

Getting the most from your health plan



Medicaid Handbook
and Certificate of Coverage

- ▶ Why is this handbook important? _____ page 7
- ▶ Certificate of Coverage _____ page 33
- ▶ Preventive Health Care Guidelines _____ page 71

For hearing-impaired TDD/TTY:

Call 888 551-6761

No English? ¿No hable inglés?

Comunicarse a el 888 389-6645 y pedir

un traductor

Priority Health Government Programs, Inc.

P.O BOX 269

Grand Rapids, MI 49501-0269

616 464-8102

888 975-8102

Walk-in hours:

Mon-Thu, 8:30 a.m.-5 p.m.

Fri, 9 a.m.-5 p.m.

Other Priority Health locations

Holland

Farmington Hills

Jackson

Kalamazoo

Traverse City

Welcome

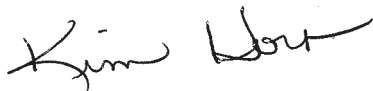
Thank you for choosing Priority Health Government Programs, Inc. We will work hard to make sure you and/or your children get the most from this Medicaid plan.

Please read this booklet carefully. You should keep it in a safe place. It will help explain how we work and how to get the care you need. It will also answer many questions you may have.

This booklet has two parts. The first part is your Member Handbook. It tells you how to use your healthcare benefits. The second part is your Certificate of Coverage. It is the legal contract between you and Priority Health Government Programs, Inc. (PHGP).

At PHGP, it is our job to help you and/or your children receive quality health care. We look forward to being your healthcare partner.

Sincerely,



Kimberly Horn
President & Chief Executive Officer
Priority Health Government Programs, Inc.

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Why is this handbook important?

- It will guide you through services that are available to you.
- It will give you information to get the care you need.
- It will make getting services easier.
- When we use the word “you” in this handbook, we mean you and any of your family members that have Medicaid with Priority Health Government Programs, Inc.
- When we use the words “us”, “health plan”, “Priority Health” or “PHGP” we mean Priority Health Government Programs, Inc.

Remember these important points:

- Work with your doctor and Priority Health Government Programs, Inc.
- Share in every medical decision.
- Make and keep your doctor appointments.
- When you need medical services, use this handbook.
- Call us at 888 975-8102 if you have any questions.

Important phone numbers

Customer service (available 24 hours a day) _____ 616 464-8102

Toll-free _____ 888 975-8102

Transportation _____ 616 464-8102

Toll-free _____ 888 975-8102

Hearing impaired, TDD _____ 616-464-8485

Toll-free _____ 888 551-6761

Mental health services _____ 616 464-8500

Toll-free _____ 800 673-8043

State of Michigan Beneficiary Hotline _____ 800 642-3195

Fair Hearing Process

Dental services and other non-plan benefits

Michigan Enrolls _____ 888 367-6557

To change plans
Enrollment questions

Add your own numbers

The name and phone number of your **primary care provider**:

The name and phone number of your **pharmacy**:

The phone number of the nearest **urgent care center**:

Other important numbers:

Be smart about your health!

Good health starts with you. Taking good care of your health will improve the quality of your life. This means you should:

- Actively share in making treatment decisions with your doctor.
- Ask questions of and share concerns with your doctor.
- Work to build a strong relationship with your doctor.
- Become aware of health problems before they become serious.

By working with your doctor, you can improve the quality of care you receive. At the first sign of health problems, you should:

- Keep written notes about the problem.
- Write down anything unusual that might be related to the problem.
- Call your doctor if the problems do not go away.
- Ask your doctor any questions you have about the problem.
- Make an appointment if necessary.

Member rights

You have the right to:

- Receive prompt medical care for medical conditions, including emergency care if necessary.
- Talk to your doctor or nurse about your care. This can help you decide what is best for you.
- Talk to your doctor about all treatment options for your condition, regardless of the cost or benefit coverage.
- Receive information about PHGP, our services, our providers and member rights and responsibilities.
- Be treated with respect.
- Have your privacy protected.
- Have your medical records kept private.
- Look at your medical records.
- Approve or deny the release of personal information. We do not need approval to release information when required by law.
- Be notified in a timely manner if we release personal information in response to a court order.
- Call us to discuss concerns about the quality of care you received from doctors or a hospital.
- Go to federally qualified health centers (FQHC), Tribal Health Centers, local health departments and child and adolescent health centers.
- File a complaint with us or the State if you have a problem with us or a provider.
- File a lawsuit if you have a problem with us or a provider.
- Expect our staff and our participating providers to meet all requirements concerning Member rights.
- Review a summary of the PHGP's Annual Report.
- Look at the full PHGP Annual Report on file with the Michigan Department of Community Health or the Office of Financial and Insurance Regulation.

Member responsibilities

As a member you also have the responsibility to:

- Read this Handbook, the Certificate of Coverage and other member materials.
- Follow the instructions given in all member materials.

- Always go to your primary care provider (PCP) for care when it is not an emergency unless we tell you otherwise in this Handbook or the Certificate of Coverage.
- Get a physical exam. Call your PCP to make an appointment.
- Keep your appointments. If you cannot make it, call your doctor at least 24 hours ahead of time to cancel.
- Get prior approval for services as noted in the Certificate of Coverage.
- Follow the limits of any approval of services.
- Show your ID card to the provider before you receive a service.
- Pay any required copays at the time service is provided.
- Use participating providers for all services and equipment not requiring prior approval unless we tell you otherwise in this Handbook or the Certificate of Coverage.
- Follow our instructions.
- Follow any instructions given to you by your provider.
- Provide all information your doctor or PHGP asks for. This will help you get proper care.
- Tell your providers and us if you have other health insurance coverage.
- Tell us as soon as possible about any change in address.
- Tell us as soon as possible if your ID card is lost or stolen.
- Treat providers and their staff with respect.
- Call us with questions.

Our nurses may work with you and your doctor to help meet your health needs.

Commonly asked questions

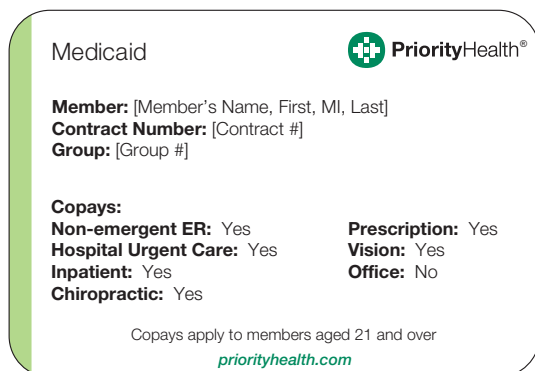
1. How do I use my ID Card?

When you become eligible and enroll in Medicaid, you will receive a plastic mihealth card from the State of Michigan. This shows that you have Medicaid coverage. When you get your mihealth ID card, make sure all your personal information is correct. If you lose your mihealth card, call the State of Michigan Beneficiary Hotline.

When you enroll with PHGP you will receive a member ID card. Use this card when you need any care. When you get your ID card, make sure all your personal information is correct. If you lose your ID card, it is stolen, or have a problem with it, call our Customer Service department at 888 975-8102. Each member of your family who has Medicaid will get a separate member ID card.

Take your ID card and your mihealth card with you every time you:

- Go to your primary care provider (PCP)
- Have a medical appointment
- Get medical care



You also need to show your member ID and mihealth card:

- At the pharmacy
- At the hospital
- At the emergency room
- At the urgent care center

2. I m in the plan, now what do I do?

Here is what you need to do to get the most from the plan:

- Make sure the name on your ID card is correct.
- If you did not choose a PCP, one was chosen for you. You may make a change by calling our Customer Service department at 616 464-8102 or 888 975-8102. If you are pregnant when you enroll, you may be able to continue seeing a doctor who is not a participating provider. See the Certificate of Coverage or call us for more information.
- Make an appointment to meet your PCP.
- Transfer your records from your old doctor if your appointment is with a new PCP.
- Make an appointment once each year with your PCP. You should make this appointment even if you are not sick. This “well visit” will help you and your doctor stay ahead of any health problems. Children under the age of 2 will need more frequent “well child visits” to stay up to date on shots.
- Call your PCP first when you have a medical problem or concern.

3. How do I choose a doctor/PCP?

We will help you find a doctor. We will ask you questions about:

- What doctor you have seen before
- Where you live, and
- Which hospital you want to use

You may also ask for a copy of our Provider Directory by calling our Customer Service department. You can also see it online at priorityhealth.com. The Provider Directory lists all of PHGP’s participating providers.

It is important that you build a good relationship with your PCP and other health professionals. If you cannot keep a good relationship with your doctors, we can ask you to choose another PCP, choose another PCP for you, or arrange for your PCP to refer you to another participating provider. We can also ask the State to disenroll you from PHGP’s Medicaid plan.

For help in picking a PCP, call our Customer Service department at 888 975-8102. You can also write to the address on page 2 of this handbook.

4. How do I change my doctor/PCP?

You can change your PCP by calling our Customer Service department at 888 975-8102. You can also write to us. The address is on page 2 of this handbook.

The primary care provider change will take effect on the day that we receive your request. Do not go to the new doctor until the change has been made.

5. How do I change health plans?

If we are not the right plan for you, you must follow these steps to change to a different health plan:

- A. If you have enrolled in PHGP's Medicaid plan within the past 90 days:
 - Call Michigan Enrolls at 888 367-6557. They can help you choose a new plan.
 - You must keep seeing your PHGP PCP.
 - Follow our rules until you are enrolled in another plan.
- B. If you have been enrolled in PHGP's Medicaid plan for more than 90 days:
 - The State allows you to change health plans once a year. Watch for the information from the State in the mail.
 - You must continue to see your PHGP PCP.
 - Follow our rules until you are enrolled in another health plan.
- C. If you have Medicare or an HMO as your primary insurance:
 - You are no longer eligible to be enrolled in a Medicaid managed care plan.
 - Notify your Department of Human Services (DHS) caseworker and they will change your health care coverage back to traditional Medicaid.
 - You must continue to see your PHGP PCP and follow our rules until you are disenrolled.

6. How can I be sure about quality?

We work hard to make sure you get the best service possible. Here are some examples of what we have done:

- We check the training and experience of every doctor.
- We test how easy it is for you to get an appointment with every doctor.
- Our Customer Service staff is trained to make sure that your needs are met.
- The State of Michigan reviews the services we give. They tell us when to change or improve services.
- You can file a complaint anytime by calling our Customer Service department at 888 975-8102. If you want, we will help you to report any problem you have with your doctor or our services.
- We give you materials to help you stay healthy. Just call us! We can give you information in pamphlets, by telephone and in person. If you want, someone can come to your home.

7. What if I need to see a specialist or have medical tests?

Talk to your primary care provider first. Your PCP will work hard to keep you healthy. If you need care or special tests, your doctor will help you see a specialist who is a PHGP participating provider. Do not see a specialist without the okay of your PCP. If you need to see a specialist who is outside our network you also need our prior approval. If you do not get prior approval from your PCP and from us when it is required, you may have to pay the bill.

If you are a new member of PHGP's Medicaid plan and are receiving medical treatment, call your PCP to have your care re-approved. If you are seeing an out-of-network specialist, our prior approval is also needed or you may have to pay the bill.

You do not have to get your PCP's approval to be treated by a participating provider for these services:

- OB/GYN (having babies or a routine female examination)
- Certified pediatric

- Family planning
- Vision (for the name of an eye doctor, call us)
- Behavioral Health (call us)

8. What if I need a ride to my appointments?

We will help you get a ride to your medical appointments. Call us for help if:

- You do not have a way to get to and from a doctor visit; or
- You do not have a way to get medical items or services covered by us

The rides you need must be approved in advance. For routine appointments, such as a doctor's appointment that is not an emergency, you must ask for a ride at least 5 days before your appointment date. Make your appointment first. Then call us to set up a ride.

To use our transportation, you must have no other way to get to your medical appointment. Call 888 975-8102 or 616 464-8102 for more information or help to arrange a ride.

You will be asked the following questions:

- Do you have a car?
- Can it be used?
- Can a relative, friend or neighbor take you?
- How have you gotten to your doctor appointments before?
- Can you get there the same way this time?

You will also be asked if you have any special needs that affect the kind of ride you need. If there is bus service available, you may be asked to use it unless there is a medical reason why you cannot do so.

You may be able to get a ride through the Community Mental Health Service Program when you are not eligible to use our transportation. For example, rides are available for persons with development disabilities to speech, language and occupational therapies when the therapies are billed through the Community Mental Health Service Program. If you need help with reaching this agency, you may contact our Behavioral Health department at 616 464-8500 or 800 673-8043.

9. When should I go to the emergency room?

For most problems, call your PCP. You can even call at night, on weekends or holidays. Only go to the Emergency Room when it is an emergency. The Emergency Room is for problems that can seriously harm your health or problems that are a matter of life or death. You should go to your PCP when emergency care is not needed.

Urgent care

When you have a problem that is serious (but is not as bad as an emergency) such as cuts, bumps or sprains, call your PCP. Remember, you can call at night, on weekends or holidays. Your PCP will give you instructions on what to do, or where to go for treatment. Your PCP must approve a visit to an Urgent Care Center. If you go without your doctor's approval, the Urgent Care Center may refuse to see you or you may have to pay for the visit.

Emergency care

An emergency is any condition that may cause death or injury if not treated right away. For an emergency, go to the emergency room or call 911 immediately.

Examples of emergencies (call 911 or seek care immediately):

Chest pain	Stroke	Convulsions
Heart attack	Severe bleeding	Unconsciousness
Severe burns	Drug overdose	

Examples that are not emergencies (call your PCP):

Sore throat	Earache	Minor cuts or bruises
Headache	Low back pain	Vaginal discharge
Colds or flu	Stomachache	Sprains or strains

When the problem is not an emergency, call your PCP's office, anytime day or night.

When you need an ambulance

In an emergency, dial 911. If you have a very serious illness or injury, an ambulance will be sent to take you to the hospital.

10. What if I am out of town when I get sick?

If you need care right away, but it's not a life-threatening situation, you should call your PCP first. Remember, you can call at night, on weekends or holidays. If you cannot reach your PCP in a reasonable amount of time and you need emergency or urgent care:

- Go to the nearest medical facility for medical care.
- Show your member ID card.
- Call your PCP for follow-up care. Tell your PCP about the medical care you needed.

Do not get routine medical care when you are out of town without getting approval from your doctor and us first.

If you need emergency care, go to the nearest medical facility. You do NOT need approval from your PCP to seek emergency care.

11. What if I move?

If you move, call your local Department of Human Services (DHS) office so they can change the State's records. Also, call our Customer Service department at 888 975-8102.

We want to update your address. If necessary, we will be happy to help you find a new PCP closer to your house.

12. What if there are changes in my family?

If the following changes apply to any member of your family enrolled in PHGP's Medicaid plan, please tell your DHS caseworker and our Customer Service department at 888 975-8102.

- New home address or telephone number
- Birth or adoption of a child
- Marriage or divorce
- Death
- Name change
- Medicare eligibility

- Eligibility for other health coverage or insurance
- If an enrolled family member moves away from home for any reason

13. What if my Medicaid coverage ends?

You will be disenrolled from PHGP's Medicaid plan. We will no longer pay your bills. If you are in the hospital when your coverage under this plan ends, we will continue paying for covered services until there is a change in the level of care you need which results in a transfer from one type of inpatient facility to another type of facility.

14. What if I get a bill?

You should not get a bill for services that you get from your PCP or that your PCP and Priority Health have approved. If you get a bill, write to us at the address on page 2. You may also call us at 888 975-8102. Be sure to give us your Medicaid ID number.

Using Priority Health Government Programs Medicaid plan

A healthy pregnancy

Each pregnancy is different. Make an appointment with your doctor as soon as you think you may be pregnant. It is important to start pre-natal care as soon as possible. Early pre-natal care improves your chances of having a healthy baby.

We want to help, too. That's why we offer **HealthyEncountersSM - Maternity Care** program. This program will give you information during the pregnancy and after the baby arrives.

Here are a few of the benefits you'll enjoy when you join:

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.

With PHGP's Medicaid plan, you and your doctor decide when you are ready to go home after the birth.

There are several important services that pregnant women and young children may be eligible for. When you are pregnant and after your baby is born, you may be eligible to receive Maternal Infant Health Program (MIHP) services. Ask your doctor about these services. It is also important that you contact your local health department. They can tell you about the programs they offer, such as WIC.

Call us when your baby arrives!

When you have your baby (and anytime your family size changes), let us know. Call your DHS caseworker so your records can be updated. Also call our Customer Service department at 888 975-8102 to report the change.

Healthy children start with you

Children need to see a doctor even when they are well! Before your child gets sick, see the doctor. Children (especially those under age two) need many checkups. At least once each year,

you should make an appointment for your child to see his or her PCP. This visit is important. Your child's PCP will use the time to get to know him or her when your child is healthy.

Your child's PCP will:

- Check how much your child is growing
- Make sure your child is eating right
- Give immunizations (shots)

Checkups help keep your child well! Call our Customer Service department at 888 975-8102 if you need help finding a PCP for your child or for transportation.

Appointments with your doctor

We can help. A good relationship with your PCP will help you and your family stay healthy and happy. If you need help picking a PCP, call us.

Make an appointment. When you are sick or need an appointment with your PCP, call your PCP's office.

Call to change or cancel. Call the PCP's office as soon as possible if you are not able to keep your appointment. They will help you to change the appointment to a different day or time. Also remember to change or cancel your ride if one is scheduled. Calling to cancel an appointment is sometimes hard to remember, but it is important to do. It lets others get the appointments they need.

Make your wishes known

You have the right to make decisions about your medical care. You have a right to accept or refuse medical or surgical treatment for yourself or your child. You also have the right to plan and decide the types of health care you get in the future if you become unable to express your wishes. You have the right to ask someone such as a family member or friend to help you with decisions about your health care.

Let your doctor know about your feelings by making a "Living Will" or "Power of

Attorney.” Call your doctor’s office or our Customer Service department at 888 975-8102 for a copy of the form. It is your choice whether you want to fill out an advance directive. The law states that no one can deny you care based on whether you have signed an advance directive. If you have signed an advance directive, and you believe your doctor or hospital has not followed the instructions on it, you may file a complaint with the Michigan Department of Community Health, Bureau of Health Professional Allegations Section, at 517 373-9196.

What services are covered?

The following services are covered when the providers are contracted with us and the services are determined to be medically necessary and appropriate. If you are 21 years of age or older, you may be responsible for copayments (or copays) for certain services. If you are eligible for both Medicaid and Medicare you will not be required to pay copays. No copays are required for family planning and pregnancy related products.

- Inpatient hospital services (a \$50 copay will apply to each non-pregnancy related admission)
- Emergency services (you may be required to pay a \$3 copay for each visit)
- Outpatient hospital services
- Primary care provider visits
- Certified pediatric or family nurse practitioner services
- Well child check-ups (up to age 21)
- Immunizations (shots)
- Blood lead follow-up (up to age 21)
- OB/GYN and Certified Nurse Midwife services
- Family planning
- Vision services (you may be required to pay a \$2 copay per visit)
- Sexually transmitted disease treatment
- Health education*
- Specialty provider visits*
- Chiropractic services* (up to age 21)
- Podiatry services* (routine foot care is not covered.)
- Transplant services*

- Pharmacy services* (you may be required to pay a \$1 copay for each generic prescription and a \$3 copay for each brand name prescription for non-family planning or non-pregnancy related medications)
- Prosthetics and orthotics*
- Durable medical equipment and supplies*
- Hospice services*
- Transportation*
- Ambulance and other emergency medical transportation
- Hearing and speech services, including hearing aids* (you may be required to pay a \$3 copay per hearing aid)
- Therapies (speech, language, physical and occupational)*
- Tobacco cessation treatment, including prescription drug and behavioral support
- Diagnostic lab, x-ray and other imaging services*
- Home health services*
- Short-term restorative or rehabilitative nursing care*
- Parenting and birthing classes*
- Medically necessary weight reduction services*
- End stage renal disease services*
- Mental health care – up to 20 outpatient visits per year
- Out-of-state services (if authorized by plan)*
- Urgent care (you may be required to pay a \$1 copay for each hospital urgent care visit)

** 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.*

Except for family planning services, FQHCs, Tribal Health Centers, local health departments, and child and adolescent health centers, out-of-network care always 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 888 975-8102 if you have questions.

Mental health and substance abuse services

We will arrange short-term treatment for mental or emotional needs for you or your family members. 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 (CMH) agency. CMH can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol. Below are some of the signs of substance abuse. If you feel you have a substance abuse problem, we encourage you to seek help.

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 our Behavioral Health department at 616 464-8500 or 800 673-8043. You can also call your local CMH agency.

Patient safety

You can make a difference.

We are working to educate all of our members about patient safety. Here is what you can do to improve the safety of your medical care:

- Give your doctors a complete health history
- Be an active member of your health care team.
- Take part in every decision about your health care.
- Speak up — ask questions.
- Ask for test results. Don't assume that no news is good news.
- Tell your doctor about any changes in your health.
- Follow your doctors' advice and the instructions for care that you and your doctor have agreed on.

It is always important that you play an active role in decisions about your health and your health care. Take responsibility — you can make a difference!

Prescription drug program

You have prescription drug coverage with PHGP. Members 21 years and older may be required to pay a \$1 copay per generic prescription, and \$3 copay for brand name prescriptions. There will only be a copay for non-family planning or non-pregnancy related medications. If you are eligible for both Medicaid and Medicare you will not be required to pay copays.

We use a formulary. This is a list of approved drugs. Doctors use it when deciding on medicines for members. The formulary includes many kinds of drugs. Some drugs that are not on the formulary are:

- Brand name drugs when the Food and Drug Administration (FDA) has approved a generic medicine that can be used instead
- Appetite control drugs
- Drugs that are not prescribed by a doctor

If you would like to know more about the PHGP medication formulary, call or write the Customer Service department. You can also visit us at priorityhealth.com and get the answers to questions, including:

- Which drugs are on the formulary?
- How can I get a copy of the formulary?
- How can I get a copy of PHGP's pharmacy policies and procedures?
- What if I need a drug that is not on the formulary?
- What if I need a drug that requires prior approval?
- What is a generic drug?
- Are generic drugs safe?

Drugs that are not included on the formulary may be covered if you follow the necessary steps to receive prior approval from us. To learn more about the steps in the prior approval process for non-formulary drugs, call or write the Customer Service department.

Your doctor will usually order a 31-day supply of medicine. It is important to know about the medicine you take. Always:

- Talk with your doctor and pharmacist about your medicine.
- 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.
- Make sure that you can read the prescriptions you get from your doctor.
- Some questions you should ask your doctor and pharmacist about your medicine are:
 - 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 medicine, ask the pharmacist if this is the medicine that was prescribed. Make sure you understand the instructions on the label.

Vision services

As a member of PHGP's Medicaid plan you can receive routine eye exams. Vision services cover lenses and frames through participating eye doctors. You may visit any participating eye doctor or you can call Customer Service for locations. When you visit the office, show them your member ID card. You may be required to pay a \$2 copay per visit. If you are eligible for both Medicaid and Medicare you will not be required to pay a copay.

You can call our Customer Service department at 888 975-8102 if you have questions about these services.

What services are not covered by PHGP s Medicaid plan?

This plan 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 and/or arranged by the State of Michigan Medicaid program. If you have any questions about these services talk with your PCP or your Department of Human Services caseworker. You can also contact the State of Michigan Beneficiary Hotline at 800 642-3195.

- Dental services
- Custodial care in a nursing facility
- Personal care or home health services
- Home and community based waiver program services
- Traumatic Brain Injury Program services

- Therapies, including speech, language, physical, and occupational therapy, provided to members with developmental disabilities when these services are billed through Community Mental Health Services providers or Intermediate School Districts

Services covered by Community Mental Health

The following services are covered and/or arranged by your local Community Mental Health agencies:

- Developmental disabilities
- Inpatient and outpatient hospital mental health
- Self help. This includes convenience items needed due to developmental delay.
- Treatment of severe and persistent mental illness, or severe emotional disturbances. CMH agencies cover treatment that cannot be provided within the 20-visit benefit provided by the health plan.
- Substance abuse. This includes:
 - Screenings and assessments
 - Detoxification
 - Intensive outpatient counseling and other outpatient services
 - Methadone treatments and certain additional substance abuse medications

If you need these services, contact your local Community Mental Health agency. If you need help with reaching this agency, you may contact our Behavioral Health department at 616 464-8500 or 800 673-8043.

Services provided by a school district and billed through the Intermediate School District

Contact your local Intermediate School District for more information about available services.

Details about covered and non-covered services are listed in the Certificate of Coverage (COC). If you have any questions about what services are covered, call our Customer Service department at 888 975-8102.

What services are not covered by Medicaid?

- Elective abortions and related services
- Experimental, investigational or unproven drugs, treatments, procedures or devices
- Elective cosmetic surgery
- Services for the treatment of infertility

Other insurance

If you have Medicaid and any other insurance, call the Customer Service department at 888 975-8102 to tell us what the other plan is. Your other insurance must always be billed before PHGP. Examples of other insurance include:

- Insurance from a new job
- Insurance from your spouse
- Insurance coverage through another driver due to an auto accident
- Medicare

If you are injured, someone else's insurance may pay your medical costs. For example, if you are injured in an automobile accident, the driver's auto insurance may be responsible for your medical costs. We will not pay any expenses that are covered by the other insurance.

Dual eligibles

Make sure to notify your DHS caseworker if you have Medicare. You will be disenrolled from PHGP and have coverage through regular Medicaid. This is required by federal rules.

Additional information

Physician incentive plan 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 888 975-8102.

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.

Inquiry and review procedures

We hope that you are always happy with the service you receive from us. We know, however, that sometimes you may have a problem or concern that you want us to know about. If you have a question, concern or complaint about us, please call our Customer Service department at 888 975-8102 or 616 464-8102. Our Customer Service representatives will try to resolve your problem as soon 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. You may contact our Customer Service department for assistance drafting a formal complaint. This formal complaint is handled through our review process. Here is a summary of the steps you can take:

1. Tell Customer Service that you want to file a Level 1 Review. Our Level 1 Internal Review Committee will look at your complaint and make a decision. They will send the decision to you in writing. You have 90 days from the date you learn of a problem to file a complaint with us.
2. If you are not happy with this decision, you can send your complaint to our Level 2 Internal Review Committee. They will review the complaint. They will also send you their decision in writing. You have 3 days after you receive your Level 1 Review decision to request a Level 2 Review.

If you have not yet received the services: Steps 1 and 2 combined must be completed, including a final decision, within a total of 30 calendar days after we receive your request for review. Up to 10 business 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.

If you have already received the services: Steps 1 and 2 combined must be completed, including a final decision, within a total of 35 calendar days after we receive your request for review. Up to 10 business 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.

3. If you are not happy with the outcome of the Level 2 Review, you can have your complaint reviewed by the Office of Financial and Insurance Regulation in Lansing, Michigan. You may request this review by filling out the External Review Form. The form will be included with the decision from the Level 2 Internal Review Committee. Your request for an external review must be made within 60 days of our final decision. You may also send your complaint to the following address:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, Third Floor
P. O. Box 30220
Lansing, MI 48909-7720
877 999-6442
www.michigan.gov/ofir

If your doctor tells us that the time it takes to resolve your complaint may put your life in danger, we will follow our emergency timeline.

Expedited Review procedure

If your doctor tells us that the time it takes to resolve your complaint may put your life in danger, interfere with your full recovery or delay treatment for severe pain, we

will follow our emergency timeline. This is our “Expedited Review” procedure. Steps 1 and 2 in an “Expedited Review” procedure must be completed within 72-hours (3 days) of receipt of your request. You may file a request for an “Expedited Review” with the Office of Financial and Insurance Regulation only after you have filed a request for an “Expedited Review” with us. If you are not happy with PHGP’s decision, you may appeal within 10 days of our final decision to the Office of Financial and Insurance Regulation.

Obtaining information about the review or “Expedited Review” procedure

To obtain a complete copy of our Level 1 Review or “Expedited Review” Procedures and Level 1 Review Form, or to find out more about your Level 2 Review rights, please contact our Customer Service department. You can also find more information in Section 11 of your Certificate of Coverage.

Administrative (Fair) Hearing

We hope that you will give us a chance to respond to your concerns by following this process. You do not have to follow this process. You can ask the State of Michigan to review the problem at any time within 90 days of the problem. This is called an Administrative or Fair Hearing. To ask for a hearing call the Customer Service department at 888 975-8102. Ask to have an Administrative Hearing form sent to you. You may also call the State of Michigan Beneficiary Hotline to request the form. Their number is 800 642-3195.

Following are the steps for the State’s Administrative (Fair) Hearing process:

- Step 1:** Fill out the request (hearing form) and return it to the address listed on the form.
- Step 2:** You will be sent a letter telling you when and where your hearing will be held.
- Step 3:** The results will be mailed to you after the hearing. If your complaint is taken care of before your hearing date, you must call to ask for a Hearing Request Withdrawal form. The phone number you should call to ask for this form will be included in that letter you receive during Step 2 of this process.

Filing a lawsuit against Priority Health Government Programs, 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 Grievance Procedure as described in Section 11 of the Certificate of Coverage. 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.

Materials alternative formats:

These materials may be available in alternative formats. If you need interpretation services, or a copy of these materials in an alternative format or another language, please call our Customer Service department for assistance.

For additional information about Priority Health Government Programs, please visit our website at priorityhealth.com.

Filed in Michigan: 2011

Doc_2473

Certificate of Coverage

Agreement Filed in: Michigan 2011

Read this entire Certificate carefully. It is a contract. It describes the rights and obligations of Members and Priority Health Government Programs, Inc. (PHGP) 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 Government Programs, Inc.

NOTE: You may be responsible for Copays for certain services as listed in the Schedule of Covered Services in Section 5.

Section 1 About This Certificate

This Certificate sets the terms and conditions of coverage as required by the agreement between Priority Health Government Programs, Inc. and the State of Michigan. This Certificate describes the health care services that are Covered for Members.

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 15. The terms “we”, “us” “our”, and PHGP refer to Priority Health Government Programs, Inc. The terms “you,” “your” and “yourself” refer to the Member.

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

Priority Health Government Programs, Inc.
Customer Service Department, MS 1105
PO Box 269
Grand Rapids, MI
49501-0269
616 464-8102 or 888 975-8102

or use our secure e-mail form in the Member Center on our Web site at priorityhealth.com.

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 Government Programs, Inc. Provider Directory is available by calling our Customer Service Department or on line at priorityhealth.com.

Choosing a PCP

When you enroll in Medicaid provided by Priority Health Government Programs, Inc., we will give you a list of PCPs to choose from. You will also find a list of PCPs to choose from at priorityhealth.com. You must choose a PCP from that list. When you choose, each member of your family may have a different PCP. If you need help choosing a PCP, call Customer Service at 888 975-8102 or 616 464-8102. 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 you may change the PCP of your child or someone else who is incapable of choosing a PCP and for whom you are the guardian) at any time. You can change your PCP by contacting Customer Service at 888 975-8102 or 616 464-8102 or on line in the Member Center at priorityhealth.com.

The PCP change will take effect on the day we receive your request for both adults and children.

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 PHGP's Medicaid plan.

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 Government Programs, 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, local health departments, and child and adolescent health centers, 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 provider unless your PCP has referred you and we have approved the referral first.** 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 or 616 464-8102 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 seek obstetrician/gynecologist and Hospital services out of

network if she is pregnant at the time of enrollment. A person may visit an obstetrician/gynecologist for her annual well-woman examination and routine pregnancy services without a referral. Referrals are still necessary for treatment of medical conditions.

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.

Services that Require Prior Approval from Priority Health Government Programs, Inc.

Services for which our prior approval is required include, but are not limited to:

1. Consultations and procedures for:
 - a. Bariatric (weight loss) surgery
 - b. Physician supervised weight loss programs
 - c. Parenteral/Enteral Feeding
 - d. Cosmetic and reconstructive surgery
 - e. Uvulopalatopharyngoplasty (UPPP)
 - f. Orthognathic surgery (jaw reconstruction)
 - g. Transplant and evaluations for transplant
 - h. Comprehensive pain and headache programs
 - i. Hospital ancillary and general anesthesia for dental treatment for adults
 - j. Male gynecomastia surgery
 2. Inpatient Care
 - a. Elective admissions
 - b. Inpatient skilled nursing, subacute, long-term acute and rehabilitation care
 3. 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
 4. All behavioral health services
 5. Referrals to Non-Participating Providers, except for family planning services unless we tell you otherwise in this Certificate (Participating Providers are those listed in the Priority Health Government Programs, Inc. Provider Directory; a provider is Non-Participating if he or she is not listed in the Provider Directory)
 6. Home health care
 7. Hospice care
 8. Home infusion services
 9. Durable Medical Equipment over \$500
 10. Prosthetics and orthotics over \$500
 11. Phase II and Phase III cancer clinical trials
 12. Certain prescription medications
 13. Selected injectable drugs in certain categories
- 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

PHGP, 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 or 616 464-8102.

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 Priority Health Government Program, Inc's Medicaid plan. 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 \$3 Copay may apply for non-emergent services provided in an emergency room. A \$1 Copay may apply for services provided in a hospital based Urgent Care Clinic.

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, 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 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:

- a. Services and supplies that you receive for a Medical Emergency (see the definition in Section 15).
- b. 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.

- c. 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:

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

Medicaid plan, we will pay the State of Michigan Medicaid rate.

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

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.

- a. In the case of a Medical Emergency, we will Cover ambulance service, to the nearest medical facility that can provide Medical Emergency care.
- b. 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 15 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 will be 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 11 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 Community Health 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 in our formulary.

You may request this information by calling or writing our Customer Service Department at the address and phone numbers below.

Priority Health Government Programs, Inc.
Customer Service Department, MS 1105
PO Box 269
Grand Rapids, MI 49501-0269
616 464-8102 or 888 975-8102

Use our secure e-mail form in the Member Center at priorityhealth.com.

Section 3 Enrollment

To be enrolled in Medicaid provided by PHGP, you must have Medicaid 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 10.C to learn more about termination for cause.

A. Newborn Enrollment

In most cases, when the mother is enrolled with us at the time of delivery, the Newborn will automatically be enrolled in our plan beginning with the child's date of birth.

B. 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 and returning it to our Customer Service Department or by calling our Customer Service Department. You must also contact your Department of Human Services (DHS) caseworker to update this information. You must notify us, and your DHS caseworker if any of the following happen to anyone Covered by PHGP:

1. change of address;
2. change in status of a dependent (such as if your child gets married);
3. eligibility for Medicare; or
4. enrollment, disenrollment or coverage by any other insurance or health plan.

Remember that these are just examples. You must let us know about any other change that, according to this Certificate, affects your Coverage or Coverage for your children. You must let us know about the change as soon as possible. You do not need to contact the State when you want to make a PCP change. Contact Customer Service at 888 975-8102 or 616 464-8102 and we will help you.

C. Loss of Eligibility

If you no longer meet Medicaid eligibility criteria as set by the State of Michigan, you will lose your eligibility and your Coverage with PHGP will terminate.

Section 4 Effective Dates of Coverage

A. General Rules

Except as explained below in subsection B and C "Non-Confinement Requirements," your Coverage will

begin on the first day of the month the State notifies us of your enrollment.

B. Non-Confinement Requirements

If you or your child is confined for treatment of an Illness or Injury in a Hospital when Coverage would otherwise begin, Coverage will not begin until there is a change in the level of required care resulting in a transfer from one type of facility to another. The non-confinement rule does not apply to a Newborn if the mother was enrolled with us on the date of delivery.

NOTE: If your child becomes eligible for Children's Special Health Care Services (CSHCS) while confined in a Hospital, your child's Coverage under this plan will end immediately. All services will be Covered by CSHCS on the date of enrollment regardless of any change in the level of required care.

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 or your child is discharged from the Skilled Nursing or Long-Term care Facility.

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

When Durable Medical Equipment, Prosthetics or Orthotics, are ordered while you are a member of another Medicaid Plan and delivered AFTER enrollment with PHGP; the payor at time the equipment was ordered is responsible for payment of the item.

Section 5 Schedule of Covered Services

NOTE: You are responsible for Copays listed in this section (5).

You are entitled to Covered Services described in Section 5 when those services are:

1. Medically/Clinically Necessary; (as defined in this Certificate and according to Medical and Behavioral Health policies established by PHGP 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 is the care provided by your PCP.

1. Health Maintenance and Preventive Health Care Services

The following services are Covered Services for each Member, even though they are not provided in connection with the diagnosis and treatment of an Illness or Injury:

- a. Well baby care, including routine physical examinations and clinical screenings given at two weeks, one month, two months, four months and six months from the date of birth plus two visits between one year and two years from the date of birth or as directed by your child's PCP.
- b. Periodic physical examinations.
- c. Routine pediatric and adult immunizations for infectious disease, in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, and as recommended by our Preventive Health Committee. For immunizations that are not Covered, see Section 6 (46), Third Party Requirements.
- d. One vision screening during each well child visit to determine vision problems that may warrant a referral. Covered vision care beyond screening is described in Section 5.B (41). See Section 6 (49) for vision care that is not Covered.
- e. One hearing screening during each well child visit to determine hearing problems that may warrant referral. Covered hearing care is described later in Section 5.B (17). See Section 6 (22) for hearing care that is not Covered.
- f. One routine "well woman" examination, including a gynecological examination and breast examination, every 12 months. A woman may visit 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 without a referral. 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.
- g. Breast cancer screening mammography as directed by your PCP or as required by state law.
- h. Maternity care as described in Section 5.C.
- i. Diagnostic and therapeutic radiology services and laboratory tests, including blood lead testing, not excluded under Sections 6 and 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. Non-emergency laboratory tests must be performed at a participating laboratory selected by your PCP.
- j. Tobacco cessation treatment, including counseling support provided through an approved telephone quit line, over-the-counter agents such as the patch, gum or lozenges, and one prescription of non-nicotine medication used to promote smoking cessation.
- k. Weight Loss Counseling.

2. Provider Care

All services listed in this Section 5 provided by your PCP during an office visit, Hospital visit, or house call, for the diagnosis and treatment of an illness or injury.

NOTE: 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: Removal of skin tags is excluded from Coverage. If your doctor removes a skin tag, Coverage for the skin tag removal 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 6 (5) 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. Chiropractic Care

For Members under the age of 21, 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.

5. Contraceptive Medications and Devices

These services and supplies do not require a referral and include, among other things, birth control pills, implantable contraceptive drugs, condoms, contraceptive foams or devices, IUDs (including insertion and removal), contraceptive jellies and ointments, even if for a medical condition other than birth control. Condoms for Members age 10 and above will be dispensed in quantities no greater than 12 at one time and no more than 36 in a 30-day period.

6. Court Ordered Services

Services required by court order, or as a condition of parole or probation, are only Covered when they are Medically/Clinically Necessary and Medicaid covered services. The services must also be recommended by your PCP and approved by us if necessary.

7. Dental Hospitalization

Hospital, ancillary and anesthesia services may be Covered for pediatric Members as follows:

- a. Multiple extractions or multiple restorations for children under the age of four;
- b. A total of six or more teeth are extracted in various quadrants,
- c. Dental treatment needs for which local anesthesia is ineffective

because of acute infection, anatomic variation or allergy,

- d. Extensive oral-facial and/or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
- e. Children with a concurrent hazardous medical condition.

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

8. Diabetic Services and Supplies

Services and supplies for Members with diabetes, as follows:

- a. Blood glucose monitors and blood glucose monitors for the legally blind.
- b. Test strips for glucose monitors, visual readings and urine test strips, lancets and spring-powered lancet devices.
- c. Syringes that are used for the administration of insulin.
- d. Diabetes self-management training to ensure that Members with diabetes and parents of children with diabetes are trained to do the proper self-management and treatment of their diabetes condition.
- e. Insulin and other medications for Members with diabetes are Covered through the Priority Health Government Programs, Inc. Prescription Drug program. For Members age 21 and older, a \$1 Copay for each generic prescription and a \$3 Copay for each brand name prescription will apply.
- f. Coverage is for standard diabetic services and supplies only. Services for the convenience of the Member or caregiver are not Covered.

- g. Dietitian Services. Up to six (6) consultative visits with a Participating dietitian, employed by a Participating Provider, upon referral by your PCP.

9. Domestic Violence

Medically/Clinically Necessary treatment, services and supplies for Injuries resulting from domestic violence.

10. Drugs for Cancer Therapy and Cancer Clinical Trials

Drugs for cancer therapy and cancer clinical trials, and the reasonable cost of administering them, are Covered regardless of whether the federal Food and Drug Administration (FDA) has approved the drugs to be used for the type of tumor for which the drugs are being used, as required by state law. Certain drugs may not be Covered if a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety or efficacy of the drugs.

Routine patient costs in connection with certain Phase II and Phase III cancer clinical trials may be Covered if approved in advance by our Medical Director.

See Section 13. (C) for Coordination of Benefits for drugs for cancer therapy and cancer clinical trials.

NOTE: For Members age 21 and older, a \$1 Copay for each generic prescription and a \$3 Copay for each brand name prescription may apply except for family planning and pregnancy related products.

11. 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:

- a. Prescribed by your PCP or by a Participating Provider upon referral from your PCP;

- b. Approved in advance by us, when required; and

- c. Obtained from a Participating Provider.

The following are also Covered:

- d. Training or education on the use of DME;

- e. Disposable supplies necessary for the proper functioning or application of the DME; and

- f. 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 6 (13) for DME that is not Covered.

12. Education

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

13. Emergency Treatment

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

14. End Stage Renal Disease

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

15. Eye Care

Coverage is limited to the treatment of medical conditions and diseases of the eye. See Section 5.B (41) Vision Care, for vision services that are Covered. See Section 6 (49) for vision services that are not Covered.

NOTE: For members age 21 and older, a \$2 Copay per visit may apply.

16. 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 Medicaid-approved family planning center:

- a. Diagnostic services for identification of the cause of infertility.
- b. Diaphragms, including measurement and fitting, and IUDs, including insertion and removal.
- c. Advice on contraception and family planning, including childbirth education.

Procedures to assist you in having children are excluded as described in Section 6 (24) under “Infertility.”

17. 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 50 batteries per six-month period are Covered.

NOTE: For Members age 21 and older, a \$3 Copay per hearing aid applies.

18. 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.

To qualify for Home Health benefits, we may require that you meet the following:

- a. Be confined to the home
- b. Be under the care of a Physician
- c. Be receiving services under a plan of care established and periodically reviewed by a Physician, and
- d. Be in need of physical, speech, or occupational therapy; or skilled nursing on an intermittent basis.

19. Hospice Care

Inpatient and outpatient Hospice Care is Covered when:

- a. Your Physician informs us that your condition is terminal; and
- b. 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.
- c. You choose to have hospice services; and
- d. The care is provided by a Medicare certified hospice program.

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

- a. 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.

b. 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 Medicaid while enrolled in a hospice you will also become ineligible for reimbursement for hospice services from PHGP.

20. Hospital Care

a. 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.

- b. Outpatient Care
- Hospital services and supplies listed in subsection (20)(a) that you receive on an outpatient basis. For Members 21 and older, a \$1 Copay for Hospital based Urgent Care Clinic services will apply for non family planning, non pregnancy related services.
21. Infertility Services
- Covered as outlined under Section 5.B (16) Family Planning. Procedures to assist with conception are not Covered.
22. Intractable Pain
- Evaluation and treatment of intractable pain.
23. Medical Supplies
- a. Medical supplies received while you're inpatient or in connection with a home health visit are Covered at your Hospital benefit level as set forth in this Certificate.
- b. Some medical supplies are Covered under your Durable Medical Equipment coverage including such supplies as catheters, syringes, ostomy supplies, feeding tubes, including enteral and TPN feedings, lancets, sterile gauze and tape.
- c. Limitations on medical supplies are based on State of Michigan guidelines.
- d. See Section 6 (35) for outpatient medical supplies that are not Covered.
24. 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 when approved by our Behavioral Health Department 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 provider.
- Solution-focused treatment, including both individual and/or group sessions, is Covered for up to a maximum of 20 outpatient sessions per calendar year. 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.
- a. Prior Authorization
- You must call our Behavioral Health Department before receiving outpatient mental health services. Mental health services do not require referral from your PCP. Call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance or a referral.
- b. 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.
- Your Coverage for mental health benefits is limited by the calendar year maximum number of visits. Coverage is provided for up to a maximum of 20 outpatient sessions per calendar year.
- c. 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 Community Health. For more information regarding Covered medications, you may contact the Customer Service or visit us online at priorityhealth.com.

25. 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 PHGP approved program along with other criteria set forth in our medical policies.

Non-compliance with treatment regimens may limit future benefits.

26. Oral Surgery

Coverage for oral surgery is limited to the following:

- a. Reduction or manipulation of fractures of facial bones.
- b. Removal of tumors or cysts of the jaw, other facial bones, mouth, lip, tongue, accessory sinuses, salivary glands, or the ducts.
- c. 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 in preparation for implants, including preparation of the bone, or dental surgery done in connection with any of the Covered Services listed above is not Covered. Read Sections 6 (12) to learn more about Coverage limitations and exclusions.

27. 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:

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

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

28. Outpatient Prescription Drugs

Covered in full with a generic substitution process. Prescriptions will be dispensed in quantities prescribed by Providers up to a 31-day supply. Prescriptions will be Covered if included on the Priority Health Government Programs, Inc. formulary. Coverage for some drugs requires prior approval from us, including non-formulary medications and off-label use of Food and Drug Administration approved drugs.

Outpatient prescription drugs include the following for the treatment of diabetes:

- a. Insulin, as prescribed by a Physician;
- b. Non-experimental medication for controlling blood sugar, if prescribed by a Physician; and
- c. Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes, if prescribed by a Physician, including a podiatrist.

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 Community Health. For more information regarding Covered medications, you may contact our Customer Service Department, or visit us online at priorityhealth.com.

NOTE: For Members age 21 and older, a \$1 Copay per generic prescription and a \$3 Copay per brand name prescription may apply, except for family planning and pregnancy related products.

29. 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.

NOTE: For Members age 21 and older, a \$1 Copay per generic prescription and a \$3 Copay per brand name prescription may apply except for family planning and pregnancy related products.

30. 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.

31. Prosthetic and Orthotic/Support Devices

Surgically implanted internal prosthetic devices and special appliances/ devices that are worn externally, when the appliances or devices:

- a. 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,
- b. 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 diabetic shoes 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 6 (39) for additional exclusions.

32. Provider Care

All services listed in this Section 5 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.

33. Radiology Examinations and Laboratory Procedures

Diagnostic and therapeutic radiology services and laboratory tests not excluded under Section 6 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.

34. Reconstructive Surgery

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

These services are Covered if:

- i. 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.

- ii. We reasonably expect the surgery to correct the condition; and
- iii. 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.

- b. 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:

- i. Reconstruction of the breast on which a mastectomy was performed;
- ii. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- iii. Prosthesis 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.

- c. Orthodontic treatment

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

See Section 6 (9) and Section 6 (40) for Cosmetic and Reconstructive Surgery that is not Covered.

- 35. Short-Term Rehabilitative Therapy

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

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

Short-term rehabilitative therapy services are Covered if:

- a. 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 5.B for more information.
- b. The therapy is restorative in nature, and
- c. 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
- d. 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
- e. A Participating Physician refers, directs and monitors the services. Therapy, beyond the initial 90 days following the initiation of outpatient therapy, must be prior authorized. See Section 6 (41) for limitations and exclusions.

- 36. Skilled Nursing Facility Care, Subacute, Inpatient Rehabilitation or Hospice 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, Subacute, Inpatient Rehabilitation or Hospice Facility when the care is restorative in nature, and we have approved a treatment plan in advance. The treatment plan will be approved based on our determination of Medical/Clinical Necessity and appropriateness, and is not dependent on Medicare guidelines. Our criteria

for Coverage 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, Rehabilitation or Hospice 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 6 (11) under "Custodial Care."

37. 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 agency in your county for a referral. If you do not know the Community Mental Health agency in your county, you may call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for more information.

38. 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:

- a. Office visits for medical evaluation and treatment.
- b. Specialty referral for medical evaluation and treatment.
- c. X-rays of the temporomandibular joint including contrast studies, but not dental x-ray.
- d. Myofunctional therapy.
- e. 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.

39. 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:

- a. Cornea
- b. Heart
- c. Lung
- d. Kidney
- e. Bone marrow or stem cell
- f. Liver
- g. Pancreas
- h. Small Bowel

Your benefits under this section are limited to one evaluation per transplant.

We will Cover the following services:

- a. Extrarenal organ transplants (skin, bone, heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologous and peripheral stem cell harvesting, and small bowel) on a patient specific basis when determined Medically Necessary according to currently accepted standards of care.
- b. 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.
- c. 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.
- d. 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 6 (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 5.

Transplants of artificial organs are not Covered.

40. 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.

41. 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:

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

Ophthalmic frames include a selection of approved ophthalmic frames.

Medically 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. Replacement glasses must be an identical replacement of the previously issued glasses unless they are no longer available.

NOTE: For Members age 21 and older, a \$2 Copay per visit may apply.

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

42. 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:

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

43. Foot Care

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

NOTE: For Members age 21 and older, a \$2 Copay per visit may apply.

C. Maternity Care

1. 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. 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.

2. 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.

3. 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.

4. 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.

5. Parenting/Birthing Classes

Covered through Participating Providers. Contact the Customer Service Department to find out about classes that are available to you.

6. 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.

7. Obstetrical Delivery In The Home

Delivery in the home is not Covered. You must deliver in a Hospital. See Section 6 (32).

D. Medical Emergency and Urgent Care

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

Section 6 Exclusions From Coverage

We will not Cover any service, treatment or supply listed in this Section 6, even if it could prevent the need for more costly Covered Service, treatment or supply, unless:

- We provide Coverage for the service, treatment or supply in any amendment attached to the Certificate; or
- 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. Other Situations Involving Actions Inconsistent with Plan Membership

We may request the State of Michigan to disenroll you from the health plan for other situations involving actions inconsistent with plan membership. See Section 10.C, Termination for Cause.

5. Allergy Testing

Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine auto-injections, bronchial or oral allergen sensitization and provocative and neutralization testing for allergies. See Section 5.B (1) for allergy tests that are Covered.

6. Autopsy

7. Biofeedback

Biofeedback for any diagnosis including mental health diagnoses.

8. 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.

9. Cosmetic Surgery and Other Services That Are Not Specifically Covered under Section 5.B (34)

Cosmetic services, prescription drugs, treatment, therapies, or procedures done primarily to improve the way any part of the body looks. Coverage is excluded for, among other things:

- Abdominoplasty (to remove excess fat),
- Blepharoplasty of lower lids,
- Breast augmentation except when provided for post-mastectomy reconstructive services (See Section 5.B (34) for full description of Covered Services),
- Chemical peel for acne,
- Collagen implants,
- Diastasis recti repair,
- Electrolysis for excessive hair growth, even if caused by an underlying medical condition,
- Excision or repair of excess or sagging skin,
- Excision of skin tags or other lesions (unless documented as pre-cancerous),
- Fat grafts,
- Hair transplants or repair of any congenital or acquired hair defect,
- Keloid treatment including laser, injection or surgery,
- Liposuction, unless an integral part of another Covered procedure,
- Procedures performed for excessive sweating,

- o. Removal of spider veins,
- p. Rhytidectomy,
- q. Rhinophyma treatment,
- r. Salabrasion,
- s. Scar revision, or removal (except for facial scars resulting from an Injury or following cancer surgery),
- t. Sebhorreic keratoses, and
- u. Tattoo removal.

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 cosmetic surgery is requested.

10. 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.

11. 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.

12. Dental Services

All dental services, including, among other things:

- a. Routine dental services,
- b. Dental x-rays,
- c. Dental surgery such as root canals and tooth extractions, even when provided in conjunction with other treatment or surgery,
- d. Orthodontia and orthodontic x-rays, even when provided in conjunction with other treatment or surgery,
- e. Orthognathic surgery (except as specifically Covered under Section 5.B. (27),
- f. Dental prostheses, including implants and preparation of the bone to receive implants and dentures,
- g. Rebuilding or repair of soft tissues of the mouth or lip except as specifically Covered in Section 5.B (26),
- h. Bite splints used for dental purposes or for Temporomandibular Joint Dysfunction or Syndrome (TMJ),
- i. Treatment of congenital dental defects, such as missing or abnormally developed teeth, and
- j. Treatment, services and supplies related to periodontal/ inflammatory gum disease.
- k. Dental services required due to accidents are not Covered. This exclusion does not apply to medical services that are Medically/ Clinically Necessary such as suturing of lacerations required in connection with an accident.

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. Hospital, ancillary and anesthesia services are Covered for pediatric Members as described in Section 5.B.7.

13. 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 5.B (11) for Durable Medical Equipment that is Covered. Examples of exclusions include, but are not limited to:

- a. Adaptive equipment (e.g., rocker knife, swivel spoon, etc),
- b. Air conditioner,
- c. Air Purifier,
- d. Environmental Control Units,
- e. Equipment not used or not used properly by the beneficiary,
- f. Exam tables/massage tables,
- g. Exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc),
- h. Generators,
- i. Heating pads,
- j. Home modifications,
- k. Hot tubs,

- l. House/room humidifier,
 - m. Insulin pumps for the purpose of solving problems of Member non-compliance,
 - n. Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons,
 - o. Lift chairs, reclining chairs, vibrating chairs,
 - p. More than one pair of shoes on the same date of service,
 - q. New equipment when current equipment can be modified to accommodate growth,
 - r. Over the counter shoe inserts,
 - s. Portable oxygen, when ordered to be used at night only,
 - t. Power tilt-in-space or reclining wheelchairs for a long term care resident because there is limited staffing
 - u. Pressure gradient garments for maternity-related edema,
 - v. Prosthetic appliances for a beneficiary with a potential functional level of K0,
 - w. 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.),
 - x. Second wheelchairs or ventilators for beneficiary preference or convenience, including travel,
 - y. Sensory Devices (e.g., games, toys, etc.),
 - z. Stair lifts,
 - aa. Standard infant/toddler formula,
 - bb. Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile),
 - cc. Thickeners for foods or liquids,
 - dd. Toothettes,
 - ee. Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain,
 - ff. Ultrasonic osteogenesis stimulators,
 - gg. Wheelchair lifts or ramps for home or vehicle (all types),
 - hh. Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.), and
 - ii. Wigs for hair loss.
14. Ear Plugs
15. Educational Services
- School based services are excluded. These services can be obtained through your local school system and include:
- a. Services for remedial education, including evaluation or treatment of learning disabilities, developmental and learning disorders, and behavioral training,
 - b. Services, treatment or diagnostic testing related to learning disabilities or developmental delays,
 - c. Education testing or training,
 - d. Services and supplies for mental retardation,
 - e. Physical, occupational, speech, cognitive and sensory integration therapy for developmental delay, apraxia and cognitive disorders,
 - f. Cognitive rehabilitation, and
 - g. 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.
16. Enuresis
- Bed wetting devices and services for the diagnosis of enuresis.
17. 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:
- a. 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;
 - b. 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;
 - c. 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;
 - d. Reliable evidence shows that the drug, device, treatment or procedure is:

- i. The subject of on-goings Phase I or Phase II clinical trials;
 - ii. The research, experimental study, or investigational arm of on-going Phase III clinical trials; or
 - iii. Otherwise under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or
- e. 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:

- i. Published reports and articles in authoritative medical and scientific literature;
- ii. 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
- iii. Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device, treatment or procedure.

Coverage is available for routine patient costs in connection with certain Phase II and Phase III cancer clinical trials. For information about which trials are Covered, your PCP should contact our medical director.

This exclusion does not apply to drugs for cancer therapy described in Section 5.B (10).

18. Food, Formula and Supplements

All food, formula and nutritional supplements are excluded, including, but not limited to:

- a. Infant formula, 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,
- b. Nutritional formula representing only a liquid form of food,
- c. Nutritional puddings/bars,
- d. Regular or dietetic foods (e.g., Slimfast, Carnation instant breakfast, etc.),
- e. Sports drinks/juices, and
- f. Weight loss or “light” products.

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

19. Foot Care

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

20. Hair Analysis and Treatment for Hair Loss

All services including wigs requested due to hair loss.

21. Health Promotion Classes

Covering such subjects as stress management, parenting and lifestyle changes except for approved maternity education or when a part of our chronic disease management programs.

22. 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.

23. 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.

24. 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 5.B (16).

25. Leave of Absence

Charges incurred when you are on an overnight or weekend pass during an inpatient stay.

26. Marital and Relationship Enhancement Counseling

Services and treatment related to marital or relationship counseling.

27. 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.

28. 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.

29. 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.

30. 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:

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

31. 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 PHGP 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 11. 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 11.

32. Obstetrical Delivery in the Home

Services and supplies received in connection with an obstetrical delivery in the home.

33. 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 5.B (39) under "Transplants" for information about what expenses related to transplants are Covered.

34. Outpatient Prescription Drugs

- a. Psychotropic and anti-viral medications are excluded from Coverage by PHGP. These medications are Covered by the Michigan Department of Community Health. For more information regarding Covered medications, contact Customer Service or visit us at priorityhealth.com.
- b. Erectile dysfunction drugs are not a Covered benefit.

35. Outpatient Medical Supplies

Medical supplies that exceed quantities allowed by the Michigan Department of Community Health or are considered not Medically/ Clinically Necessary.

36. 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:

- a. 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.
- b. The purchase or rental of household fixtures, such as escalators, elevators, swimming pools and similar fixtures.
- c. 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.
- d. Car seats and modifications to motorized vehicles.

37. Private Duty Nursing

38. Providers Barred from Reimbursement

Services and supplies received from, or ordered or referred by, providers who have been:

- a. Terminated from our provider network for failing to meet our credentialing criteria,

- b. Terminated for non-compliance with our quality standards and programs, or

- c. Identified as sanctioned by Medicare or Medicaid.

39. Prosthetic and Orthotic/ Support Devices

Orthopedic shoes, shoe inserts, and other supportive devices of the feet except as identified as Covered in Section 5.B (31).

40. Reconstructive Surgeries

Those not specifically Covered under Section 5.B (34).

41. Rehabilitation and Therapy Services

- a. 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.

- b. Physical, speech or occupational therapy to correct an impairment, when the impairment is not due to Illness, Injury or a congenital defect for which you have received corrective surgery.

- c. Cognitive rehabilitative therapy is not Covered. Cognitive rehabilitative therapy is defined as neurological training or retraining.

- d. Strength training and exercise programs.

- e. Sensory integration and visual therapy

- f. Rehabilitation services obtained from non-Health Professionals, including massage therapists.

- g. Summer programs meant to maintain physical condition or developmental status during periods when school programs are unavailable.

- h. All therapies for developmental delays, apraxias and cognitive disorders, including physical, occupational, speech, cognitive and sensory integration therapy.

- i. Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluation and all return to work programs.

- j. Orthoptic (vision) therapy for limited medical conditions are Covered.

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 5.B (35).

42. Religious Counseling

Services and treatment related to religious counseling or provided by a religious counselor who is not a Participating Provider.

43. 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.

44. Sex Change or Transformation.

Any procedure or treatment, including hormone therapy, required for, or designed to change your physical characteristics from your biologically determined sex to those of the opposite sex. This exclusion applies despite any diagnosis of gender role or psychosexual orientation problems.

45. Sex Therapy

Services and treatment related to sex therapy.

46. Third Party Requirements

Services required or recommended by third parties, including, but not limited to:

- a. Physical examinations in excess of those required by federal guidelines performed by your PCP,
- b. Physical examinations performed by a Physician other than your PCP, and
- c. 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.
- d. 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.

47. Treatment in a Federal, State,

or Governmental Entity

The following are excluded to the extent permitted by law:

- a. Services and supplies provided in a Non Participating Hospital owned or operated by any federal, state, or other governmental entity.
- b. 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 PHGP's Medicaid plan.

48. Unauthorized Services and Supplies

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

- a. Services and supplies that your PCP did not perform, prescribe, or arrange according to the guidelines of this Certificate.
- b. Services and supplies that were provided without any required advance approval by us.
- c. Services and supplies from any Health Professional upon self-referral by you.
- d. 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 routine

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.

49. Vision Care

- a. Non-prescription ophthalmic lenses and frames,
- b. Special independent diagnostic tests or treatment procedures,
- c. Any other eye or vision service not specifically listed in Section 5.B (41) of this Certificate.

50. Vocational Rehabilitation

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

51. 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 5.B (25).

52. Chiropractic Care

All chiropractic services for Members age 21 and over.

Section 7 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 5 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

We will not pay for services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison. You will be disenrolled from PHGP's plan.

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: PHGP 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, PHGP 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 8 Member Rights and Responsibilities

As a Member of Medicaid provided by PHGP you have the following rights:

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

- 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.
- You may go to federally qualified health centers (FQHC), Tribal Health Centers, local health departments and child and adolescent health centers.
- You may receive information about us, our services, our providers and Member rights and responsibilities.
- You may participate in decisions regarding your health care.
- We will treat you with respect.
- We will protect your privacy.
- We will keep your medical and financial records maintained by us confidential, whether in electronic or written form.
- 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 Medicaid plan, or for anonymous use in statistical studies and medical research.
- You may inspect your medical records and those of your minor dependents. Your right as a parent or legal guardian to access your minor's medical records, without the minor's consent, is limited as provided by law.
- You may contact us to discuss concerns about the quality of care you have received from a Participating Provider.
- 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.

- You may file a Fair Hearing request.
- You may initiate a legal proceeding if you experience a problem with us or a provider after you have exhausted the review process.
- We will notify you in a timely manner if we release personal information about you in response to a court order.
- You may expect our staff and our Participating Providers to meet all requirements concerning Member rights.
- You may review a summary of the PHGP annual report, and inspect the full report on file with the Michigan Department of Community Health or the Office of Financial and Insurance Regulation.
- You may suggest changes to our Member rights and responsibilities policies.
- You must contact Participating Providers to arrange for medical appointments, and notify providers in a timely manner if an appointment must be canceled.
- You must pay Copays at the time service is provided.
- You must present your ID card to the provider before you receive a service.
- You must participate in your health care as much as possible by working to understand your health problems.
- 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.

As a Member you also have the following responsibilities:

- You must read the Certificate of Coverage and Member materials, and comply with the requirements.
- You must call us with questions.
- 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.
- 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 Government Programs, Inc. Provider Directory, and comply with the limits of any approval of services.
- You must use Participating Providers for all services and equipment not requiring prior approval unless we tell you otherwise in this Certificate.
- You must supply, to the extent possible, information needed by us and health care professionals to provide proper care.
- You must notify providers and us if you have other health insurance coverage.
- You must provide truthful information to us.
- You must promptly notify us of any change in address.
- You must promptly notify us if your ID card is lost or stolen.
- You must cooperate with us to prevent the unauthorized use of your ID card and to prevent anyone from obtaining benefits in your place.
- You must treat providers and staff with respect.

Section 9 Claims Provisions

When you receive Covered Services from a Participating Provider, you will not be required to pay any amount except for applicable Copays as shown in Section 5, Covered Services. 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 Medicaid plan.

Reimbursement Request Time Limit

We ask that you make your request within 60 days of the date you obtained the services. If you do not ask for reimbursement within 60 days, 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 Government Programs, 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 11 to find out more about that procedure.

Section 10 Termination of Coverage

A. Termination of Agreement between Priority Health Government Programs, Inc. and the State

The State of Michigan may terminate the Agreement between PHGP 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 Medicaid eligibility criteria as required by the State of Michigan. 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 PHGP's Medicaid plan for cause immediately if either of the following happens:

1. We find out you have committed fraud against us or you have been dishonest with us about some important or material matter. For example, we may request that the State disenroll you from our plan if we find out you gave us wrong or misleading information, you obtained a prescription under false pretenses or you let someone else use your ID Card. We can collect from you the Reasonable and Customary Charges for Covered Services that you received after the effective date of termination and we paid for, plus our cost of recovering those charges (including attorney's fees); or
2. You act so disruptively that you upset our ordinary operations or those of a Participating Provider, including making verbal or physical threats against us or a Participating Provider.

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 11 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.

The State must provide you with a Certificate of Creditable Coverage upon your disenrollment from PHGP's Medicaid Plan.

Section 11 Inquiry and Review

We hope that you are always happy with the service you receive from us. We know, however, that from time to time you may have a problem or concern that 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 616 464-8102. 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. You may contact our Customer Service department for assistance drafting a formal complaint. This formal complaint is handled through our review process. You have 90 days from the date you learn of a problem to file a complaint with us. You can file a complaint to ask us to change a decision about any of the following:

- Benefits (may include experimental or investigational or not Medically/Clinically Necessary or appropriate services)
- Eligibility
- Payment of claims (in whole or in part)
- How we've handled payment or coordination of health care services
- Contracts with our providers
- Availability of care or providers
- Delivery or quality of health care services or

- 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 a Level 1 Review with us. You must file a Level 1 Review within 90 days of an adverse decision or learning of an adverse decision, whichever is later. Our Level 1 Internal Review Committee will meet to discuss your review and we will mail you a written response. Our Level 1 Internal Review Committee is comprised of PHGP employees and a Physician, none of whom were involved in the initial determination or who are subordinates of someone who made the initial decision.

Step 2:

If your Level 1 Review has not been resolved to your satisfaction, you may request a hearing before our Level 2 Internal Review Committee. You must file this request within three days after receiving your Level 1 Review decision. The Level 2 Internal Review 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 the decision of the Level 1 Internal Review Committee or who are subordinates of someone who served on the Level 1 Internal Review Committee.

We will let you know the date and time for the hearing. You may attend the

portion of the Level 2 Review Committee hearing that applies to your review. Within five business days of the hearing, we will send you a written decision.

If you have not yet received the services: Steps 1 and 2 combined must be completed with a final decision made within a total of 30 calendar days after we receive your request for review. Up to 10 business 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. Neither Step 1 nor Step 2 may take more than 15 days, respectively.

If you have already received the services: Steps 1 and 2 combined must be completed with a final decision made within a total of 35 calendar days after we receive your request for review. Up to 10 business 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. Neither Step 1 nor Step 2 may take more than 30 days, respectively.

Step 3:

If you are not satisfied with the resolution of your problem or complaint after completing all the steps of our Review Procedure, you may request a review by the Office of Financial and Insurance Regulation within sixty days of our final decision. Direct reviews to the commissioner at the following address and telephone number:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, Third Floor
P. O. Box 30220
Lansing, MI 48909-7720
877 999-6442
www.michigan.gov/ofir

B. 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 Level 1 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. Steps 1 and 2 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 Office of Financial and Insurance Regulation only after filing a request for “expedited review” with us. If you are not satisfied with PHGP’s resolution of your problem or complaint after completing the “expedited review” procedure, you may appeal within 10 days of our final decision to the Office of Financial and Insurance Regulation.

C. Obtaining Information About the Review Procedure

To obtain a complete copy of our Level 1 Review or “expedited review” Procedures and Level 1 Review Form, or to find out more about your Level 2 review rights, please contact our Customer Service department.

D. 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.

E. Filing a Lawsuit Against Priority Health Government Programs, 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 Grievance Procedure as described in this Section 11. 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.

F. Administrative (Fair) Hearing

We hope that you will give us a chance to respond to your concerns by following our inquiry and review procedure. You do not have to follow this process. You can ask the State of Michigan to review the problem at any time within 90 days of the problem. This is called an Administrative or Fair Hearing. You may call the State of Michigan Recipient Hotline to request the form. Their number is 800 642-3195.

Section 12 Extension of Benefits

We will continue paying for your Covered Services if the Agreement is terminated while you are confined for medical treatment in a Hospital, Long-term Acute Care Facility or Inpatient Rehabilitation Facility. We will Cover such services only if you are confined. We will pay only for the specific medical condition causing that confinement until there is a change in the required level of care which results in a transfer from one type of inpatient facility to another. As soon as one of the following happens, you will stop receiving benefits under this section:

1. You are moved from one inpatient facility to another type of inpatient

facility or experience a similar change in the level of required care.

2. The confinement is no longer Medically/Clinically Necessary.
3. You reach the maximum benefit limits for the Covered Services available for that confinement or condition.
4. You are discharged from the Hospital, Long-term Acute Care Facility or Inpatient Rehabilitation Facility to an alternative care facility such as a Skilled Nursing Facility or Hospice Facility which does not require confinement.
5. Your child becomes eligible for Children’s Special Health Care Services.

Section 13 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. Guidelines to Determine Primary Coverage If You Are Covered by Two or More Plans

1. Medicaid is always the payer of last resort. All other insurance must be billed first.
2. If you have prescription drug coverage under another health plan,

prescription drugs, drugs for cancer therapy and cancer clinical trials will be Covered by your other health plan before Coverage under your Medicaid plan provided by PHGP will apply.

D. Effect on Benefits

Your Medicaid plan provided by PHGP is always the Secondary Payer. In that case, the Primary Payer must pay up to its highest benefit level. When the benefits under the Primary Payer’s plan are reduced because a Covered person did not comply with the provisions of the primary plan, the amount of that reduction will not be considered an Allowable Expense (defined below) for determining our liability. Examples of such provisions include those related to second surgical opinions, pre-approval of admissions or services, and use of Participating Providers.

When we are the Secondary Payer, we will not Cover expenses unless all of the requirements for Coverage under this Certificate have been followed. We will pay for health care only when you follow our rules and procedures, including using Participating Providers and obtaining any necessary Certification from us. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you may only be able to receive benefits from the primary plan. Duplicate coverage will never extend your benefits beyond those available under this Certificate.

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. We are not required to pay claims or coordinate benefits for services that are not provided by Participating Providers, approved by us, or that are not Covered Services under this Certificate unless we tell you otherwise in this Certificate.

For purposes of this Section 13, “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.

E. 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.

F. 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 provided

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.

G. Subrogation and Reimbursement

You or your dependent 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 or your dependent have or had a legal or equitable cause of action against a third party, you assign (or transfer) to us, on your own and your dependent's 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 you or your dependent's shoes and sue a third party directly for you or your dependent's Illness or Injury) and a right of reimbursement (which means

that we have a right to be reimbursed out of any recoveries you or your dependent receive or have received from third parties relating to you or your dependent's 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 provided 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 or your dependent 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 or your dependent receives 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 or your dependent recovers. Our reimbursement claim will be paid before any other claims are paid, whether or not you or your dependent has recovered the total amount of you or your dependent's damages. If you or your dependent receive policy proceeds, settle a claim or action against a third party or receive a judgment, you or your dependent 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 or your dependent) 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 13.G, the terms "you" or "your dependent" include you, your child or other dependent and/or any other person(s) claiming through or on behalf of you or your child, including but not limited to relatives, guardians, heirs, assigns and successors.

Section 14 Medicare and Other Federal or Government Programs

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 13 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 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 effective the first of the month following the initiation of dialysis.

4. Eligibility for Medicare

If you are eligible for Medicare, you must apply for both Parts A and B. 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 PHGP's plan to be secondary to Medicare, our plan will be secondary to Medicare as permitted by that statute or regulation.

Section 15 Definitions

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 assesses and arranges all mental health services for Members. The department is available for assessment 24 hours a day.

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.

Certificate of Creditable Coverage.

A certificate issued to you by the State of Michigan upon termination of Coverage under this Certificate.

Child Placed for Adoption. A child for whom you have custody and for whom you have assumed and retain a legal obligation for partial or total support in anticipation of adoption.

CMH. A (county) community

mental health agency.

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

Copays. The amount you must pay directly to a provider of Covered Services for those services and supplies. You must pay this amount when you receive Covered Services. The Copay amounts are listed in Section 5, Schedule of Covered Services.

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.

DHS. Department of Human Services is the agency of the State of Michigan that operates the eligibility portion of the State's Medicaid program.

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 which is: (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.

Health Professional. An individual who is licensed, certified or authorized under state law to practice a health profession.

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.

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.

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. The services or supplies needed to diagnose, care for or treat your physical or mental condition. The Medical Director, or anyone acting at the Medical Director's direction, in consultation with your PCP, or, for Mental Health services, the Behavioral Health Department, determines whether services or supplies are Medically/Clinically Necessary according to PHGP medical and behavioral health policies or adopted criteria that have been approved by community Physicians and other providers.

Medically/Clinically Necessary services and supplies must be widely accepted professionally by PHGP 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.

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 Government Programs, Inc. Provider Directory.

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

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 Government Programs, 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 Government Programs, Inc (PHGP). A Michigan non-profit corporation and licensed health maintenance organization providing benefits under this Certificate of Coverage.

Reasonable and Customary Charges. The charge for a Covered Service that is the lower of: (a) the provider's usual charge for furnishing the service; and (b) the charge we determine to be the prevailing charge level made for the service or supply in the geographical area where it is furnished. In determining the reasonable charge for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, we may consider things like the complexity of the service, the degree of skill needed, the type or specialty of the provider, the range of services provided by a facility, and the prevailing charge in other areas.

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.

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 an obstetrician/gynecologist for her annual well-woman examination and routine pregnancy services without a referral.

Urgent Care. Services provided at a licensed facility other than a Hospital to treat non-life threatening conditions that require immediate medical attention to limit severity and prevent complications.

Urgent Care Center. A licensed facility, not including a Hospital that provides Urgent Care for the immediate treatment of an Injury or Illness.

We, us or our, or PHGP. Priority Health Government Programs, Inc.

You, your or yourself. The Member who is enrolled in Medicaid provided by Priority Health Government Programs, Inc..

Section 16 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 11.

B. 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.

C. Non-assignment

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

D. 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.

E. 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.

F. 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 17. 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 Government Programs, Inc. (“PHGP”) understands the importance of handling protected health information 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 PHGP or use services provided by one of our plans, your protected health information may be released to us and by us. This information is used and disclosed to coordinate and oversee your medical treatment, pay your medical claims and assist in health care operations. The use and disclosure of your health information ends when your coverage ends, except to pay for services received relating to the time that you were Covered or for certain health care operations of PHGP or our providers.

Federal law requires that we provide you with this Notice of Privacy Practices. This Notice states our legal duties and privacy

practices regarding your protected health information. It also states your rights under these laws with respect to the use and disclosure of your health information. We are required by law to follow the terms of the Notice currently in effect.

Use and Release of Your Health Information

The sections below describe the ways PHGP uses and releases your health information. Your health information is not shared with anyone who does not “need to know” to perform one of the tasks below:

Treatment. We may use your health information or disclose it to third parties to coordinate and oversee your medical care. For example, we may use your health information to help you find a doctor or a hospital that can treat your specific health needs.

Payment. We may use your health information or disclose it to third parties to 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. We may use your health information and disclose it to third parties in order to assist in our everyday work activities such as looking at the quality of your care, carrying out utilization review, confirming benefit eligibility, employee training and review processes, monitoring and auditing activities, and our business management and general administrative duties. For example, your health information may be

released to members of our staff to review the quality of care and outcomes. Your health information may also be released to doctors or doctor groups involved in your care to improve patient care.

Other Permitted or Required Uses and Disclosures

PHGP may also use or release your health information:

- When required by state or federal law and the use or disclosure complies with and is limited to the requirements of such law
- When permitted for law enforcement purposes
- When permitted to be released to government authorities in cases of abuse, neglect or domestic violence (in which case, you will be notified unless the notification would place you at risk of serious harm)
- When permitted for certain public health activities, such as disease control or public health investigations
- When permitted to be released to public health authorities in child abuse and neglect investigations
- When permitted to be released for certain FDA investigations and activities, such as investigations of product defects or to permit product recalls, repairs or replacements
- When permitted to prevent a serious threat to an individual or a community's health and safety
- When permitted by certain court proceedings (either judicial or administrative)
- When permitted for health oversight activities led by governmental agencies and authorized by law
- When permitted to be released about an inmate to a correctional facility, or otherwise permitted for release in law enforcement custodial situations
- When information about a deceased individual is required by a coroner, medical examiner, law enforcement official or funeral director to carry out their legal duties
- When permitted to be released to cadaveric organ, eye or tissue donation and transplant organizations
- For research purposes when the research has been approved by an institutional review board that has reviewed proposals and established protocols to ensure the privacy of your health information
- When authorized by and to the extent necessary to comply with workers' compensation laws
- When permitted for purposes of providing you with treatment alternatives or other health-related benefits and services
- When permitted to be released to the Armed Forces for active personnel
- When permitted to be released to the Veterans Administration for determining if you are eligible for benefits
- When permitted to be released to Intelligence Agencies for national security
- When permitted to be released to the Department of State for foreign services reasons (e.g. security clearance)
- When permitted to be released to Government Agencies for protection of the President

In order to use or disclose your health information in the above ways, we may have to follow additional state and federal requirements. Also, in some cases, we may share your information with one of our "business associates," a person or company that provides certain services to PHGP. In those cases, we will have a contract with the business associate, as needed. This contract will require the business associate to confirm they will keep your health information private.

Disclosures to Health Plan Sponsors

PHGP may share health information with the Michigan Department of Community Health (DCH). The DCH may use this information to develop premium information for health insurance coverage or to decide whether to modify, amend or terminate the plan. We may also share your protected health information to help DCH seek available subsidies.

Other Uses of Health Information – By Authorization Only

Other uses and disclosures of health information not Covered by this Notice or the laws that apply to us will be made only with your written authorization. Some common examples of when Authorization is typically needed for certain releases of information concern mental health issues, substance abuse issues, prenatal and pregnancy related issues, venereal disease or HIV/AIDS and grievance/appeals. We can provide you with a Sample Authorization Form.

If you provide us with an authorization to use or release health information about you, you may end that authorization at any time by writing to PHGP's Compliance Department. (See Contact Information section) If you end your authorization,

we will no longer use or release health information about you for the reasons Covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization.

A parent, legal guardian, or properly named patient advocate may represent you and provide us with an authorization (or may end an authorization) to use or release 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

HIPAA (the federal privacy law) 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.

Confidentiality in all Settings

We have policies and procedures in place that protect the privacy of your information.

- Every employee signs a statement when they are hired that they understand they are required to keep member information private. They also learn about the actions the company will take if the privacy policies are not followed.
- PHGP has strict control of access to electronic and paper information specific to members. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access

is only given to those who need it to manage care for members or for administrative purposes.

We tell all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours.

We review our confidentiality policies and procedures every year. We also review how we collect, use, dispose of and disclose your information. Members (or prospective members) and providers have the right to review PHGP's confidentiality policies and procedures. You may get copies by contacting our Compliance Department. (See Contact Information section)

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. This includes medical and billing records, but does not include psychotherapy notes. There are other limited circumstances in which we may deny your request to inspect and copy under federal and state law. If you are denied access to health information, you may request that the denial be reviewed.

To inspect and copy health information, contact PHGP's Compliance Department in writing. (See Contact Information section)

If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

Right to Amend

You have the right to request that we amend any health information (medical or billing) we have about you. However, we will not amend any record that:

- we did not create (unless there is a reasonable basis to believe that the creator of the information is no longer available to act on the requested amendment)
- is not part of the medical or billing information we have about you
- is not part of information which you would be permitted to inspect and copy
- is determined by us to be accurate and complete

To request that we amend your health information, you must write to our Compliance Department (See Contact Information section) and include a reason to support the change.

Right to Know About Disclosures

You have the right to know when your health information is disclosed to third parties. You can request a list of disclosures going back six years from the date of your request. This list will not include disclosures:

- to carry out treatment, payment or health care operations
- that were made to you
- for national security or intelligence purposes
- to correctional institutions or law enforcement officials
- that were incidental to a use or disclosure that was permitted or required
- that were made with an authorization by the individual
- of a subset of information called a "limited data set"
- that were prior to April 14, 2003

To request a list of disclosures, you must send your request in writing to our Compliance Department. (See Contact Information section) Your request must specify the time period desired. There will be no charge for the first list you request within a 12-month period. There may be a small charge for any further requests. We will let you know of the cost involved and you may choose to stop or change your request at that time before any costs occur.

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 our Compliance Department. (See Contact Information section) In your request, you must tell us:

- what information you want to limit
- whether you want to limit our use, disclosure or both
- to whom you want the limits to apply

We will notify you of receiving your request, either in writing or by telephone, of the restrictions we have put in place.

Right to Request Confidential Communications

PHGP will agree to any reasonable request asking that you receive information from the health plan by different means or at a different location. For us to honor this request, you must clearly state that the disclosure of all or part of that information without the change could be a risk to you.

To request confidential communications, you must make your request in writing to our Compliance Department. (See Contact Information section)

Right to a Paper Copy of This Notice

You have the right to a paper copy of PHGP's current Notice upon request. To obtain a paper copy of this Notice, please call our Customer Service Department. (See Contact Information section) Otherwise, you may also print a copy of this Notice from our website at, priorityhealth.com.

Changes to this Notice

PHGP has the right to change the terms of this Notice. We have the right to make these changes apply to health information we already have about you as well as any we receive in the future. We will always post a copy of the current Notice on our website. You will also receive materially revised Notices within 60 days of their effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with PHGP and/or the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS). To file a complaint with us, please call or send a written explanation of the issue to our Compliance Department. (See Contact Information section) You will not be penalized for filing a complaint.

Contact Information

If you have any questions or complaints, please contact Priority Health Government Programs' Compliance Department or Customer Service Department as noted above at:

Priority Health Government Programs, Inc.
Compliance Department, MS 3230
PO Box 269
Grand Rapids MI 49501-0269
616 942-0954
800 942-0954

If this information is unclear or if you do not understand it, please call us for assistance at 888 975-8102 (for TDD service, please call 616 464-8485).

This Notice is effective: April 14, 2003.

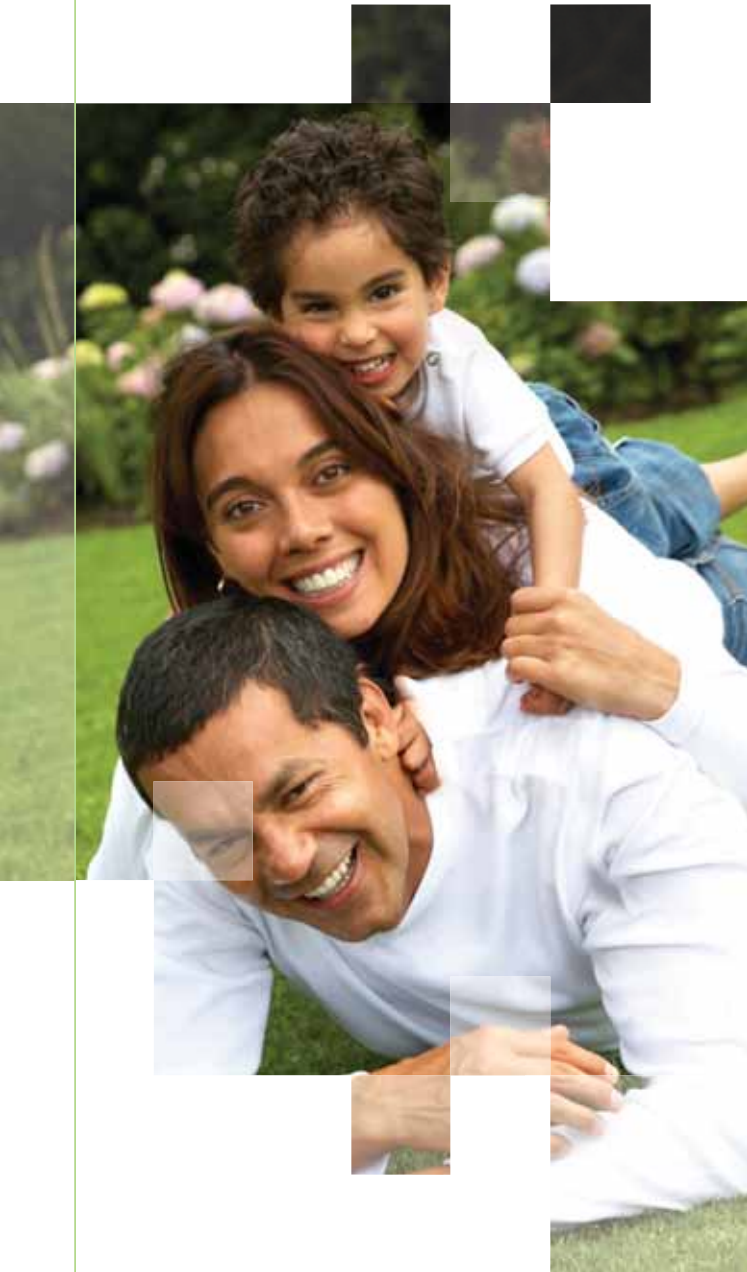
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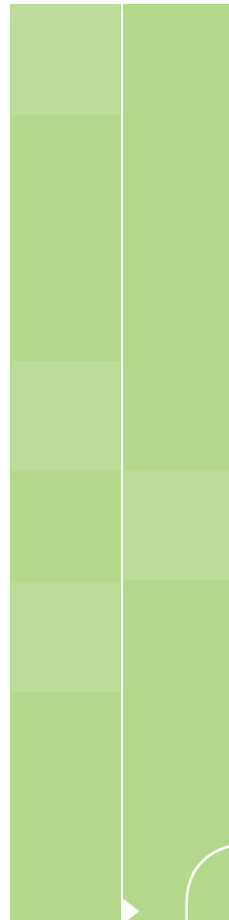
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Understanding your coverage

Preventive health
care guidelines



Preventive services are immunizations, screenings, lab tests and other services that either help prevent illness or help find diseases or medical problems before you experience symptoms.

These guidelines list preventive services covered by your Priority Health plan. For more detailed information, see your plan documents or our website at priorityhealth.com or the federal government list of preventive services at healthcare.gov.



How Priority Health covers preventive services

When services listed are performed for preventive purposes, Priority Health will pay for them as follows:

- If your plan is not grandfathered*, these services will be covered at 100%. You will not need to pay anything.
- If your plan is grandfathered*, these services will be covered at your preventive health care services benefit level. If your plan covers prescription drugs, the drugs listed here will be covered according to your prescription drug rider. If your plan doesn't cover prescription drugs, the drugs listed here aren't covered by Priority Health.

Sometimes a doctor may provide or order these approved preventive services more frequently than suggested in these guidelines. When this happens, these approved preventive services are still considered preventive and your plan's deductible will not apply.

*A plan's grandfathered status under the Affordable Care Act is determined at the first renewal after March 23, 2010, and each renewal after that date. Please ask your employer if your plan is a grandfathered plan. Or you may call our Customer Service department using the phone number on the back of your member ID card.

When are services *preventive*?

Not all tests and screenings that your doctor may recommend for you are preventive services. Tests and services to monitor, diagnose or treat diseases, even if listed here, may not be covered as preventive services in some situations.

If the services you receive are not preventive services, your deductible will apply, along with applicable office visit copays and coinsurance for tests and screening.

Here are some examples:




- If you have a chronic disease, your doctor may run certain tests on a regular basis to monitor your condition. Because these tests are part of managing your illness, they are not considered preventive services.
- If you have a preventive screening and the results indicate a health problem, your doctor may run additional tests to help diagnose the condition or confirm a diagnosis. Such follow-up tests are not considered preventive services.
- If your doctor orders tests based on existing symptoms, these tests would not be considered preventive services.
- If your doctor recommends a screening or test that is not on this list, your deductible and applicable copayments and coinsurance will apply. Sometimes a doctor may recommend a test that is not on this list. In some cases, there is not enough medical evidence to suggest that it has an overall benefit. It's important to talk to your doctor and understand why your doctor thinks a service is right for you.



Examples of preventive and non-preventive services

Before you have a test or screening, it's good to understand if it will be covered as a preventive service in your plan. Remember – if the service is not preventive, your deductible and applicable copayments and coinsurance will apply. The following examples may help.

Colorectal cancer screening

-  If your doctor recommends a routine colonoscopy or sigmoidoscopy to screen for early signs of colorectal cancer based on your age or family history, the procedure is considered a preventive service and is covered under the preventive benefit.
-  If you are having a colonoscopy or sigmoidoscopy for another reason – for example, to diagnose problems with bleeding or irregularity – the service is not considered preventive.
-  If a polyp (an abnormal growth that can sometimes be precancerous) is discovered and removed during your preventive colonoscopy, your doctor will often send the sample to a lab to be tested for cancer. While the screening colonoscopy and removal of the polyp is considered preventive, the pathology testing (if needed) is diagnostic.

continued >

Diabetes screening



A blood glucose test is used to detect whether you have a problem with your blood sugar control, even though you may not have any symptoms. This is a preventive service when screening for diabetes.



If it is confirmed that you have diabetes, your doctor will want to check your glucose control regularly over time using a different test called an “A1c.” This becomes part of monitoring your condition and making sure that your diabetes is under control, and is not considered preventive.

Cervical cancer screening



The pap test is the standard screening procedure for determining if a woman has early signs of cervical cancer. Screening for cervical cancer using the pap test is covered as a preventive service.



Under some conditions, your doctor might recommend that you also get a human papillomavirus (HPV) test, either to diagnose whether an HPV infection may be causing abnormal cells in your cervix or to provide an additional level of screening for cervical cancer. The HPV test is considered diagnostic.

Metabolic panels



Your doctor may recommend that you have a metabolic panel to check certain aspects of your blood chemistry. This test is not considered a preventive service, because there is not enough medical evidence to show that it helps to detect or prevent treatable diseases before symptoms occur. Sometimes this test is done to monitor the effects of a health condition or treatment on different functions in your body. In either case, the test is considered diagnostic.

Get Answers

If you have questions about preventive services, please call the Customer Service number on the back of your Priority Health ID card.

Physical exam frequency

Age	Recommendation
Newborns	Three to five days after discharge
0 to 2 years	Well child visits at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months
3 to 6 years	Routine visit at 30 months. One visit every 12 months for ages 3 to 6 years
7 to 10 years	One visit every 12 to 24 months
11 to 18 years	One visit annually
19 to 21 years	One visit every 2 to 3 years, annually if desired
22 years and older	One visit every 24 months, annually if desired

Immunization vaccines for children from birth to age 18



Immunizations	
Diphtheria, tetanus, pertussis	At ages 2, 4, 6 and 18 months, once between 4 and 6 years, a single dose of Tdap for booster between ages 11 and 12 and subsequently every 10 years
Haemophilus influenzae type B	At ages 2, 4, 6 and 15 to 18 months
Hepatitis A	Two doses at least six months apart at ages 12 to 23 months. From age 2 to 18 years, at physician's discretion: two doses at least six months apart if not vaccinated previously and at high risk
Hepatitis B	Three doses in the first 18 months. (First dose of Hep B to be administered to all newborns before leaving the hospital.) May begin three-dose series age 2 to 18 years if not vaccinated in infancy
Human papillomavirus (HPV)	Three dose series at age 11 to 12 years on a zero, two and six-month schedule for females. Minimum spacing: four weeks between #1 and #2; 12 weeks between #2 and #3; must be 24 weeks between doses #1 and #3
Inactivated poliovirus	At ages 2, 4 and 6 to 18 months, once between ages 4 and 6 years
Influenza	For healthy children receiving the immunization for the first time, ages 6 months to 9 years, two doses separated by four weeks. Annually for children 2 years and older after first immunization
Measles, mumps, rubella (MMR)	Two vaccinations, the first at ages 12 to 15 months. MMR vaccinations should never be given less than one month apart. Second vaccination given between ages 4 and 6 years. After age 7, two doses if not previously vaccinated or no history of disease
Meningococcal	One dose for ages 2 to 10 years if high risk. One dose between 11 to 12 years. One dose 13 to 18 years if not previously vaccinated
Pneumococcal	For all children ages 23 months and younger, four doses at 2, 4, 6, and 12 to 15 months. For ages 2 to 6 years, a single dose, if not immunized previously for healthy children. One additional dose for children with underlying medical conditions who have already received three doses. Vaccinate high risk groups after age 7
Rotavirus	At 2, 4 and 6 months
Varicella	One vaccination between ages 12 and 18 months. Second dose to be given at 4 to 6 years. Two-dose series for children 7 years to adult if no history of varicella and no previous vaccination



Assessments and screenings for children from birth to age 18

Assessments, screenings and counseling	
Alcohol and drug use assessments	All adolescents, during each visit for age 11 to 18 years
Anticipatory guidelines as defined by Bright Futures	For all children at physician discretion
Autism screening	Children at 18 and 24 months
Blood pressure	Beginning at 3 years
Cervical dysplasia/cancer screening	At start of sexual activity for females
Chlamydia infection, gonorrhea and syphilis screenings	All sexually active adolescents to be screened for sexually transmitted infections (STIs)
Congenital hypothyroidism screening	Newborns
Depression screening and behavioral assessments	Children of all ages
Developmental screening	Children under the age of 3 to be checked at 9, 18 and 30 months
Dyslipidemia screening	Risk assessment at 2, 4, 6, 8 and 10 years old, then annually through age 21. (Routine lab testing not recommended, but may be done for children identified as high risk)
Gonorrhea preventive medication	For the eyes of all newborns
Hearing screening	All newborns, 4, 5, 6, 8 and 10 years. After 11 years if at high risk
Height, weight and body mass percentile measurements	Height and weight at each visit up to 2 years. Starting at 2 years body mass percentile at each visit
Hematocrit or hemoglobin screening	Once at 12 months, once between ages 11 and 21, once annually for menstruating adolescents
HIV screening	Annually for adolescents at high risk
Lead screening	Children at risk of exposure. Risk assessment for lead exposure between ages 6 and 12 months and again at 24 months and assess for risk between ages 2 to 6. Blood tests for those identified as high risk
Medical history	All children throughout development
Newborn screenings as identified by the federal Health Resources and Services Administration	Once at birth, screenings include but are not limited to PKU and sickle cell screenings
Obesity screening and physical activity and nutrition counseling	6 years and older
Oral health risk assessment	12, 18, 24 and 30 months. 3 and 6 years
Sexually transmitted infection (STI) prevention counseling	Adolescents at higher risk, anticipatory guidance at physician discretion for ages 11 to 18 years
Tuberculin testing	Children at high risk of tuberculosis
Urinalysis	Once between ages 11 and 21
Vision screening	3, 4, 5, 6, 8, 10, 12, 15 and 18 years

Immunization vaccines for adults



Immunizations	
Hepatitis A	For high risk groups
Hepatitis B	For high risk groups
Herpes zoster	One dose at age 60 and older
Human papillomovirus	Three dose series at age 19 to 26 years on a zero, two and six-month schedule for females. Minimum spacing: four weeks between #1 and #2; 12 weeks between #2 and #3; must be 24 weeks between doses #1 and #3
Influenza	Annually
Measles, mumps, rubella (MMR)	One to two doses if not vaccinated previously or no history of disease. For high risk groups age 40 years and older
Meningococcal	For ages 19 to 24, one dose if not vaccinated previously. For high risk groups 24 years and older
Pneumococcal	For high risk groups under age 65. One after age 65
Tetanus, diphtheria and pertussis (Td/Tdap)	Every 10 years (One dose of Tdap if pertussis booster was not received previously) After 65 Td alone
Varicella	Two-dose series for adults if no history of varicella and no previous vaccination





Assessments and screenings for adults

Assessments, screenings and counseling	
Abdominal aortic aneurysm screening	Men between ages 65 and 75 who have ever smoked, a one-time screening for abdominal aortic aneurysm
Alcohol misuse screening	All adults at physical exam
Anticipatory guidance for family and intimate partner violence, breast self-exam, menopause counseling, safety, injury prevention	At physician discretion for all adults
Bacteriuria (urinary tract or other infection screening)	Pregnant women
Blood pressure screening	All adults at physical exam
Breast feeding counseling	Interventions to support and promote breast feeding for new mothers
Cervical dysplasia/cancer screening	Start screening at beginning of sexual activity or at 21, whichever is first. Annual screening up to age 30. For ages 30 and older, screening every two to three years. Suggest stopping at 70 if three or more normal Pap tests in a row, no abnormal Pap test in previous 10 years and not at high risk
Chlamydia infection, gonorrhea and syphilis screenings	All sexually active adults to be screened for sexually transmitted infections (STIs)
Colorectal cancer screening	Adults over 50. Beginning at age 50, one of the following screening options: <ul style="list-style-type: none"> • Fecal occult blood test annually • Flexible sigmoidoscopy every five years • Colonoscopy every 10 years. Those with a family history (first degree relative) of colorectal cancer or adenomatous polyps: begin screening at age 40 or 10 years before the youngest case in the immediate family. Colonoscopy every five years. Consider stopping screening at age 75. Use individual consideration between ages 75 and 85. Screening is not recommended for individuals older than 85
Counseling for breast cancer chemoprevention	Women at high risk
Counseling related to BRCA screening	Women at high risk
Depression screening	All adults, during each physical exam
Diabetes screening	Fasting plasma glucose test every three years in adults with hypertension or hyperlipidemia
Diet counseling	Adults at higher risk for chronic disease
Height, weight and body mass percentile measurements	All adults during physical exam
Hematocrit or hemoglobin screening	Once every two years for adults
Hepatitis B screening	Pregnant women at their first prenatal visit
HIV screening	Annually for adults at high risk
Iron deficient anemia screening	On a routine basis for pregnant women

continued >

Lipoprotein profile	For all adults age 20 and older, a fasting lipoprotein profile (total cholesterol, LDL, HDL and triglyceride) once every five years
Mammography	Women ages 40 to 49, every one to two years. Annually for ages 50 and older
Obesity screening and counseling	All adults
Osteoporosis screening	Once every two years as a part of physical exam (does not include bone density test) for women 40 to 64 years old. Bone density test beginning at 65, or at 60 for women at risk
Rh incompatibility screening	All pregnant women on first visit and follow-up testing for women at higher risk
Sexually transmitted infection (STI) prevention counseling	Adults at higher risk
Tobacco use screening	All adults during each visit (includes cessation interventions for tobacco users) expanded counseling for pregnant tobacco users
Tuberculin testing	Adults at higher risk of tuberculosis
Urinalysis	Once between ages 11 and 21

Drugs (prescription required)

Prescription	Recommendation
Fluoride supplements	Children without fluoride in their water source
Folic acid supplements	Women who may become pregnant
Iron supplements	Children ages 6 to 12 months at risk for iron deficiency anemia
Low-dose aspirin therapy for the prevention of cardiovascular disease	Men ages 45 to 79 years, women age 55 to 79 years and others with risk factors. Consult your doctor before beginning aspirin therapy

Note: *The drugs listed above are provided at no charge for non-grandfathered plans. If your plan is grandfathered, the drugs listed here will be covered according to your prescription drug rider. If your grandfathered plan doesn't cover prescription drugs, the drugs listed here aren't covered.*

The Preventive Health Care Guidelines were approved by Priority Health network physicians.

***For physician use only:** Specific EPSDT requirements may vary from the guidelines.*

Please refer to the online Provider Manual to review the EPSDT periodicity chart for the mandated health screening program for Medicaid recipients younger than age 21.

References:

American Academy of Family Physicians

American Academy of Pediatrics

American Cancer Society

American College of Obstetricians and Gynecologists

American College of Physicians

American Medical Association

Centers for Disease Control

National Cancer Institute

U.S. Preventive Services Task Force, U.S. Public Health Service

Healthcare.gov

Go to ahrq.gov/clinic/prevenix.htm for a complete list of evidence-based preventive services and risk factors from USPSTF.

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