatric services,
- Intermittent or short-term restorative or rehabilitative services in a nursing facility after 45 days,
- Mental health services in excess of 20 outpatient visits each calendar year,
- Mental health services for enrollees meeting the guidelines under Medicaid policy for serious mental illness or severe emotional disturbance,
- Outpatient partial hospitalization psychiatric care,
- Personal care or home help services,
- Services provided by school district and billed through the Intermediate School District,
- Services, including therapies (speech, language, physical, occupational) provided to persons with developmental disabilities and billed through Community Mental Health Services Program providers or Intermediate School District,
- Substance abuse and detoxification services,
- Transportation for services not covered by Molina Healthcare,
- Traumatic Brain Injury Program services.

If you need help obtaining these services, please call Member Services at 1-888-898-7969.

Services Not Covered By Healthy MI

The following services are not covered by Healthy MI:

- Abortions (elective) and related services. Abortions and related services are covered when medically necessary to save the life of the mother, if the pregnancy is a result of rape or incest, treatment is for medical complications occurring as a result of an elective abortion or treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy.
- Services for treatment of infertility;
- Experimental / investigational drugs, procedures, or equipment; and
- Cosmetic surgery (elective).

If you have questions about these health care services, please call our Member Services Department at 1-888-898-7969.
Grievance and Appeal Section

Grievance Process
You can file a grievance with Molina Healthcare. If you are not happy with the health plan, this is called a grievance. You can also file a grievance if you are not happy with one of our providers.

You can submit a grievance orally or in writing. Molina Healthcare's Appeal and Grievance Coordinator can help you write your grievance. If your grievance is submitted by a representative but the authorization for the representative is not received in writing, the timeframe does not begin until after its receipt. We will make a decision regarding your grievance within 30 days of receipt.

The Coordinator will look into your grievance. The Coordinator will ask other staff who know about the issue. This may be a nurse or a doctor who knows about the problem (if it is medical). Molina Healthcare will keep a written account of your grievance. It will be confidential (private). Grievances about the care you receive are sent to the Quality Improvement Department. This Department will investigate the complaint further.

If you would like to make a grievance, please call our Member Services Department at 1-888-898-7969.

Appeal Process:
You can file an appeal if Molina Healthcare denied, suspended, terminated, or reduced a requested service. This is called an adverse determination.

- You have 90 calendar days from the date of the adverse action notice to file an appeal.
- You have the right to appeal orally or in writing to the Appeals Review Committee of Molina Healthcare. Molina Healthcare's Appeal and Grievance Coordinator can help you write your appeal. If you would like to file an appeal, please call our Member Services Department at 1-888-898-7969.
- You have the right to include an authorized representative (anyone you choose, including an attorney) during the appeals process and to attend the Appeals Review Committee meeting. You must inform us of your authorized representative in writing. If your appeal is submitted by a representative but the authorization for the representative is not received in writing, the timeframe does not begin until after its receipt.
- You can bring any information that you feel will help the Committee make a better decision.
- The Coordinator will tell you the time and place the appeal will be held.
- Molina Healthcare will use reviewers who were not involved in the initial decision to review. The reviewers are health care professionals who have the appropriate clinical expertise in treating your condition or disease. A decision will be mailed to you in 30 calendar days from the date that Molina Healthcare received your appeal. Molina Healthcare will communicate to you in a way you will understand.
- An additional 10 calendar days are allowed to obtain medical records or other important medical information if you request the extension, or if the Plan can demonstrate that the delay is in your best interest.
- The Inquiry Dispute/Appeal Resolutions Coordinator will assist you in filing written appeals, including interpreter services if required. Oral interpretation is available for all languages. Hearing-impaired members are instructed to utilize the MI Relay line at 1-800-649-3777 and “non-English” speaking members are assisted by our Bi-Lingual Representatives and Language Line services for all languages. Please call Member Services at 1-888-898-7969 for assistance.
- Molina Healthcare will continue your benefits if all of the following conditions apply:
  - The appeal is filed timely, meaning on or before the later of within 10 days of Molina Healthcare
mailing the notice of action or the intended effective date of the action
◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
◆ The services were ordered by an authorized doctor
◆ The authorization period has not expired
◆ You request an extension of benefits

• If Molina Healthcare continues or reinstates your benefits while the appeal is pending, the benefits will be continued until one of the following occurs:
  ◆ You cancel the appeal
  ◆ You do not request a fair hearing within 10 days from when Molina Healthcare mails an adverse action notice
  ◆ A State Fair Hearing decision adverse to you is made
  ◆ The authorization expires or authorization limits are met

• If Molina Healthcare reverses the adverse action decision or the decision is reversed by the State Fair Hearing, Molina Healthcare must pay for services provided while the appeal is pending and authorize or provide disputed services promptly, and as quickly as your health condition requires.

• You may be required to pay the cost of the services if the denial is upheld.

• Molina Healthcare will inform you of our decision in writing.

Expedited Appeal (Urgent Cases)
If you or your doctor believes that the usual 30 day timeframe for appeals will cause harm to your health, or affect your normal body functions, your appeal may be expedited (urgent). You, your Provider or an authorized representative may file an expedited appeal within 10 days of the adverse determination. Expedited appeals are decided in 72 hours and mailed in two days. You have the right to ask for a copy of the benefit guidelines used to make this decision. You may request an expedited appeal with the Department of Insurance and Financial Services (DIFS) after you have filed an expedited with Molina Healthcare. If Molina Healthcare denies your request for an expedited appeal, you may request an expedited external review with DIFS within 10 days of the denial.

Department of Insurance and Financial Services
You can ask for an external review if you do not get an answer within 30 days from Molina Healthcare or you are not happy with the result of your appeal. You may appeal in writing to DIFS for an external review. The appeal request should be sent to:

Department of Insurance Financial Services (DIFS)
Healthcare Appeals Section Office of General Counsel
P.O. Box 30220
Lansing, MI 48909-7720
1-877-999-6442
Fax Number: 1-517-284-8838

You must appeal in writing to DIFS within 60 days after you receive the final answer from Molina Healthcare. Molina Healthcare can explain the external review process to you. We can also mail the external review forms to you. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 days of accepting your appeal.
You, your authorized representative or your doctor can also request an expedited appeal decision from DIFS at the same address above within 10 days after receiving an adverse determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours.

**State Fair Hearing Process**

If you have any problems about the care you are getting, you can request a hearing at any time within 90 days of the adverse determination directly with the Michigan Department of Health and Human Services (MDHHS). Molina Healthcare will include a hearing request form along with a self-addressed stamped envelope. You can file an appeal with Molina Healthcare at the same time. Below are the steps for the State’s Medicaid Fair Hearing process.

**Step 1**  
Call Molina Healthcare’s Appeal & Grievance Department at 1-888-898-7969 or Michigan ENROLLS at 1-888-367-6557; or Michigan Administrative Hearings System at 1-877-833-0870 to have a Hearing Request form sent to you. You may also call to ask questions about the hearing process.

**Step 2**  
Fill out the request form and return it to the address listed on the form.

**Step 3**  
A hearing will be scheduled.

**Step 4**  
The results will be mailed to you from MDHHS after the hearing is held. If your complaint is taken care of before your hearing date, you must call to ask for a Hearing Request Withdrawal Form. You can call 1-877-833-0870 to request this form. The address to request this Hearing Request Withdrawal form is:

**Michigan Administrative Hearings System**

P.O. Box 30763  
Lansing, MI 48909  
Attn: Hearings/Appeals  
1-877-833-0870

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**Your Rights and Responsibilities Section**

**Member Rights and Responsibilities**

Molina Healthcare staff and providers will comply with all requirements concerning your rights.

**Molina Healthcare members have the right to:**  
- Get information on the structure and operation of the health plan, its services, practitioners and providers and member rights and responsibilities.  
- Choose your Primary Care Provider  
- Know if a copayment or contribution is required  
- Know the names, education, and experience of your health care providers  
- Be treated with respect with recognition of your dignity and your right to privacy
• Take part in decision making with your doctor about your health care, including the right to refuse treatment and candidly discuss appropriate or medically necessary treatment options of your conditions, regardless of cost or coverage.
• Get a fair and timely reply to requests for service.
• Voice complaints or appeals about the organization and the care it provides.
• Know that your member information will be kept private. It is only used in reports to the state to show that the Plan is following state rules and laws.
• Ask how your doctor is paid.
• To make recommendations regarding the Plan’s member rights and responsibility policy.
• Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience or retaliation.
• Request and receive a copy of your medical records, and request that they be amended or corrected.
• Be provided covered healthcare services
• Be free to exercise your rights without adversely affecting the way Molina, our providers or the State treat you.
• Be free from other discrimination prohibited by State and Federal regulations.
• Request clinical practice guidelines upon request
• Get a second medical opinion
• Get help with any special language needs

Molina Healthcare members have the responsibility to:
• Provide Molina Healthcare and its practitioners and providers with the necessary information needed to care for you.
• Know, understand, and follow the terms and conditions of the health plan.
• Seek out information in order to make use of the services.
• Take part in decision-making about your healthcare. Understand your health problems and participate in developing mutually agreed-upon treatment goals.
• Report other insurance benefits, when you are eligible, to your Department of Human Services Specialist and the Beneficiary Helpline at 1-800-642-3195.
• Show your MIHealth or Molina Healthy MI card to all providers before receiving services
• Never let anyone use your MIHealth or Molina Healthy MI card
• Choose a primary provider, schedule an appointment within 60 days of enrollment and build a relationship with the provider you have chosen
• Make appointments for routine checkups and immunizations (shots)
• Keep your scheduled appointments and be on time
• Provide complete information about your past medical history
• Provide complete information about current medical problems
• Ask questions about your care
• Follow your provider’s medical advice
• Respect the rights of other patients and health care workers
• Use emergency room services only when you believe an injury or illness could result in death or lasting injury
• Notify your primary provider if emergency treatment was necessary and follow-up care is needed
• Make prompt payment for all cost-sharing responsibilities
• Report changes that may affect your coverage to your Department of Human Services specialist. This could be an address change, birth of a child, death, marriage or divorce, or change in income
• Promptly apply for Medicare or other insurance when you are eligible.
REPORTING HEALTHY MI PLAN BENEFICIARY FRAUD

You may be prosecuted for fraud if you:

- Withhold information on purpose or give false information when applying for the Healthy MI Plan or other assistance programs; or
- Do not report changes that affect your eligibility to your Department of Human Services specialist.

If you are found guilty under federal law, you can be fined as much as $10,000 or can be sent to jail for up to a year or both. Also, your Healthy MI Plan or other medical benefits may be suspended for one year.

You can also be prosecuted for fraud under state law. If you are found guilty, you can be sent to jail, fined and ordered to repay the state monies paid on your behalf for health care. If you are convicted of a felony under state law, your jail sentence may be up to four years.

Report cases of suspected fraud to your local Department of Human Services office, or call 1-800-222-8558. You do not have to give your name.

REPORTING HEALTHY MI PLAN PROVIDER FRAUD

A health care provider who is enrolled in Medicaid is also subject to federal and state penalties for Healthy MI Plan fraud. Report any provider you suspect of:

- Billing for a service he or she did not perform, or
- Providing a service that is not needed.

Report suspected provider fraud to:

**Michigan Department of Health and Human Services**
Office of Health Services Inspector General
PO Box 30479
Lansing, MI 48909-7979

You may call the 24-hour hotline at 1-855-MIFRAUD (1-855-643-7283) toll free or visit the website at:
www.michigan.gov/fraud

You do not have to give your name.

**About Our Members: Protecting Your Privacy**

Your privacy is important to us. We take confidentiality very seriously. Molina Healthcare wants to let you know how your health information is shared or used.

**Your Protected Health Information (PHI)**

PHI stands for these words: protected health information. PHI means health information that includes your name, member number, or other things that can be used to identify you, and that is used or shared by Molina Healthcare.
Why does Molina Healthcare use or share our members’ PHI?
- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law.

When does Molina Healthcare need your written authorization (approval) to use or share your PHI?
Molina Healthcare needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?
- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does Molina Healthcare protect your PHI?
Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or PHI in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI.
- Only Molina Healthcare staff with a need to know PHI may use PHI.
- Molina Healthcare staff is trained on how to protect and secure PHI.
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI.
- Molina Healthcare secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

What can you do if you feel your privacy rights have not been protected?
- Call or write Molina Healthcare and file a complaint.
- File a complaint with the U.S. Department of Health and Human Services.

The above is only a summary.
Our Notice of Privacy Practices has more information about how we use and share our members’ PHI. Our Notice of Privacy is included below and is on our website at www.MolinaHealthcare.com. You may get a copy of our Notice of Privacy Practices by calling our Member Services Department at 1-888-898-7969.
NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF MICHIGAN

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

Molina Healthcare of Michigan (“Molina” or “we”) uses and shares protected health information about you to provide your health benefits. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private. We have policies in place to obey the law. The effective date of this notice is March 1, 2007.

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

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

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

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

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

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

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

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

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

In addition to treatment, payment and health care operations, the law allows or requires Molina Healthcare to use and share your PHI for several other purposes, including the following:

**Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:**

- The information is directly relevant to the family or friend’s involvement with your care or payment for that care; and
- You have either orally agreed to the disclosure or have been given an opportunity to object and have not objected.

**Required by law.**

We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS).

**Public Health.**

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

**Health Care Oversight.**

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

**Research.**

Your PHI may be used or shared for research in certain cases, when approved by a privacy or institutional review board.

**Legal or Administrative Proceedings.**

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

**Law Enforcement.**

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

**Health and Safety.**

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

**Government Functions.**

Your PHI may be shared with the government for special functions, such as national security activities.

**Victims of Abuse, Neglect or Domestic Violence.**

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

**Workers Compensation.**

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

**Other Disclosures.**

PHI may be shared with funeral directors or coroners to help them to do their jobs.
When does Molina Healthcare need your written authorization (approval) to use or share your PHI?
Molina Healthcare needs your written approval to use or share your PHI for a purpose other than those listed in this notice. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?
You have the right to:

► Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)
You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to fill out a form to make your request.

► Request Confidential Communications of PHI
You may ask Molina Healthcare to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to fill out a form to make your request.

► Review and Copy Your PHI
You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina Healthcare member. You will need to fill out a form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases, we may deny the request.

► Amend Your PHI
You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to fill out a form to make your request. You may file a letter disagreeing with us if we deny the request.

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

- for treatment, payment or health care operations;
- to persons about their own PHI;
- sharing done with your authorization;
- incident to a use or disclosure as otherwise permitted or required under applicable law;
- as part of a limited data set for research or public health activities;
- PHI released in the interest of national security or for intelligence purposes;
- to correctional institutions having custody of an inmate; or
- shared prior to April 14, 2003.

We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You must fill out a form to request a list of PHI disclosures.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Manager of Member Services at 1-888-898-7969.
What can you do if your rights have not been protected?
You may complain to Molina Healthcare and to the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care will not change in any way.

You may complain to us at:

**Molina Healthcare of Michigan**
Attention: Supervisor, Member Services
880 West Long Lake Road, Suite 600
Troy, MI 48098-4504
Phone: 1-888-898-7969

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

**Office for Civil Rights**
U.S. Department of Health & Human Services
223 North Michigan Avenue, Suite 240
Chicago, IL 60601
1-800-368-1019
1-800-537-7697 (TDD)
1-312-886-1019 FAX

What are the duties of Molina Healthcare?
Molina Healthcare is required to:
- Keep your PHI private.
- Give you written information such as this on our duties and privacy practices about your PHI.
- Follow the terms of this Notice.

This Notice is Subject to Change
Molina Healthcare reserves the right to change its information practices and terms of this notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, a new notice will be sent to you by US Mail.

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

Molina Healthcare of Michigan
Supervisor, Member Services
880 West Long Lake Road, Suite 600
Troy, MI 48098-4504
Phone: 1-888-898-7969

Advance Directives
(Michigan’s Durable Power of Attorney for Health Care)
An advance directive is a written advance care-planning document that explains how medical decisions should be made for a patient who is unable to make or express his or her wishes concerning health care.
The durable power of attorney for health care (DPAHC) is the form of advance directive recognized by the Michigan Department of Health and Human Services (1998, Public Act 386). This lets you choose another person to make decisions about your care, custody, and medical treatment if you cannot make these decisions for yourself. This way, your desire to accept or refuse medical treatment is honored when you cannot make that choice yourself.

According to Michigan Law:
- Anyone age 18 or older, and of sound mind, may have a DPAHC for health care in case something happens and you cannot make decisions for yourself.
- This act allows you to select a relative or other person as your patient advocate to make medical treatment decisions for you.
- You may change the person you appoint as your advocate at any time.
- You may write on the form the types of treatment you do and do not want.
- If you write on the form that you want your patient advocate to order doctors to withhold or withdraw life-sustaining treatment in certain situations, the doctors must honor your wishes.
- You should keep a copy of your DPAHC with you at all times.

If you find that your wishes are not followed by a health care provider, or they do not comply with your DPAHC you may file a complaint with:

**Bureau of Health Professions (BHP), Grievance & Allegation Division.**
PO Box 30670
Lansing, MI 48909-8170
1-517-373-9196 or bhpinfo@michigan.gov
The BHP Grievance & Allegation website is www.michigan.gov/healthlicense (click on “file a complaint”).

For complaints about how your health plan follows your wishes, write or call:

Department of Insurance and Financial Services (DIFS)
Toll free at 1-877-999-6442 or www.michigan.gov/difs
Fraud and Abuse Section

Fraud, Waste & Abuse

Molina Healthcare's Fraud, Waste and Abuse Plan benefits Molina, its employees, members, providers, payors and regulators by increasing efficiency, reducing waste, and improving the quality of services. Molina Healthcare takes the prevention, detection, and investigation of fraud, waste and abuse seriously, and complies with state and federal laws. Molina Healthcare investigates all suspected cases of fraud, waste and abuse and promptly reports all confirmed incidences to the appropriate government agencies. Molina Healthcare takes the appropriate disciplinary action, including but not limited to, termination of employment, termination of provider status, and/or termination of membership.

Definitions:

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR §455.2)

Here are some examples of abuse:

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

“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. (42 CFR § 455.2)
Here are some examples of fraud:
- Using someone else's member ID card
- Changing a prescription written by a doctor
- Billing for services that were not provided
- Billing for the same service more than once

Here are some ways you can help stop fraud:
- Do not give your Molina Healthcare ID card, MIHealth ID Card, or ID number to anyone other than a health care provider, a clinic, or hospital, and only when receiving care.
- Never let anyone borrow your Molina Healthcare ID card.
- Never sign a blank insurance form.
- Be careful about giving out your social security number.

If you think fraud, waste and abuse has taken place, you can report it without giving your name to:

**Molina Healthcare of Michigan**
Attention: Compliance Director
880 West Long Lake Road, Suite 600
Troy, MI 48098-4504
Phone: 1-866-606-3889
Fax: 1-248-925-1797
E-mail: MHMCompliance@MolinaHealthcare.com
Online: MolinaHealthcare.alertline.com

Or

**Michigan Department of Health and Human Services**
Office of Inspector General
P. O. Box 30479
Lansing, MI 48909
1-855-MI-FRAUD (1-855-643-7283)
www.michigan.gov/fraud
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Article I. General Conditions

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

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

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

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

Article II. Definitions

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

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

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

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

2.5 **Department** means the Department of Health and Human Services or its successor agency which administers the Medicaid Program in the State of Michigan.

2.6 **Michigan Department of Health and Human Services** is the State agency responsible for Medicaid eligibility determinations.

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

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

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

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

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

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

2.14 **Hospital Services** means those Covered Services which are provided by a Hospital.

2.15 **Medicaid Contract** is the contract between the State and the Plan under which the Plan agrees to provide or arrange for Covered Services for Members.

2.16 **Medicaid Program** means the Department's program for Medical Assistance under Section 105 of Act No. 280 of The Public Acts of 1939, as amended, MCL 400.105, and Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq.
2.17 **Medical Director** means a Physician designated by the Plan to supervise and manage the quality of care aspects of the Plan's programs and services.

2.18 **Medically Necessary** means the services, equipment or supplies necessary for the diagnosis, care or treatment of the Member's physical or mental condition as determined by the Medical Director in accordance with accepted medical practices and standards at the time of treatment. Medically Necessary does not in any event include any of the following:
   a. Services rendered by a Health Professional that do not require the technical skills of such a provider; or
   b. Services, equipment and supplies furnished mainly for the personal comfort or convenience of the Member, any individual who cares for the Member, or any individual who is part of the Member's family; or
   c. That part of the cost of a service, equipment or supply which exceeds that of any other service, equipment or supply that would have been sufficient to safely and adequately diagnose or treat the Member’s physical or mental condition, except when rendered by, or provided upon the referral of, a Primary Care Provider, or otherwise authorized by the Plan, in accordance with the Plan's procedures.

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

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

2.21 **Member Agreement** means this Certificate, the membership card issued by the Plan to the Member and the Member's current Medicaid card, including any amendments, addenda and appendices to any of the foregoing.

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

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

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

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

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

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

2.28 **Payer** means all insurance and other health plan benefits, including Medicare and other private and governmental benefits.
2.29 **Plan** means Molina Healthcare of Michigan, a Michigan for Profit Corporation and a licensed health maintenance organization.

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

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

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


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

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

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

**Article III. Eligibility and Enrollment**

3.1 **Member Eligibility.** To be eligible to enroll in the Plan an individual must be eligible for the Healthy Michigan Plan as determined by the Michigan Department of Health and Human Services and must reside within the Service Area. The Michigan Department of Health and Human Services is solely responsible for determining the eligibility of individuals for the Medicaid Program. The Department assigns individuals to health plans. Eligible individuals may choose a health plan, or the Department may choose a health plan for the eligible individuals.

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

3.3 **Newborns.** The Member’s newborn child is automatically enrolled in the Medicaid Health Plan as a Member for the month of birth, and may be eligible for enrollment for additional time periods. The newborn is entitled to Covered Services retroactive to the date of birth. The Member shall notify the Plan as soon as possible of the birth of a newborn. The Plan will notify the Department of the birth in accordance with Department procedures. The Michigan Department of Health and Human Services is solely responsible for determining the continued eligibility and the Department is responsible for the enrollment of a newborn.
3.4 **Change of Residency.** The Member shall notify the Michigan Department of Health and Human Services and the Plan when the Member changes residence. Residing outside of the Service Area is grounds to request the termination of the Member’s enrollment in the Plan under Article 9.

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

**Article IV. Relationship with Participating & Non-Participating Providers**

4.1 **Selecting a Primary Care Provider.** By the effective date of enrollment, the Member should select a Primary Care Provider. If the Member is incapable of selecting a Primary Care Provider, an authorized person should select a Primary Care Provider on behalf of such Member. An authorized person may select a pediatrician as the Primary Care Provider for a Member who is under the age of 21. The Plan may select a Primary Care Provider for a Member in the event that a Primary Care Provider is not selected by or for the Member. The Plan will use prescribed guidelines to make such a selection.

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

4.3 **Changing a Primary Care Provider.** The Member may change to another Primary Care Provider by contacting Member Services. All changes must be processed by Member Services which will then notify the Member of the effective date of the change.

4.4 **Specialist Physicians and Other Participating Providers.** Except as otherwise expressly stated in this Section 4.4 or other sections of this Certificate, the Member may receive Covered Services from Specialist Physicians and other Participating Providers. The Plan does not require authorization for most in-network Specialist Physician Services. In some circumstances, certain medical services, equipment and supplies are not covered or may require prior authorization by the Plan. Prior authorization is required for most services provided out of the Plan’s provider network. The Member may contact the Plan to obtain a list of services requiring prior authorization. If the Member does not obtain the necessary authorization from the Plan, the Member may be financially responsible for payment of medical services, equipment or supplies if notified by the provider prior to the service. A female Member may receive an annual well-woman examination and routine obstetrical and routine gynecological services from an obstetrician-gynecologist or women’s health specialist who is a Participating Provider without prior authorization from the Primary Care Provider or the Plan. A pediatrician may be selected as the Primary Care Provider for a Member under the age of 2 as indicated in Section 4.1.

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

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

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

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

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

**Article V. Member Services**

5.1 **Release and Confidentiality of Member Medical Records.**

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

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

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

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

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

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

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

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

5.2.1 **Grievance Process.** The Member may submit a grievance with the Plan either in person, in writing or by telephone. The Plan's Appeal and Grievance Coordinator may assist the Member filing the grievance. The Plan will make a decision regarding the Member's grievance within 30 days of receipt.

5.2.2 **Standard Appeal Process.** The Member can file an appeal if the Plan denies, suspends, terminates, or reduces a requested service. This is called an adverse determination. The Member has 90 calendar days from receiving the adverse determination to file an appeal. The Member has the right to appeal in person, in writing, or by telephone to the Plan's Appeals Review Committee. The Plan's Appeal and Grievance Coordinator can help assist with filing the appeal. The Member has the right to include an authorized representative throughout the appeals process and to attend the Appeals Review Committee meeting. The Member must inform the Plan of the authorized representative in writing. The Plan will use reviewers who were not involved in the adverse determination. A decision will be mailed to the Member within 30 calendar days from the date that the Plan received the appeal. An additional 10 calendar days are allowed to obtain medical records or other pertinent medical information if the Member requests the extension, or if the Plan can demonstrate that the delay is in the Member's interest.
5.2.3 **Expedited Appeal Process.** An expedited appeal process is available if the Member or the Member’s physician believes that the usual 30 day timeframe for appeals will cause harm to the Member’s health, or affect the Member’s normal body functions. Expedited appeals are decided in 72 hours. The Member may request an expedited appeal with DIFS after an expedited appeal is filed with Molina Healthcare. If the Plan denies the Member’s request for an expedited appeal, the Member may request an expedited external review with the Department of Insurance and Financial Services (DIFS) within 10 days of the denial.

5.2.4 **Department of Insurance and Financial Services** The Member may request for an external review if the member does not receive a decision from the Plan within 30 days from the Plan or is not satisfied with the result of the appeal. The appeal request should be sent to Department of Insurance and Financial Services (DIFS), Healthcare Appeals Section, Office of General Counsel, P.O. Box 30220, Lansing, MI 48909-7720.

5.2.5 **State Fair Hearing Process.** A Member has the right to a Medicaid fair hearing on any decision made by the Plan that the Member believes is inappropriate by contacting the Michigan Administrative Hearings System by calling 1-877-833-0870 or 1-517-335-2484. The fax number is 1-517-373-4147. The address is Michigan Administrative Hearings System, P.O. Box 30763, Lansing, MI 48909. The Member must request the Medicaid Fair Hearing within 90 days of the Plan's decision.

5.3 **Member Handbook.** Members will receive a copy of the Member Handbook when they enroll in the Plan and may receive additional copies at any time by telephone request to Member Services. The Member Handbook is also available on the Plan website at www.MolinaHealthcare.com.

5.4 **Membership Cards.**

5.4.1 The Plan will issue a membership card to each Member. The Member must present the membership card to Participating Providers each time the Member obtains Covered Services.

5.4.2 If the Member permits the use of the membership card by any other person, the Plan may immediately reclaim the card. Permitting the use of the membership card by any other person may be grounds to request the termination of the Member’s enrollment in the Plan, under Article 9.

5.4.3 If the Member’s membership card is lost or stolen, the Member must notify Member Services by the end of the next business day following the Member’s discovery of the loss or the date of the theft.

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

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

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

6.3 **Claims.**

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

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

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

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

6.4 **Non-Participating Providers.** The Member is financially responsible for payment for all services, supplies and equipment received from Non-Participating Providers unless those services are included as Covered Services on Appendix A of this Certificate and are authorized as required by the Plan. However, prior authorization is not required for Emergency Services, Family Planning Services, treatment of communicable diseases at the Member’s local health department, immunizations at the Member’s local health department, services from child and adolescent health centers and programs and federally qualified health centers.
6.5 **Non-Covered Services.** The Member may be financially responsible for payment for any Non-Covered Services received by the Member if the Member knew or reasonably should have known that the services were Non-Covered Services at the time the services were rendered. The Plan may recover from the Member the expenses for Non-Covered Services.

Article VII. Covered Services & Coordination of Care Services

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

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

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

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

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

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

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

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

7.4 **Out-of-Area Services.**

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

7.4.2 Hospitalization. If an Emergency requires hospitalization, the Member, the Hospital or a responsible person must contact the Plan and Member's Primary Care Provider as soon as possible after the Emergency hospitalization begins. The Plan or Member's Primary Care Provider may require the Member to move to a Participating Hospital when it is physically possible to do so.
7.5 **Coordination of Care Services.** The Plan will refer Members to agencies or other providers for certain services which the Member may be eligible to receive, but which are not Covered Services. These services are set forth on Appendix B.

Article VIII. Exclusions and Limitations

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

8.2 **Limitations.**

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

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

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

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

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

Article IX. Term and Termination

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

9.2 **Termination of Certificate by the Plan or the Department.**

9.2.1 This Certificate will automatically terminate upon the effective date of termination of the Medicaid Contract. Enrollment and coverage of all Members will terminate at 12:00 Midnight on the date of the termination of this Certificate, except as otherwise provided by the Medicaid Contract.
9.2.2 In the event of cessation of operations or dissolution of the Plan, this Certificate may be terminated immediately by court or administrative agency order or by the Board of Directors of the Plan. The Plan will be responsible for Covered Services to Members as otherwise prescribed by the Medicaid Agreement.

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

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

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

a. The Member moves out of the Service Area.

b. The Member ceases to be eligible for the Healthy Michigan Plan or the Plan as determined by the Michigan Department of Health and Human Services and the Department.

c. The Member dies.

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

e. The Member is incarcerated in a correctional facility.

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

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

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

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

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

9.3.5 In all cases, the Department will make the final decision concerning termination of a Member’s enrollment under this Section 9.3. The Department also will determine the effective date of termination.
9.4 Disenrollment by Member.

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

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

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

Article X. Coordination of Benefits

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

10.2 Assignment.

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

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

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

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

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

10.4 Notification. Each Member must notify the Plan of any health insurance or health plan benefits, rights to payment and money paid for any claims for health care when the Member learns of them.
10.5 **Order of Benefits.** In establishing the order of Payer responsibility for health care benefits, the Plan will follow coordination of benefits guidelines authorized by the Department and DIFS and applicable provisions of the Michigan Coordination of Benefits Act, Public Act 64 of 1984, as amended, MCL 550.251 et seq., as required by Section 21074 of the Michigan Public Health Code, Public Act 368 of 1978, as amended, MCL 333.21074.

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

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

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

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

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

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

**Article XI. Subrogation**

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

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

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

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

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

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

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

Molina Healthcare of Michigan
Attn: Member Services
880 West Long Lake Road, Suite 600
Troy, Michigan 48098-4504

Appendix A - Benefit Detail of Covered Services

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

1. Allergy testing, evaluations and injections, including serum costs.

2. Ambulatory Surgical Services and Supplies. Outpatient services and supplies furnished by a surgery center for a covered surgical procedure.

3. Ambulance Services. Professional ambulance services, including air ambulance services for the following situations or conditions:

   a. Ambulance transportation to the emergency department of a Hospital due to an Emergency;

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

   c. Transportation from a non-participating hospital to a Participating Hospital; and

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

4. Antineoplastic Drug Therapy. Antineoplastic drugs are covered in accordance with Section 21054b of the Public Health Code.
5. **Blood Lead Screening and Follow-Up.** Blood lead screening and follow-up services are covered for Member’s under the age of 21.

6. **Cardiac Rehabilitation Therapy.**

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

7. **Contraceptive Medications and Devices.** Contraceptive medications, supplies, and devices are covered. Over-the-counter family planning drugs and supplies are covered with a prescription.

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

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

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

   3. Syringes.

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

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

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

   1. Insulin.
   2. Non-experimental medication for controlling blood sugar.
   3. Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes.

9. **Disposable Items and Other Medical Supplies:**

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

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

10. **Durable Medical Equipment and Supplies.** Durable medical equipment is covered in accordance with Department guidelines.

11. **Emergency Services.**
12. **End Stage Renal Disease Services.**

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

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

   b. **Diaphragms and Intrauterine Devices (IUDs).**

   c. **Advice on Contraception and Family Planning.**

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

14. **Hearing Care.** Hearing exams and supplies are covered. Hearing aid batteries and maintenance and repair of hearing aids are covered. Batteries are distributed in one month supplies.

15. **Health Education.**

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

17. **Hospice Services.**

18. **Hospital Services.**

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

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

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

19. **Infusion Therapy.**

20. **Maternity Care.**

   a. **Hospital and Physician.** Services and supplies furnished by a Participating Hospital or Participating Physician for prenatal care, genetic testing, delivery and postnatal care.
b. Certified Nurse Midwife Services.

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

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

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

f. Parenting and Birthing Classes.

21. Medically Necessary Weight Reduction Services. Medically Necessary weight reduction services are covered for Members with life endangering medical conditions. Prior authorization is required.

22. Mental Health Services. Short-term outpatient therapy is covered for up to 20 visits per calendar year. The outpatient mental health benefit is not meant to cover severe and/or persistent mental disease or illness of children or adolescents with severe emotional disturbances.

23. Non-Emergent Transportation. Non-Emergent transportation to covered services is provided.


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

   i. Emergency repair and treatment of fractures of the jaw and facial dislocation of the jaw.

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

b. Orthognathic Surgery. Orthognathic surgery (surgery to correct the relationship or positions of the bones and soft tissues of the jaw) for congenital syndromes which directly affect the growth, development and function of the jaw and surrounding structures is covered.
25. **Organ and Tissue Transplants.** Cornea and kidney transplants are covered benefits. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologous, and peripheral stem cell harvesting, and small bowel) are covered on a Member specific basis when determined Medically Necessary according to currently accepted standards of care. The Plan has a policy to evaluate, document and act upon a Member's request for an extrarenal transplant. A Member may obtain a copy of the policy upon request to the Plan. Antineoplastic drugs are covered in accordance with Section 21054b of the Public Health Code.

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

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

28. **Podiatry Services.** Podiatry services are covered.

29. **Prescription Drugs.**
   a. Formulary drugs are covered every 30 days.
   b. Condoms are covered, limited to 36 condoms every 30 days.
   c. Over-the-counter drugs and medical supplies must have a prescription to be covered.
   d. Infertility drugs are not covered.
   e. Off-label use of a federal food and drug administration approved drug and reasonable cost of supplies Medically Necessary for administrator of the drug as required under MCL 500.3406q.

30. **Professional Care Services by Physicians and Other Health Care Professionals.** Coverage is provided for the Member for office visits to Physicians, Certified Pediatrics and Nurse Practitioners and other Health Care Professionals. Covered Services include:
   b. Routine pediatric and adult immunizations as recommended by the U.S. Public Health Services guidelines.
   c. Health education.

31. **Prosthetic Devices and Orthotics.** Standard prosthetic and orthotic supports and devices are covered in accordance with Department guidelines. Prosthetic devices are custom made artificial devices used to replace all or a portion of a part of the body (e.g. artificial limb). Breast prosthesis after mastectomy is covered.
32. **Radiology Examinations and Laboratory Procedures.** Diagnostic and therapeutic radiology services and laboratory tests if not excluded elsewhere in the Certificate.

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

34. **Restorative, Habilitative, or Rehabilitative Services (in a place of service other than a nursing facility).**

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

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

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

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

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

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

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

39. **Treatment of Communicable Diseases.** Treatment for communicable disease require no prior authorization when received from a local health department or other clinic.

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

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

42. **Second Surgical Opinion Consultations** are covered when recommended by a Participating Physician or desired by the enrolled Member or Member's representative.
Appendix B - Coordination of Care Services

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

a. **Dental Services.** Diagnostic, preventive, restorative, prosthetic and medically/clinically necessary oral surgery services, including extractions, are covered. The Plan will provide Members with the names of participating dentists in their area who are available to provide dental services.

b. **Mental Health Services.** Mental health services are not covered by the Member Agreement, except for 20 mental health outpatient visits each calendar year. Members may be eligible to receive other mental health services through coordinating agencies in their area. The Plan will provide Members with information regarding these services upon request, may refer Members for these services and will coordinate the Member's services with the coordinating agency as appropriate.

c. **Developmental Disability Services.** Developmental disability services are not covered by the Member Agreement. Members may be eligible to receive developmental disability services through coordinating agencies in their area. The Plan will provide Members with information regarding these services upon request, may refer Members for these services and will coordinate the Member's services with the coordinating agency as appropriate.

d. **Substance Abuse Services.** Substance abuse services are not covered by the Member Agreement. Members may be eligible to receive substance abuse services through coordinating agencies in their area. The Plan will provide Members with information regarding these services upon request, may refer Members for these services and will coordinate the Member's services with the coordinating agency as appropriate.

e. **Coordination with Local Health Department.** The Plan will coordinate certain services with the Member's local health department and will make certain referrals as appropriate.

f. **Maternal and Infant Health Program Services.** Maternal and Infant Health Program Services are not covered by the Member Agreement. Services are provided by certified providers for pregnant Members and infants to ensure healthy deliveries, which may include home visits, social services and transportation. The Plan will refer eligible members to certified providers for program services.

g. **Inpatient Hospital Psychiatric Services.**

h. **Outpatient Partial Hospitalization Psychiatric Care.**

i. **Traumatic Brain Injury Program Services.**

j. **Nursing Facility Services.** Intermittent or short-term restorative rehabilitative services in a nursing facility after 45 days and custodial care provided in a nursing facility.

k. **School Based Services.** Services provided by a school district and billed through the Intermediate School Districts.
l. **Developmental Disability Services.** Services, including therapies (speech, language, physical, occupational) provided to persons with developmental disabilities which are billed through the Community Mental Health Service Program providers or Intermediate School Districts.

m. **Home Community Based Waiver Services.**

n. **Personal Care or Home Help Services.**

o. **Transportation Services.** Transportation for services not covered by the Plan to include therapies (speech, language, physical, occupational) provided to persons with developmental disabilities which are billed through the Community Mental Health Program.

p. **Cost Sharing Information.** Cost sharing refers to the two types of payments you may make for your health services. It includes contributions and copays. Your cost sharing amount may change if you adopt healthy behaviors. Cost sharing cannot exceed 5% of your income. It is mandated by the Michigan Department of Health and Human Services.

q. **Contributions.** The Healthy Michigan Plan requires people with annual incomes between 100% and 133% percent of the Federal Poverty Level to contribute 2% of annual income as a contribution.

r. **Copays.** Some covered services have a copay. A copay is a small amount of money you pay each time you get health care. Copays are paid to Molina Healthcare of Michigan.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits (including Free-Standing Urgent Care Centers)</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Outpatient Hospital Clinic Visit</td>
<td>$1 per visit</td>
</tr>
<tr>
<td>Hospital Emergency Room Visit (Copay only applies to non-emergency services)</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$1 for each generic brand drug</td>
</tr>
<tr>
<td></td>
<td>$3 for each name brand drug</td>
</tr>
<tr>
<td>Chiropractic Visits</td>
<td>1 per visit</td>
</tr>
<tr>
<td>Dental Visits</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$3 per aid</td>
</tr>
<tr>
<td>Podiatric Visits</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Vision Visits</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Inpatient Hospital Stay (Copay only applies to elective/non-emergent admissions)</td>
<td>$50 for the first day of the hospital stay</td>
</tr>
</tbody>
</table>

There are no copays for:

- Family planning products or services
- Any pregnancy-related products or services or if you are pregnant
- Services related to chronic conditions, such as heart disease and diabetes
Appendix C - Excluded Services & Limitations

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

4. ** Abortions.** Elective therapeutic abortions and related services.

5. **Acupuncture.** Acupuncture services are not covered.

6. **Alternative Procedures and Treatments.** Alternative procedures and treatments which are not generally recognized or accepted by the medical community are excluded. Also excluded are procedures and treatments which are primarily educational in nature.

7. **All Services or Supplies that are not Medically Necessary are not covered.**

8. **Ambulance Services.** Use of an ambulance for transportation for any reason other than an Emergency or because the Member's medical condition necessitates use of an ambulance is not a Covered Service.

9. **Autopsy.** Autopsy services are not covered.

10. **Biofeedback.** Biofeedback services are not covered.

11. **Cognitive Evaluation and/or Retraining and Related Services.** Cognitive services, training and/or retraining, and any related care, supplies or procedures, are excluded regardless of who provides them.

12. **Cosmetic Surgery/Procedures.** Surgery, medications, injections, procedures and related services performed to reshape normal structures of the body in order to improve or alter the Member's appearance or self-esteem are excluded. Examples include, but are not limited to, elective rhinoplasty, spider/varicose vein removal and elective breast reduction. Cosmetic alteration done simultaneous to surgery for a medical condition is not covered. Wigs, prosthetic hair or hair transplants are not covered. As provided in Appendix A, breast reconstructive surgery following a mastectomy is covered.

13. **Court-Ordered Services.** Charges for services ordered by a court of law will not be covered unless they are otherwise Medically Necessary and all Plan requirements are met.

14. **Custodial or Domiciliary Care.** Custodial or domiciliary care, including such care in a nursing home, is excluded.

15. **Developmental Disability Services.** Services provided to a Member with a developmental disability and billed through Community Mental Health Services Program providers are not covered. Members may be eligible to receive developmental disability services through providers or agencies in their areas as indicated in Appendix B of the Certificate.

16. **Experimental, Investigational or Research Drugs, Biological Agents Devices, Supplies, Treatments, Procedures or Equipment.** These services are not covered.

17. **Forms.** Charges for time involved in completing necessary forms, claims or reports are not covered.
18. Government-Provided Medical Care. Medical expenses incurred in any government hospital or for services of a government physician or other health professional are excluded.

19. Hair Analysis.

20. Home and Community Based Waiver Program Services.

21. Hospital Confinement. Days of confinement for non-medical reasons are not covered.

22. Long-Term Therapies. Long-term therapies which exceed the defined benefit are not covered.

23. Medical Equipment and Supplies. Excluded from coverage are: replacement and/or repair of most covered items due to misuse, loss or abuse as defined by the Medicaid Provider Manual; experimental items; batteries (except hearing aid batteries); and comfort and convenience items such as over-bed tables, heating pads, protective helmets, adjusta-beds, telephone arms, air conditioners, sauna baths, whirlpool baths, hot tubs and elevators.

24. Mental Health Services. Mental health services are limited to 20 outpatient visits each calendar year. Inpatient hospital psychiatric services and outpatient partial hospitalization services are excluded. Physician services required for other than psychiatric care during a psychiatric inpatient admission are covered if the service is prior authorized by the Plan and is otherwise a covered benefit. Court ordered examinations to determine competence and expenses for expert witness’ testimony as to the mental condition of a Member are excluded. Court ordered treatment for mental conditions is excluded unless it is otherwise Medically Necessary and all Plan requirements are met. Diagnosis and treatment of mental illnesses not classified in the current Diagnostic Statistical Manual are excluded. Marital and relationship counseling and job counseling are excluded.

25. Non-Medical Services. Non-medical services such as on-site vocational rehabilitation and training or work evaluations, school, home or work site environmental evaluations, or related employee counseling are excluded.

26. Obstetrical Delivery in the Home. Services and supplies related to obstetrical delivery in the home are not covered.

27. Oral Splints and Appliances. Oral Splints and appliances associated with TMJ, orthognathic, and oral and maxillofacial surgeries are excluded.

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

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

30. Personal Care and Home Help Services.

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

   a. Medications prescribed for cosmetic purposes;
b. Experimental, investigational or research drugs;

c. Drugs prescribed to treat infertility;

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

e. Drugs prescribed for weight loss are excluded unless Medically Necessary; and


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

33. Reproductive Services and Transsexual Surgery. Reversal of elective sterilization is excluded. Sex-transformation surgery and all expenses in connection with such surgery are excluded. In vitro fertilization, GIFT, artificial insemination, ZIFT, intrauterine insemination (IUI), surrogate parenthood, and any infertility treatments are excluded.

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

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

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

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

38. Speech Therapy. Therapy to treat delays in speech development is excluded. Speech therapy in the home is excluded.

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

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