Priority Health Choice, Inc. Member Handbook and Certificate of Coverage **2023**

Priority Health™

Amendment to Priority Health Choice, Inc. Member Handbook

Effective: Immediately

Read this amendment carefully. The Certificate of Coverage is a contract that describes the rights and obligations of Members and Priority Health Choice, Inc. (PHC). This amendment has been made a part to the Agreement between you and us. The following Coverage is subject to all of the terms and conditions in the Certificate as well as the terms and conditions set forth in this amendment.

Transportation Services (non-emergency)

We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services covered by your Medicaid health plan, and other covered services.

Effective December 1, 2023, transportation services for members residing in Macomb, Oakland, and Wayne counties will be serviced by SafeRide.

- Please contact them at 1-833-944-0535 or the phone number on the back of your ID card.
- You will be asked to provide your health plan member number, medical appointment details and medical needs.
- Visit *priorityhealth.com/michigan-medicaid/member/plan/transportation-services* to learn more about your transportation assistance benefit and scheduling a ride.

Grievances

If you have questions or need help, call Priority Health Choice, Inc. at 1-888-975-8102 or TDD (1-888-551-6761) TTY(711)

Appeal Process

You have the right to ask for a State Fair Hearing/External Review and how to do it.

Priority Health Choice, Inc. may request an extension up to 14 more days in order to get more information before we make a decision.

We will call you to tell you our decision and send you and your authorized representative the Notice of Internal Appeal Decision. The Notice of Internal Appeal Decision will tell you what we will do and why.

If the decision made by Priority Health Choice, Inc. does not agree with the Notice of Adverse Benefit Determination, we will approve the services right away.

How Can You Expedite Your Appeal?

Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision.

What Happens Next?

After you receive the Notice of Internal Appeal Decision in writing, you do not have to take any action and your appeal file will be closed.

State Fair Hearing Process

If you asked for services to continue in your health plan appeal and want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing within 10 calendar days of the date on the decision notice. If you do not win this hearing, you may be responsible for paying for the services provided to you during the hearing process. You can also ask for a State Fair Hearing if you do not receive a Notice of Internal Appeal Decision from us within the required time frame.

External Review of Appeals

Send your request to:
Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Or call: 877-999-6442
Fax: 517-284-8838
Online: *difs.state.mi.us/Complaints/ExternalReview.aspx*

If you need assistance, you can contact Customer Service at 1-888-975-8102 or TTY(711) TDD (1-888-551-6761).

Miscellaneous Provisions

If there is any conflict between these provisions and the Certificate, the provisions of this amendment will prevail. All other terms and conditions of the Certificate will remain in full force and effect.

Nothing contained in this amendment varies, alters, waives, or extends the terms, conditions, provisions, or limitations of the Certificate other than as stated above.

Contents

Welcome to Priority Health Choice, Inc.

Priority Health Choice, Inc. has a contract with the Michigan Department of Health and Human Services to provide health care services to Medicaid Enrollees. We work with a group of doctors and specialists to help meet your needs.

This handbook is your guide to the services we offer. It will also give you helpful tips about Priority Health Choice, Inc. It has two parts. The first part is your member handbook — it tells you how to use your health care benefits. The second part is your Certificate of Coverage, which is your legal coverage contract. Please read this book and keep it in a safe place in case you need it again. If you need another copy, it is available upon request and free of charge by contacting Customer Services. You can also access this handbook and on our website at *priorityhealth.com*

Interpreter Services

We can get an interpreter to help you speak with us or your doctor in any language. We also offer our materials in other languages. Interpreter services and translated materials are free of charge. Call Priority Health Choice, Inc. for help getting an interpreter or to ask for our materials in another language or format to meet your needs. Priority Health Choice, Inc. complies with all applicable federal and state laws with this matter.

¿Habla español? Por favor contacte a al 1-888-389-6645 y pedir un traductor.

Hearing and Vision Impairment

TTY/TDD services are available free of charge if you have hearing problems. The TTY/TDD line is open 24/7 by calling 711 or 1-888-551-6761.

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, transcription services, and assistive listening devices. We offer the Member Handbook and other materials in Braille and large print upon request and free of charge. Call Customer Services at 1-888-975-8102 to request materials in a different format to meet your needs.

Priority Health Choice, Inc. makes sure services are provided in a culturally competent manner to all members:

- With limited English proficiency
- Of diverse cultural and ethnic backgrounds
- With a disability
- Regardless of gender, sexual orientation, or gender identity

Important Numbers and Contact Information

Customer Service Toll-Free Help Line	1-888-975-8102 Monday–Thursday 7:30 a.m.–7 p.m. Friday 9:00 a.m.–5 p.m. Saturday 8:30 a.m.–12 noon
Customer Service Help Line TTY/TDD	TTY (711) TDD (1-888-551-6761)
Website	*priorityhealth.com*
Address	1231 East Beltline NE Grand Rapids, MI 49525
24 Hour Toll-Free Emergency Line	1-800-673-8043
Pharmacy Services	1-888-975-8102
Transportation Services (non-emergency)	1-888-975-8102 Residents of Wayne, Oakland, or Macomb counties contact MTM at 1-855-922-0422
Dental Services (Delta Dental)	1-800-524-0149
Vision Services (EyeMed)	1-866-608-9378
Mental Health Services	1-800-673-8043
To file a complaint about Medicaid services	1-888-975-8102
To request a Medicaid Fair Hearing	1-877-833-0870
Grievance and Appeals	1-888-975-8102
To report Medicaid fraud and/or abuse	Customer Service 1-888-975-8102 Compliance Hotline 1-800-560-7013
To find information about urgent care	1-888-975-8102
Michigan ENROLLS	1-888-367-6557
Michigan Beneficiary Help Line	1-800-642-3195 or TTY: 866-501-5656.
MIChild Program	1-888-988-6300
MDHHS office locations and phone numbers	***www.michigan.gov/mdhhs/inside-mdhhs/county-offices***
Women, Infants and Children (WIC)	1-800-942-1636
Free service to find local resources. Available 24/7	2-1-1
Social Security Administration	(800) 772-1213 TTY/TDD: 800-325-0778
In an emergency	9-1-1
Suicide and Crisis Lifeline	9-8-8

Your State Issued Medicaid ID Card

When you have Medicaid, the Michigan Department of Health and Human Services will send you a mihealth card in the mail. The mihealth card does not guarantee you have coverage. Your provider will check that you have coverage at each visit.

You may need your mihealth card to get services that Priority Health Choice, Inc. does not cover. Always keep this card even if your Medicaid coverage ends. You will need this card if you get coverage again.

If you have questions about this coverage or need a new mihealth card, you should call the Beneficiary Help Line at 800-642-3195. This number is located on the back of your mihealth card.

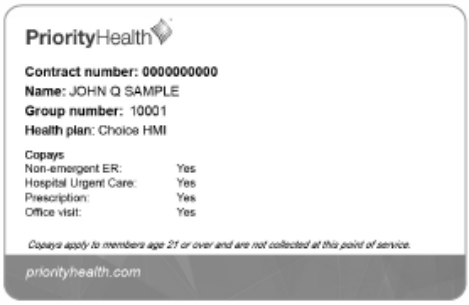
It is important to keep your contact information up to date so you don't lose any benefits. Any changes in phone number, email, or address should be reported to MDHHS. You can do this by calling your local MDHHS office or by visiting *www.michigan.gov/mibridges*. If you do not have an account, you can create one by selecting "Register". Once in your account, when reporting changes, please make sure you do so in both the profile section and the report changes area.

Your Priority Health Choice, Inc. Member ID Card

You should have received your Priority Health Choice, Inc. ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own Member ID card.

Medicaid Members

Healthy Michigan Plan Members



If you have questions about this coverage or need a new Priority Health Choice, Inc. Member ID card, you should call Customer Services at 1-888-975-8102.

NOTE: The member ID card we send you will NOT include the Medicaid plan name. As you can see below, it will say "Priority Health Choice MDC". The State of Michigan require this. Your provider will know that you are in the Medicaid plan.

Important ID Card Notes

- Carry both cards with you at all times and show them each time you go for care.
- Make sure all of your information is correct on both cards
- Call your local MDHHS office to change your records if your name or address changes
- When getting care you may be asked to show a picture ID. This is to make sure the right person is using the card
- Do not let anyone else use your cards

Getting Help from Customer Services

Our Customer Services Department can answer all of your questions. We can help you choose or change your doctor, find out if a service is covered, replace a lost ID card, find out how to appeal something we denied, find out how to file a grievance when you are unhappy with your care, help you understand written materials, and more. You can call us anytime.

Contact Us

You may call us at 1-888-975-8102, or TTY 711
Monday–Thursday 7:30 a.m. - 7 p.m.
Friday 9:00 a.m. - 5 p.m.
Saturday 8:30 a.m. - 12 noon

Walk-in Hours
Monday–Thursday, 8:30 a.m.–5 p.m. Friday, 9 a.m.–5 p.m.
1231 East Beltline NE
Grand Rapids, MI 49525

Mail
Priority Health Choice, Inc.
PO Box 269
Grand Rapids, MI 49501-0269

For **urgent** medical concerns regarding you or your child's health after hours, we can connect you to our medical Emergency Help Line for assistance. Call 1-800-673-8043.

Our Website

You can visit our website at *priorityhealth.com* to access online services such as:

- Member Handbook and Certificate of Coverage
- Sign up for an online member account

- Find a doctor tool
- Access your claims

Confidentiality

Your privacy is important to us. You have rights when it comes to protecting your health information. Priority Health Choice, Inc. recognizes the trust needed between you, your family, and your providers. Priority Health Choice, Inc. staff have been trained in keeping strict member confidentiality.

Transition of Care

If you're new to Priority Health Choice, Inc. you may be able to keep your doctors and services for at least 90 days from your enrollment date. Examples include medical, behavioral health, and pharmacy services.

If you are pregnant, you can stay with your doctor through the pregnancy and post-partum period.

If you are a Priority Health Choice, Inc. member and your doctor no longer participates with us, you can continue to see your doctor if you are receiving treatment for certain chronic diseases.

We will not approve continued care by a non-participating doctor if:

- You only require monitoring of a chronic condition
- The doctor has a restriction and you might be at risk
- The doctor is not willing to continue your care
- Care with the non-participating doctor was started after you enrolled with Priority Health Choice, Inc.
- The doctor does not meet Priority Health Choice, Inc. policies or criteria

Priority Health Choice, Inc. will help you choose new doctors and help you get services in our network. Your doctor may call Customer Services if they want to be in our network.

If you are receiving Children's Special Health Care Services (CSHCS), please contact us for help transitioning your care services.

Please contact us at 1-888-975-8102 to request transition of care services or if you have any questions about your care.

Choosing A Primary Care Provider

When you enroll in our plan, you will need to choose a primary care provider (PCP). Your PCP is the health care provider or doctor who takes care of all your health needs. You can choose a different doctor for each family member or you can choose one doctor for the whole family.

You can choose one of the following provider types as your primary care provider:

- General practice doctor
- Family practice doctor
- Nurse Practitioner
- Internal medicine doctor
- Pediatrician doctor
- OB/GYN doctor

If you do not choose a doctor within 30 days of enrollment, we will select one for you. You can change your doctor anytime.

You do not need a referral to see an in-network pediatrician or OB/GYN provider for routine and preventive health services.

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists addresses, office hours, languages spoken, and information about accessibility. It is located at *www.priorityhealth.com*. You can view or print the provider directory from the website. You can also request a copy of our provider directory, free of charge by calling 1-888-975-8102. Remember provider information changes often. Visit our website for the most up-to-date information. Call Customer Service if you need help finding a doctor.

You can also get medical care from these types of medical providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable).

If you have certain health care needs, you may be able to choose a specialist as your primary care provider. Talk to your doctor or call Customer Service for more information.

Make sure you ask the provider office if they participate in the Priority Health Choice, Inc. network.

Additional information is located in the Certificate of Coverage section of this handbook.

Getting Care from Your Doctor

Your doctor's office should be your main source for medical health. You should see your doctor for preventive checkups. Call your doctor's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at 1-888-975-8102.

Your visit is important. Please be on time. Call the office as soon as you can if you cannot make it to your visit. You can set up a new visit when you call to cancel. Some offices will not see you again if you do not call to cancel.

Getting Care from a Specialist

If you need care that your doctor cannot give, they will refer you to a specialist who can. Your doctor works with you to choose a specialist and arrange your care. If you have special health care needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. Talk to your doctor or call Customer Service for more information. Do not see a specialist without your PCP's approval.

Specialist as PCP

If you have a chronic health condition you may need to see a specialist for care often. In certain cases, a specialist may be authorized to provide or arrange all of your care. Call our Customer Service department if you think you need a specialist to be your PCP. They will help you submit a request. Our health management department will review your request.

Out-of-Network Services

You must get most of your care from providers in our provider network. Customer Service can help you find a provider in our network

If we do not have a doctor or specialist in our provider network in your area who can give you the care you need, or if we do not have a provider that can see you timely, we will get you the care you need from a provider outside our network. This is called an out-of-network referral. We will only cover the services by an out-of-network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure that the cost to you is no greater than it would be if the service was provided in-network.

Out of State Services

All services out of the state require prior authorization.

Out of Country Services

Health care services provided outside the country are not covered by Priority Health Choice, Inc.

Physician Incentive Disclosure

You may ask if we have special financial arrangements with our doctors that can affect the use of referrals and other services that you might need. If you have any questions about this, please call Customer Service at 1-888-975-8102.

Prior Authorization

Some services and medications will need to be approved before you or your child can get them. This is called Prior Authorization (PA). Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. We must approve the PA request before you get the care. If we do not approve the service, we will notify the doctor and send you a written notice of the decision.

Getting a Second Opinion

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from a Priority Health Choice, Inc. network provider. Second opinions do not require prior authorization from us as long as the provider is a Participating Provider. Please call Customer Service to learn how to get a second opinion.

Information About Your Covered Services

It is important you understand the benefits covered under your plan. As a Priority Health Choice, Inc. member you do not have to pay co-pays for covered services. NOTE: You may have co-pays for covered services if you are a Healthy Michigan Plan member. You may also have to pay a monthly premium for the MIChild program. See Cost Sharing and Copayments section for more information.

If there are any significant changes to the covered services outlined in this handbook, we will notify you in writing at least 30 days before the date the change takes place.

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. The Certificate of Coverage is included with this handbook.

Make sure a service is covered before the service is done. You may have to pay for services not covered by Priority Health Choice, Inc. under the Medicaid program.

Priority Health Choice, Inc. does not deny reimbursement or coverage for services on any moral or religious grounds. Services and treatment related to religious counseling or provided by a religious counselor who is not a Participating Provider are not covered.

Telehealth/Telemedicine services

Telehealth/Telemedicine care is a convenient way to get care for a variety of common illnesses without having to go to the emergency room or urgent care. For non-emergency issues, including the flu, allergies, rash, upset stomach, and much more, you can connect with a doctor through your phone or computer to receive care where you are, when you need it. Doctors can diagnose, treat, and even prescribe medicine, if needed. Call your doctor's office to see if they offer telehealth services or contact Customer Service for more information.

To schedule a telemedicine/virtual care visit:

1. Check with your doctor's office to see if they provide telemedicine/virtual care OR
2. Log into your Priority Health member account at *member.priorityhealth.com.*

Covered services include:

- Ambulance and other emergency medical transportation**
- Aquatic/Pool Therapy is covered only when part of the physical therapy treatment plan
- Blood lead follow-up (up to age 21)
- Breast pumps; personal use, double-electric
- Certified pediatric or family nurse practitioner services
- Chiropractic services*
- Diagnostic lab, x-ray, and other imaging services*
- Durable medical equipment
- Emergency services
- End stage renal disease services*
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Habilitative therapies (speech, language, physical and occupational) *
- Health education*
- Hearing aids*
- Hearing and speech services
- Home Health services*
- Hospice services*
- Immunizations (shots)
- Inpatient hospital services
- Intermittent or short-term restorative or rehabilitative services, in a nursing facility care, up to 45 days*
- Long term acute care*
- Medically necessary weight reduction services*

- Mental health care
- Ob/GYN and Certified Nurse Midwife services
- Outpatient hospital services
- Out-of-state services (if authorized by plan)*
- Parenting and birthing classes*
- Podiatry services* (Routine foot care is not covered)
- Practitioners' services
- Primary care provider visits
- Prosthetics and orthotics*
- Restorative or rehabilitative services in a place of service other than a nursing facility
- Sexually transmitted disease treatment
- Specialty provider visits*
- Telemedicine/Virtual care
- Therapies (speech, language, physical and occupational)*
- Transplant services*
- Urgent care
- Vision services
- Well-child/early and periodic screening, diagnostic and treatment for persons under age 21

All care provided out-of-network (except for family planning services and care provided at FQHCs, Tribal Health Centers and Local Health Departments) requires our prior approval before you receive services unless we tell you otherwise in the Certificate of Coverage (COC). There may be a limit to the number of visits approved based upon medical necessity. The Certificate of Coverage lists these limitations in greater detail. Your PCP will help you arrange these services. You may also call our Customer Service department at 1-888-975-8102 if you have questions.

**These services are covered when they are medically necessary and appropriate. Except in a life-threatening emergency, these must be referred by your primary care provider.*

***Ambulance rides between facilities are covered. They must be approved by your PCP or us. All ambulance rides that are not an emergency must be authorized.*

Pharmacy Services

You have prescription drug coverage with this Priority Health Choice Plan. We work with the Michigan Department of Health and Human Services (MDHHS), and other health plan partners, to determine what medications will be covered by this plan. The list of covered medications is called the Michigan Medicaid Common Formulary. You and your doctor should use this list when deciding what medications to take. Coverage for some drugs requires prior approval from us. You and your doctor should contact us when prior approval is needed.

If you are eligible for Medicare, most medications will be covered by Medicare. There are some drugs that Medicare will not pay for, but that this Medicaid plan will cover. These drugs include:

- Select over the counter (OTC) drugs
- Certain over the counter agents used to promote smoking cessation
- Select vitamins and minerals

If you would like to know more about how drugs are covered, call or write the Customer Service department. You can also use the approved drug list tool at *priorityhealth.com/formulary/medicaid* to see what medications are covered by this plan.

It is important to know that some medications cannot be covered by this plan. Please reference the Certificate of Coverage for a complete list of medications that cannot be covered.

It is important to know about the medicine you take. You should always:

- Make sure that all of your doctors know about all over-the-counter medicines you are taking.
- Make sure that all of your doctors know about all vitamins and supplements you are taking.
- Make sure that your doctors know about any allergies and reactions to medications that you have had.
- Understand what the medicine is for, how to use it, where to store it, and what side effects (if any) you might expect.

Talk with your doctor and pharmacist about your medicine. Here are some questions you should ask your doctor and pharmacist about your medicine:

- What are the brand and generic names of the medicine?
- What does the medicine look like?
- How should it be taken?
- How long should you take it?
- What should you do if you miss a dose?
- What should you do if side effects occur?

When you pick up the prescription, make sure you understand the instructions on the label and ask the pharmacist if you have any questions.

Medications that are administered by a healthcare provider are covered by this plan. Coverage for some medical benefit drugs requires prior approval from us. You and your doctor should contact us to know if a drug is covered and when prior approval is needed.

Covered medications can only be paid for by this plan when the dispensing provider is both in-network with Priority Health Choice and authorized by the State of Michigan. To find a pharmacy, you can call the Customer Service department or use the Find a Doctor tool on *priorityhealth.com.*

Dental Services

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with Delta Dental of Michigan to provide your dental benefits. We are contracted with many dentists to provide dental benefits. For a complete list of covered dental service, please see the Adult Medicaid Dental handbook on our website at *priorityhealth.com.* You can request a copy free of charge by contacting Delta Dental.

If you have any questions about your dental services, please contact Delta Dental at 1-800-524-0149.

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. The two plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card and Member Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at 800-642-3195 for help.

Blue Cross Blue Shield of Michigan
Michigan Health Insurance Plans | BCBSM
Phone: 800-936-0935

Delta Dental of Michigan
Individual Dental Plans | Delta Dental of Michigan (deltadentalmi.com)
Phone: 866-696-7441

Transportation Services

Non-Emergency

Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up and other covered services. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.

Please call Customer Service at 1-888-975-8102 for more information and to schedule a ride. Please call 3 days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment.

Have this information ready when you call:

- Your name, Medicaid ID number and date of birth

- The address and phone number of where you will be picked up
- The address and phone number of where you are going
- Your appointment date and time
- The name of your provider

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor.

Please be sure to call us as soon as possible if you need to cancel.

Emergency

If you need emergency transportation, call 911

Vision Services

Eye care is an important part of your overall health. To make sure your eyes are healthy and help you see the best you can, we cover the following services:

- One eye exam every 24 months
- One pair of glasses every 24 months
- Eye glass frames
- Contact lenses

You do not need a referral to get eye care. If you need glasses or an eye exam, call EyeMed at 1-866-608-9378. You can also call a provider from our list of vision providers. For medical eye problems, talk to your doctor.

Hearing Services

How well you hear affects your quality of life. We cover services and supplies for the diagnosis and treatment of diseases of the ear, including:

- Hearing exams
- Medically necessary hearing aid evaluations and fittings
- Medically necessary hearing aids

If you need a hearing exam or think you need hearing aids, call Customer Service at 1-888-975-8102. You can also call a provider from our list of hearing providers.

Obstetrics and Gynecology Care

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network. You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN even if they aren't your primary care doctor.

To make sure you get the care you need to be at your best for you and your family, we cover:

Birth control and birth control counseling	Delivery care
Depression Screening	Doula Services
Mammograms and breast cancer services, such as treatment and reconstruction	HIV/AIDS testing and treatment of sexually transmitted diseases
Family Planning	Midwife services in a health care setting
Mammograms and breast cancer services, such as treatment and reconstruction	Parenting and birthing classes
Pregnancy and maternity care, including the Maternal Infant Health Program	Pap tests

Family Planning Services

Family planning care is covered. Both men and women can get this care. Family planning is an important part of staying healthy. You can get family planning information from your doctor, OB/GYN, or a Family Planning Center. You do not need a referral from your doctor for this care. Please contact Customer Service as soon as you discover you are pregnant to help maximize the support and benefits available to you.

Family planning services include:

- Counseling to help you decide when to have children
- Help to decide how many children to have
- Birth control services and supplies
  (It is recommended to get a Pap test and chlamydia test before getting birth control)
- Sexually transmitted disease testing and treatment
- Testicular and prostate cancer screening

Pregnancy Services

If you are pregnant, early and regular checkups can help protect you and your baby's health. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done

during pregnancy. Please call Customer Service and your local MDHHS office as soon as you find out you are pregnant so we can provide support.

Personal support: You will have access to a Nurse Health Advisor. You can talk about any health concerns you have, or health plan benefits, at your convenience.

Free educational materials: You will get free booklets on topics you may be interested in. Topics include the care of your newborn, breastfeeding, or postpartum depression. We will provide you with a list of topics from which to choose.

Postpartum Care

It's important to take care of yourself after you have a baby. You should have a postpartum checkup 7 to 84 days after your pregnancy. We cover this exam.

The doctor may check your blood pressure and your weight. They may talk to you about birth control, feeding options, and provide other postpartum counseling. You can also talk to your doctor about any new feelings you may have.

When you have your baby, let us know. Call your local MDHHS office so your records can be updated. Also call Customer Service to report the change. This starts the process of signing your baby up for health care services. Your baby is covered by your health plan at the time of birth. Make sure you tell us the day you gave birth, your baby's name, and your baby's Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Customer Service if you need help.

Change in Family Size

When you experience a change in family size, contact Customer Service to let us know and we will be able to assist you. A change in family size includes marriage, divorce, childbirth, adoption and/or death. Please reach out to your local MDHHS office if there is a change in family size.

Maternal Infant Health Program (MIHP)

The MIHP is a home visiting program for women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include:

- Prenatal teaching
- Childbirth education classes
- Nutritional support, education, and counseling
- Breastfeeding or formula feeding support
- Help with personal problems that may complicate your pregnancy
- Newborn baby assessments
- Referrals to community resources and help finding baby cribs, car seats, clothing, etc.
- Support to stop smoking

- Help with substance abuse
- Personal care or home help services

Call Customer Service for more information on how you can access these services.

Children's Health

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a good time for you to ask questions about your child's health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral. Children up to three years old are recommended to have a developmental screening done with their doctor once a year.

Babies from birth through 15 months need at least six well-child visits. These visits often are at these ages:

3-5 days	2 weeks	1 month
2 months	4 months	6 months
9 months	12 months	15 months

It is important for your child to get a blood lead test once before age one and again before age two. Children who are at risk or who are high risk should be checked more often. These children should be tested at least one time per year. Children who are high risk are those who have had lead poisoning in the past. This includes children who live in old homes or apartments. Lead poisoning can happen even if you do not live in an older home. Lead can be found in paint, soil, ordinary dust, playgrounds, and toys, as well as other places. Have your child tested for lead poisoning so that it may be treated. If untreated, lead poisoning can lead to disabilities and behavioral problems. This simple test will help keep your little one on track!

Teenagers should also receive annual well-child visits. At these visits, teens will have their height, weight and BMI checked. Providers can talk about health, safety and preventive measures that are useful to teens. Required immunizations can also be given at these visits.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a special healthcare program for children under 21 years of age who are covered by Medicaid. Under EPSDT, children and teens enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development.

EPSDT checkups include:

Well-care visits	Physical and mental developmental/behavioral assessments

Health history and physical exam, including school and sports physicals	Crucial lab tests, including lead screening
Developmental screening	Nutrition assessment
Health education guidance	Immunizations
Hearing, vision, and dental screening assessment	Follow-up services

Children's Special Health Care Services

If your child has a serious, chronic medical condition, they may be eligible for Children's Special Health Care Services (CSHCS).

CSHCS provides extra support for children and some adults who have special health care needs. This is in addition to the medical care coordination from Priority Health Choice, Inc.

There is no cost for this program. It doesn't change your child's Priority Health Choice, Inc. benefits, service, or doctors. CSHCS provides services and resources through the following resources through the following agencies.

MDHHS Family Center for Children and Youth with Special Health Care Needs:

This center provides a parent support network and training programs. It may also provide financial help for conferences about special needs and more. If you have questions about this program, call the CSHCS Family Phone Line at 1-800-359-3722 from 8 a.m. to 5 p.m. Monday through Friday.

Local County Health Department:

Your local county health department can help you find local resources. These may include parent support groups, adult transition help, childcare, vaccines and more. For help finding your local county health department, visit your county's website or *Michigan.gov*. Call Customer Service for assistance.

Children's Special Needs Fund:

The Children's Special Needs fund helps families get items not covered by Medicaid or CSHCS. These items promote the health, mobility, and development of your child. They may include wheelchair ramps, van lifts and mobility equipment. To see if you qualify for help from this fund call 1-517-241-7420.

CSHCS member transitioning to adulthood

We can help members who have special health care needs on how to plan a successful move from pediatric health care to adult health care services.

Preventive Health Care for Adults

Preventive health care for adults is important to Priority Health Choice, Inc. You should have a wellness exam each year to prevent and detect health problems. It is important to find and treat health problems early.

Make sure to schedule an appointment and ask your doctor to check:

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression Screening
- Prostate and Colorectal Screenings

You can also ask your doctor about:

- Immunizations
- HIV/AIDS testing and treatment of sexually transmitted diseases

Preventive health is also about making the right choices for good health habits. Seeing your doctor for routine care is a good preventive health habit that keeps you healthy. We have programs to help you make good preventive health choices for yourself and your family.

You can improve you and your family's health by taking responsibility and following healthy behaviors. Getting needed yearly preventive care is the first step! Some other things you should and should not do to take control of your health are listed below.

Things you should do:	Things you should **not** do:
• Eat healthy • Exercise • Get enough sleep • Manage your stress • Don't smoke or use tobacco • Don't use drugs or drink alcohol • Go to the dentist for regular cleanings and preventive services • Visit your doctor each year for yearly preventive care	• Eat foods high in fat, sugar, and salt • Live an inactive lifestyle • Hold in your feelings or emotions if you're feeling stressed or depressed • Use drugs, alcohol, or tobacco • Forget to set up your dentist visits for regular cleanings and preventive services • Forget to set up a yearly visit to your doctor • Avoid going to the doctor

Hepatitis C

Treatment is available for Hepatitis C. Hepatitis C is a liver infection caused by the Hepatitis C virus. It's spread through contact with blood from an infected person, even amounts too small to see. People with Hepatitis C often don't feel sick or show symptoms. When symptoms do appear, they're often a sign of advanced liver disease. It's important to get tested (screened) for Hepatitis C before it becomes severe, when it's easier to treat. All adults should be screened for Hepatitis C at least once. Pregnant beneficiaries should be screened during each pregnancy.

For members under age 21, the screening is covered under the Early and Periodic Screening, Diagnosis and Treatment program, or EPSDT. This includes coverage of any medically necessary follow-up services and referrals.

Hospital Care

Hospital care is for care like delivering a baby or taking care of a bad sickness. It also covers care you would get in the hospital, like lab tests or x-rays. Your doctor sets up your hospital care if you need it. A different doctor at the hospital may fill in for your doctor to make sure you get the care you need if an emergency happens.

You should call your doctor as soon as you are admitted (checked in) to the hospital if it was not arranged by your doctor. Ask a family member or friend to call for you if you cannot. It is important to call your doctor right away and set up a visit within seven days of being sent home. You can talk about and arrange your care after you leave the hospital during this follow-up visit.

Emergency Care

Emergency care is for a life-threating medical situation or injury that a reasonable person would seek care right away to avoid severe harm. Here are some examples of emergencies:

Convulsions	Broken bones
Uncontrollable bleeding	Loss of consciousness (fainting or blackout)
Chest pain	Jaw fracture or dislocation
High fever	Tooth abscess with severe swelling
Serious breathing problems	Knife or gunshot wounds

If you believe you have an emergency, call 911 or go to the emergency room. You do not need an approval from Priority Health Choice, Inc. or your doctor before getting emergency care. You can go to any hospital. Be sure to follow up with your doctor to make sure you get the right follow-up care and services.

Urgent Care and after-hours care

Urgent care centers and after-hours clinics are helpful if you need care quickly but can't see your primary care doctor. You don't need a referral or prior authorization to go to an urgent care center or after hours-clinic in our network.

These places can treat illnesses that should be cared for within 48 hours, such as the flu, high fevers, or a sore throat. They can also treat ear infections, eye irritations and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

If you aren't sure if you need urgent care, call your doctor. They may be able to treat you in their office.

Routine Care

Routine care is for things like:

- Yearly wellness exams

- School physicals
- Health screenings
- Immunizations
- Vision and Hearing Exams
- Lab tests

Your doctor should set up a visit within 30 business days of request.

Mental Health and Substance Abuse Services

We want you to feel your best, including your mental and emotional feelings. To help you, we cover short-term treatment for mental or emotional needs. This applies to members with mild to moderate mental health services. These visits may be with a network therapist, such as a counselor, licensed clinical social worker or psychologist. Telehealth may be an option for you. Talk to your mental health provider to learn more. Treatment for long term, severe mental conditions, or severe emotional disturbances for children, as well as inpatient and intensive outpatient treatment must be arranged through the local Community Mental Health Services Program (CMHSP) agency. CMHSP can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol. If you feel you have a substance abuse problem, we encourage you to seek help. If you need help getting services, call your doctor or Customer Service.

Signs and symptoms of substance abuse:

- Failure to finish jobs at work, home, or school
- Being absent often
- Performing poorly at work or school
- Using alcohol or drugs when it is dangerous. This includes while driving or using machines.
- Having legal problems because of drinking or drug use
- Needing more of the substance to feel the same effects
- Failing when trying to cut down
- Failing when trying to control the use of the substance
- Spending a lot of time getting the substance
- Spending a lot of time using the substance
- Spending a lot of time recovering from the substances effects
- Giving up or reducing important social, work, or recreational activities because of substance use

- Continuing to use the substance even though it has negative effects

If you have questions about your mental health or substance abuse benefits call Priority Health Choice, Inc. You can also call your local CMHSP agency.

If you need emergency care for a life-threatening condition, or if you're having thoughts of suicide or death, go to the nearest emergency room or call 911. You can also call the Suicide and Crisis Lifeline by dialing 988. Help is available for you now.

Home Health Care, Skilled Nursing Services and Hospice Care

Sometimes, you may need long-term care. To help you get the care you need, we may cover:

- Short-term nursing home services up to 45 days in a nursing facility (long-term care is provided by the State of Michigan)
- Home health care services for members who are homebound
- Supplies and equipment related to home health care
- Hospice care

These services require prior authorization from Priority Health Choice, Inc. More information on these benefits is located in the Certificate of Coverage section in this handbook.

Care Coordination

Do you have a chronic health problem or disability? Do you have barriers that are causing you issues with accessing your care? Do you see multiple providers or need special care? It's easy to feel overwhelmed with being in charge of your care if you have many health issues and see many providers. It can add more stress to your daily life. We are here to help you!

Our goal is to offer personalized care coordination services to help guide you through health care. We have nurses, care coordinators, social workers, and other health experts to help you get the best care possible from your care team.

The care coordination program focuses on you and your needs. We help you reduce the barriers you are having accessing your care by linking you to services and resources near you to help improve your health. We also assist you in reducing your barriers by helping to arrange care with your care team and providers. This ensures you are able to better manage your health and improve your quality of life.

How Can Care Coordination Help You?

If you are eligible, you will be assigned your own care coordinator. This person helps you address and eliminate barriers that cause you issues with obtaining care by:

- Completing assessments and reviewing medications
- Making a plan of care to help you identify and meet your health goals
- Linking you with services and community resources near you, including the local health departments
- Helping you better control your healthcare needs
- Collaborating with your providers
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits

Call Customer Service for more information about the care coordination program.

Community Health Workers (CHW)

Community Health Workers are the front-line public health workers within the community, assisting members with navigating health care. CHWs serve as a bridge between health care and social services by building trusting relationships. CHWs full range of services include:

- Meeting face to face to improve your access to health care
- Helping others find providers and set up visits
- Finding local support like food and housing
- Teaching ways to live a healthy life
- Helping with provider follow-up visits after going to the hospital or emergency room
- Helping set up rides for medical or pharmacy visits

Contact Customer Service for more information.

Durable medical equipment

Some medical conditions need special equipment. Durable medical equipment we cover includes:

- Equipment such as nebulizers, crutches, wheelchairs, and other devices
- Disposable medical supplies, such as ostomy supplies, catheters, peak flow meters and alcohol pads
- Diabetes supplies, such as lancets, test strips, insulin needles, blood glucose meters and insulin pumps.
- Prosthetics and orthotics – Special note: Prosthetics replace a missing body part, such as a hand or leg. They may also help the body function. Orthotics correct, align, or support body parts that may be deformed.

To get durable medical equipment, you need a prescription from your doctor. You may also need prior authorization from us. You must get your item from a network provider. To find network durable medical equipment providers, call Customer Service.

Benefits Monitoring Program

We participate in MDHHS' Benefits Monitoring Program. This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper use of medical services and help you get services from appropriate providers. Examples of things that could get you enrolled in this program include:

- Going to the emergency room when it's not an emergency
- Seeing too many different doctors instead of your primary care doctor
- Getting more medicines than may be safe
- Activity that may indicate fraud

Using the right health services in the right amount helps us make sure you're getting the very best care.

Tobacco Cessation

We want to help you quit smoking. If you smoke, talk to your doctor about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor can help you. Priority Health Choice, Inc. can also help you. To get more information, call Customer Service. We cover the following services to help you:

- Therapy and counseling services
- Educational materials
- Prescription inhalers or nasal sprays used to stop smoking

- Non-nicotine drugs
- Over-the-counter items to help you stop smoking
    - Patches
    - Gums
    - Lozenges

Cost Sharing and Copayments

MIChild Members:

Families with children who are enrolled through MIChild pay $10 a month for all eligible children in the family. If you have questions about your MIChild premiums, call MIChild at 1-888-988-6300 (TTY: 1-888-263- 5897).

Healthy Michigan Plan Members:

You will be required to pay a copayment for some services covered under the Healthy Michigan Plan. You are only responsible for copayments if you are age 21 and older. No copayments are required for family planning products or services, pregnancy related products or services, or for preventive health care services. Copayments will be made directly to MDHHS through a special health care account called the MI Health Account and not paid at the time you receive a service. Copayments will not be collected for the first 6 months after enrollment in our health plan but will be paid to us through your MI Health Account at a later time.

The Healthy Michigan Plan also requires people with an annual income between 100% and 133% of the federal poverty level to contribute 2% of annual income to their MI Health Account for cost sharing purposes. You may be able to reduce your annual contribution requirement and copayment amounts by participating in health behavior activities. You can complete an annual health risk assessment or change an unhealthy activity.

Cost sharing cannot exceed 5% of your annual income. See your Certificate of Coverage for additional information about required cost sharing

Medicaid Members:

You do not have to pay a co-pay or other costs for covered services under the Medicaid program. You must go to a doctor in Priority Health Choice, Inc. Medicaid network, unless otherwise approved. If you go to a doctor that is not in Priority Health Choice, Inc. Medicaid network and did not get approval to do so, you may have to pay for those services.

Services Covered by Medicaid not Priority Health Choice, Inc.

Priority Health Choice, Inc. does not cover all services that you may be eligible for as a member of Medicaid.

Services Covered by State of Michigan Medicaid:

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at 800-642-3195.

- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days)
- Behavioral health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
- Substance Abuse Care including:
    - Screening and assessment
    - Detox
    - Intensive outpatient counseling
    - Other outpatient care
    - Methadone treatment

Your State of Michigan Medicaid benefit provides options for transportation to and from these visits. If you need transportation to or from an appointment, and live in Wayne, Oakland, and Macomb counties, call ModivCare at 866-569-1902 to arrange a ride. If you do not live in Wayne, Oakland, or Macomb counties, contact your local MDHHS office.

MDHHS office locations and phone numbers may be found at:
https://www.michigan.gov/mdhhs/inside-mdhhs/county-offices

Non-Covered Services

- Elective abortions and related services
- Experimental/investigational drugs, biological agents, treatments, procedures, devices, or equipment

- Elective cosmetic surgery
- Services for the treatment of infertility

Additional Information for Healthy Michigan Plan Members

As a Healthy Michigan Plan member, you are eligible to receive a healthy behavior incentive. You must take part in healthy behavior activities, as well as, filling out a Healthy Michigan Health Risk Assessment form each year with your provider and committing to a healthy behavior. These choices may include quitting smoking, losing weight, lowering your blood pressure or cholesterol, or getting a flu shot. You may qualify for a reduction in your cost-sharing contribution, depending on your income.

Take action today:

- Call your primary care doctor for an appointment within 60 days. You should see your doctor within 150 days of joining our plan.
- Fill out sections 1, 2, and 3 of the Health Risk Assessment form. Take your form to your doctor's appointment. Your doctor will complete section 4 and return the form to us. You will need to complete this form every year. Please call us if you need a form.

Rights and Responsibilities

You have rights and responsibilities as our member. Our staff will respect your rights. We will not discriminate against you for using your rights. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your health care services
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private
- Participate in decisions regarding your health care, including the right to refuse treatment and express preferences about treatment options
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected

- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you
- To file a grievance, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand
- Receive Federally Qualified Health Center and Rural Health Center services
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
- To request information on the structure and operation of the Priority Health Choice, Inc.
- To make suggestions about our services and providers
- To make suggestions about member rights and responsibilities policy
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval

You have the Responsibility to:

- Review this handbook and Priority Health Choice, Inc. Certificate of Coverage
- Make and keep appointments with your Priority Health Choice, Inc. doctor
- Treat doctors and their staff with respect
- Protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your Health Plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.
- Apply for Medicare or other insurance when you are eligible.

- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to https://newmibridges.michigan.gov/.

Grievances and Appeals

We want you to be happy with the services you get from Priority Health Choice, Inc. and our providers. If you are not satisfied, you can file a grievance or appeal.

Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as a treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your doctor. Your doctor can often handle the problem. If you have questions or need help with the appeal process, call Priority Health Choice, Inc. at 1-888-975-8102 (TTY 711).

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your doctor, you can file a grievance at any time. Priority Health Choice, Inc. has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits. These are examples of when you might want to file a grievance.

- Your provider or a(n) Priority Health Choice, Inc. staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a(n) Priority Health Choice, Inc. staff member was rude to you.
- Your provider or a(n) Priority Health Choice, Inc. staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Priority Health Choice, Inc. at 1-888-975-8102 (TTY: 711). You can also file your grievance in writing via mail or fax at: 1231 East Beltline SE, Grand Rapids, MI 49525, or fax to 616-975-8894

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling 1-888-975-8102 (TTY: 711). We will let you know when we have received your grievance. We may contact you for more information.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your "representative." If you decide to have someone represent you or act for you, inform Priority Health Choice, Inc. in writing with the name of your representative and their contact information. Your grievance will be resolved within 90 calendar days of submission. We will send you a letter of our decision.

Appeal Process

An appeal is a way for you to ask for a review of our actions. If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get an "Adverse Benefit Determination" letter from us. This letter will tell you the following:

- The adverse benefit determination the contractor has made or intends to make
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision.
- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not telling you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

You can file your appeal on the phone by calling Priority Health Choice, Inc. at 1-888-975-8102 (TTY: 711). You can also file your appeal in writing via mail or fax at: 1231 East Beltline SE, Grand Rapids, MI 49525, or fax to 616-975-8894

You have several options for assistance. You may:

- Call Customer Services and we will assist you in the filing process
- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter their contact information or, 2) fill out the Authorized Representative Appeals form. You may call and request the form or find this form on our website at *priorityhealth.com*.

We will send you a notice saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.

Priority Health Choice, Inc. will send our decision in writing to you within 30 calendar days of the date we received your appeal request. Priority Health Choice, Inc. may request an extension up to 14 calendar more days in order to get more information before we make a decision. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Decision Notice. The Decision Notice will tell you what we will do and why.

If Priority Health Choice, Inc.’s decision agrees with the Notice of Adverse Benefit Determination, you may have to pay for the cost of the services you got during the appeal review. If Priority Health Choice, Inc.’s decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services to start right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when Priority Health Choice, Inc. reviews your appeal.

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal. We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the decision notice.

How Can You Withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. Priority Health Choice, Inc. will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Priority Health Choice, Inc. at 1-888-975-8102 (TTY: 711).

What Happens Next?

After you receive the Priority Health Choice, Inc. appeal Decision Notice in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or asking for an External Review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS). You can choose to ask for both a State Fair Hearing and an External Review or you may choose to ask for only one of them.

State Fair Hearing Process

You, your representative, or your provider can ask for a State Fair Hearing with MOAHR. You must do this within 120 calendar days from the date of your appeal denial notice. A Request for Hearing form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. If you want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing Appeal within 10 calendar days of the date on the decision notice. If you do not win this appeal, you may be responsible for paying for the services provided to you during the appeal process. You can also ask for a State Fair Hearing if you do not receive a decision from us within the required timeframe.

Call Priority Health Choice, Inc. 1-888-975-8102 if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited State Fair Hearing. If you qualify for one, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions, you can call MOAHR at 800-648-3397.

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can also request a fast appeal decision from DIFS within 10 calendar days after receiving a final determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Community-Based Supports and Services

We want to provide efficient and appropriate care in a timely manner. We also connect our members to community resources.

- Do you and your family struggle with having enough to eat?
- Do you need help finding a place to stay, or do you need heating assistance?
- Do you need a ride to your doctors' appointments?
- Do you need help with employment?

If you answered yes to any of the above questions, we can help. We know it's difficult to get to your doctor for important health screenings or other care when you're facing these challenges. If you're struggling with a similar problem, or need assistance, reach out to your care manager. If you don't have a care manager, and need help please call Customer Services at 1-888-975-8102. TTY users should call 711.

You can also access resources at the following:

- Online through our website: *www.priorityhealth.com*
- Online through the State of Michigan portal: *newmibridges.michigan.gov*
- Online through the Michigan 2-1-1 website: *www.mi211.org*

Women, Infants, and Children (WIC) is a free program that provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care. Call 800-262-4784 to find a WIC clinic near you or call Customer Services for assistance.

Care Management

We offer a care management program for members with chronic and/or complex health conditions. This is a voluntary program that allows you to talk with a care coordinator about your health care. A care coordinator helps you:

- Coordinate care between health care providers
- Set personal goals to manage your medical conditions
- Talk to your doctors or other providers when you need help
- Understand your medical conditions
- Access community-based supports, services, and resources

If you are interested in joining this program, please call Customer Service to be connected with a care coordinator.

Make Your Wishes Known: Advance Directives

Priority Health Choice, Inc. supports your right to file an “Advance Directive” according to Michigan law. This document is a written statement of your wishes for medical care. It explains, in advance, what treatments you want or don’t want if you have a serious medical condition that prevents you from telling your provider how you want to be treated.

The state of Michigan only recognizes an advance directive called a *durable power of attorney for health care*. To create one, you will need to choose a patient advocate.

This person carries out your wishes and makes decisions for you when you cannot. It is important to pick a person that you know and trust to be your advocate. Make sure you talk with the person to let them know what you want.

Talk to your family and primary care physician about your choices. File a copy of your advance directive with your other important papers. Give a copy to the person you designate as your patient advocate. Ask to have a copy placed in your medical record.

Call Customer Service for more information and the forms you need to write an advance directive.

If your wishes aren't followed or if you have a complaint about how your provider follows your advance directive, you may file a complaint with:

Department of Licensing & Regulatory Affairs
BPL/Investigations & Inspections Division
P.O. Box 30670 Lansing,
MI 48909-8170
Call: 517-373-9196
Or click below:
www.michigan.gov/lara/bureau-list/bpl
Click on *File a Complaint*

If you have complaints about how Priority Health Choice, Inc. follows your wishes, you may call the state of Michigan's Department of Insurance and Financial Services. Call toll-free at 877-999-6442 or go to *www.michigan.gov/difs*.

Help Identify Health Care Fraud, Waste and Abuse

Medicaid pays doctors, hospitals, pharmacies, clinics, and other health care providers to take care of adults and children who need help getting medical care. Sometimes, providers and patients misuse Medicaid resources. Unfairly taking advantage of Medicaid resources leaves less money to help other people who need care. This is called fraud, waste, and abuse.

Fraud

Fraud is purposefully misrepresenting facts. 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

Waste

Waste is carelessly or ineffectively using resources. It is not a violation of the law, but it takes money away from health care for people who need it. Here are some examples of waste:

- Using transportation services for non-medical appointments
- Doctors ordering excessive or unnecessary testing
- Mail order pharmacies sending you prescriptions without confirming you still need them

Abuse

Abuse is excessively or improperly using those resources. Here are some examples of abuse:

- Using the emergency room for non-emergent health care 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

You can Help

We work to find, investigate, and prevent health care fraud. You can help. Know what to look for when you get health care services. If you get a bill or statement from your doctor or an Explanation of Benefit Payments statement from us, make sure:

- The name of the doctor is the same doctor who treated you
- The type and date of service are the same type and date of service you received
- The diagnosis on your paperwork is the same as what your doctor told you

Health care fraud is a felony in Michigan. Being involved in fraud or abuse can put your benefits at risk or make other legal problems. If you suspect fraud, waste, and abuse has taken place, please report it. You do not have to give your name.

Report your concerns in one of these ways:

- Call Customer Service at 888.975.8102, Monday through Thursday 7:30 a.m. to 7:00 p.m., Friday 9:00 a.m. to 5:00 p.m., Saturday 8:30 a.m. to 12:00 p.m.
- Call the 24-hour Compliance Hotline at 800.560.7013
- Download, complete and mail the Fraud, Waste and Abuse Report form(PDF) Submit the form in one of these ways:

- By Mail to: Fraud, Waste and Abuse Program Priority Health, MS 3175,1231 East Beltline NE Grand Rapids, MI 49525-4501
- By fax to “Fraud, Waste and Abuse Program” at 616.942.7916 OR
- Email it to *SIU@priorityhealth.com*

You may also report or get more information about health care fraud by writing:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

Or call toll-free: 1-855-MI-FRAUD (1-855-643-7283)

Or visit: *michigan.gov/fraud* Information may be left anonymously

Helpful Definitions

These managed care definitions will help you better understand certain actions and services throughout this handbook.

Appeal: An appeal is the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:

Denies your request for:

- A healthcare service
- A supply or item
- A prescription drug that you think you should be able to get

Reduces, limits, or denies coverage of:

- A healthcare service
- A supply or item
- A prescription drug you already got

Your plan stops providing or paying for all or part of:

- A service
- A supply or item
- A prescription drug you think you still need

Does not provide timely medical services

Copayment: An amount you are required to pay as your share of the cost for a medical service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug

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

Durable Medical Equipment: Equipment and supplies ordered by a healthcare provider for everyday or extended use. This may include:

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

Emergency Medical Condition: An illness, injury, or condition so serious that you would seek care right away to avoid harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Care given for a medical emergency when you think that your health is in danger.

Emergency Services: Review of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Medical services that your plan doesn't pay for or cover.

Grievance: A complaint that you let your plan know about. You may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person or provider treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered or denied (see Appeal).

Habilitation Services and Devices: Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Services for people with disabilities

Health Insurance: Health insurance is a type of coverage that pays for medical and/or drug costs for people. It can pay the person back for costs from illness or injury. It can also pay the provider directly. Health insurance requires the payment of premiums (see premium) by the person getting the insurance.

Home Health Care: Healthcare services that a healthcare provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

Hospice Services: Hospice is a special way of caring for people who are terminally ill and provide support to the person's family.

Hospitalization: Care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not need an overnight stay.

Medical Health Plan: A plan that offers healthcare services to members who meet State eligibility rules. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The State pays the premium on behalf of the member.

Medically Necessary: Healthcare services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- An illness
- Injury
- Condition
- Disease or
- Symptom

Network: Health care providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

Network Provider/Participating Provider: A healthcare provider that has a contract with the plan as a provider of care.

Non-Participating Provider/Out-of-Network Provider: A healthcare provider that *does not* have a contract with the Medicaid Health Plan as a provider of care.

Physician Services: Healthcare services provided by a person licensed under state law to practice medicine.

Plan: A plan that offers health care services to members that pay a premium.

Preauthorization: Approval from a plan that is required before the plan pays for certain:

- Services
- Medical equipment or
- Prescriptions

This is also called prior authorization, prior approval, or precertification. Your plan may require preauthorization for certain services before you receive them. This excludes an emergency.

Premium: The amount paid for health care benefits every month. Medicaid Health Plan premiums are paid by the State on behalf of eligible members.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that require a prescription by law by a licensed Provider.

Primary Care Provider: A licensed physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides and manages your health care services. This can also be called a Primary Care Physician. Your primary care provider is the person you see first for most health problems. They make sure that you get the care you need to keep you healthy. They also may talk with other doctors and healthcare providers about your care and refer you to them.

Provider: A person, place or group that's licensed to provide health care like doctors, nurses, and hospitals.

Referral: A request from a PCP for his or her patient to see another provider for care.

Rehabilitation Services and Devices: Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Psychiatric rehabilitation services

Skilled Nursing Care: Services in your own home or in a nursing home provided by trained:

- Nurses
- Technicians
- Therapists

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

Urgent Care: Care for an illness, injury, or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

Notice of Privacy Practices

Are located in the Certificate of Coverage section of this handbook.

Filed in Michigan: 2023

10003-75

Certificate of coverage

Agreement Filed in: Michigan 2023

Read this entire Certificate carefully. It is a contract. It describes the rights and obligations of Members and Priority Health Choice, Inc. It is your responsibility to understand the terms and conditions of your health benefits contained in this Certificate. In some circumstances certain medical services are not Covered, or may require prior approval by Priority Health Choice, Inc.

Section 1 - About this Certificate

This Certificate has been applied for as Healthy Michigan Plan Coverage. This Certificate sets the terms and conditions of coverage and describes the health care services that are Covered for Members under the Healthy Michigan Plan.

This Certificate only Covers Medically/Clinically Necessary services or supplies that are furnished while a person is a Member. It replaces and takes the place of any Certificate we might have issued in the past.

Words that are capitalized in this Certificate are special terms that are defined in Section 16. The terms “we”, “us”, “our” and “Health Plan” refer to Priority Health Choice, Inc. The terms “you,” “your” and “yourself” refer to the Member.

If you have any questions about Coverage, contact Customer Service at:

Priority Health Choice, Inc.
Customer Service Department, MS 1105
PO Box 269
Grand Rapids, MI 49501-0269
888.975.8102

Or, login to your member account at *priorityhealth.com* and send us a secure email.

Section 2 - Obtaining Covered Services

A. Primary Care Provider (PCP)

Your PCP arranges your medical care. Your PCP may be a family practitioner, a general practitioner, an internal medicine doctor, an obstetrician/gynecologist, a pediatrician, a nurse practitioner or a physician assistant. In special cases, the PCP may also be a Specialist. He or she provides you with basic health care. Your PCP also coordinates the ordering of lab tests and x-rays, prescribing of medications or therapies and arranging hospitalization, among other things. We will only Cover services that your PCP provides or refers, and that we approve, unless we tell you otherwise in this Certificate.

You must talk with your PCP about any issues concerning your medical care, and you must contact your PCP before you receive medical services, except in a Medical Emergency.
Your PCP also refers you to and consults with Specialist Providers, Participating Providers, and Non-Participating Providers when necessary. All referrals to or services received from Non-Participating Providers (providers not listed in our Provider Directory) must be prior approved by us unless we tell you otherwise in this Certificate. A referral from your PCP is not sufficient for us to Cover services from a Non-Participating Provider. If you do not receive written approval from us prior to obtaining services from a Non-Participating Provider, you may be responsible for payment. A copy of the Priority Health Choice, Inc. Provider Directory is available by calling our Customer Service department or on line at *priorityhealth.com*.

Choosing a PCP
When you enroll in the Healthy Michigan Plan administered by Priority Health Choice, Inc., you can choose a PCP. A copy of the Provider Directory is available by calling our Customer Service department or on line at
priorityhealth.com. Each member of your family may have a different PCP. If you need help choosing a PCP, call Customer Service at 888.975.8102. When you enroll, if you have not chosen a PCP, we will select one for you.

Changing a PCP
You can change your PCP (and the parent/guardian may change the PCP of someone who is incapable of choosing a PCP) at any time. You can change your PCP by contacting Customer Service at 888.975.8102 or online in your member account at *priorityhealth.com*.

The PCP change will take effect on the first day of the month after we receive your request.

A PCP change cannot be made while you are in the Hospital.

When you change your PCP, all medical treatment you are currently receiving must be re-approved by your new PCP.

B. Establishing and Maintaining a Provider-Patient Relationship
It is important that you establish and maintain a good relationship with your PCP and other Health Professionals. We require your PCP and other Participating Providers to discuss with you all treatment options available to you, regardless of benefit Coverage limitations. Providers are not expected to inform you when services have limitations or are excluded from Coverage. This Certificate of Coverage provides this information, or you may contact our Customer Service department with any questions.

If you cannot maintain a good relationship with a Participating Provider, we can do any of the following:

1. Ask you to choose another PCP;

2. Select another PCP for you;

3. Arrange for your PCP to refer you to another Participating Provider; or

4. Ask the State to disenroll you from the Healthy Michigan Plan administered by Priority Health Choice, Inc.

C. Referrals

At times you may need services from another Participating Provider, including a Specialist Provider, or a Non-Participating Provider.

Participating Providers are those listed in the Priority Health Choice, Inc. Provider Directory.

A Non-Participating Provider is one not listed in the directory. Your PCP does not need approval from us to refer to a Participating Provider, except for a few specific services that are listed at the end of this subsection. Except for family planning services, FQHCs, Tribal Health Centers, and Local Health Departments, all referrals to a Non-Participating Provider must be prior-approved by us unless we tell you otherwise in this Certificate. Referral by your PCP is not sufficient for Coverage of services received from a Non-Participating Provider.

Do not go to another Participating or Non-Participating Provider unless your PCP has referred you and we have approved the referral first when we consider approval necessary. You must pay for services from a Non-Participating Provider if we have not approved them first. You must also pay for services you receive in excess of the services that we approved.

You may call Customer Service at 888.975.8102 to find out if a provider is participating or non-participating.

You may also call Customer Service to find out if we have approved a request from your PCP for referral to a Non-Participating Provider.

NOTE: Sometimes your PCP may refer or suggest a service for you that we do not Cover. Just because your PCP refers or suggests the service for you does not mean you will have Coverage for that service. Remember, if you receive services that we do not Cover, you must pay for the services.

A Second Medical Opinion

A second medical opinion from a Specialist may be appropriate for certain health conditions and proposed surgeries. Requests for second opinions must be initiated by your PCP, not a Specialist Provider.

We will Cover second medical opinions requested by your PCP from Participating Providers having skills and training substantially similar to those of the doctor making the original treatment recommendation. If no Participating Provider is available and your PCP tells us about the need for a second opinion, we may Cover a second medical opinion from a Non-Participating Provider, if approved by us before the second opinion is received. Any tests, procedures, treatments or surgeries

recommended by the consulting provider, must be performed by a Participating Provider, unless we approve the services in advance.

We may also require a second opinion from a Specialist that we have chosen. This required second opinion will be used to assist us in determining whether services or supplies are Medically/Clinically Necessary according to our medical and behavioral health policies or adopted criteria.

Annual Well-Woman Examinations and Routine Pregnancy Services
A person may visit her PCP, or another Participating obstetrician/gynecologist without a referral, for her annual well-woman examination and routine pregnancy services. Referrals are still necessary for treatment by a Participating obstetrician/gynecologist of medical conditions. If a woman is pregnant at the time of enrollment she may seek all Medically/Clinically Necessary prenatal and obstetrical care from an out-of-network obstetrician/gynecologist without a referral. However, please call Customer Service at 888.975.8102 and let us know the Non-Participating Provider's name and contact information.

A person may also access family planning services such as services to prevent pregnancy or treatment for sexually transmitted disease, from any Participating or Non-Participating family planning center without prior approval from us.

Covered Services that Require Prior Approval
Services that require our prior approval in order to be Covered include, but are not limited to:

1. Consultations and procedures for:
    - Bariatric (weight loss) surgery
    - Comprehensive pain and headache programs
    - Cosmetic and reconstructive surgery
    - Hospital ancillary and general anesthesia for dental treatment
    - Male gynecomastia surgery
    - Orthognathic surgery (jaw reconstruction)
    - Parenteral/Enteral Feeding
    - Physician supervised weight loss programs
    - Transplant and evaluations for transplant
    - Uvulopalatopharyngoplasty (UPPP)
2. Inpatient care
    - Elective admissions
    - Inpatient skilled nursing, subacute, long-term acute and rehabilitation care

3. Long-term Acute care
4. Certain outpatient procedures and therapies
   Certain radiology examinations, including positron- emission tomography (PET scans), magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies and implantable cardioverter defibrillator
5. Referrals to Non-Participating Providers, except for family planning services or unless we tell you otherwise in this Certificate (Participating Providers are those listed in the Priority Health Choice, Inc. Provider Directory; a provider is Non-Participating if he or she is not listed in the Provider Directory)
6. All follow up care provided outside the Service Area after a Medical Emergency or Urgent Care situation
7. Home health care
8. Hospice care
9. Home infusion services
10. Durable Medical Equipment over $500
11. Prosthetics and orthotics over $500
12. Certain prescription medications
13. Certain injectable/medically administered drugs

We may revise the list of services that require prior approval at any time. A current list is available by calling Customer Service department or visit *priorityhealth.com*.

D. Termination of Provider's Participation

Priority Health Choice, Inc. or a Participating Provider, can terminate a Participating Provider's contract or limit the number of patients a Participating Provider will accept. We do not promise that you will be able to receive services from a specific Participating Provider the whole time you are enrolled with us. We will notify you if your PCP or Specialist Provider is no longer a Participating Provider. You agree to choose another PCP with our help if needed.

If you choose or are assigned another PCP, you must have all medical treatment you are currently receiving approved by your new PCP. If you are being actively treated (or are hospitalized) at the time a Participating Provider's contract with us is terminated, and the provider is able to continue to treat you, you may continue to be treated by the terminated provider until treatment is completed or until we have made arrangements for another provider to provide the services. In addition, if, at the time of termination, you are undergoing treatment for a chronic or disabling condition, or if you are in the second or third trimester of pregnancy, you may continue to see the terminating provider for up to 90 days, or through the completion of postpartum care. This paragraph does not apply if the Participating Provider's contract with us has been terminated for quality of care reasons.

Any provider you use in addition to your PCP may also stop being a Participating Provider. If that

happens, you must contact your PCP for another referral. Otherwise, we may not Cover any services you receive from the provider.

If a provider is suspended or terminated from the Medicaid or Medicare programs, we are prohibited from paying for services provided, referred or ordered by the provider, including prescriptions.

We will assist you in finding another Participating Provider and in receiving care during the transition if your Participating Provider's contract with us is terminated. If you have any questions please call Customer Service at 888.975.8102.

E. Non-Emergent Care After Regular Office Hours

Your PCP must have telephone coverage 24 hours a day, 7 days a week. If you become Ill or are Injured after regular office hours, you should call your PCP's office, and tell them you are a Member of the Healthy Michigan Plan administered by Priority Health Choice, Inc. Your PCP or a Participating Provider who is covering for your PCP may give advice over the phone, prescribe medicine or therapy, ask you to come into the office, or refer you to an Urgent Care Center, emergency room or another Participating Provider to receive help.

F. Medical Emergency or Urgent Care

You have Coverage for Medical Emergency care and Urgent Care Services. The rules for that Coverage depend on whether you receive care inside or outside of the Service Area and whether the care is for a Medical Emergency or an Urgent Care situation. A copayment applies for non-emergency services provided in an emergency room, ranging from $3 – $8 based on Federal Poverty Level. Additional copayment details listed in Section 5 of this document.

NOTE: If you are confined in a Hospital after a Medical Emergency, you (or someone on your behalf) must let your PCP know about your confinement as soon as it is reasonably possible to provide that notice.

1. Inside the Service Area

   If you have a Medical Emergency, seek medical help immediately. You can receive emergency room Coverage in any Medical Emergency. But if you use an emergency room for care your PCP could have given, or for something that is not a Medical Emergency, we may not Cover the cost.

   When you need Urgent Care Services, you must try to contact your PCP's office before you obtain those services. Otherwise, you may be responsible for any of the services you receive. Your PCP will tell you either to go to his or her office or to another Participating Provider's office. If you are unable to reach your PCP's office and your problem requires Urgent Care, please contact our afterhours line at 888.975.8102 before going to the emergency room or Urgent Care Center.

If you go to a Participating Urgent Care Center or Participating Hospital emergency room, present your ID Card when you receive care. Afterward, contact your PCP for all follow-up care.

If you use an emergency room or an Urgent Care Center for care that is not for a Medical Emergency, or Urgent Care or that could have been provided by your PCP, you must pay for the services. Do not return to the emergency room for follow-up care that can be provided by your PCP.

The following are Covered Services within the Service Area:

1. Services and supplies that you receive for a Medical Emergency (see the definition in Section 16).

2. Services and supplies that you receive for any condition that, following our review of the proper medical records, we determine to have required Urgent Care at the time you received the services and supplies.

3. Hospitalization for a Medical Emergency in a facility that is a Non-Participating Provider, until, in our determination, it is appropriate for you to be transferred to a Participating Provider.

We will not Cover services or supplies you receive from a Non Participating Provider for a situation that is not a Medical Emergency or does not require Urgent Care unless we have given prior approval for those services or supplies unless we tell you otherwise in this Certificate. This includes follow-up care after a Covered emergency.

If you receive Medical Emergency or Urgent Care services, you must contact your PCP's office as soon as you can after you receive the services to allow your PCP to arrange follow up care with a Participating Provider. Except for emergency services, any services received from a Non-Participating Provider must be prior approved by us, and your PCP, or you may be financially responsible for the services unless we tell you otherwise in this Certificate.

Remember, your PCP must provide or arrange all follow-up and continuing care unless we tell you otherwise in this Certificate.

2. Outside the Service Area

If you become Ill or are Injured while you are temporarily away from the Service Area, we will Cover care for Medical Emergencies and Urgent Care.

Services and supplies for Medical Emergencies and Urgent Care situations that you receive outside the Service Area are Covered if:

1. You could not reasonably have expected, before you left the Service Area, to need the services and supplies; and

2. It would be hazardous to your health to wait for those services and supplies until you could

reasonably return to receive them from a Participating Provider.

If you have a Medical Emergency, seek help immediately. You can receive emergency room Coverage in any Medical Emergency.

If you need Urgent Care services outside of the Service Area, you must try to contact your PCP's office or Customer Service before you obtain those services. Otherwise, you may be responsible for any services you receive. If you are unable to reach your PCP and your problem requires Urgent Care, go to an Urgent Care Center or a Hospital emergency room. We will not Cover services and supplies you receive during travel outside the Service Area if the only reason for the travel is to obtain medical services or supplies, unless we approve them in writing first.

If you receive Medical Emergency or Urgent Care services while you are outside of the Service Area, you must contact your PCP as soon as reasonably possible after you receive the services to allow your PCP to arrange follow up treatment. Services received from a Non-Participating Provider (other than emergency services) must be prior approved by us, as well as by your PCP unless we tell you otherwise in this Certificate.

For providers who are outside of the Service Area for our Healthy Michigan Plan, we will pay the Reasonable and Customary rate. We will only Cover one visit, approved in advance by your PCP and us, for each Medical Emergency or Urgent Care situation, unless we and your PCP approve additional visits in advance.

Remember, your PCP must provide or arrange all follow up and continuing care. Otherwise, you will not have Coverage for the services you receive.

NOTE: Services outside of the United States are not covered.

3. Ambulance Services

"Ambulance" includes a motor vehicle or rotary aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

1. In the case of a Medical Emergency, we will Cover ambulance service, to the nearest medical facility that can provide Medical Emergency care.

2. We will cover ambulance transfers between facilities that are approved by your PCP or us as Medically/Clinically Necessary. Any other non-emergent transportation by ambulance is not Covered.

G. Prior Approval of Certain Health Care Services and Supplies

As stated in Section 2.C, certain services and supplies that Health Professionals recommend or provide to you must receive prior approval from us before they can be Covered. In most cases, we will approve, deny or partially approve or deny a request for prior approval within 14 days of receipt. However, in urgent cases, the determination period is reduced to 72 hours. In some cases we may ask you for additional information or additional time in which to make our determination. After the decision is made, we will notify you in writing if the requested services and supplies are Covered, not Covered or partially Covered. In the case that your PCP is requesting services from a Non-Participating Provider, you and your PCP will receive a letter from us indicating whether or not the services will be Covered. If you do not receive a letter from us with the decision, you may contact Customer Service and request that they investigate the status of the request. In all cases, if you receive services that we say are not Covered, or if you receive services in excess of what has been approved, you will be responsible for the payment for those services. If you want our decision to be reviewed, you must contact us. Section 12 tells you how to do that.

H. Additional Information

We will provide you with the following additional information when you request it by calling or writing our Customer Service department:

1. Our current Provider Directory. This lists our current provider network, including: (a) names and locations of Participating Providers by specialty, (b) details on how to access referrals to Specialists, and (c) names of providers who are not accepting new Members.

   You may also find our Provider Directory at *priorityhealth.com*.

2. The professional credentials of our Participating Providers, including, but not limited to, Participating Providers who are board certified in the specialty of pain medicine and the evaluation and treatment of intractable pain and have reported that certification to us, and the Participating Hospitals where they have privileges.

3. The telephone number of the Michigan Department of Health and Human Services where you can call to find out information regarding disciplinary actions or formal complaints filed against a provider.

4. Any prior approval requirements and any limitations, restrictions or exclusions on services, benefits or providers.

5. The type of financial relationships between us and our provider network.

6. How we evaluate new technology for inclusion as a Covered Service.

7. How we evaluate new drugs for inclusion on our approved drug list.

You may request this information by calling or writing our Customer Service department at the address

and phone numbers below.

Priority Health Choice, Inc.
Customer Service Department, MS 1105
PO Box 269
Grand Rapids, MI 49501- 0269
888.975.8102

or, login to your member account at *priorityhealth.com* and send us a secure email.

Section 3 - Enrollment

To be enrolled in the Healthy Michigan Plan administered by Priority Health Choice, Inc., you must have Healthy Michigan Plan coverage and have selected our plan, or been assigned to our plan by the State's enrollment broker. If you were disenrolled for cause, in some cases you may be able to reenroll after one year. Read Section 11.C to learn more about termination for cause.

A. Newborn Enrollment

1. Please notify your Michigan Department of Health and Human Services (MDHHS) caseworker as soon as possible after your child's birth.
2. Your caseworker will give you your baby's Medicaid ID number.
3. Call Priority Health Choice, Inc.'s Customer Service department to tell us your baby's Medicaid ID number, name and gender.
4. Call Michigan ENROLLS at 888.367.6557 and tell them you'd like Priority Health Medicaid Choice for your baby.

B. How to keep your Healthy Michigan Plan

Healthy Michigan Plan members who have incomes above 100% of the Federal Poverty Level (FPL) and have not completed the healthy behavior requirements outlined must transition to the Marketplace Option, except for members deemed medically frail or exempt from premiums and cost-sharing.

To avoid being transitioned to the Marketplace plan, follow the following steps:

1. Schedule your yearly physical/wellness appointment with your doctor.
2. Choose a healthy behavior to work on for the year
3. Give your HRA to your doctor to complete and discuss which healthy behavior your selected
4. Ask your doctor to send your completed form to Priority Health Choice

C. Notification of Change in Status

You must let us know about any changes that affect your Coverage under this Certificate. You do that by filling out a change form. The Change form is available in your member account at *priorityhealth.com*. Return your form to our Customer Service department using the address or fax number displayed on the form. You may also call our Customer Service department at 888.975.8102.You must also contact your MDHHS caseworker to update this information.

You must notify us, and your MDHHS caseworker if any of the following happen to anyone Covered by this plan:

1. Change of address;
2. Eligibility for Medicare;
3. Enrollment, disenrollment or coverage by any other insurance or health plan; or
4. You become pregnant

Remember that these are just examples. Let us know as soon as possible about any other change that, according to this Certificate, may affect your Coverage. All changes must be reported to us no more than 31 days after the change occurs.

You do not need to contact the State when you want to make a PCP change. Contact Customer Service at 888.975.8102 and we will help you.

D. Loss of Eligibility
If you no longer meet the Healthy Michigan Plan eligibility criteria as set by the Michigan Department of Health and Human Services, you will lose your eligibility and your Coverage under this plan will terminate.

Section 4 - Effective Dates of Coverage

A. General Rules
Except as explained below in subsection B and C, your Coverage will begin on the first day of the month the State notifies us of your enrollment.

B. Non-Confinement Requirements
If you are confined for treatment of an Illness or Injury in a Hospital when Coverage would otherwise begin, Coverage will not begin until that confinement is no longer Medically/Clinically Necessary. The non-confinement rule does not apply to a Newborn if the mother was enrolled with us on the date of delivery. Individuals confined in a Skilled Nursing or Long-term care facility at the time Coverage would otherwise begin are ineligible for enrollment with us. Coverage will be provided by the State of Michigan until such time that you are discharged from the Skilled Nursing or Long-term care facility.

C. Durable Medical Equipment and Prosthetics and Orthotics Ordered Prior to Enrollment

When custom Durable Medical Equipment, prosthetics or orthotics, are ordered while you are a member of another health plan and delivered after enrollment with Priority Health Choice, Inc.; the payer at time the equipment was ordered is responsible for payment of the item.

Section 5 - Copayment Information

Some Covered Services may have a Copayment. This means that you need to pay a fee to MI Health account when you get those services. All Copayments are listed below and also following the coverage details provided in Section 6. You will:

1. Only have to pay your Copayments if you are age 21 and older and a Healthy Michigan Plan member;
2. Not have Copayments for family planning products or services;
3. Not have Copayments for any pregnancy related products or services;
4. Not have Copayments for preventive health care services.

Covered service	**Copay**	
	Income ≤ 100% FPL*	**Income > 100% FPL***
Physician office visit (including free-standing urgent care centers)	$2	$4
Outpatient hospital clinic visit	$2	$4
Emergency room visit for non-emergency services (Copayment only applies to non-emergency services, there is no copayment for true emergency services)	$3	$8
Inpatient hospital stay (with the exception of emergent admissions)	$50	$100
Pharmacy	$1 preferred generic drug; $3 non-preferred brand-name drug	$4 preferred generic drug; $8 non-preferred brand-name drug
Chiropractic visits	$1	$3
Dental visits	$3	$4
Hearing aids	$3 per aid	$3 per aid
Podiatry visits	$2	$4
Vision visits	$2	$2

**Federal poverty level*

NOTE: In addition to Copayments, you will be responsible for a contribution equal to 2% of your adjusted gross income if your income is between 100-133% of the Federal Poverty Level. This amount will be paid to Priority Health Choice, Inc. Contact Customer Service at 888.975.8102 if you have any questions.

Copayments only apply to Healthy Michigan Plan members. Medicaid members do not pay any copayments.

Section 6 - Schedule of Covered Services

You are entitled to Covered Services described in Section 6 when those services are:

1. Medically/Clinically Necessary; (as defined in this Certificate and according to Medical and Behavioral Health policies established by Priority Health Choice, Inc. with the input of Physicians we do not employ or according to criteria developed by reputable external sources and adopted by us); and

2. Provided by your PCP, or provided by a Participating Provider and approved in advance by us when we consider approval necessary, or provided by a Non-Participating Provider upon referral from your PCP and approved in advance by us unless we tell you otherwise in this Certificate (See Section 2.C and 2.G for prior approval requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services); and

3. Not excluded elsewhere in this Certificate or in an amendment attached to this Certificate.

NOTE: Sometimes your PCP may refer you or suggest a service that we do not Cover. Just because your PCP refers you or suggests the service does not mean you will have Coverage for that service. If you receive services that we do not cover, you must pay for the services.

You should carefully review the rest of this Certificate for information about the extent of your Coverage.

The Covered Services are:

A. Primary Care

Primary care is the care provided by your PCP.

1. Health Maintenance and Preventive Health Care Services
Preventive care can help you stay healthy and catch problems early. Yearly check-ups, immunizations, screenings and lab tests that help prevent Illness or find disease, and certain medicines are just a few of the Covered Preventive Health Care Services available under the plan. Some Preventive Health Care Service are Covered to meet women's specific health needs. See our Preventive Health Care Guidelines available at *priorityhealth.com*. You may also request a copy from our Customer Service department at 888.975.8102.

The following services are just a sample of what is Covered for each Member even when these services are not provided in connection with the diagnosis and treatment of an Illness or Injury:

1. Periodic physical examinations.

2. Routine immunizations for infectious disease, in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, and as recommended by our Preventive Health Committee. Immunizations may be provided by the Health Department without Prior Approval. For immunizations that are not Covered, see Section 7 (47), Third Party Requirements.

3. One routine "well woman" examination, including a gynecological examination and breast

examination, every 12 months. A woman may visit her PCP, or a Participating obstetrician/gynecologist or nurse midwife acting within the scope of his or her license or specialty certification for her annual well-woman examination and routine pregnancy services. A person may also access family planning services to prevent pregnancy or treatment for sexually transmitted disease, from any Participating or Non-Participating family planning center without prior approval from us.

4. Breast cancer screening mammography as directed by your PCP or as required by state law.

5. Maternity care as described in Section 6.C.

6. Tobacco cessation treatment, including counseling support provided through an approved telephone quite line, over-the-counter agents such as the patch, gum or lozenges, and one prescription of non-nicotine medication used to promote smoking cessation.

7. Health education services.

8. Habilitative therapies (speech, language, physical and occupational).
Medicaid members up to age 21 and Healthy Michigan Plan members

9. Weight loss counseling.

10. Care related to the promotion of Healthy Behaviors.

Provider Care
All services listed in this Section 6 provided by your PCP during an office visit, Hospital visit, or house call, for the diagnosis and treatment of an Illness or Injury.

Sometimes your PCP may provide a service that we do not Cover. Just because your PCP provides a service does not mean you will have Coverage for that service. For example: Acupuncture and other non-traditional services are excluded from Coverage. If your doctor performs acupuncture or another non-traditional service, Coverage for the service will not be provided. Remember, if you receive services that we do not Cover, you must pay for the services.

B. Referral Care
Referral care is care provided by a Specialist Provider, including Participating Providers and Non-Participating Providers. You should only seek care from a Specialist if referred by your PCP, and approved in advance by us when we consider approval necessary, including all non-emergency referral care provided by Non-Participating Providers. See Section 2.C and 2.G for the requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services.
1. Allergy Testing

Evaluations and injections including serum costs. See Section 7 (4) for allergy tests that are not Covered.

2. Ambulance Services
   Described in Section 2.F (3)

3. Ambulatory Surgical Services and Supplies
   Outpatient services and supplies furnished by a surgery center along with a Covered surgical procedure on the day of the procedure.

4. Antineoplastic Therapy
   Antineoplastic drug therapy is covered in accordance with Michigan law.
   Antineoplastic drug therapy will not be covered if use is determined to be experimental, investigational, or being used as part of a clinical trial.See Section 6 for a complete listing of exclusions.

5. Chiropractic Care
   Up to 18 visits per calendar year when referred by the Member's PCP. Care limited to spinal manipulation for subluxation of the spine only.

6. Contraceptive Medications and Devices
   Priority Health Choice covers contraceptives as directed by MDHHS. Condoms are covered for all beneficiaries without a prescription.
   Not all brands are covered. Members are allowed 36 condoms per every 30 days.

7. Dental Services
   Emergency, diagnostic, and preventive dental services are covered for all Members.
   Additional Covered services include:

   - Therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or the supportive structures
   - Restorative treatments
   - Endodontics
   - Periodontics
   - Prosthodontics (removable only)
   - Oral surgery
   - Adjunctive general services

   NOTE: A copayment applies to members age 21 and older. See Section 5 for details.

8. Dental Hospitalization
   Hospital, ancillary and anesthesia services for adults require prior approval from us.

9. Diabetic Services and Supplies Services and supplies for Members with diabetes, as follows:

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

- Test strips for glucose monitors, visual readings and urine test strips, lancets and spring-powered lancet devices.
- Syringes that are used for the administration of insulin.
- Diabetes self-management training to ensure that Members with diabetes are trained to do the proper self-management and treatment of their diabetes condition.
- Insulin and other medications for Members with diabetes are Covered through the Priority Health Choice, Inc. Prescription Drug program.
- Coverage is for standard diabetic services and supplies only. Services for the convenience of the Member or caregiver are not Covered.
- Dietitian Services
  Up to six (6) consultative visits with a Participating dietitian, employed by a Participating Provider, upon referral by your PCP.

10. Durable Medical Equipment (DME)
    Equipment intended for repeated use to meet a medical need. DME is generally not useful to a person without an Illness or Injury. DME is appropriate for use in the home. DME over $500 must be approved in / advance by us. Some examples of DME are manual and electric wheelchairs, glucose monitoring devices, and CPAP machines.

Covered DME is:

- Prescribed by your PCP or by a Participating Provider upon referral from your PCP;
- Approved in advance by us, when required; and
- Obtained from a Participating Provider.

The following are also Covered:

- Training or education on the use of DME;
- Disposable supplies necessary for the proper functioning or application of the DME; and
- Ostomy supplies.

Coverage is for standard DME only. Equipment that is not conventional or not Medically/Clinically Necessary as determined by us, or is for the convenience of the Member or caregivers will not be Covered. Equipment must be appropriate for home use and meet authorization guidelines. Coverage for DME is limited to one piece of same-use equipment. We may substitute one type or brand of DME for another when the items are comparable in meeting your medical needs.

DME may be rented, purchased, repaired or replaced. The decision to rent, purchase, repair or replace DME is at our discretion. Repairs or maintenance of DME required as the result of normal use are Covered. All repairs and maintenance that result from misuse or abuse are your responsibility.

We will Cover the repair or replacement, and fitting and adjustment of Covered DME that is the result

of normal use, body growth or body change. We reserve the right to limit replacement of DME to the expected life of the equipment. You may contact our Customer Service department to find out if the DME you need is Covered. See Section 7 (12) for DME that is not Covered.

11. Education

Education about how to manage chronic disease states such as diabetes or asthma. Education programs must be conducted by Participating Providers.

12. Emergency Treatment

Covered without prior approval if Medically/Clinically Necessary as defined in state law (read more about emergency treatment in Section 2.F).

13. End Stage Renal Disease

Services and supplies necessary to diagnose and treat end stage renal disease.

14. Family Planning

The following are Covered Services for each Member even if they are not provided in connection with the diagnosis and treatment of an Illness or Injury. No referral is necessary if you receive these services at a plan-approved family planning center.

- Diagnostic services for identification of the cause of infertility.
- Diaphragms, including measurement and fitting, and IUDs, including insertion and removal.
- Advice on contraception and family planning, including childbirth education.
- Treatment for sexually transmitted diseases (STD).

Procedures to assist you in having children are excluded as described in Section 7 (24) under "Infertility."

15. Habilitation Services

(Healthy Michigan Plan members and Early Periodic Screening, and Diagnostic and Treatment for Medicaid members up to age 21)

Services provided to Members with disabilities in order to help them keep, learn or improve skills and functioning for daily living. Covered Habilitative Services include physical and occupational therapy services and speech therapy services. These services are Covered when:

- There is a written order from a Participating Provider;
- They are provided in accordance to a written treatment plan established by the ordering provider;
- They are provided by a properly qualified and credentialed Health Professionals; and
- They are provided in a Participating outpatient facility.

Physical and occupational therapy services are Covered without prior approval.

- 2 evaluations or re-evaluations per year.

Speech therapy services are Covered without prior approval up to:

- 36 visits in a calendar year, and
- 2 evaluations or re-evaluations per year.

NOTE: Additional Habilitative Services may be Covered when prior approved by Priority Health Choice, Inc.

16. Hearing Care

Health services provided for the diagnosis and treatment of diseases of the ear. Hearing exams and hearing aid evaluations are available from a Participating Provider. Coverage is for the purchase, fitting and dispensing of one monaural or binaural hearing aid(s) in a 3 year period for Members under age 21. Coverage is for the purchase, fitting and dispensing of one monaural or binaural hearing aid(s) in a 5 year period for Members age 21 and over. Hearing aids must meet minimum specifications and be Medically/Clinically Necessary.

A maximum of 72 batteries per year are Covered. 36 disposable batteries per hearing aid.

17. Home Health Care

Intermittent skilled services, when approved in advance by us and furnished in the home by a Home Health Care Agency or by a registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist or speech therapist. Custodial care is not Covered, even if you receive home health care services along with custodial care.

18. Hospice Care

Inpatient and outpatient Hospice Care is Covered when:

- Your Physician informs us that your condition is terminal; and
- We determine hospice to be Medically/Clinically Necessary according to the criteria set forth in applicable medical policies and when approved in advance by us
- You choose to have hospice services; and
- The care is provided by a Medicare certified hospice program.

Covered hospice services, provided through a hospice provider, may include:

- Inpatient Hospice Care

  Short term inpatient Hospice Care is Covered when Medically/Clinically Necessary for skilled nursing care that cannot be provided in other settings, or up to five (5) days for inpatient respite.

- Outpatient Hospice Care

  Outpatient Hospice Care is Covered and may include continuous or intermittent skilled services by a registered nurse or licensed practical nurse, physician care, home health aide services, medical supplies, drugs and biological, physical, or speech therapy, medical social work, dietary counseling, and bereavement counseling.

Based on hospice eligibility criteria, the duration of hospice services is 6 months or less. There is no

minimum period of hospice enrollment. A change in prognosis could eliminate the need for Hospice Care. Hospice services may be cancelled at any time by the Member without cause. If you become ineligible for the Healthy Michigan Plan while enrolled in a hospice you will also become ineligible for reimbursement for hospice services from Priority Health Choice, Inc.

19. Hospital Care

- Inpatient Care
  Hospital inpatient services and supplies including services performed by Health Professionals, semi-private room and board, general nursing care, observation care and related services and supplies. Non-emergency Hospital stays, (other than Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section), must be approved in advance by us.
- Outpatient Care
  Hospital services and supplies listed in subsection (19)(a) that you receive on an outpatient basis.

20. Infertility Services
  Covered as outlined under Section 6.B (14) Family Planning. Procedures to assist with conception are not Covered.

21. Intractable Pain/ Pain Management
  Evaluation and treatment of intractable pain.

22. Mental Health
  Evaluation, consultation and treatment to determine a diagnosis and treatment plan for acute crisis intervention and other short-term, mild to moderate mental health conditions as Medically/Clinically Necessary and received from a Participating Provider.

  Brief, solution-focused treatment and crisis interventions are Covered for mild to moderate psychiatric signs and symptoms with minor or temporary functional limitations or impairments.

  We do not Cover long-term psychotherapy or specialty mental health services necessary for the treatment of significant, persistent, complex and/or serious psychiatric conditions that require multiple, intensive, and sustained mental health interventions and supports. These services are provided by the local Community Mental Health Services Program.

  Solution-focused treatment, including both individual and/or group sessions. The average course of treatment, which can vary depending upon your condition, is usually 5-6 sessions in length. We Cover services that result in measurable and substantial improvement in mental health status.

The main goal of solution-focused treatment is (a) to stabilize your current situation through an emphasis on personal strengths and coping skills, and (b) to intervene in ways that will have a positive, lasting impact beyond treatment’s end.

- Initial Screening

You do not need to call our Behavioral Health Department before receiving outpatient mental health services. Mental health services do not require referral from your PCP. You can call our Behavioral Health Department at 800.673.8043 for assistance or a referral.

- Covered Treatment Settings
  The only Covered level of treatment is outpatient treatment, the least intensive level of service.

  Outpatient treatment is typically provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group) therapies per day. Services provided over the telephone are not Covered.
- Coverage Limitations
  The following Coverage services may be provided for a Member with mild to moderate mental health conditions:
  - Diagnostic evaluation and management visit to assess mental health status
  - Psychotherapy or counseling with medication management when indicated
  - Family psychotherapy or counseling
  - Pharmacological management, including prescription, use and review of medical with minimal psychotherapy or counseling
  - Interpretation or explanation of results of psychiatric or other medical examinations and procedures to family or other responsible persons, or advising them how to assist the Member

Coverage for behavioral health medications is limited to those drugs that are not considered psychotropic medications. Psychotropic medications are covered by the Michigan Department of Health and Human Services. For more information regarding Covered medications, you may contact Customer Service or visit us online at *priorityhealth.com*.

23. Obesity
Medical and surgical treatment of extreme obesity is Covered when Medically/Clinically Necessary, as determined according to our medical policies. All treatment for extreme obesity must be approved by us in advance and provided by a provider or facility approved by us. Physician-supervised weight loss programs are Covered only if obtained from a program approved by us. Services must meet medical policy criteria and be approved by us in advance.

Co-morbid health conditions, such as poorly controlled diabetes, hypertension (high blood pressure) inadequately controlled with conventional treatment or uncontrolled hyperlipidemia (ex: high cholesterol) must exist and all reasonable non-surgical options must have been tried before surgical treatment will be considered. Surgical treatment will only be considered with evidence of compliance with medical treatment in a program we have approved along with other criteria set forth in our medical policies.
Non-compliance with treatment regimens may limit future benefits.

24. Oral Surgery

Coverage for oral surgery is limited to the following:

- Reduction or manipulation of fractures of facial bones.
- Removal of tumors or cysts of the jaw, other facial bones, mouth, lip, tongue, accessory sinuses, salivary glands, or the ducts.
- Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury within 48 hours of Injury. Rebuilding or repair for cosmetic purposes is not Covered.

Coverage for oral surgery must be approved in advance by us in consultation with your PCP (and if necessary a dental consultant) as Medically/Clinically Necessary. Orthodontic treatment is not a Covered Service, even when provided along with oral surgery.

Dental surgery done in connection with any of the Covered Services listed above is Covered. See Section 6.B (6) and Section 7 (11) to learn more about Covered dental services.

25. Orthognathic Surgery

"Orthognathic surgery" is defined as oral surgical therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment to correct bodily dysfunction. We will only Cover the following orthognathic surgery services, and only when the services are approved in advance by us in consultation with your PCP (and if necessary a dental consultant) as Medically/Clinically Necessary:

- Referral care for evaluation and orthognathic treatment.
- Cephalometric study and x-rays.
- Orthognathic surgery and post-operative care.
- Hospitalization.

Orthodontic treatment is not a Covered Service, even when provided along with orthognathic surgery.

26. Outpatient Prescription Drugs

Prescription drugs will be covered if they are included on the Priority Health Choice formulary, written by a participating provider and dispensed by a participating pharmacy. The MI Medicaid Common Formulary Workgroup, in partnership with MDHHS, determines what outpatient prescription drugs will be covered for this plan. Limitations apply and coverage for some drugs requires prior approval. For more information regarding covered medications, you may contact our Customer Service department, or visit us online at priorityhealth.com/formulary/Medicaid. Certain medications are excluded from coverage. Please see section 6 Exclusions from Coverage for a full list of excluded outpatient prescription drugs.

Prescriptions will be dispensed in quantities prescribed by your Provider. Most medications are

limited to a one-month supply per dispensing. Some family planning drugs can be filled for up to three months supplies per dispensing.

Coverage for behavioral health medications is limited to those drugs that are not considered psychotropic medications.

Psychotropic and anti-viral medications are covered by the Michigan Department of Health and Human Services. For more information regarding Covered medications, you may contact our Customer Service department, or visit us online at *priorityhealth.com*.

27. Over the Counter Drugs and Supplies
Certain over the counter drugs and supplies are Covered when ordered by a Participating Provider and dispensed by a Participating Pharmacy.

28. Port Wine Stains and Vascular Malformations
We will Cover laser therapy for removal of port wine stains and vascular malformations when approved in advance by us as Medically/Clinically Necessary, as determined by our medical policies.

29. Prosthetic and Orthotic/Support Devices
Surgically implanted internal prosthetic devices and special appliances/devices that are worn externally, when the appliances or devices:

- Temporarily or permanently replace all or part of the functions of an inoperative or malfunctioning internal body organ, or an external body part lost, weakened or deformed as a result of Injury or Illness, and when they are;
- Prescribed by your PCP, or prescribed by a Participating Provider upon referral from your PCP and approved in advance by us.
- Prosthetic and orthotic/support devices over $500 must be prior approved by us.

When an appliance or device is Covered, we will repair or replace it if necessary because of normal growth or normal wear and tear.

You have Coverage for standard prosthetics and orthotic/support devices only. Prosthetic or orthotic devices that are not conventional, not Medically/Clinically Necessary as determined by us, or for the convenience of the Member or caregivers are not Covered.

Custom molded shoes for Members with Diabetes are Covered when prior approved by us in accordance with medical policy.

Shoe inserts are Covered only when the Member requires a depth shoe or custom molded diabetic shoe. Shoe inserts require prior approval by us in accordance with medical policy. See Section 7 (39) for additional exclusions.

30. Provider Care

All services listed in this Section 6 provided by a Participating Provider or Non-Participating Provider during an office visit, Hospital visit or house call for the diagnosis and treatment of an Illness or Injury upon referral by your PCP and approved in advance by us if necessary. Referral by your PCP and prior approval by us is required if the referral Provider is a Non-Participating Provider unless we tell you otherwise in this Certificate.

31. Radiology Examinations and Laboratory Procedures

Diagnostic and therapeutic radiology services and laboratory tests not excluded under Section 7 in this Certificate.

Certain radiology examinations, including positron-emission tomography (PET scans), magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies, require prior approval from us.

32. Reconstructive Surgery

Reconstructive surgery to correct congenital birth defects and/or effects of Illness or Injury

These services are Covered if:

- The defects and/or effects of Illness or Injury cause clinical functional impairment. Clinical functional impairment exists when the defects and/or effects of Illness or Injury:
- Cause significant disability or major psychological trauma,
- Interfere with employment or regular attendance at school,
- Require surgery that is a component of a program of reconstructive surgery for congenital deformity or trauma, or
- Contribute to major health problems.

NOTE: Psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the Illness or Injury for which the reconstructive surgery is requested.

- We reasonably expect the surgery to correct the condition; and
- The services are approved in advance by us in consultation with your PCP and you receive them within two years of the event that caused the impairment, unless either of the following applies:
- The impairment was not recognized at the time of the event. In that case, treatment must begin within two years of the time that the problem is identified; or
- Your treatment needs to be delayed because of developmental reasons.

We will Cover treatment to completion that needs to be performed in stages if that treatment begins within two years of the event causing the impairment so long as you remain a Member. We will do that even if the treatment takes longer than two years. We will make the final decision about Coverage in consultation with your PCP.

Necessary surgery following cancer surgery (such as following a mastectomy) and major trauma

(severe lacerations and burns) is a Covered Service as required by law.

- Reconstructive surgery following breast cancer
  In compliance with the Women's Health and Cancer Rights Act of 1998, we will consult with your PCP to determine Coverage for these services:
  - Reconstruction of the breast on which a mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

The requirement to receive services within two years of the event that caused the impairment does not apply to reconstructive surgery following breast cancer.

- Orthodontic treatment Orthodontic treatment is not a Covered service, even when provided along with reconstructive surgery.

  See Section 7 (8) and Section 7 (40) for Cosmetic and Reconstructive Surgery that is not Covered.

33. Short-term Rehabilitative Therapy

Physical therapy, cardiac rehabilitation, pulmonary therapy, occupational therapy, and speech therapy for treatment of medical diagnoses if due to:

- An Injury;
- An Illness; or
- A congenital defect for which you have received corrective surgery.

Short-term rehabilitative therapy services are Covered if:

- You receive them as an outpatient or in the home. Rehabilitative services provided in the home must be prior approved by us and be based upon Medical Policy. Please see Referral Care Section 6.B for more information.
- The therapy is restorative in nature, and
- There is progressive meaningful improvement in your ability to perform functional day-to-day activities that are significant in the Member's life roles within 90 days, and
- The services cannot be provided by any federal or state agency or by any local political subdivision, including school districts, when you are not liable for the costs in the absence of insurance, and
- A Participating Physician refers, directs and monitors the services. See Section 7 (41) for limitations and exclusions.

Removal of skin tags, multiple fibrocutaneous tags, any area.

34. Skilled Nursing Facility Care

A maximum of 45 total days for care and treatment, including therapy, and room and board in semi-private accommodations, at a Skilled Nursing Facility. Criteria for Coverage under this plan is not the same as Medicare's, therefore, just because Medicare is covering your stay in a Skilled Nursing Facility does not mean the services are Covered under this Certificate.

Coverage is provided for up to 45 days of intermittent or short term restorative or rehabilitative service in a facility in a rolling 12-month period.

Custodial care is not Covered, even if you receive skilled nursing services or therapies along with custodial care. Admission to a Skilled Nursing Facility is not Covered if the necessary skilled care or therapies are clinically appropriate to be provided in the home, outpatient setting or provider office. Custodial care and services are excluded as described in Section 7 (10) under "Custodial Care."

35. Substance Abuse

You are entitled to receive substance abuse services, which are provided by the local coordinating agency in your area. You may call the Community Mental Health Services Program in your county for a referral. If you do not know the Community Mental Health Services Program in your county, you may call our Behavioral Health Department at 800.673.8043 for more information.

36. Telemedicine/Virtual Care

Telemedicine appointments are covered including visits with your primary care and specialty doctors. These video-call appointments allow you to receive care without leaving your home. Not all appointments can be conducted by telemedicine. You can call Customer Service at 888.975.8102 for more information.

37. Temporomandibular Joint Dysfunction or Syndrome "Temporomandibular Joint Syndrome" or "TMJ" means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction.

Medical care or services to treat TMJ dysfunction or TMJ syndrome resulting from a medical cause or Injury are Covered.

You have Coverage for the following services if they are prior approved by us:

- Office visits for medical evaluation and treatment.
- Specialty referral for medical evaluation and treatment.
- X-rays of the temporomandibular joint including contrast studies, but not dental x-ray.
- Myofunctional therapy.
- Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

Bite splits, orthodontic treatment or other dental services to treat TMJ dysfunction or syndrome are not Covered.

38. Transplants

Transplants of the following organs at a facility approved by us are Covered only when we have prior approved the transplant as appropriate, Medically/Clinically Necessary and non-experimental:

- Cornea
- Heart
- Lung
- Kidney
- Bone marrow or stem cell
- Liver
- Pancreas
- Small bowel

Your benefits under this section are limited to one evaluation per transplant.
We will Cover the following services:

- Extrarenal organ transplants (skin, bone, heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologus and peripheral stem cell harvesting, and small bowel) on a patient specific basis when determined Medically Necessary according to currently accepted standards of care.
- All costs associated with transplant surgery and care. Related care may include but is not limited to organ procurement, donor searching and typing, harvesting of organs, and related donor medical costs if the donor does not have transplant coverage under any other health care plan. Coverage includes Hospital, surgical and laboratory and x-ray expenses incurred by the person donating an organ or tissue.
- We will Cover expenses related to the typing or screening of a potential donor only if the person proposed to receive the transplant is a Member.
- We will Cover computer organ bank searches and any subsequent testing necessary after a potential donor is identified, unless covered by another health plan.

See Section 7 (33) under “Organ, Tissue and Blood Cell Donors” for expenses that are not Covered. This provision shall not conflict with the Coverage of drugs for cancer therapy, which are Covered as described above in this Section 6.

Transplants of artificial organs are not Covered.

39. Transportation

Non-emergency transportation to Covered medical services may be arranged by us if you do not have a way to get to and from a doctor visit, or to get Covered medical items or services.

All non-emergency transportation requires prior approval and scheduling by us.

40. Vision Care

Services and supplies relating to vision care, including, among other things: one eye exam every 24 months to determine the need and proper prescription for corrective lenses, one pair of single vision, multi-focal or cataract lenses and ophthalmic frames. Ophthalmic lenses include standard crown glass or CR 39 plastic lenses in all sizes and powers. Lenses include the following designs:

- Standard single vision;
- Standard bifocal (Flattop 25 and 28, round 22mm); and
- Standard trifocals (CV 7/25 and 7/28).

Ophthalmic frames include a selection of approved ophthalmic frames.

Medically/Clinically necessary replacement lenses are a Covered benefit if there has been a change in the member's vision.

Repair of frames/lenses is Covered. Replacement of frames/lenses due to loss or breakage (if they cannot be repaired) is Covered once every 12 months for Members age 21 and over and twice every 12 months for Members under age 21.

Vision Therapy (orthoptic service) is Covered for limited clinical conditions.

41. Voluntary Sterilizations

We will Cover procedures such as tubal ligations and vasectomies for the purpose of rendering you unable to produce children if you are age 21 or older. We will only Cover a vasectomy if it is performed in a Physician's office, or when in connection with other Covered inpatient or outpatient surgery. We will Cover voluntary sterilizations if:

- You are at least 21 years of age,
- You are mentally competent,
- You have completed a consent form 30 days prior to the procedure,
- The services are supervised by a doctor, and
- You have received prior approval from your PCP and us.

42. Foot Care

Podiatry services, including medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle or nails.

43. Maternity Care

- Hospital and Provider Care Services and supplies furnished by a Hospital or Provider for prenatal care (including genetic testing), postnatal care, Hospital delivery, and care for the complications of pregnancy. A woman may visit a participating obstetrician/gynecologist or nurse midwife acting within the scope of his or her license or specialty certification. A woman may seek obstetrician/gynecologist and Hospital services out of network if she is pregnant at the time of enrollment. Please call Customer Service at 888.975.8102 and let us know the Non-Participating Provider's name and contact information. The mother and Newborn have the right to stay no less than 48 hours following a normal vaginal delivery and no less than 96 hours following a cesarean section. If the mother and the attending Physician agree, the mother and Newborn may be discharged from the Hospital sooner and these restrictions would not apply.
- Newborn Child Care
  In most cases, routine inpatient care for a Newborn child, if the mother is enrolled with us on the child's date of birth. If the parent or guardian wants to change the Newborn to another health plan, he or she must contact Michigan Enrolls.
- Home Care Services
  Telephone assessment and home visit by a registered nurse within three days after the date of the mother's discharge for evaluation of the mother, Newborn and family. These services are only available if you are discharged within the guidelines of our short-term stay maternity program or if your provider identifies a medical need.
- Early Care Healthy Family Program – (Maternal Infant Health Program – MIHP)
  Available through your local health department and/or Hospital. Contact your local health department or the Customer Service department to find out how to get access to these providers.
- Parenting/Birthing Classes
  Covered through Participating Providers. Contact the Customer Service department to find out about classes that are available to you.
- Out of Area Services
  Coverage does not include prenatal maternity care and postpartum care provided while you are outside of the Service Area unless you receive prior approval from us.
- Obstetrical Delivery In The Home
  Delivery in the home is not covered. You must deliver in a Hospital. See Section 7 (32).

44. Medical Emergency and Urgent Care

See Section 2.F for information about your Coverage for a Medical Emergency and Urgent Care.

Section 7 - Exclusions from Coverage

We will not Cover any service, treatment or supply listed in this Section 7, even if it could prevent the need for more costly Covered Service, treatment or supply, unless:

1. We provide Coverage for the service, treatment or supply in any amendment attached to the Certificate; or
2. Coverage is required under applicable state or federal law.

The following is a list of exclusions from your Coverage.

1. Abortions
   All services and supplies related to elective abortions to terminate pregnancy are not Covered unless a Physician certifies that the abortion is Medically/ Clinically Necessary to save the life of the mother or is for a pregnancy that is the result of rape or incest. Treatment for medical complications occurring as a result of an elective abortion and for spontaneous, incomplete or threatened abortions and for ectopic pregnancies is Covered.
2. Acupuncture and Other Non-traditional Services
   Including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy.
3. Adaptive Aids/Self-Help Items
   Services and supplies designed for self-assistance. Examples include, among other things, reachers, feeding, dressing and bathroom aids.
4. Allergy Testing
   Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine auto-injections, bronchial or provocative and neutralization testing for allergies. See Section 6.B (1) for allergy tests that are Covered.
5. Autopsy
6. Biofeedback
   Biofeedback for any diagnosis including mental health diagnoses.
7. Clinical Ecology and Environmental Medicine
   Services and supplies provided to effect changes in or treatment to you and/or your physical environment."Clinical ecology" and "environmental medicine" means medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems.
8. Elective abortions and related services.
9. Experimental, investigation, or unproved drugs, treatments, procedures, or devices.
10. Elective cosmetic surgery
11. Services for the treatment of infertility.
12. Court Ordered Services

Services required by court order and services required to file an action with a court, including evaluations and testing, or services required as a condition of parole or probation. We will Cover services according to the terms of this Certificate if they are Medically/Clinically Necessary and you have not exhausted your benefits for the contract year.

13. Custodial Care

Any care you receive if, in our opinion, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. Custodial care includes room and board, nursing care, home health aides and personal care designed to help you in the activities of daily living and home care and adult day care that you receive, or could receive, from members of your family. Custodial care, personal care and home health care may be covered through the State of Michigan or other community offices. Call your local Department of Human Services for more information.

14. Dental Services

Services that are not specifically Covered under Section 6.B (6), including:

- Orthodontia and orthodontic x-rays, even when provided in conjunction with other treatment or surgery;
- Orthognathic surgery (except as specifically Covered under Section 6.B (25));
- Gold crowns, gold foil restorations, inlay/onlay restorations;
- Bite splints used for dental purposes or for Temporomandibular Joint Dysfunction or Syndrome (TMJ);
- Fixed bridges;
- Mouth guards;
- Sports appliances;
- TMJ services except as specifically Covered in Section 6.B (36);
- Services or surgeries that are experimental in nature.
- Dental devices not approved by the FDA; and
- Analgesia and/or inhalation of Nitrous Oxide.

Inpatient or outpatient Hospital services, such as anesthesia and facility charges, received in connection with Non-Covered dental services are not Covered unless prior approved by us.

15. Durable Medical Equipment (DME) and Devices

Equipment and devices solely for the convenience of you or your caretaker, home fixtures, modifications, and equipment installation, and self-help or adaptive aids. Wheelchair Coverage is generally limited to a manually operated wheelchair unless prior approved by us, based upon Medically/ Clinically Necessary. We reserve the right to limit replacement to the expected life of the equipment. See Section 6.B (10) for Durable Medical Equipment that is Covered. Examples of exclusions include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc);

- Air conditioner;
- Air purifier;
- Environmental control units;
- Equipment not used or not used properly by the beneficiary;
- Exam tables/massage tables;
- Exercise equipment (e.g. tricycles, exercise bikes, weights, mat/mat tables, etc);
- Generators;
- Heating pads;
- Home modifications;
- Hot tubs;
- House/room humidifier;
- Insulin pumps for the purpose of solving problems of Member non-compliance;
- Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons;
- Lift chairs, reclining chairs, vibrating chairs;
- More than one pair of shoes on the same date of service;
- New equipment when current equipment can be modified to accommodate growth;
- Over the counter shoe inserts;
- Portable oxygen, when ordered to be used at night only;
- Power tilt-in-space or reclining wheelchairs for a long term care resident because there is limited staffing;
- Pressure gradient garments for maternity-related edema;
- Prosthetic appliances for a beneficiary with a potential functional level of K0;
- School items or items recommended or required as part of an Individual Education Plan (IEP) (e.g. computers, writing aids, book holder, mouse emulator, etc.);
- Second wheelchairs or ventilators for beneficiary preference or convenience, including travel;
- Sensory devices (e.g. games, toys, etc.);
- Stair lifts;
- Standard infant/toddler formula;
- Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile);
- Toothettes;
- Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain;

- Ultrasonic osteogenesis stimulators;
- Wheelchair lifts or ramps for home or vehicle (all types);
- Wheelchair accessories (e.g. horns, lights; bags, special colors, etc.); and
- Wigs for hair loss

16. Ear Plugs

17. Educational Services
School based services are excluded. These services can be obtained through your local school system and include:

- Services for remedial education, including evaluation or treatment of learning disabilities, developmental and learning disorders, and behavioral training;
- Services, treatment or diagnostic testing related to learning disabilities or developmental delays;
- Education testing or training;
- Services and supplies for mental retardation;
- Physical, occupational, speech, cognitive and sensory integration therapy for developmental delay, apraxia and cognitive disorders;
- Cognitive rehabilitation, and
- School-based services.

Scholastic/Educational Testing is not Covered. Intelligence, developmental delays and learning disability testing and evaluations should be requested and conducted by the child's school district.

18. Enuresis
Bed wetting devices and services for the diagnosis of enuresis.

19. Experimental, Investigational or Unproven Services
Any drug, device, treatment or procedure that is experimental, investigational or unproven, or is an integral step of, or necessary to receive, an experimental procedure. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:

- The drug or device cannot be lawfully marketed in the United States without the approval of the Food and Drug Administration (FDA) and that approval has not been granted;
- An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy;
- The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy;
- Reliable evidence shows that the drug, device, treatment or procedure is:
    - The subject of on-goings Phase I or Phase II clinical trials;

- The research, experimental study, or investigational arm of on-going Phase III clinical trials; or
- Otherwise under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or

- Reliable evidence shows that a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis.
  "Reliable evidence" includes any of the following:
  - Published reports and articles in authoritative medical and scientific literature;
  - A written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same or a similar drug, device, treatment or procedure; or
  - Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device, treatment or procedure.

20. Food, Formula and Supplements All food, formula and nutritional supplements are excluded, including, but not limited to:

- Protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements. Enteral formula to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet;
- Nutritional formula representing only a liquid form of food;
- Nutritional puddings/bars;
- Regular or dietetic foods (e.g., Slimfast, Carnation instant breakfast, etc.);
- Sports drinks/juices; and
- Weight loss or "light" products.

Enteral feedings may be Covered if criteria under the applicable medical policy are met.

21. Foot Care

- Routine foot care, including corn and callous removal, nail trimming, and other hygienic or maintenance care; and
- Cleaning, soaking, and skin cream application for the feet.

22. Habilitative Therapies (speech, language, physical, and occupational therapies)
Services provided to members with disabilities in order to help them keep, learn or improve skills and functioning for daily living. Covered habilitative services include physical, occupational, and speech therapy services, except those habilitative services that are specifically covered under Section 6. 15.

23. Hair Analysis and Treatment for Hair Loss
All services including wigs requested due to hair loss.

24. Health Promotion Classes Covering such subjects as stress management, parenting and lifestyle changes.

25. Hearing Care
Alternative listening devices, hearing aids that do not meet U.S. Food and Drug Administration (FDA) and Federal Trade Commission (FTC) requirements, hearing aids requested solely or primarily for the elimination of tinnitus, equipment requested solely or primarily for cosmetic reasons or package features relative to cosmetics, alerting devices, spare equipment.

26. Home Health Care
Home Health Care or respite services that we determine not to be Medically/Clinically Necessary, when you reside in an Adult Foster Care or other facility based setting, or when services are requested as the result of the AFC policies and limitations.

27. Hypnotherapy

28. Infertility
All services and supplies relating to treatments for infertility including, among other things, artificial insemination, in vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, fees to a surrogate parent, prescription drugs designed to achieve pregnancy, harvest preservation and storage of eggs or sperm and services to reverse voluntary sterilizations. Diagnostic services are Covered as described under Section 6.B (14).

29. Leave of Absence
Charges incurred when you are on an overnight or weekend pass during an inpatient stay.

30. Marital and Relationship Enhancement Counseling Services and treatment related to marital or relationship counseling.

31. Mental Health and Substance Abuse Services
Mental Health services for conditions which, in the professional judgment of our Behavioral Health Department, will not improve through short-term therapy. Long-term psychotherapy is not a Covered Service through us. Treatment for substance abuse, significant, persistent, complex and/or serious psychiatric conditions, and severe emotional disturbances that generally require multiple, intensive and sustained mental health services and supports are not Covered. Other non-Covered treatments include, but are not limited to, experimental/investigational or unproven treatments and services, biofeedback, hypnotherapy, Methadone maintenance and light boxes for phototherapy.

32. No Legal Obligation to Pay
Any service or supply that you would not have a legal obligation to pay for without this Coverage, including, among other things, any service performed or item supplied by a relative of yours if, in the absence of this Coverage, you would not be charged for the service or item.

33. No-Show Charges
Any missed appointment fee charged by a Participating or Non-Participating Provider because you failed to show up at an appointment, except in the case of a Medical Emergency or unless prior

approved by us. Some providers may require you to agree in writing to pay any missed appointment fees before they will perform any services.

34. Non-Participating Providers

Providers who are not listed in our Provider Directory. For the most up-to-date directory, call our Customer Service department or visit us at *priorityhealth.com*. Services and supplies from providers who have not contracted with us to provide services and supplies under this Certificate are not Covered, except in the case of:

- Medical Emergency or if approved by us in writing prior to obtaining the services and supplies;
- The treatment of communicable diseases such as TB or immunization services received at a local health department;
- Family planning services or the treatment of sexually transmitted diseases (STD) received at a plan-approved family planning center or at a local health department; and
- Services or supplies obtained from local health departments, Tribal Health Centers or FQHCs.

35. Not Medically/Clinically Necessary Services

Services and supplies that we determine are not Medically/Clinically Necessary, as defined in this Certificate and according to Medical and Behavioral Health policies established by Priority Health Choice, Inc. with the input of Physicians we do not employ or according to criteria developed by reputable external sources and adopted by us. If you disagree with us about Medical/Clinical Necessity, you (with a Participating Provider, if you wish) may review our determination as described in Section 12. Unless and until we agree with you that the services and supplies will be Covered Services, they will be excluded from Coverage.

If we exclude Coverage because a service or supply is not Medically/Clinically Necessary, that decision is a determination about benefits and not a medical treatment determination or recommendation. You, with a Participating Provider, may choose to go ahead with the planned treatment at your own expense. You have the option of appealing our denial of your claim for Coverage under our inquiry and review procedure as set forth in Section 12.

36. Obstetrical Delivery in the Home Services and supplies received in connection with an obstetrical delivery in the home.

37. Organ, Tissue and Blood Cell Donors

Community wide searches for a donor. All donor expenses, even those of Members, for transplant recipients who are not Members. See Section 6.B (37) under “Transplants” for information about what expenses related to transplants are Covered.

38. Excluded Outpatient Prescription Drugs

The following drug categories are excluded from coverage:

- Agents used for anorexia
- Agents used for weight gain
- Agents used for cosmetic purposes or hair growth

- Agents used for symptomatic relief of cough and colds
- Experimental or investigational drugs
- Agents used to promote fertility
- Agents used to promote smoking cessation not on the Michigan Pharmaceutical Product List (MPPL)
- Vitamin/Mineral combinations not for prenatal care, end stage renal disease or pediatric fluoride supplementation
- Covered outpatient drugs that the Labeler seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the Labeler or their designee
- Covered outpatient drugs where the Labeler limits distribution
- Purposed less-than-effective (LTE) drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Over-the-counter drugs not on the Michigan Pharmaceutical Product List (MPPL)
- Drugs of Labelers not participating in the Rebate Program
- Drugs prescribed for “off label” use if there is no generally accepted medical indication in peer reviewed medical literature (Index Medicus), or listing of such use in standard pharmaceutical references such as Drug Facts and Comparisons, AMA Drug Evaluations, American Hospital Formulary Service Drug Information, or DRUGDEX Information Systems
- Drugs prescribed specifically for medical studies
- Drugs recalled by Labelers
- Drugs past CMS termination dates
- Lifestyle agents
- Standard Infant Formulas
- Drugs not FDA approved or licensed for use in the United States
- Agents used for treatment of sexual or erectile dysfunction
- Drugs “carved-out” to Fee For Service Medicaid.

39. Outpatient Medical Supplies

Medical supplies that are not considered Medically/Clinically necessary or that exceed quantities allowed by the Michigan Department of Health and Human Services are considered not covered.

40. Personal Comfort or Convenience Items, Household Fixtures and Equipment

Even if ordered by your PCP, or other Physician, services and supplies such as the following are not Covered:

- Services and supplies not directly related to your care, such as, among other things: guest

meals and accommodations, telephone charges, travel expenses, take home supplies and similar costs.

- The purchase or rental of household fixtures, such as escalators, elevators, swimming pools and similar fixtures.
- The purchase or rental of household equipment that have customary non-medical purposes, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds, spas, tanning equipment and other similar equipment.
- Car seats and modifications to motorized vehicles.

41. Private Duty Nursing

42. Providers Barred from Reimbursement
Services and supplies received from, or ordered or referred by, providers who have been:
    - Terminated from our provider network for failing to meet our credentialing criteria;
    - Terminated for non-compliance with our quality standards and programs; or
    - Identified as sanctioned by Medicare, Medicaid, or other federal exclusion lists.

43. Prosthetic and Orthotic/Support Devices
Orthopedic shoes, shoe inserts, and other supportive devices of the feet except as identified as Covered in Section 6.B (29).

44. Reconstructive Surgeries
Those not specifically Covered under Section 6.B (32).

45. Rehabilitation and Therapy Services
    - Long-term rehabilitation services that is not restorative in nature. Long-term therapy, specifically therapy beyond 90-days following the initiation of therapy, is not covered if there is not meaningful improvement in your ability to perform functional day-to-day activities that are significant in your life roles. Therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition including, but not limited to, cerebral palsy and developmental delays, is not Covered.
    - Physical, speech or occupational therapy to correct an impairment, when the impairment is not due
      to (a); an illness, (b); an injury or (c); a congenital defect as described in Section 6.B (33).
    - Cognitive rehabilitative therapy is not Covered. Cognitive rehabilitative therapy is defined as neurological training or retraining.
    - Strength training and exercise programs.
    - Sensory integration.
    - Rehabilitation services obtained from non-Health Professionals, including massage therapists.
    - Summer programs meant to maintain physical condition or developmental status during

periods when school programs are unavailable.

- Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluation and all return to work programs.
- Orthoptic (vision) therapy for limited medical conditions are Covered.

46. Relational, educational or sleep therapy and any related diagnostic testing.
    This exclusion does not apply to therapy or testing provided as part of a Covered Inpatient Hospital service. Short term rehabilitative therapy is Covered as described in Section 6.B (33).
47. Religious Counseling
    Services and treatment related to religious counseling or provided by a religious counselor who is not a Participating Provider.
48. Residential or Assisted Living
    Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aides, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.
49. Self-Referral
    Services and supplies from any Health Professional upon self-referral. This exclusion does not apply to:
    - Medical Emergency care or when we have given prior approval for services;
    - The treatment of communicable diseases such as TB or sexually transmitted diseases (STDs) at a local health department or plan-approved family planning center;
    - Family planning services received at a plan-approved family planning center or at a local health department;
    - Immunizations;
    - Mental health services; or
    - As otherwise stated in this Certificate.
50. Sex Therapy
    Services and treatment related to sex therapy.
51. Third Party Requirements
    Services required or recommended by third parties, including, but not limited to:
    - Physical examinations in excess of those required by federal guidelines performed by your PCP;
    - Physical examinations performed by a Physician other than your PCP; and
    - Diagnostic services and immunizations related to: getting or keeping a job, getting or keeping

any license issued by a governmental body, getting insurance coverage, foreign travel, adopting children;

- Physical exams for school admission or attendance and participation in athletics outside of the normal schedule of well-child exams and/or by a Non-Participating Provider.

52. Treatment in a Federal, State, or Governmental Entity

The following are excluded to the extent permitted by law:

- Services and supplies provided in a Non Participating Hospital owned or operated by any federal, state, or other governmental entity.
- Services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment. If you are incarcerated, you will be disenrolled from the Healthy Michigan Plan administered by Priority Health Choice, Inc.

53. Unauthorized Services and Supplies

The following are excluded unless we tell you otherwise in this Certificate:

- Services and supplies that your PCP did not perform, prescribe, or arrange according to the guidelines of this Certificate;
- Services and supplies that were provided without any required advance approval by us;
- Services and supplies from any Health Professional upon self-referral by you;
- Services and supplies sought only for the purpose of obtaining benefits under this Certificate and for which there is no evidence that such services or supplies are Medically/Clinically Necessary.

This exclusion does not apply to services necessary to treat a Medical Emergency or Urgent Care situation, or for services and supplies received from a participating obstetrician/gynecologist for an annual well-woman examination or most Medically/Clinically Necessary pregnancy services upon self-referral by you. See Section 2.C and 2.G for a list of services that must be prior approved by us.

54. Vision Care

- Non-prescription ophthalmic lenses and frames;
- Special independent diagnostic tests or treatment procedures;
- Any other eye or vision service not specifically listed in Section 6.B (39) of this Certificate.

55. Vocational Rehabilitation

Evaluations of the worksite, work-hardening and work-related therapy.

56. Weight Loss and Control

Weight loss services, supplies, equipment or facilities in connection with weight control or reduction, whether or not prescribed by a Physician or associated with Illness, including but not limited to:

food, food supplements, gastric balloons, stomach stapling, jaw wiring, liposuction, physical fitness or exercise programs. Physician supervised weight loss programs are Covered as set forth in Section 6.B (23).

Section 8 - Limitations

Unless we tell you otherwise in this Certificate, you may only receive services from a Participating Provider or another Health Professional if your PCP has approved those services, and the services have been prior approved by us when necessary. See Section 2.C and 2.G for requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services. Do not go to another provider unless your PCP has referred you and we have approved the referral first. Otherwise, you must pay for the services. You also must pay for services you receive in excess of approved services. You may call our Customer Service department to find out if we have approved the services. This limitation does not apply to an annual well- woman examination, routine obstetrical services with Participating Providers, family planning services with approved family planning centers, FQHCs, Tribal Health Centers, child and adolescent health centers, or local health departments.

NOTE: Sometimes your PCP may refer you for or suggest a service that we do not Cover. Just because your PCP refers you or suggests the service does not mean you will have Coverage for that service. Remember, if you receive services that we do not Cover, you may have to pay for the services.

A. Benefit Maximums
Some of the Covered Services described in this Certificate are subject to maximum limitations. The list of Covered Services in Section 6 lists those maximums. Once you have reached a maximum for a Covered Service, you will be responsible for the cost of additional services.

B. Services While in Detention or Incarcerated
If you are placed in detention or incarcerated in a facility such as a youth home, jail or prison, and you are disenrolled from the plan we will not pay for any services and supplies.

C. Services Received While a Member
We will only pay for Covered Services you receive while you are enrolled in our plan. A service is considered to be received on the date on which services or supplies are provided to you. We will only Cover services and supplies for the diagnosis or treatment of Illness or Injury, except as specifically provided elsewhere in this Certificate.

NOTE: We will pay for Covered custom-made equipment ordered during a Hospital stay Covered under this plan even if you are no longer a Member on the date the equipment is delivered. Additionally, Priority Health Choice, Inc. will pay for any custom-made, -fit, or –modified service that is prior approved by us before your disenrollment from this plan and received within 30 days from the effective date of disenrollment.

D. Uncontrollable Events

A national disaster, war, riot, civil insurrection, epidemic or other event we cannot control may make our offices, personnel or financial resources unable to provide or arrange for the provision of Covered Services. To the extent that happens, we will not be liable if you do not receive those services or if they are delayed. But we will make a good faith effort to see that services are provided, considering the impact of the event.

Section 9 - Member Rights and Responsibilities

As a Member of the Healthy Michigan Plan administered by Priority Health Choice, Inc., you have the following rights:

1.You may receive prompt medical care appropriate to your condition, including emergency care if necessary.

2. You may receive information regarding appropriate or medically necessary treatment options which will enable you to make an informed decision about the treatment you receive, regardless of cost or benefit Coverage.

3. You may go to federally qualified health centers (FQHC), rural health centers (RHC), Tribal Health Centers and local health departments.

4. You may receive information about us, our services, our providers, and beneficiary and plan Member rights and responsibilities.

5. You may participate in decisions regarding your health care.

6. We will treat you with respect and with due consideration for his or her dignity and privacy.

7. We will protect your privacy.

8. We will keep your medical and financial records maintained by us confidential, whether in electronic or written form.

9. We will not disclose information from your medical records without your consent, except when permitted or required by law, in connection with the administration of our Healthy Michigan Plan, or for anonymous use in statistical studies and medical research.

10. You may inspect your medical records.

11. You may contact us to discuss concerns about the quality of care you have received from a Participating Provider.

12. You may register a complaint or file a request for review with us or the State of Michigan, if you experience a problem with us or a provider.

13. You may file a fair hearing request.

14. You may initiate a legal proceeding if you experience a problem with us or a provider after you have exhausted the review process.

15. We will notify you in a timely manner if we release personal information about you in response to a court order.
16. You may expect our staff and our Participating Providers to meet all requirements concerning Member rights.
17. You may review a summary of our annual report, and inspect the full report on file with the Michigan Department of Health and Human Services or the Department of Insurance and Financial Services (DIFS).
18. You may suggest changes to our Member rights and responsibilities policies. You have a right to know how to access continued services upon transition to a health plan.

As a Member you also have the following responsibilities:

1. You must schedule an appointment for a physical exam with you Primary Care Provider (PCP) within 60 days of joining this plan.
2. You must be seen by your PCP for that physical exam within 150 days of joining the plan.
3. You must read the Certificate of Coverage and Member materials, and comply with the requirements.
4. You must call us with questions.
5. You must coordinate all medical services through your Primary Care Provider except in the case of a Medical Emergency unless we tell you otherwise in this Certificate.
6. You must obtain prior approval from your PCP and us for services as noted in this Certificate, including all services from providers who are not listed in the Priority Health Choice, Inc Provider Directory, and comply with the limits of any approval of services.
7. You must use Participating Providers for all services and equipment not requiring prior approval unless we tell you otherwise in this Certificate.
8. You must contact Participating Providers to arrange for medical appointments, and notify providers in a timely manner if an appointment must be canceled.
9. You must present your ID card to the provider before you receive a service.
10. You must participate in your health care as much as possible by working to understand your health problems.
11. You must follow the treatment goals and other instructions given to you by your provider. You may participate in developing our treatment goals when possible. We or your providers may ask you to enter into an explicit written agreement to ensure you understand the instructions.
12. You must supply, to the extent possible, information needed by us and health care professionals to provide proper care.
13. You must notify providers and us if you have other health insurance coverage.
14. You must provide truthful information to us.

15. You must promptly notify us of any change in address.
16. You must promptly notify us if your ID card is lost or stolen.
17. You must cooperate with us to prevent the unauthorized use of your ID card and to prevent anyone from obtaining benefits in your place.
18. You must treat providers and staff with respect.

Section 10 - Claims Provisions

When you receive Covered Services from a Participating Provider, you will not be required to pay any amount except for applicable Copayments as shown in Sections 5 and 6. You will not be required to submit any claim forms for Covered Services received from Participating Providers.

You are responsible for the cost of any services you receive from Non-Participating Providers unless those services were arranged by your PCP and prior approved by us, or unless you need them to treat a Medical Emergency, Urgent Care situation or unless we tell you otherwise in this Certificate. See Section 2.C and 2.G for the requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services.

If You Pay for Covered Services
If you must pay a health care provider for Covered Services, you may ask us in writing to be reimbursed for those services. With your request, you must give us proof of payment that is acceptable to us. You must send a bill that shows exactly what services were received, including applicable diagnosis and CPT codes, and the date and place of service. The bill must also identify the provider of services. A statement that shows only the amount owed is not sufficient. If you have questions about what to send us, you may call our Customer Service department.

We will only provide reimbursement for Covered Services provided by a Participating Provider, including Participating Pharmacies, or for Urgent/Emergent Care provided by a Non-Participating Provider if you are outside of the service area for our Healthy Michigan Plan.

Reimbursement Request Time Limit
We ask that you make your request within 90 days of the date you obtained the services. If you do not ask for reimbursement within one year, we can limit or refuse reimbursement. But we will not limit or refuse reimbursement if it is not reasonably possible for you to give us proof of payment in the required time, as long as you give us the required information as soon as reasonably possible. We will never

be liable for a claim or reimbursement request if we obtain proof of payment for it more than one year after the date you received the services, unless you are legally incapacitated. We will only reimburse you for Covered Services.

Where to Send your Bills
Send your itemized medical bills promptly to us at:

Priority Health Choice, Inc.
Claims Department, MS 2205
PO Box 232
Grand Rapids, MI 49501-0232

Information May be Required for Payment
Before we pay health care providers or reimburse you for services you receive, we may require you to give us more information or documentation to prove they are Covered Services. We will not be liable for a claim or reimbursement request if we ask for additional information from you and you do not respond within 60 days after we request the additional information, unless you are legally incapacitated. Our right to that information or documentation may be limited by state or federal law.

Satisfaction with Benefit Determination
If you are not satisfied with any benefit determination we have made, you can dispute it under the Inquiry and Review Procedure. Read Section 12 to find out more about that procedure.

Section 11 - Termination of Coverage

A. Termination of Agreement between Priority Health Choice, Inc. and the State
The State of Michigan may terminate the Agreement between Priority Health Choice, Inc. and the State. If the State terminates the Agreement, all Coverage under this Certificate will terminate at 11:59 p.m. on the effective date of the termination. It is the State's responsibility to let you know your Coverage has ended if the Agreement is terminated. If we do not tell you your Coverage has ended, your Coverage will still end on the date of the termination.

B. Loss of Eligibility
You will lose your eligibility and your Coverage will terminate if you no longer meet the Healthy Michigan Plan eligibility criteria as required by the Department of Human Services. If you lose eligibility, Coverage will terminate at 11:59 p.m. on the date you lose your eligibility.

C. Termination for Cause Due to Your Behavior with Participating Providers
We can ask the State to disenroll you from the Healthy Michigan Plan administered by Priority Health Choice, Inc. for cause immediately if either of the following happens:

1. If the Enrollee acts in a violent or threatening manner not resulting from the Enrollee's special needs as prohibited in the Disenrollment Discrimination section of the Contract. Violent/

Threatening situations involve physical acts of violence; physical or verbal threats of violence made against Contracted Providers, staff, or the public at Contractor locations or stalking situations.

2. Priority Health Choice, Inc. must make contact with law enforcement, especially in cases of imminent danger, when appropriate, before seeking disenrollment of Enrollees who exhibit violent or threatening behavior. Michigan Department of Health and Human Services reserves the right to require additional information from Priority Health Choice, Inc. to assess the appropriateness of the disenrollment.

3. When disenrollment is warranted, the effective disenrollment date must be within 60 Days from the date that Michigan Department of Health and Human Services received the complete request from Priority Health Choice, Inc. that contains all information necessary for MDHHS to render a decision. If the Beneficiary exercises their right of Appeal, the effective disenrollment date must be no later than 30 Days following resolution of the Appeal.

4. Michigan Department of Health and Human Services may consider reenrollment of beneficiaries.

If we tell you that we are requesting disenrollment from our plan, you can file a request for a review within 30 days. (Read Section 12 to learn more about the inquiry and review procedure.) If you file a request for review, we will leave your Coverage in place until a final determination is made. If the final determination is in our favor, we can terminate your Coverage effective the date indicated by the State of Michigan.

NOTE: If you are still eligible for Coverage under this Certificate, we will not request disenrollment based on your health or your health care needs. Also, we will not request disenrollment just because you used the inquiry and review procedure to file a complaint against us.

Section 12 - Inquiry and Review

Your confidence in us and your satisfaction with our services is very important. We understand that there will be times when you will have a concern or a problem you want us to address. If you have a question, concern or complaint about us, please call our Customer Service department at 888.975.8102 or log in and send us a secure email from your member account at *priorityhealth.com*. Our Customer Service representatives will help you with your problem as quickly as possible.

If you are not happy with the answers that our representative has provided, you or someone acting on your behalf can send us a formal complaint, called a grievance. You may also send us a formal request, which is called an appeal.. You may contact our Customer Service department for assistance drafting a formal appeal. This formal appeal is handled through our review process. You have 60 days from the date you learn of a problem to file an appeal with us. You can file an appeal to ask us to change a decision about any of the following:

1. Benefits (may include experimental or investigational or not Medically/Clinically Necessary or appropriate services);
2. Eligibility;
3. Payment of claims (in whole or in part);
4. How we've handled payment or coordination of health care services;
5. Contracts with our providers;
6. Availability of care or providers;
7. Delivery or quality of health care services; or
8. A decision not in your favor. This may include services that have been reviewed by us and denied, reduced or terminated. It also may include a slow response to a request for a decision from us.

Here is a summary of the steps you can take:

A. Review Procedure

Step 1:

Contact our Customer Service department to file an Appeal with us. You must file an Appeal within 60 days of an adverse decision or learning of an adverse decision, whichever is later. Our Appeal Committee will meet to discuss your review and we will mail you a written response. Our Appeal Committee may include a community physician, our members, employers who offer Priority Health to their employees and our employees, none of whom were involved in the initial determination or who are subordinates of someone who made the initial decision.

We will let you know the date and time for the hearing. You may attend the portion of the Appeal Committee hearing that applies to your review. Within five business days of the hearing, we will send you a written decision. The Appeal procedure must be completed with a final decision made within a total of 30 days after we receive your request for review. Up to 14 days can be added to receive information from Health Professionals or others with information necessary to resolve your concern if it would be to your benefit. In addition, if an Appeal is submitted by a third party without a signed document from you or your authorized representative, the 30 day timeframe begins on the date the signed document is received.

Step 2:

If you are not satisfied with the resolution of your Appeal after completing step 1 of our Review Procedure, you may request a review by the Department of Insurance and Financial Services (DIFS) or file an Administrative Fair Hearing from the Michigan Office of Administrative Hearings and Rulings (MOAHR).

Mail:
Office of General Counsel - Healthcare Appeals Section
Department of Insurance and Financial Services (DIFS)
P. O. Box 30220
Lansing, Michigan 48909-7720
877.999.6442
michigan.gov/difs

Delivery Service:
Office of General Counsel - Healthcare Appeals Section
Department of Insurance and Financial Services (DIFS)
530 W. Allegan St., 7th Floor
Lansing, Michigan 48933-1521
877.999.6442
michigan.gov/difs

Online:
https://difs.state.mi.us/Complaints/ExternalReview.aspx

Fax:
517-284-8848

B. Administrative (Fair) Hearing

You can ask the Michigan Office of Administrative Hearing and Rulings (MOAHR) for the Department of Health and Human Services to review the problem only after completing our appeal procedure. This is called an Administrative or Fair Hearing. You have 120 days from the date of our appeal notice to file an Administrative Fair Hearing. If we fail to meet the timing requirements of the appeal procedure, you can ask for an Administrative Fair Hearing. To use the State of Michigan's Administrative or Fair Hearing process, you will need to take the following steps:

Step 1:
Call 877.833.0870 or email the MOAHR at *administrativetribunal@michigan.gov* to have a hearing request (complaint) form sent to You. You may also call to ask questions about the hearing process.
Step 2:
Fill out the request (complaint form) and return it to the address listed on the form. If you'd like, we can send a copy and help you fill out the State's form.
Step 3:
You will be sent a letter telling You when and where Your hearing will be held.
Step 4: The results will be mailed to You after the hearing is held. If Your appeal is taken care of before the hearing date, You must call to ask for a hearing request withdrawal form. You can call

877.833.0870 to request this form.

C. Expedited Review Procedure

If your Physician tells us (either in writing or by telephone) that the time it takes for us to review your concern under the normal Appeal Review Procedure would put your life in serious danger, interfere with your full recovery or delay treatment for severe pain, we will follow an “expedited review” procedure. You or your Physician must file a request for an “Expedited Review” within 10 days of the adverse decision. If we deny your request for an expedited review, we will tell you within 2 days of receiving your request. We will also transfer your request to the normal appeal procedure. Step 1 in an “expedited review “ procedure must be completed within 72-hours of receipt of your request, unless you agree to give us more time. You may file a request for “expedited review” with the Department of Insurance and Financial Services only at the same time as filing a request for “expedited review” with us. In addition, if you are not satisfied with our resolution of your problem after completing the “expedited review” procedure, you may appeal within 10 days of our final decision to the Department of Insurance and Financial Services.

D. Obtaining Information about the Review Procedure

To obtain a complete copy of our Appeal Review or “expedited review” Procedures and Appeal Review Form, or to find out more about your Appeal Review review rights, please contact our Customer Service department.

E. Obtaining Information about your Review

You have the right to receive, free of charge, access to and copies of all documents relevant to a claim denial.

F. Filing a Lawsuit Against Priority Health Choice, Inc.

You have the right to bring an action for benefits under Section 500.3422 of the Michigan Insurance Code. However, before filing a lawsuit against us, you must complete our Appeal Procedure as described in this Section 12. In addition, no action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of (3) three years after the time written proof of loss is required to be furnished.

Section 13 - Extension of Benefits

If you are already getting a Medicaid service that is going to be reduced or stopped and you file your Internal Appeal within 12 calendar days of being notified of this, you will continue to get your same level of services while your Internal Appeal is pending. We will continue paying for your Covered Services if the Agreement is terminated while you are confined for medical treatment in a Hospital. After termination we will pay for Covered Services only if you are confined as an inpatient and only for the specific medical condition causing the confinement. As soon as one of the following happens, you

will stop receiving benefits from this plan:

1. The hospitalization is no longer Medically/Clinically Necessary or becomes only necessary in order to
   provide non-Covered Services such as custodial care;
2. You obtain Coverage from another health plan for the inpatient stay

Section 14 - Coordination of Benefits

A. Purpose of Coordination of Benefits

Coordination of Benefits (COB) is the system that determines how benefits are paid when you are covered by more than one health care plan. The primary plan is responsible for paying the full benefit amount allowed by the member's contract. The secondary plan is responsible for paying any part of the benefit not covered by the primary plan as long as the benefit is covered by the secondary plan. The secondary plan adjusts the amount of benefits paid so that the total benefits available to the member for the considered service will not exceed that to which the member would otherwise be entitled. The total paid by both plans may provide payment up to, but not exceeding our benefit amount. The amount that either plan is required to pay is known as its "liability."

We will coordinate benefits with the following types of plans:

1. Group insurance, or any other arrangement of coverage for individuals in a group, whether on an insured
   or uninsured basis, including government programs such as Medicare (but not including specialty plans
   such as dental or disability insurance); and
2. Automobile insurance required by law and provided through arrangements other than those described in
   subsection (1), but only to the extent that automobile insurance law requires benefits.

B. Information about Coverage from Other Plans

Your case worker will ask for information about your coverage from other plans. That information is very important and you should give it to your case worker and us truthfully. If your coverage from another plan changes in any way, you must notify your DHS case worker and us. You must cooperate with us to coordinate our Coverage with coverage from other plans, including providing us with copies of court orders and other documents necessary to coordinate coverage. All information provided must be kept confidential.

C. Effect on Benefits

Your Healthy Michigan Plan administered by Priority Health Choice, Inc. is always the secondary payer. The primary payer must pay up to its highest benefit level for the services outlined in this Certificate before we will begin to Cover any allowable expenses (as defined below).

Follow all the rules and provision of the primary payer's plan, such as obtaining prior approval of admissions and services, using Participating Providers, and seeking second surgical opinions. Benefits under your primary plan may be reduced if you do not comply with required provisions. A benefit reduction is not an allowable expense. That means Coverage available under this plan will not be increased to Cover the additional costs you will be required to pay.

When we are the secondary payer, certain requirements for Coverage under this Certificate will be waived. We will Cover expenses for most services received from Participating or Non-Participating Providers, without prior approval from us, so long as you have followed the rules of your primary plan and the services are Covered under this plan. Even though we are the secondary plan, the following services, received from Participating or Non-Participating Providers, require prior approval from us:

1. Inpatient Hospital services;
2. Inpatient and outpatient behavioral health services;
3. Certain outpatient prescription drugs, including non-formulary medications, off-label use of FDA approved drugs, and select injectable drugs.

Additional rules for coordination of benefits when we are the secondary payer:

1. A primary payer, as determined above, must provide its covered benefits without considering our Coverage.
2. If a primary payer does not cover services that we Cover, those services will be Covered as if we are the primary payer.
3. If we Cover services not fully covered by a primary payer, we will coordinate our Coverage with the primary payer's coverage to pay up to 100% of the Medicaid Allowable Expenses or our contracted rate, whichever is less, for those services.
4. Except as explained above, we are not required to pay claims or coordinate benefits for services that are not provided by Participating Providers, approved by us, or listed as Covered Services under Section 5 above unless we tell you otherwise in this Certificate.

For purposes of this Section 14, "allowable expense" means a necessary, reasonable and customary expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. When we provide services, the reasonable cash value of each service is the allowable expense and is a benefit paid.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an allowable expense under the above definition unless your stay in a private Hospital room is Medically/Clinically Necessary.

D. Release

We may release to and obtain from any other insurer, plan or party, any information that we consider necessary for coordination of benefits or recovery of overpayments. You must cooperate to provide all requested information.

E. Recovery of Overpayments; Conditional Benefit Payments

If the amount of the payments we made is more than we should have paid under this COB provision, or if we have Covered services which should have been paid by a primary payer, we may recover the excess or the reasonable cash value of the services, as applicable, from one or more of: (i) the persons we paid or for whom we have paid a provider; (ii) insurance companies; or (iii) other organizations. We can recover those amounts as we choose. If you incur medical expenses for which another party is or may be responsible, we may provide Coverage subject to our right to reimbursement. If we ask, you (or your legal guardian) must sign any agreements or other documents and cooperate with us to make sure that we can recover the overpayments or obtain the reimbursement described in this paragraph. Reimbursement will be made to the extent of, but not exceeding, the total amount of recovery payable to or on your behalf (or on behalf of your guardian or estate) from: (i) any policy or contract from any insurance company or carrier (including your insurer); and (ii) any third party, plan or fund as a result of a judgment or settlement.

F. Subrogation and Reimbursement

You may experience an Illness or Injury for which a third party is currently responsible or was responsible for in the past. When we pay for Covered Services that relate to that Illness or Injury for which you have or had a legal or equitable cause of action against a third party, you assign (or transfer) to us, on your own behalf, rights of recovery with regard to that cause of action. These rights of recovery include a right to subrogation (which means that we can stand in your shoes and sue a third party directly for your Illness or Injury) and a right of reimbursement (which means that we have a right to be reimbursed out of any recoveries you receive or have received from third parties relating to your Illness or Injury). These rights of recovery extend to any recoveries from third-parties, including but not limited to tort-feasors, underinsured/uninsured motorist coverage, other substitute coverage, any other group or non-group policy of insurance providing health and/or accident coverage (including, but not limited to, any insurance policy having to do with payment of medical benefits that result from an automobile accident, and any riders or attachments to that policy). These rights of recovery also extend to all forms of recovery whether legal or equitable, in the form of policy proceeds, settlement or judgment, or based in tort, contract, or in any other body of law. Our rights of recovery will be to the fullest extent permitted by law, and shall equal, as a dollar amount, the total amount paid by us, or the cost of services Covered by us, plus reasonable collection costs, relating to the Illness or Injury at issue.

You must tell us immediately, in writing, about any situation that might allow us to invoke our rights of recovery under this section. (This would include informing us about any past recoveries you received that relate to an Illness or Injury for which we are paying Covered Services.) You must also cooperate

with us to help protect our rights of recovery under this section. Neither you, nor anyone acting for you, including legal counsel, may do anything to harm our rights under this section. If you receive any proceeds of a policy, settlement or judgment, and if we have a right of reimbursement with regard to those proceeds, you must hold those proceeds in trust for us. (We can recover from you any expenses we incur because you failed to cooperate in enforcing our rights under this section.) You agree that our rights of recovery precede any other party's rights of recovery. Specifically with regard to our right of reimbursement, we will have first priority claim against any monies you recover. Our reimbursement claim will be paid before any other claims are paid, whether or not you have recovered the total amount of your damages. If you receive policy proceeds, settle a claim or action against a third party or receive a judgment, you will be considered to have been "made whole" by the proceeds, settlement or judgment, and the federal law "make whole" concept will not apply. We have the right to be reimbursed in full before any amounts (including attorney's fees incurred by you) are deducted from the policy proceeds, judgment or settlement. Our rights of recovery are not limited by designation of certain funds as being or not being intended for payment of medical services.

For purposes of this subsection 14.F, the term "you" includes you or any other person(s) claiming through or on behalf of you, including but not limited to relatives, guardians, heirs, assigns and successors.

Section 15 - Medicare and Other Federal or State Government Programs

If you obtain Medicare coverage, you will be disenrolled from the Healthy Michigan Plan. Until disenrollment,
the following will apply:

A. Nonduplication of Benefits
Your benefits under this Certificate cannot be doubled up with any benefits you are, or could be, eligible for under Medicare, MI Choice waiver program, HAB Waiver, or any other federal or state government program. If we Cover a service that is also covered by one of those programs, any sums payable under that program for that service must be paid to us. We will apply the rules for Coordination of Benefits described in Section 14 after your benefits from us have been calculated under the rules in this section. We will reduce Allowable Expenses by any benefits available for those expenses under Medicare or any other federal or state governmental program. You must fill out and return to us any documents we ask for to make sure we receive reimbursement by those programs.

B. Coordination with Medicare
The following rules apply with respect to coordination with Medicare, except as required otherwise by applicable law:

1. Members Age 65 and Over
   If you are at least age 65 (or your spouse is at least age 65) and you qualify for Medicare, Medicare will always be primary.
2. Disabled Members Under Age 65

If you are disabled, Medicare will be primary.

3. Members Eligible for Medicare ESRD Benefits
Except as provided below, if you are entitled to or eligible for end-stage renal disease (ESRD) Medicare benefits, Medicare will be primary. If you have coverage under Medicare by reason of age or Disability and you later become eligible for Medicare ESRD benefits, Medicare will remain primary to this plan.

4. Eligibility for Medicare
If you are eligible for Medicare, you must apply for Parts A, B and D. If you are eligible for Medicare and Medicare is primary, we will pay as if Medicare is primary, even if you have not enrolled in Medicare.

5. Statutory and Regulatory Changes Despite any other provision of this Certificate, if any existing statute or regulation is amended or altered, or if any new statute or regulation is enacted or adopted, further permitting this plan to be secondary to Medicare, our plan will be secondary to Medicare as permitted by that statute or regulation.

Section 16 - Definitions

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

Agreement. The Agreement between the State of Michigan and us. The Agreement is a contract for health benefits. The Agreement includes this Certificate, any amendments and any attachments. A copy of the Agreement is available on request from us and may also be available from the State of Michigan.

Behavioral Health Department. The department that assists with all mental health services for Members. The department is available 24 hours a day.

Brand Name Drug. A prescription drug approved by the Food and Drug Administration (FDA) that is protected by a patent, supplied by a single company and marketed under the manufacturer’s brand name.
Certificate of Coverage. The document that you receive from us that describes your and our rights and duties. It includes amendments and attachments to the document. The Certificate is your agreement with us.

CMHSP. A (county) Community Mental Health Services Program.

Congenital Birth Defect. A condition that is present at birth.

Contract Year. The period of time that starts on the day the Agreement is effective and ends 365 days later (unless the Agreement says otherwise).

Copayments. Copayments are not made to the plan. You will be charged/pay for copays through your MIHA account. Copays are not due at the time of service.

Cosmetic Surgery. Surgery performed to reshape structures of the body in order to improve the patient's appearance and self-esteem.

Covered Services, Coverage, Cover or Covered. Those services and supplies that you are entitled to under this Certificate, if they are Medically/Clinically Necessary and you have met all other requirements of this Certificate. This Certificate limits what we will pay for some services and supplies. When we say we will "Cover" a service or supply that means we will treat the service or supply as a Covered Service.

Disabled or Disability. Under the Social Security Act, you are Disabled or have a Disability if, taking into account your age, education and past work experience, you are unable to perform any substantial gainful activity by reason of a medically determinable physical or mental impairment, or a combination of impairments, which can be expected to result in death or which has lasted or can be expected to last at least 12 consecutive months.

Durable Medical Equipment. Equipment or supplies which are: (a) made for repeated use; (b) mainly used for a medical purpose; (c) appropriate to use at home; and (d) generally not useful unless a person has an Illness or Injury.

FQHC. Federally Qualified Health Centers are public and private non-profit healthcare organizations that meet certain criteria under the Medicare and Medicaid programs of the Social Security Act and receive funds under the Health Center Program.

Fraud. 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).

Generic Drug. A prescription drug approved by the Food and Drug Administration (FDA) that is produced and distributed without patent protection and contains the same active ingredient as the Brand Name Drug.

Habilitative Services. Services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Professional. An individual who is licensed, certified or authorized under state law to practice a health profession.
Health Risk Assessment. A protocol approved by the Michigan Department of Health and Human Services to measure readiness to change and specific healthy behaviors of HMP enrollees.

Healthy Michigan Plan. The program operated under a 1115 Waiver approved by the Centers for Medicare and Medicaid Services (CMS) to provide Medicaid coverage to all adults in Michigan with incomes up to and including 133 percent of federal poverty level.

HMP or HMI. Healthy Michigan Plan.

Home Health Care Agency. An agency or organization that is licensed to provide skilled nursing services and other therapeutic services in an
outpatient setting.

Hospice Care. Services for the terminally ill and their families including pain management and other supportive services.

Hospital. An appropriately licensed acute care institution that provides inpatient medical care and treatment for Ill and Injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24 hour-a-day nursing and Physician service.

HRA. Health Risk Assessment.

ID Card. The Member Identification Card you receive from us as evidence of your enrollment with us.

Ill or Illness. A sickness or a disease, including congenital defects or birth abnormalities.
Injury or Injured. Accidental bodily Injury.

Initial Enrollment. First enrollment in the Healthy Michigan Plan following determination of eligibility; re-enrollment in a Healthy Michigan Plan following a gap in eligibility of less than two months is not considered initial enrollment.

Medicaid/Medical Assistance Program.
A federal/state program authorized under Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq,; and Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being 400.105 of the Michigan Compiled Laws; which provides federal matching funds for a medical assistance program. Specified medical and financial eligibility requirements must be met to be covered under Medicaid.

Medical Director. A Michigan-licensed Physician we have designated to supervise and manage the

medical aspects of our health care delivery system.

Medical Emergency. The sudden onset of a medical condition with signs and symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy; in the case of a pregnant woman, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Medically/Clinically Necessary. Covered Services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity, or malfunction, threaten to cause of to aggravate a disability, or result in illness or infirmity; an (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly community Physicians and other providers.

Medically/Clinically Necessary services and supplies must be widely accepted professionally by our network Physicians as effective, appropriate, and essential, based upon nationally accepted evidence-based standards.
All of the following are considered not to be Medically/Clinically Necessary:

- Those services rendered by a Health Professional that do not require the technical skills of such a provider;
- Those services and supplies furnished mainly for the personal comfort or convenience of you, anyone who cares for you, or anyone who is part of your family;
- Those services and supplies furnished to you as an inpatient on any day on which your physical or mental condition could safely and adequately be diagnosed or treated as an outpatient; and
- Any service or supply beyond those services sufficient to safely and adequately diagnose or treat your physical or mental condition.

Medicare. Title XVIII of the Social Security Act, as amended.

Member. A person who: (a) meets all applicable eligibility requirements of the State of Michigan; and (b) has enrolled for Coverage.

Member Open Enrollment. A period of time established by the State during which you may change health plans.

Motorized Vehicle. Any self-propelled vehicle with two or more wheels, designed for use on or off public roads, waterways or in the air.

Newborn. A Newborn child is defined as a child 30 days old or younger.

Non-Occupational Illness and Non-Occupational Injury. An Illness or Injury that does not arise out of (or in the course of) any work for pay or profit, and does not in any way result from an Illness or Injury that arose from work for pay or profit. If we obtain proof that you are covered under a Worker's Compensation law or similar law, but that you are not covered for a particular Illness or Injury under that law, that Illness or Injury will be considered "non-occupational" regardless of cause.

Non-Participating Provider. A Health Professional or other entity; including a hospital or outpatient facility that has not contracted with us to provide Covered Services to Members. Health Professionals who practice outside of our Service Area are Non-Participating Providers. Non-Participating Providers are not listed in the Priority Health Choice, Inc. Provider Directory.
Out-of-Area Services. Services and supplies provided outside our Service Area.

Participating Hospital. A Hospital that contracts with us to provide Covered Services to Members. Participating Hospitals are located within our Service Area and are listed in our Provider Directory.

Participating Physician. A Physician who contracts with us to provide Covered Services to Members. Participating Physicians are listed in our Provider Directory.

Participating Provider. A Health Professional or other entity that contracts with us to provide Covered Services to Members. Most Participating Providers practice within our Service Area and are listed in the Priority Health Choice, Inc. Provider Directory.

Physician. An appropriately licensed physician or surgeon.

Primary Care Provider (PCP). The Participating Provider, as chosen under Section 2.A, who is responsible to provide, arrange, and coordinate all aspects of your health care.

Priority Health Choice, Inc. A Michigan non-profit corporation and licensed health maintenance organization administering benefits under this Certificate of Coverage.

Reasonable and Customary Charges. The Medicaid fee-for-service rate.

Residential Treatment. 24-hour services provided in a facility where the focus of care is custodial, and inpatient Medical/Clinical Necessary criteria are not met.

RHC. A rural health center.

Service Area. A geographical area, designated by us and approved by Michigan, in which we are authorized to offer Covered Services. We publish precise Service Area boundaries and you may obtain that information from our Customer Service department or on our website at *priorityhealth.com*.

Skilled Nursing, Sub-acute, Long-term Acute or Inpatient Rehabilitation Facility. A facility that is

appropriately licensed to provide services in lieu of hospitalization including skilled nursing care and related services, sub-acute and long-term acute services and short-term rehabilitative therapy care on an inpatient basis.

Specialist Provider. A Participating Provider, other than a PCP, under contract with us to provide Covered Services upon referral by the PCP and approval in advance by us. A woman may visit a Participating obstetrician/gynecologist for her annual well-woman examination and routine pregnancy services without a referral.

Urgent Care (Dental). Services required to prevent serious deterioration of oral health following the onset of an unforeseen condition or injury

Urgent Care (Medical). Medical care provided for a condition that without timely treatment could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

Urgent Care Center. A licensed facility, not including a Hospital that provides Urgent Care for the immediate treatment of an Injury or Illness.
Waste. The overutilization of services or practices that result in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.

We, us or our, or Health Plan. Priority Health Choice, Inc.

You, your or yourself. The Member who is enrolled in the Healthy Michigan Plan administered by Priority Health Choice, Inc.

Section 17 - General Provisions

A. Independent Contractors

We do not directly provide any health care services under this Certificate, and we have no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by Health Professionals in consultation with you. We are only obligated under this Certificate to provide Members a network of health care services.

We are responsible for making benefit determinations under this Certificate and our contracts with

Participating Providers. Health Professionals are responsible for making independent medical judgments.
Health Professionals and you may choose to continue medical treatment even if we deny Coverage for those treatments. In such event, you will be responsible for the cost of those treatments. Health Professionals and you may ask for a review of any of our benefit decisions. Any review must follow the inquiry and review procedure explained in Section 12.

B. Authorization to Release Medical Information
We care about Your privacy. The information We collect about You is private. Only people who have both the need and the legal right may see Your information. Unless You give permission in writing, We will only disclose Your information for purposes of treatment, payment, business operations, or when We are required by law to do so.

You agree to cooperate with Us and Our Participating Providers by providing health history information and by helping Us to obtain Your medical records if We ask. If We ask You for a signed authorization for release of medical records, You agree to provide Us with one.

C. Entire Agreement
This Certificate of Coverage, and any amendments or attachments, is the entire Agreement between you and us. Beginning on the effective date of Coverage, this Certificate supersedes all other agreements for health care services and benefits between you and us.

D. Non-Assignment
You may not assign or transfer any of your rights to benefits or services under this Certificate.

E. Truth In Application and Statements
You agree to complete and submit to us the enrollment form and other forms as we reasonably request. You will ensure, and warrant that all information contained in such forms is true, correct, and complete.

F. Loss of Theft of ID Card
You must promptly notify us of the loss or theft of your ID Card upon discovery of the loss or theft.

G. General Obligations
Priority Health Choice, Inc. will not discriminate against Members because of race, color, ancestry, religion, age, sex, national origin, marital status, health status, or Disability.
We will ensure Covered Services are rendered to Members in the same manner, in accordance with the same standards and within the same time availability as Health Professionals offer those services to individuals not Covered under the Healthy Michigan Plan. The Health Professionals will not segregate Members in any way or treat them in a location or manner different from any of their patients that are not Covered under the Healthy Michigan Plan.

H. Conformity with State and Federal Law
We will apply this Certificate in agreement with state and federal laws and regulations. If any part of this Certificate does not agree with state or federal laws or regulations, we will change our procedures to agree with the laws and regulations.

I. Clerical Errors
Clerical errors, such as incorrect transcriptions of effective dates, termination dates or erroneous mailings, will not change the rights or obligations of you or us under this Certificate and will not operate to grant additional benefits to Members, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

J. Governing Law and Severability
This Certificate will be governed by Michigan law and any applicable federal law. If any provision of this Certificate is held to be invalid or unenforceable, the remaining provisions of this Agreement will remain in force and effect.

Section 18 - Notice of Privacy Practices

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

Our commitment to you
Priority Health Choice, Inc. (herein after “Priority Health”) understands the importance of handling protected health information (PHI) with care. We are committed to protecting the privacy of our members’ health information in every setting. State and federal laws require us to make sure that your health information is kept private. When you enroll with Priority Health or use services provided by one of the Priority Health plans, your PHI may be disclosed to Priority Health, and by Priority Health. This information is used and disclosed to coordinate and oversee your medical treatment, pay your medical claims and for the other purposes described below.

Federal law requires that we provide you with this Notice of Privacy Practices. This Notice states our legal duties and privacy practices regarding your PHI. It also states your rights under these laws with respect to the use and disclosure of your health information. Priority Health is required by law to follow the terms of the Notice currently in effect. We are also required to notify affected individuals following a breach of unsecured PHI.

Use and disclosure of your health information
The sections below describe the ways Priority Health uses and discloses your health information

without your authorization. Your health information is not shared with anyone who does not have a "need to know" to perform one of the tasks below.

Treatment. Priority Health may use or disclose your health information to professionals who are treating you and to coordinate and oversee your medical care. For example, we may disclose information about your prescription medications to your doctor so that s/he can better understand how to provide you medical care.

Payment. Priority Health may use your health information or disclose it to third parties to collect premiums, establish eligibility or pay for your medical care. For example, we may use your health information when we receive a claim for payment. Your claim tells us what services you received and may include a diagnosis. We may also disclose this information to another insurer if you are covered under more than one health plan.

Health care operations. Priority Health may use or disclose your health information to third parties in order to assist in Priority Health's everyday work activities, such as looking at the quality of your care, carrying out utilization review and conducting disease management programs. For example, your health information (along with other Priority Health members' information) may be used by Priority Health's staff to review the quality of care furnished by health care providers. Priority Health may also use and disclose your health information for underwriting, enrollment and other activities related to creating, renewing or replacing a benefits plan. Priority Health may not, however, use or disclose genetic information to decide whether we will give you coverage and price of that coverage.

Please note that we do not destroy personal information about you when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

To you and your personal representative. We may disclose your PHI to you or to your personal representative (someone who has the legal right to act on your behalf).

To others involved in your care. We may, under certain circumstances, disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person's involvement in your health care or payment for health care. For example, we may discuss a claim decision with you in the presence of a friend or a relative, unless you object. If you are not able to tell us your preference, for example if you are unconscious, we share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

This notice also applies to the Priority Health Organized Health Care Arrangement (OHCA) between Priority Health and Spectrum Health. Priority Health will share PHI with Spectrum Health for treatment, payment and health care operations purposes. Priority Health reserves the right to change

participation in its OHCA by any individual or organization.

Other permitted or required uses and disclosures without your written authorization

Priority Health is allowed or required to share your information in other ways— usually in ways that contribute to the public good, such as public health and research. Priority Health may also use or disclose your health information:

1. When required by law.
   - For law enforcement purposes.
   - When necessary for judicial or administrative (i.e., court) proceedings.
   - For compliance with workers' compensation requirements, as authorized by applicable law.
   - For various government functions, such as disclosures to health oversight agencies for activities authorized by law, the Armed Forces for active personnel, to Intelligence Agencies for national security, and the Department of State for foreign services reasons (e.g., security clearance).
   - As necessary for a coroner, medical examiner, law enforcement official or funeral director to carry out their legal duties with respect to a deceased individual or to cadaveric organ, eye or tissue donation and transplant organizations
2. For matters of public interest:
   - Reporting adult abuse, neglect or domestic violence.
   - To prevent a serious threat to an individual or a community's health and safety.
   - Reporting to organ procurement and tissue donation organizations.
   - For public health and safety activities, including disease control and vital statistic reporting, child abuse reporting, and Food and Drug Administration oversight.
   - For research purposes (as long as applicable research privacy standards are met).
3. To make a collection of "de-identified" information that cannot be traced back to you.
4. From time to time, we engage third parties called Business Associates to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

Other uses of health information – by authorization only

Priority Health may not use or disclose your PHI without your written authorization, except as described in this notice. You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it (take it back) at any time by notifying Priority Health's Compliance department in writing. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your authorization, but it will not affect any use or disclosure permitted by the authorization while it was in effect. We also must obtain your written authorization to sell information about you to a third party or, in most circumstances, to use or disclose your PHI to send you communications about products and services. We do not need your written authorization, however, to send you communications about treatment alternatives, treatment reminders, health related products or services, as long as the products or services are associated with your coverage or are offered by us.

We will never sell your PHI or use or disclose it for marketing purposes without your written authorization.

We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities.

A parent, legal guardian or properly named patient advocate may represent you and provide us with an authorization (or may revoke an authorization) to use or disclose health information about you if you cannot provide an authorization. Court documents may be required to verify this authority.

Potential impact of other applicable laws
Health Insurance Portability and Accountability Act (HIPAA) generally does not preempt, or override other laws that give people greater privacy protections. Therefore, if any state or federal privacy law requires us to provide you with more privacy protections, we are obligated to comply with that law in addition to HIPAA.

Your rights regarding your health information
You have the following rights:

Right to inspect and copy. You have a right to look at and get a copy of health information that may be used to make decisions about your care and payment for your care as long as we maintain them. There are limited circumstances in which we may deny your request to inspect and copy these records. If you are denied access to health information, you may request that the denial be reviewed. If you request a copy of the information, we may charge a fee for the cost of copying, mailing and other costs associated with your request.

To inspect and receive a copy of your health information, contact Priority Health's Compliance department.

Right to correct your health and claims record. You have the right to request that Priority Health amend any information that we use to make decisions about you. Generally, Priority Health will not amend these records if we did not create them or we determine that they are accurate and complete. To request that we amend your health information, you must write to Priority Health's Compliance Department and include a reason to support the change.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures," which is a list of the disclosures we made regarding your health information for 6 years prior to the

date of your request, except the following types of disclosures:
1. To carry out treatment, payment or health care operations.
2. To you or your personal representative.
3. For which you have given your written permission (authorization).
4. For national security or intelligence purposes.
5. To correctional institutions or to law enforcement, as described in this notice.
6. As part of a limited data set (a collection of information that does not directly identify you).

Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within 12 months will be free. We may charge you for the costs of providing additional lists. We will notify you of the cost and you can choose to withdraw or modify your request at that time before any fees are incurred.

Right to request restrictions. You have the right to request a limit on the health information that we use or disclose about you. We are not required by law to agree to your request. If we do agree to your request for restriction, we will comply with it unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to Priority Health's Compliance department. In your request, you must tell us:
1. What information you want to limit.
2. Whether you want to limit our use, disclosure or both.
3. To whom you want the limits to apply.
Priority Health will notify you (either in writing or by telephone) when we receive your request and of any restrictions to which we agree.

Right to request confidential communications. You may request that Priority Health communicate with you through alternative means or an alternative location. For example, you might want us to send health information (e.g. Explanation of benefits (EOB) and other claim information) to a different address. Priority Health will agree to your request if you clearly state in writing that communicating with you without using the alternative means or location could endanger you. Priority Health will accommodate your request if it is reasonable, specifies the alternative means or location, and permits us to collect premiums and pay claims.

To request confidential communications, you must make your request in writing to Priority Health's Compliance department.

Right to a paper copy of this notice. You have the right to a paper copy of Priority Health's current notice upon request. To obtain a paper copy of this notice, please call our Customer Service department. Otherwise, you may also print a copy of this notice from our website at priorityhealth.com.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with Priority Health and/or the Office for Civil Rights at the U.S. Department of Health and Human Services. To file a complaint with Priority Health, please call or send a written explanation of the issue to Priority

Health’s Privacy department. You will not be retaliated against for filing a complaint.

Our responsibilities

We are required by law to maintain the privacy and security of your PHI.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to this notice

Priority Health has the right to change our privacy practices and the terms of this notice at any time. Any new terms of our notice will be effective for all PHI that we maintain, including PHI regardless when it was created or received. We will provide a copy of the new notice (or information about the changes to our privacy practices and how to obtain the new notice) in our next annual mailing to members who are then covered by one of our health plans. The new notice will also be available upon request and posted on our website.

Contact information

If you have questions about how your medical information may be used and disclosed and how to get access to this information, please contact Priority Health Privacy Department below. For any other questions or concerns, please contact Priority Health Compliance Department below.

Priority Health Privacy Department:
Priority Health
Chief Privacy Officer

100 Michigan Street NE
Grand Rapids, MI 49503
616.486.4113

Priority Health Compliance Department:
Priority Health Compliance Department
1231 East Beltline NE
Grand Rapids MI 49525
616.942.0954
800.942.0954

This notice is effective: September 1, 2019.

Priority Health Choice, Inc. refers to a Michigan non-profit corporation and licensed Michigan health maintenance organization. Priority Health is a registered trademark and is used by the permission of the owner.

Priority Health is an Equal Opportunity Employer.

Priority Health Choice HMI, A Healthy Michigan Plan

Filed in Michigan: 2023

10003-75

Priority Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Priority Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Priority Health:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Priority Health customer service by calling the number at the back of your membership ID card (TTY users call 711).

If you believe that Priority Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex you can file a grievance with:

Priority Health Compliance Department
Attention: Civil Rights Coordinator
1231 East Beltline Ave NE
Grand Rapids, MI 49525-4501
Toll free: 866.807.1931 (TTY users call 711) Fax: 616.975.8850
PH-compliance@priorityhealth.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance the Priority Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov* or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at *hhs.gov/ocr/office/file/index.html*

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم:711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請撥打會員卡背面的客服電話 (TTY: 711）。

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܚܟܝܬܘܢ ܠܫܢܐ ܣܘܪܝܝܐ (ܐܬܘܪܝܐ) ، ܐܝܬ ܠܟܘܢ ܚܠܡܬܐ ܝܠܦܢܝܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܐܢ ܚܫܚܬܘܢ ܡܢܘܢ ܠܗܘ ܡܢ ܗܪܬܐ ܡܗܝܪܝܬܐ ܕܝܠܦܢܝܐ ܥܠ ܡܢܝܢܐ ܕܐܝܬܠܗ ܒܟܪܬܐ ܠܒܣܬܪ ܕܦܬܩܐ ܕܗܕܡܘܬܐ ܕܗܕܡܘܬܐ. (TTY: 711)

CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin hãy gọi tới số điện thoại của bộ phận dịch vụ khách hàng có ở mặt sau thẻ ID thành viên của quý vị. (TTY: 711).

KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Ju lutem kontaktoni qendrën e shërbimit për klient në pjesën e pasme të ID kartës tuaj të anëtaresimit (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 멤버쉽 ID카드의 뒷면에 있는 고객 서비스 번호로 전화해 주십시오. (TTY: 711)

লক্ষ্য করুনঃ আপনি বাংলায় কথা বলতে পারলে আপনার জন্য নিঃখরচায় ভাষা সহায়তা সেবা সুলভ রয়েছে। অনুগ্রহ করে আপনার সদস্যপদ আইডি কার্ডের পেছনে থাকা গ্রাহক সেবা নম্বরে কল করুন। (TTY: 711)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer telefonicznej obsługi klienta wskazany na odwrocie Twojej legitymacji członkowskiej (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienste zur Verfügung. Bitte rufen Sie die Kundendienstnummer auf der Rückseite Ihrer Mitgliedskarte an. (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero sul retro della tessera identificativa di membro. (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。メンバーシップIDカードの裏面にあるお客様サービスセンターの番号までお電話にてご連絡ください。(TTY: 711).

ВНИМАНИЕ! Если Вы говорите на русском языке, то Вам доступны услуги бесплатной языковой поддержки. Пожалуйста, позвоните в службу поддержки клиентов по номеру, указанному на обратной стороне Вашей идентификационной карточки участника (телетайп (TTY: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Molimo nazovite broj službe za korisnike na pozadini vaše članske iskaznice (TTY: 711).

Kung nagsasalita ka ng Tagalog,mga serbisyo ng tulong sa wika, ng libre, ay available para sa iyo. Pakitawan ang numero ng customer service sa likod ng iyong ID card ng pagiging miyembro. (TTY: 711).