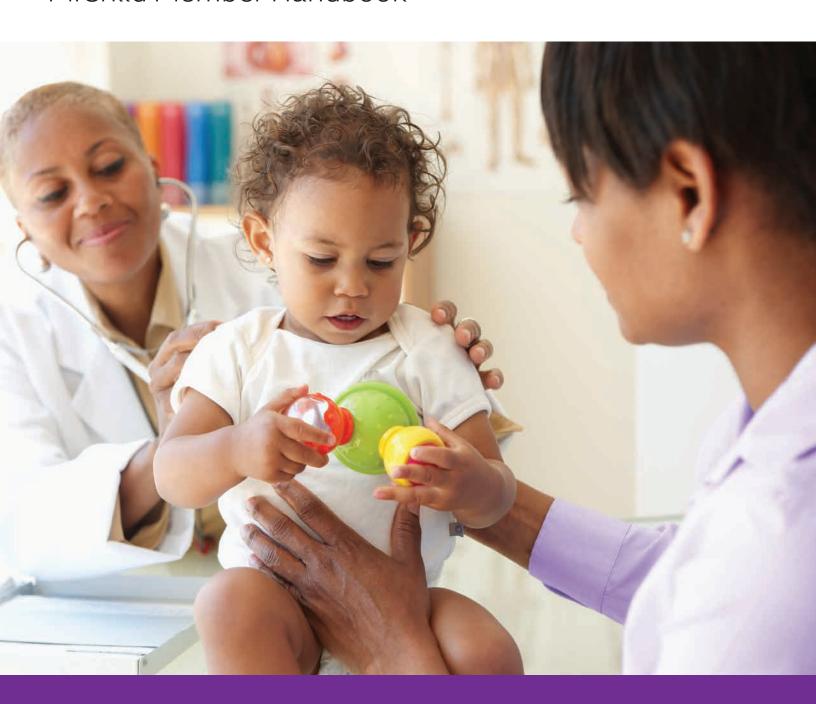


# **AETNA BETTER HEALTH® OF MICHIGAN**

MIChild Member Handbook



### **Important information**

Aetna Better Health of Michigan Member Services Department 1333 Gratiot Ave., Suite 400 Detroit, MI 48207

Member Services 1-866-316-3784 (TTY 711)

MIChild Help Line 1-888-988-6300

**24 Hour Nurse Line** 1-866-711-6664 (TTY 711)

Emergency 911

Vision (VSP) 1-800-877-7195

### Personal information and contact list

My member ID number	
Primary care provider (PCP)	
My PCP's phone number	



### **AETNA BETTER HEALTH® OF MICHIGAN**

Welcome and thank you for choosing Aetna Better Health of Michigan as your child's health plan. We have a strong network of doctors, hospitals and other health care providers. They offer a wide range of services to meet your child's health care needs.

It is important that you understand how our plan works. This Member Handbook has information you need to know about your child's MIChild benefits. Please take the time to read it carefully. You can also download a copy from our website **www.aetnabetterhealth.com/michigan**.

Our Member Services department is always ready to answer your questions. Call **1-866-316-3784** (**TTY 711**), Monday - Friday, 8 a.m. to 5 p.m.

We look forward to serving you and your family.

Sincerely,

**Executive Director** 

Bendy S. Aller

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# Section 1: Important information about your child's MIChild coverage

### About your child's coverage

If you need to contact someone about your child's coverage, please contact:

Aetna Better Health of Michigan

Member Services Department

1333 Gratiot Avenue, Suite 400

Detroit, MI 48207

1-866-316-3784, TTY 711

Get answers to your medical questions 24/7, just call the 24 Hour Nurse Hotline at **1-866-711-6664**, TTY **711**. They'll help answer questions about your child's symptoms and tell you what you need to do.

Please make sure you read and understand the complaints/grievance and appeals procedures in this Handbook. Please read it before taking any other action.

To file a complaint, grievances or appeals contact us at:

Aetna Better Health of Michigan Attn: Appeals Coordinator 1333 Gratiot Avenue, Suite 400 Detroit, MI 48207

1-866-316-3784

### **Communication and translation services**

We want to make sure you understand your benefits. Members Services can help if you:

- Have problems hearing
  - Call TTY **711**
  - We can arrange for interpreters for situations requiring communication between hearing and deaf persons.
  - If you need a sign language interpreter, we can arrange this service.
- Have vision problems
  - You can request this Handbook in another format including Braille or on tape.
- Have problems reading
  - You can request another format or an interpreter.
- Do not speak English
  - You can request translated materials in another language.

#### Interpreter services

If you do not speak or understand English, call **1-866-316-3784** to ask for help. We will get you an interpreter when needed. All Interpreter services are free.

### Other languages spoken at provider offices

If you speak a language other than English, please check our provider directory for a provider who speaks your language. If you need a free provider directory, we easily can mail you one. Just call Member Services at **1-866-3784**, TTY **711**. You can also go to **www.aetnabetterhealth.com/michigan** for a provider list. For the most up-to-date information, just visit our website and select "Find a Provider."

#### Other insurance and coordination of benefits

#### Does your child have other insurance?

If your dependent has more than one type of insurance coverage, please notify us. We may manage benefits so your child can get the highest payment on claims.

Your child may be eligible for coordination of benefits if:

- He or she has health care or prescription drug coverage through some other type of insurance, such as automobile, home owners or workers' compensation
- He or she is covered by Medicare
- He or she is covered by coverage through their other parent's health care plan
- Your spouse is employed and has coverage through his or her employer

Call Member Services at **1-866-316-3784** or call the MIChild Help Line at **1-888-988-6300** so that we can work together to insure your child has full service coverage.

### Extra Aetna Better Health of Michigan benefits

- The Disease Management Program helps members learn how to manage certain chronic conditions such as:
  - Asthma
  - COPD
  - Diabetes
  - Congestive heart failure

- Chronic renal failure
- High risk pregnancy
- Hypertension

• Preventive Health Education and Reminder Mailings

- Member Advisory Board is a committee that allows us to hear from members about how we can better serve you. For more information, call Member Services at **1-866-316-3784, TTY 711**.
- Unlimited calls to your PCP's office with a free cell phone from Assurance Wireless. Call Member Services for details.

### Benefits available from the State of Michigan

The State of Michigan covers some services that Aetna Better Health of Michigan does not. You can call MIChild Help Line at **1-888-988-6300** to learn how to get these benefits and services:

- Routine Dental services
  - If you need help finding a dentist, call the MIChild Help Line at 1-888-988-6300 or Member Services at 1-866-316-3784
- Inpatient and Outpatient Services for Behavioral Health
- Behavioral Health and Substance Use Disorder Services are the responsibility of the Behavioral Health and Developmental Disabilities Administration (BHDDA) and Coordinating Agencies (CA)
- Services provided by a school district and billed through the Intermediate School District
- Substance Use Disorder services through accredited providers include:
  - Screening and Assessment
  - Detoxification
  - Intensive Outpatient Counseling and Other Outpatient Services
  - Methadone Treatment

### Women, Infants and Children (WIC)

WIC is a food supplemental program for young women and children. This means that WIC helps you save on groceries so you have more to spend on other things your family needs. You may qualify if:

- You have a child under age 5
- You are pregnant or breastfeeding

WIC is a free service to families who qualify. WIC offers health education, nutrition information and coupons. The coupons are for free healthy food. **Some of our medical offices offer WIC services**.

WIC also offers referrals for medical and dental care, health insurance, childcare, housing utility help and other services that can benefit the whole family.

You can participate in WIC if you:

- Have a nutritional need
  - WIC staff can help you determine this

- Have a family income within WIC guidelines or have Medicaid coverage
- Have a child less than 5 years of age, are pregnant, recently had a baby or are breastfeeding a baby

To learn more about WIC or make an appointment, call **1-866-230-6419**.

### **Children Special Health Care Services (CSHCS)**

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

Aetna Better Health of Michigan members who have CSHCS get additional benefits.

- Help from your local Health Department with:
  - Community resources, schools, community mental health, respite care, financial support, childcare,
     Early On and the Women, Infants and Children program (WIC)
  - Transitioning to adulthood services
- Help from the Family Center for Child and Youth with Special Health Care Needs
  - Call the CSHCS toll-free Family Phone Line at **1-800-359-3722**, Monday-Friday from 8 a.m. to 5 p.m.
  - Parent-to-parent support network
  - Parent/Professional training programs
    - Financial help to go to conferences about CSHCS medical conditions and "Relatively Speaking," a conference for siblings of children with special needs
- Help from Children's Special Needs Fund (CSN). The CSN Fund helps CSHCS families get items not covered by Medicaid or CSHCS. To see if you qualify for help from the CSN Fund, call **1-517-241-7420**. Examples of help include:
  - Wheelchair ramps
  - Van lifts and tie downs
  - Therapeutic tricycles
  - Air conditioners
  - Adaptive recreational equipment
  - Electrical surge upgrades for eligible equipment
- Services that are not covered by Aetna Better Health and are only covered by CSHCS include:
  - Orthodontia services provided for certain diagnosis\*
  - Respite Services\*
  - Certain over-the-counter medications
  - Hemophilia drugs
  - Certain Orphan drugs

For members enrolled in MIChild and CSHCS, MIChild is the primary payer and CSHCS is secondary.

<sup>\*</sup> These services will be coordinated by the Local Health Department

# Section 2: Rights and responsibilities

### Your child's rights and responsibilities

# As a member or Parent/Guardian of a member of MIChild Aetna Better Health of Michigan, you and your child have the right to:

- Choose a Primary Care Provider (PCP) as his or her personal medical provider
- Be treated with respect and dignity
- Be assured his or her personal information is kept private and confidential (See Notice of Privacy Practices)
- Seek advice and help
- Make recommendations about our members' rights and responsibilities policy
- · Work with doctors in making decisions about his or her health
- Get information about his or her health, PCP, our providers and Aetna Better Health services and members' rights and responsibilities
- Discuss all treatment options for his or her condition, regardless of cost or benefit coverage
- Receive information about his or her rights and responsibilities as an Aetna Better Health Member
- Know about a diagnosis, treatment and prognosis
- Get prompt and proper treatment for physical and emotional problems
- Receive discharge planning
- · Receive quidance and suggestions for more medical care if health care coverage is ended
- Access his or her medical records in accordance with state and federal law
- Voice grievances, complaints and appeals and offer suggestions about Aetna Better Health and/or the services we provide
- Get information about how their PCP is paid. If you need more information, call Member Services at 1-866-316-3784
- Request an emergency PCP transfer if his or her health or safety are threatened
- Request information on how the health plan operates and its structure.

Our staff and participating providers will comply with all requirements concerning enrollee rights.

# As a member or Parent/Guardian of a member of MIChild Aetna Better Health of Michigan, you also have responsibilities. These responsibilities include:

- Giving information to the Plan, its Practitioners and Providers needed for our staff to take care of you
- Following the instructions given to you by your doctors
- Understanding your health condition and sharing in the decisions for your health care
- Treating Aetna Better Health staff and doctors with respect and dignity
- Keeping all appointments and calling to cancel them when you cannot make them
- · Understanding what medicine to take

- Giving us feedback about your child's health rights and responsibilities
- Letting us know of any changes in your name, address or telephone number

Members have a responsibility to follow the Aetna Better Health guidelines. Failure to follow our guidelines could result in a request for disenrollment from the Plan.

### Reporting fraud, waste and abuse

You have a right and responsibility to report instances of suspected fraud, waste and abuse. Fraud involves getting benefits or services that were not approved. Waste is spending that can be eliminated without reducing the quality of care. Abuse is doing things that result in unneeded costs.

Provider fraud may include billing for services, procedures, or supplies that were not provided. Waste may include inefficient claims processing and health care administration. Abuse may include providing treatment or services that are not needed to treat an illness.

An example of member fraud would be using changed or forged prescriptions. An example of member abuse would be frequent requests for early prescription refills. An example of member waste would be unnecessary Emergency Room (ER) visits.

If you suspect a provider, member, or someone else of fraud or abuse, you can report it without giving your name. You should call our Fraud and Abuse Hotline at **1-866-806-7020**. You may also write to us:

Aetna Better Health of Michigan 1333 Gratiot Avenue, Suite 400 Detroit, MI 48207

#### Member rights and treatment

Members who are 18 years and older have rights under Michigan law regarding their preferred medical care. If the Member is 18 years old or older, he or she is allowed to make decisions about his or her own medical care. The Patient Self Determination Act protects members' rights regarding preferred medical care. This means people who are 18 years and older can make decisions about their own medical care. This includes the right to accept or refuse medical or surgical treatment. You must put your desires in writing in advance.

## Advance Directives (Michigan's Durable Power of Attorney for Health Care)

An advance directive is a written advance care planning document that explains how medical decisions should be made for a patient who is unable to make or express his or her wishes concerning health care. The Durable Power of Attorney for Health Care (DPAHC) is the form of advance directive recognized by the Michigan

Department of Health and Human Services (1998, Public Act 386). This lets a patient choose another person to make decision about their care, custody and medical treatment if they cannot make these decisions for themselves. This way, a person's desire to accept or refuse medical treatment is honored when they cannot make that choice themselves.

#### **According to Michigan Law**

Anyone **age 18 or older**, and of sound mind, may have a DPAHC in case something happens to them and they cannot make decisions for themselves.

This act allows a person to select a relative or other person as their patient advocate to make medical treatment decisions for them.

- He or she may change the person they appoint as their advocate at any time.
- He or she may write on the form the types of treatment they do and do not want.
  - If a member writes on the form that they want their patient advocate to order doctors to withhold or withdraw life-sustaining treatment in certain situations, the doctors must honor their wishes.
- You should keep a copy of your DPAHC with you at all times.

For complaints about how Aetna Better Health follows your wishes, write or call:

Bureau of Health Professions (BHP), Grievance & Allegation Division P.O. Box 30670 Lansing, MI 48908-8170

1-517-373-9196 or e-mail bhpinfo@michigan.gov or BPLHelp@michigan.gov

Visit BHP, Grievance & Allegation online at www.michigan.gov/healthlicense or www.michigan.gov/bpl

### How your child's doctor is paid

You can request information about how Aetna Better Health of Michigan pays its doctors. If you would like to know more, just call Member Services at **1-866-316-3784**. You have a right to learn how we pay our doctors and what that means to your child.

You can also get the following information about our providers:

- License information
- Qualifications and education
- What services need authorization

We don't prevent our providers from:

- Speaking on our member's behalf
- Discussing treatment and services
- Discussing payment arrangements between the provider and the plan

We do not pay our providers or encourage them in any way to withhold or deny medical care or services. Decisions about your child's health care are based on medical needs. If you have any questions, you can call Member Services at **1-866-316-3784**.

Aetna Better Health and its providers cannot refuse care on the basis of pre-existing health conditions, creed, age, national origin, handicap, sexual preference or cost of medical treatment.

### How does Aetna Better Health make sure providers are qualified?

We makes sure when you child receives care, it's from a qualified doctor. Our doctors meet certain education and experience standards. We require our network of doctors to give you high quality health care services. You can get more facts about your child's doctor's education or clinical qualifications by calling Member Services at **1-866-316-3784**.

# Section 3: Enrollment and eligibility

#### **Enrollment**

Michigan's Medicaid Enrollment Broker, MI ENROLLS is available to assist you with enrollment in a health plan. You can reach them at **1-888-367-6557** or **1-800-975-7630**. Once your child becomes our member, we will help you to sign up with an in-network provider (if you did not already choose one when you enrolled your child in our plan through MI ENROLLS). MI ENROLLS is also there to help you if there are problems with your enrollment in a health plan.

#### Causes for disenrollment

Your child can be disenrolled from the plan. Here are some reasons why your child can be disenrolled:

- Moving out of our Service Area
- Unable to verify United States Citizenship
- Child no longer meets the age limits
- Failure to pay Premiums

You can ask your child to leave a health plan:

- For any reason in the first 90 days of being a health plan member or after the state sends you a Notice of Enrollment
- During annual Open Enrollment
- If you and your child's PCP believe that your child is not receiving the care they need

### Change of address or other status changes

It's important for us to get in touch with you. If you change your address or telephone number, call Member Services at **1-866-316-3784** to let us know of these changes. You will also need to call the MIChild Help Line at **1-888-988-6300** (Hearing Impaired call **1-888-263-5897**) if you move. If you move outside the Aetna Better Health of Michigan service area, your child may be disenrolled. You also need to let Aetna Better Health and MIChild know of other changes such as if your child's name changes, if your child joins the military or if your child goes to prison.

#### Member ID card

When your child becomes a member of Aetna Better Health of Michigan, he or she will get a Member ID Card. An ID card is needed to get most services. You will want to carry this card with you at all times. If you lose your child's ID card, call Member Services at **1-866-316-3784**. Member Services will send you another card.



In case of an emergency go to the nearest emergency room or call 911.

IMPORTANT NUMBERS FOR MEMBERS

 Member Services
 1-866-316-3784

 Behavioral Health Crisis Line
 1-866-827-8704

 24 Hour Nurse Line
 1-866-711-6664 (TTY 711)

 Hearing Impaired
 TTY 711

IMPORTANT NUMBERS FOR PROVIDERS

Pharmacy 1-855-432-6843
Eligibility 1-866-316-3784
Authorization 1-866-874-2567 (24 hours)
Behavioral Health 1-866-827-8704
Emergency admissions, elective admissions and outpatient surgery must be preauthorized.

**Submit claims to** PO Box 66215, Phoenix, AZ 85082-6215

Payer ID 128MI

MICHILD1

#### Your child's Member ID card includes:

- Your child's Name
- Your child's Member ID number
- Your child's Primary Care Provider (PCP) name or Health Center
- Your child's PCP's phone number

All covered family members will have their own ID card. Only the person on the card may use it for service. You and/or your child may be asked to show a picture ID when using the ID card. This is to make sure no one else is using your child's ID Card.

#### A new card will be sent to your child if you:

- Change or correct the spelling of your child's name
- Call because your child's card is lost or stolen
- · Change your child's or Health Center

# Section 4: Getting help

#### **Member Services**

Aetna Better Health of Michigan has a toll-free line for Member Services **1-866-316-3784**. The Member Service staff will help you:

- Select or change your child's Primary Care Provider (PCP) or doctor
- Understand how to use the plan and how it works
- Change your child's address or phone number
- Get an ID card

- Get an address or phone number for a PCP or Specialist doctor
- Get claims or billing information
- Get benefit or coverage information
- File a grievance or appeal

You can reach Member Services at **1-866-316-3784**, Monday – Friday, 8 a.m. to 5 p.m. You can also visit us online at **www.aetnabetterhealth.com/michigan** to get answers to most of your questions.

If you do not speak English, we have someone to help you. We have oral interpretation services. We have a Spanish speaking Member Service Representative to help you. All other languages are assisted by the use of our language line. If you are hearing impaired please use our TTY line **711**. There is no cost to use the interpretation services or language line.

### **Member Web Portal and Health Management Tools**

MyActiveHealth is an easy way to take charge of your health. So you can feel better- for good. And as a member of Aetna Better Health, you'll get MyActiveHealth at no cost to you. To access the site, just sign into your secure member portal at **www.aetnabetterhealth.com/michigan**. Once signed in, you can:

- Keep track of health records
- · Get help for health goals like quitting smoking and weight management
- Sign up for digital health coaching program
- Find information on healthy lifestyle program
- View health and wellness videos and podcast
- Access the member portal and MyActiveHealth from any device-computer, tablet or smartphone.

Aetna Better Health (MyActiveHealth) also offers members help with the use of an online tool to get and ask for services. You and your family can ask questions, make changes, or get information about your child's health benefits. You can:

- · View medical and pharmacy claims
- See if your child is active with Aetna Better Health (eligibility)

- See your child's benefits
- View authorizations and referrals
- Check hospital quality ratings
- Print, view and request ID cards
- Ask benefit questions
- Change your child's PCP (Primary Care Provider)
- Update your address and phone number
- Notify us of other insurance
- Request member materials
- View service requests
- Get information on our Quality Improvement Program (QIC)

### **Care Management programs**

Aetna Better Health of Michigan offers a Care Management program to help members with health needs. This is a voluntary program that allows you to talk with a nurse about your child's health care. The nurse can help you learn more about your child's health needs and teach you how to better manage their care. Our nurses are friendly and will help you get the care you need.

#### **Complex Care Managed program**

If your child has a complex health issue such as HIV, Sickle Cell Anemia or Heart Disease, our Complex Care Management program can help you. Our nurses will work with you and your child's doctors to make sure they get needed medical care. If you would like more information, call Member Services at **1-866-316-3784**.

### **Disease Management program**

Our Care Manages are available to help members learn how to manage certain chronic conditions. These include Asthma, Diabetes Hypertension and High Risk Pregnancy. Members may ask to be enrolled into the program or the Plan may enroll them based on information provided by doctors and hospitals. If your child is placed in this program and you do not want them to be in the program, call Member Services at **1-866-316-3784.** 

### **Pregnancy program**

Prenatal care and postpartum care is important for a healthy baby and mom. Aetna Better Health offers this program to help pregnant members have a healthy pregnancy and a healthy baby.

It's important for your teen to visit her OB/GYN doctor as soon as she knows that she's pregnant. Her doctor may have her come in for six or more visits during her pregnancy. Try to ensure that she make all of her visits. Our outreach staff can help her make prenatal and postpartum appointments. If she is high risk, she may want to talk to our High Risk OB Care Manager nurse. If you would like to learn more on our Pregnancy Program call our Outreach Department at **1-855-737-0770**.

#### **Social Worker services**

Aetna Better Health of Michigan also has a Social Worker to help with you and your child's medical and mental health needs. If you need help, call Member Services at **1-866-316-3784**.

The Social Worker services include but are not limited to:

- Education and support about Medicaid benefits
- Outreach to members with health conditions to connect them with providers and agencies that provide treatment and help
- Information and referrals to government and community support services

### **Lead Screening program**

Children are at risk if they come in contact with lead. Lead can be found in older homes. It has been found in the paint, soil, clay products, pipes and solder. All children should be tested for lead exposure at ages 1 and 2. All children over age 3 who have not been tested should be tested. Children should also get a lead screening at least one time between the ages of 3 and 6.

Those children who are at risk or who are high risk will need to be checked more often. These children should be tested at least one time per year. Children who are high risk are those with a history of lead poisoning or those who live in old homes or apartments. Our program provides the lead level testing, tracks your child's levels and will make sure they have follow-up care from their Primary Care Provider (PCP).

### **Authorization questions**

If you have specific questions about an authorization, you can call Member Services at **1-866-316-3784**, TTY **711**. They can help answer your questions or they will get a nurse who can help answer your questions. Our nurses are available during normal business hours. After business hours you can call our 24 hour nurse line at **1-866-711-6664**, TTY **711**. Of you do not speak or understand English, interpreter services are available.

# Section 5: Using your child's benefits

### **Choosing and changing your child's Primary Care Provider (PCP)**

Your child's PCP is the health care provider who takes care of all your child's health needs. When possible, they're the first person you should contact if your child needs health care. You'll need to choose a PCP for your child as soon as they join our plan.

Your child's PCP will see him or her for well care checkups and medical problems. Your child's PCP is his or her medical home. Having a medical home helps make sure the right medical care is available when your child needs it. Get to know your child's PCP. If your child has a new PCP, call and make an appointment, even if he or she is not sick. Your child's PCP will learn about your child's overall health, this will help him prevent future illness. You'll find a list of PCPs in our Provider Directory. You can ask Member Services for a list or search for providers on our website at **www.aetnabetterhealth.com/michigan**. Just select "Find a Provider" at the top of any page. You can choose one of the following doctor types as your child's PCP:

- General Practice doctor
- Family Practice doctor
- Internal Medicine doctor

- Pediatric doctor
- OB/GYN doctor
- Nurse Practitioner

If your child has a chronic health condition like diabetes or end stage renal disease (ESRD), you may need a specialist to take care of him or her as your PCP. Member Services can help you with this decision. Just call **1-866-316-3784**.

Your child may also get services from a Federal Qualified Health Center (FQHC), a Rural Health Center (RHC), a Child and Adolescent Health Center (CAHC) or at Tribal Health Center (THC) for primary care. These centers can be in or out of our network.

When you select Aetna Better Health of Michigan, your child must have an in-network PCP. You may choose your PCP. If you do not, one is chosen for them. Your child's PCP will manage his or her health care needs. You can change your child's PCP at any time for any reason. If you need help locating or changing your child's PCP, call Member Services at **1-866-316-3784**. You can also do this online through the Member web portal. Most changes will take effect on the first of the next month.

Your child's PCP will help you get the health care services he or she needs. When your child needs care:

- Call and make an appointment as soon possible
- Take your Child's Aetna Better Health ID card with you to the appointment
- Arrive on time

If you cannot keep your appointment, call and cancel it as soon as possible.

### Seeing a Specialist

If your child needs to see a specialist his or her PCP will arrange for these services for you. Your child's PCP is the best person to help you locate the right specialist for his or her needs. If your child needs to see an OB/GYN or a Pediatrician, you can choose one from our provider list and take them on your own. They will not need a referral or approval to see an OB/GYN or Pediatrician. Your daughter can get regular OB/GYN care without seeing her PCP first. If your child needs to see a doctor that is not in our network, Aetna Better Health must approve it first. Your child's PCP will work with the Plan to make sure he or she gets this care.

Other medical services, equipment and supplies may require an authorization by Aetna Better Health. If you have questions on what services require authorization, you can call Member Services at **1-866-316-3784**.

Tell your PCP when your child is receiving care from any other doctors. You may get a list of our specialists from Member Services at **1-866-316-3784**. You can also find them on our website at **www.aetnabetterhealth. com/michigan**.

### Behavioral Health services / Mental Health providers

MIChild members will receive Behavior Health services through their local Behavioral Health and Developmental Disabilities Administration (BHDDA) at no cost. If your child needs help finding a provider, call the MIChild Help Line at **1-888-988-6300** or Member Services at **1-866-316-3784**. Behavioral Health and Substance Use Disorder pharmacy services are covered when:

- Prescribed by an in-network provider
- Or BHDDA or the Coordination Agency (CA)
- And listed (included) in the Aetna Better Health pharmacy formulary

#### **Substance Use Disorder services**

MIChild members must use their local Behavioral Health and Developmental Disabilities Administration (BHDDA) for help with substance use disorders. There is no cost for this service.

Services include:

- Screening and assessment
- Detoxification

- Outpatient counseling and other services
- Methadone

If your child needs help finding a provider, call the MIChild Help Line at **1-888-988-6300** or Member Services at **1-866-316-3784**.

### Getting the care your child needs

It's important to be prepared and to understand where to go and when to go for medical care before your child needs care. This helps you get the right care at the right time and at the right place. Use the information below to help guide you to the right place of care for your child's medical needs. Remember to go to the emergency room only for true emergencies. Be sure to know the difference between a medical emergency and a situation where your child should see their PCP or an urgent care clinic.

#### **Primary Care – your child's Primary Care Provider (PCP)**

If your child has a cough, sore throat, rash or other medial concern, call to schedule an office visit. Your child's PCP should provide most of his/her care. This includes regular checkups, care for medical problems and follow up care.

#### 24-Hour Nurse Line

The best place to start when you have a question about your child's health is our **free** 24-Hour Nurse Line at **1-866-711-6664**. You'll speak to a registered nurse who will give you quick answers and expert advice about your child's health. They'll help you decide what to do next, have your child see their doctor, go to the emergency room or they may help you treat the problem at home. Our 24-hour Nurse Line is open for our members 24/7. Our nurses speak English and Spanish. Interpreters are available for other languages.

#### After hours care or urgent care

For non-emergency care after normal business hours, you should call your child's PCP. The PCP will provide instructions for getting the care your child needs. If you cannot reach the PCP, our 24-Hour Nurse Line can help you. Urgent care clinics are places you can go when your child cannot see their PCP. They treat conditions that need immediate attention. These conditions are not life threatening. You should not use urgent care clinics for routine care. You should schedule your child's routine care with their PCP.

#### **Emergency care**

Aetna Better Health will cover all emergency services without prior approval when a person, acting reasonably, believes they have an emergency.

Your child should get emergency care when he or she has severe pain or a serious illness or injury that will cause death or disability if not treated at once. Examples are:

- Chest pains or heart attack
- Choking or breathing problems
- Poisoning

- Broken bones
- A lot of bleeding or bleeding that will not stop

Call **911** or go to the nearest hospital emergency department for care.

Your child's PCP must arrange all follow-up care. Always bring your child's Aetna Better Health ID card with you when going to the hospital. Never go to the Emergency department for routine care.

#### Care 'out of state' or 'out of the area'

If your child is out of town and has a medical emergency or needs urgent care, go to the nearest urgent care center or emergency department for care. The hospital or urgent care center may call Aetna Better Health for authorization to treat your child. Remember to make an appointment with your child's PCP after all emergency or urgent care visits.

#### **Hospital services**

All hospital services, except emergency care, must be approved or arranged by your PCP or Aetna Better Health. There may be some exceptions. Call Member Services if you have questions about a hospital stay or visit.

### Getting a second opinion

You may want a second opinion about an illness or surgery to confirm the treatment or care your child's PCP says they need. If you need help getting a second opinion, talk to your child's PCP. You can also find help through Member Services. Just call **1-866-316-3784**, TTY **711**. There is no additional cost to you for the second opinion from an Aetna Better Health provider. Second opinions from an out-of-network provider will require pre-authorization from Aetna Better Health.

### **Section 6: Covered services**

Aetna Better Health of Michigan covers the following services. We will cover these services if they are medically needed. Medically needed services include the tests to find out if your child is ill or injured, medical care to treat your child if they're ill or injured and preventive care to help your child avoid becoming ill or injured. Medically needed services must:

- Be appropriate
- Meet your child's basic health care needs
- Be given to your child in an appropriate and cost–effective way
- Be the services that medical research and science guidelines recommend
- Be used to treat his/her health condition
- Not be experimental

#### **Covered services**

See your Certificate of Coverage for details on these benefits:

- Abortion (to save the life of the mother or in cases of rape or incest)
- Acupuncture therapy
- Ambulance services and other emergency medical transportation
- Blood lead testing in accordance with the protocols recommended by the American Academy of Pediatrics and the Centers for Disease Control
- Certified Pediatric and family Nurse Practitioner services
- Chiropractic services
- Diagnostic Lab, x-ray and other Imaging services
- Doctor's office visits
- Durable medical equipment and supplies
- Emergency services
- Family planning services (no prior authorization required)
- · Health education
- Hearing & speech services
- Hearing aids
- · Home health care
- Hospice services (if requested by the member)
- Immunizations (shots) (no prior authorization required)
- Inpatient and outpatient hospital services (including consultations)
- Midwife services
- Oral surgery (Limited Benefit)
- Out-of-state services authorized by the Plan
- Outreach for included services, especially, pregnancy related and well-child care
- Peritoneal Dialysis services

- Pharmacy services including medications for ADD and ADHD as well as other psychotropic, substance
  use disorder medications
- Physician and other professional provider services
- Behavioral health services consistent with physician scope and practice
- Prosthetics & orthotics
- Second surgical opinion
- Skilled nursing facility
- Therapeutic services (speech, physical, occupational)
- Tobacco cessation including pharmaceutical and behavioral support
- Transplant services
- Transportation (emergency transportation only)
- Treatment for sexually transmitted diseases (STD) (no prior authorization required)
- Vision services
- Weight loss counseling for morbid obesity
- Well-child/EPSDT for persons under age 19

To learn more about your child's benefits and limits, just call Member Services at **1-866-316-3784**. You'll find a more detailed description of some of your child's benefits below. Review your child's Certificate of Coverage for more details on benefits, limits and exclusions.

### **Emergency transportation**

If your child needs a ride to the hospital for emergency medical services, dial **911**. Ambulance services are covered when required for a trip to or from the hospital, a skilled nursing facility or member's home.

### **Medical equipment**

When your child needs a wheelchair, walker, crutches, or a brace, see your child's PCP. The doctor will arrange for your child to get this equipment from an Aetna Better Health provider. The doctor may also give your child a prescription for the equipment. You can take this prescription to an Aetna Better Health medical equipment provider. If you need help with this, just call Member Services at **1-866-316-3784**.

#### **Vision services**

Eye care services are provided through our eye doctors. If your child needs glasses or an eye exam, just call **1-866-316-3784** or call a provider from our list of vision providers. For medical eye problems, talk with your child's PCP.

### **Hospice services**

Hospice Services are covered for any member who has six months or less to live. Hospice gives support to you and your family. Hospice care and curative treatment for the terminal illness can be given at the same time. If you would like more facts on hospice, you can call **1-866-316-3784**.

### **Prescription services**

Your Aetna Better Health benefits include coverage for prescriptions. You can fill your child's prescriptions at over 65,000 pharmacies nationwide and at over 1,900 in Michigan. Aetna Better Health uses a closed formulary, which means that only drugs listed on the formulary are covered (except with prior approval in special circumstances).

**Coverage for ADD/ADHD medication and other psychotropic medications are included with some restrictions.** For more information on the formulary or drugs that require our prior approval, call Member Services at **1-866-316-3784**. If your child needs a prescription filled, present his or her Aetna Better Health ID card with the prescription at any participating pharmacy.

### **Hearing services**

The diagnosis or treatment of diseases or conditions of the ears is covered when authorized by the PCP. Hearing and speech services and supplies are covered for the following, limited to a maximum of once every thirty-six months (36 months must have passed since the Member's last hearing examination, hearing test, or hearing aid was paid for by the Plan):

- Audiometric examination and hearing aid evaluation testing by a participating provider
- The purchase and fitting of a hearing aid, including one follow-up visit.

Repairs, maintenance and replacement batteries for hearing aids are not covered.

#### Orthotic and/or Prosthetic services

When your child needs Orthotic and/or Prosthetic services their PCP or specialist can arrange this service from an Aetna Better Health provider. The doctor may also give your child a prescription for the orthotic or prosthetic services. You can take this prescription to an Aetna Better Health provider. If you need help with this, just call Member Services at **1-866-316-3784** or speak with our nurse care manager. Member Services will help you get to the right person.

#### **Dental services**

Routine Dental Services are covered by the Michigan Department of Health and Human Services not Aetna Better Health. If your child needs help finding a dentist, call the MIChild Help Line at **1-888-988-6300** or Member Services at **1-866-316-3784**.

#### Health education

We want to help our members stay healthy. It's important that your child sees their PCP for regular checkups eats right and exercises regularly. If your child is pregnant, it's important that she sees her doctor for prenatal care immediately. Your child should not drink alcohol or smoke, especially if she is pregnant. Also, children should receive all of their shots and well-child visits. We can help you take care of your child through preventive care services such as:

- Regular checkups and exams for your child
- Vision and Hearing screenings
- Routine Pediatric Shots (immunizations)
- Family Planning Services
- Nutrition Education and Counseling
- Prenatal and Postpartum services
- Screening examination, including childhood immunizations for children from birth to age 19
- Health Education services

### If you receive a bill

Let Aetna Better Health know if you receive a bill for your child's care for any covered services. Call Member Services at **1-866-316-3784** or send the bills to Aetna Better Health right away. Do not throw it away or ignore it. Let us know if your child actually received the services listed on the bill; also include a brief description of the service. Don't forget to give us a phone number; we may need to contact you if we have any questions. Send to:

Aetna Better Health of Michigan

Attn: Member Services

1333 Gratiot Avenue. Suite 400

Detroit, MI 48207

#### Other insurance

If your child has any other health insurance, Aetna Better Health needs to know. To update your child's insurance information, call Member Services at **1-866-316-3784**.

### Member out of pocket costs (Copays)

Your child will not have any copays or deductibles with Aetna Better Health of Michigan benefits. Aetna Better Health will pay for all of your covered services. There are no copayments, deductibles, or any other out of pocket cost for covered services. You should not sign or agree to pay for any services that are covered by the health plan. You may be required to pay for services if you ask for your child to receive services that are **not** covered by Aetna Better Health.

### New medical technologies

Aetna Better Health reviews new technologies to see if they can be used for our members. Our doctors look at new treatments as they become available to see if they should be added to our benefit plan. We review the services area listed below at least once a year:

- Medical services
- Behavioral Health services
- Pharmacy
- Medical equipment

### Section 7: General services not covered

#### Services not covered by Aetna Better Health of Michigan

- Any health care provided outside of the service area and not authorized by the Plan (except Emergency Services)
- Cosmetic services and surgery
- Dental services (except as specified in the certificate of coverage)
- Elective termination of pregnancy (abortion) and related services
- Fees, costs and expenses incurred by a person who donates an organ or tissue (unless the recipient is a Plan Member and the donor's health plan does not cover the expenses)
- Non-emergency transportation
- Personal comfort items such as telephone, television and similar items
- Testing to determine parentage or DNA testing

#### Other exclusions are listed in the Certificate of Coverage.

If you have questions on whether a procedure is covered, talk with your child's PCP or call Member Services at **1-866-316-3784**, TTY **711**.

# Section 8: Emergency services and urgent care

When an unexpected illness or injury occurs that is not an emergency your first choice should be to call your child's PCP. When this is not possible, there are other choices for care. It's important to recognize a true medical emergency and be familiar with other choices. You do not need permission to go to the emergency room. If your child needs medical care that is urgent, but not an emergency call your child's PCP. Your child's PCP will have 24 Hour seven days a week coverage. You can also call our 24-Hour Nurse Line at **1-866-711-6664**. You'll find help from a registered nurse who can answers your health care questions.

You do not need permission to go to the emergency room.

### **Medical emergency**

A medical emergency is a serious medical condition resulting from an injury or illness. Emergencies arise suddenly and unexpectedly. They require immediate care and treatment to avoid placing your child's health in serious harm. Examples of a medical emergency include:

- Chest pain
- Unconsciousness (blacking out)
- Poisoning
- Severe cuts or burns
- A serious accident

- Trouble breathing
- Sudden onset of severe pain
- Convulsions or seizures
- Severe or unusual bleeding
- Any vaginal bleeding in pregnancy

If you're ever in a medical emergency go immediately to the nearest emergency room at the nearest hospital. If you need help getting your child to an emergency room fast, call **911**.

### Prudent layperson and emergency services

A Prudent layperson is a person who does not have medical training but who uses their practical experience to make a decision regarding whether or not emergency medical treatment is needed. A prudent layperson will be considered to have acted reasonably, if another layperson would have made the same decision in the same situation. Aetna Better Health uses this guideline when they cover emergency services based on symptoms.

### **Urgent care**

Urgent care is for an unexpected illness or injury, which is not life threatening but requires fast medical attention. After-hours care facilities are available in some areas for medical conditions not considered a medical emergency.

Examples of urgent care include:

- Most broken bones
- Cuts
- Burns

- Sprains
- Mild to moderate bleeding

Examples of conditions that are not usually urgent or require emergency care:

- Colds and Flu
- Sinus Congestion
- Headaches

- Sore Throat
- Rash
- Toothache

# Section 9: Routine screening, testing and cancer-related checkups

### Well-child visits and important screening tests

### Keep your children healthy at any age

Even if children aren't sick, they need to see the doctor regularly. Well-child visits can help children stay healthy. Screening tests can find diseases early when they are easier to treat.

Follow the schedule below to know how often to take your child to the doctor for a well-child visit. These visits may include screening tests. Your child's doctor can give these tests on schedule, as long as you bring your child in regularly according to the schedule. If your child has missed some well-child visits, don't worry, but don't delay.

Children should get check-ups regularly. The first well-child visit will be in the hospital when your baby is born. You must set up a well-visit with your child's PCP when your child is:

• 3-5 days old

• 1 month old

• 2 months old

4 months old

• 6 months old

9 months old

• 12 months old

• 15 months old

• 18 months old

24 months old

• 30 months old

Set up annual well-child visits with your child's PCP beginning at the age of 3.

Schedule for well-child visits*		
Child's age	When to visit	
Up to 2 years old	At 2 to 4 weeks of age	
	At 2 months of age	
	At 4 months of age	
	At 6 months of age	
	At 9 months of age	
By 1 year of age, your child should at least	At 12 months of age	
have 5 well-child visits.		
	At 14 to 15 months of age	
	At 16 to 19 months of age	
	At 23 to 25 months of age	
3 to 7 years old	Every year	
At ages 8 – 11	During each of these years	
12 to 21 years old	Every year	

<sup>\*</sup>A different schedule may be used. Ask your pediatrician.

Screening test	Why it's performed	When it should be done			
<b>Evaluation and screening</b>	Evaluation and screening may vary, based on your doctor's judgment.				
Health history	To check for certain illnesses that may run in your family. To discuss any new health problems your child has.	First visit and updated at all visits.			
Complete physical	Important measurements will be checked such as height, weight and blood pressure (3 years old and up). If your child is under 2, his or her head circumference will be measured periodically.	Portions of this test are done at all visits.			
Growth & development assessment	To make sure your child's growth is right for his or her age. To help your doctor learn how your child speaks, thinks, moves and relates to others.	Portions of this test are done at all visits.			
Nutrition discussion	To make sure your child is eating a healthy diet.	All visits.			
Hearing & vision screening	To check for hearing and vision problems.	Every year for children ages 3 to 11. Beginning at age 12, every other year through age 21.			
Immunizations (shots)	To protect your child from disease.				
Lab tests	To check for serious diseases and conditions. Sexually active adolescents will be routinely offered pregnancy and HIV testing as appropriate. Screening for sexually transmitted diseases will also be done once sexual activity has begun.	Lead: 1 and 2 years old; more often if you live in a community with high lead levels.  Sickle cell: Part of newborn screening done between 2 and 4 weeks.  Anemia: Done at 9 months and all visits from 2 years old on.  Tuberculosis: Between 1 to 2 years of age; 3 to 10 years of age and 11 to 21 years of age.			
Health education & counseling	The doctor will discuss childcare, nutrition and safety to help your child stay healthy. At later ages, he or she will talk to your child about school, friends and family experiences, as well as explain the dangers of smoking, drug and alcohol use and unsafe sex.	Done at all visits in different ways, depending on your child's age.			

#### **Immunizations**

Immunizations (shots) are needed to help the body fight disease. It's important for your child to get their shots on time. Children must have a record of these shots in order to begin school. **You'll be required to provide a record of your child's shots when you enroll them in school.** 

Some of the recommended immunizations for children aged 0-18 years include:

- Measles
- Mumps
- Rubella
- Diphtheria
- Tetanus
- Pertussis (Whooping Cough)

- Polio
- Varicella (Chickenpox)
- Hepatitis B
- Human Papillomavirus (HPV)
- Meningitis

Set up an appointment with your child's PCP for this service.

### Immunization program

Our immunization program helps parents get their children the shots they need. You may get a call or a letter reminding you it's time for your child's shots. We also print reminders and information about shots or immunizations on our website and in our newsletters.

### **EPSDT (Early Periodic Screening, Diagnosis and Treatment)**

EPSDT is a special health program that covers health screening and treatment for members age 19 and younger. The EPSDT program providers regularly schedule health checkups, test and immunizations that are appropriate for your child's age. It also provides the care needed to treat any health problems found during an EPSDT checkup. Routine EPSDT checkups are a good way to keep your child healthy. These checkups are important because some children may look healthy and feel well and still have health problems. EPDST checkups include:

- Health history and Physical Exam, including school and sports physicals
- · Hearing, Vision and Dental screening
- Crucial Lab Tests, including Lead screening
- Immunizations to help prevent illness
- Health Education
- Developmental/behavioral assessment

Make sure to set up your child's EPSDT checkup with their PCP.

### **Preventive Services for young women**

Our Members may see any Aetna Better Health OB/GYN doctor without a referral.

- Female members who are sexually active should have a pap smear every year to screen for cervical cancer.
- Female members, age 16 and older, who are sexually active, should have a Chlamydia test every year and be screened for Sexually Transmitted Diseases (STD).

### **Family Planning services**

Aetna Better Health of Michigan covers family planning services. Services include:

- Counseling to help your child decide when to have children
- Providing information and prescriptions for birth control
- Providing treatment for Sexually Transmitted Diseases (STD)

Your child does not need a referral to get family planning services. Your child can get family planning services from any doctor or clinic.

# Section 10: Grievance and appeals

### Complaint, grievance and appeal procedures

We want to keep our members happy. We know there are times when members have questions or concerns about the service that they receive. When this happens, feel free to call Member Services at **1-866-316-3784**. We'll try to clear up any concerns as quickly as possible. If you're still not happy, we have procedures for addressing your concerns. For a more complete explanation of the complaint, grievance and appeal process, look to your Certificate of Coverage. You may also call Member Service at **1-866-316-3784** or go to our website at **www.aetnabetterhealth.com/michigan**.

#### What is the Grievance and Appeals Program (GAP)?

You may occasionally encounter problems with the Plan, you may have difficulty scheduling appointments, there may be long wait times in your child's doctor's office, the quality of service may not be as expected, you may have a disagreement with one of your child's care providers, or your child may have a denial of service. Member Services resolves most Member concerns during the initial call or within three business days. However, if this is not the case, the Plan has a formal process for dealing with problems you encounter. It's called the Grievance and Appeals Program (GAP).

### What is a grievances or appeal?

A **grievance** may occur when you are upset about the quality, availability, or delivery of services that your child received. You may file an appeal if Member Services does not resolve your grievance or you are not happy with the decisions covering or paying for services. It is your right to ask us to investigate your concern or to review our decision.

### How can I file a grievance or appeal?

You can mail or deliver your grievance or appeal to: Aetna Better Health of Michigan ATTN: Appeals Coordinator 1333 Gratiot Avenue, Suite 400 Detroit, MI 48207

If you send your child's grievance or appeal to us in writing, we'll send you a letter within three days of receiving your grievance or appeal letting you know we have it. Aetna Better Health staff reviewing your grievance/ appeal will not have been previously involved in any prior decisions about your grievance or appeal. Aetna Better Health will make sure that the staff reviewing your grievance has the necessary qualifications to review your grievance or appeal.

## When can I ask for a grievance or appeal?

You have 90 calendar days from the date that we made the decision that you are unhappy with. This may be the date on the "Adverse Action Notice" that you receive. You can start the process by calling Member Services. You must follow up with a letter. If you need help filing your child's grievance or appeal, Member Service can help you. With your permission, someone else may ask for a grievance or appeal on your child's behalf. This person can be a friend, a relative, a doctor or an attorney. This person known as an Authorized Representative.

You can file an appeal before you have a service, if you already know that we will not cover or pay for the service. You can also file an Appeal after you have received a service and we have declined to cover it. If you wish to present a grievance or appeal or to contact the Appeals Coordinator, call the following toll free telephone number: 1-866-316-3784.

Your Appeal request should include:

- Name
- Aetna Better Health ID number
- Date of Birth
- Details on the matter you want reviewed (include types of services or disputed claims) and explanation of why we should reverse our decision with copies of any information that will support your request
- When you were scheduled to receive services, or when you received the services
- Name of Provider(s) that ordered services
- If you have an authorized representative, you should also send us the Authorized Representative Form
  - We cannot begin to review ¬your appeal until we receive the Authorized Representative form
  - If you send the Authorized Representative form to us during the 90 day timeframe that you have to send us a grievance or appeal, we will start to process your appeal
  - If we do not get the form in the 90 day timeframe, we will close your appeal

We may tell you that we need more time to look at your grievance or appeal or obtain additional information from your treating provider. If it's in your best interest, we will only use up to 10 more days to review your grievance or appeal. We will only do this if it is in your best interest.

Within five working days of receipt of your grievance or appeal, the Appeals Coordinator will send a letter to you or your child's authorized representative letting them know that we have received the grievance or appeal. We will send written notice of our decision to you or your child's authorized representative within 30 calendar days after your grievance or appeal is received.

# **Expedite (fast) urgent grievance/appeals**

You or your child's authorized representative (which may include the treating provider) may file an urgent grievance or appeal in writing or orally concerning an urgent care claim. If your treating provider asks for an urgent grievance or appeal for your child, we will treat it like an urgent grievance or appeal. If you ask us for an

urgent grievance or appeal but your child's doctor does not send us information about that request, we will check to see if it is really an urgent grievance or appeal. If it is not an urgent grievance or appeal, we will handle it like a regular grievance or appeal and send you an answer in 30 days.

Your grievance or appeal should include:

- Name
- Aetna Better Health ID number
- Date of Birth
- Details on the matter you want reviewed (include types of services or disputed claims) and explanation of why we should reverse our decision with copies of any information that will support your request
- Date of service
- Name of Provider(s)
- If your child has an authorized representative, other than your child's doctor, you should also send us the Authorized Representative Form with the authorized representative's mailing address and telephone number within the first 48 hours. If you cannot send the form because of an emergency or because of your health, we will go ahead with your grievance or appeal and talk with your Authorized Representative if it's in your best interest. We will only talk to your authorized representative about your grievance or appeal.

You will be notified if there aren't enough facts provided with the urgent grievance or appeal. We will notify you or your child's authorized representative by phone of the facts needed.

If you or your child's Authorized Representative asks for more time when we are looking at your urgent grievance or appeal, the grievance or appeal will have to be moved to the regular 30 day timeframe. We will send you a letter within 2 days to tell you this. If you or your child's Authorized Representative want us to look at the grievance or appeal quickly again, you can ask us to do so and we will give you an answer within 72 hours.

When the information is received, a hearing will be scheduled with an Appeal Committee. The hearing will take place within 48 hours of your request. Your grievance or appeal will be resolved within 72 hours of your request. If the facts are not received, the Appeal Committee will make a decision based on the information available.

# Your child's rights - continuing your child's benefits

During the time that we are processing your child's grievance or appeal due to an Adverse Determination or while your child's PRIRA review is pending, your child may be entitled to continuation of benefits. If the denial is upheld, you may be responsible for payment of these benefits. Please refer to Section 10.4 of your Certificate of Coverage for more information.

# Your child's rights -- Patient Right to Independent Review Act (PRIRA)

Your child has the right to use the PRIRA process. You can send a PRIRA appeal to the Michigan Department of Insurance and Financial Services (DIFS):

- After you have used our Grievance and Appeal program and we have sent you our final decision for a non-urgent appeal. You must request a PRIRA review within 60 days of your receipt of our final decision; or
- When you ask us for an urgent grievance or appeal regarding an Adverse Determination and we do not think it is urgent; you must request PRIRA review within 10 days from when we tell you it is not urgent; or
- When you ask us for an urgent grievance or appeal regarding an Adverse Determination, you can also ask for an expedited PRIRA appeal within 10 calendar days of filing with us.

You should use the "Health Care Request for External Review Form" that we provide to you. This form can also be found on online at: www.michigan.gov/documents/cis\_ofis\_fis\_0018\_25078\_7.pdf.

To qualify for PRIRA review:

- Your child must have received an Adverse Determination and a final decision from Aetna Better Health (except in urgent cases explained above);
- Your child must have been covered by us on the date of service in question;
- The service you requested for your child must reasonably appear to have been a Covered Service in the Certificate of Coverage; and
- Your child must have exhausted their grievance/appeal rights with us except in the case of an urgent/expedited grievance or appeal.

If an expedited PRIRA review is required, DIFS will finish it within 72 hours after your written request was submitted. If you need help completing the "Health Care Request for External Review Form," call Member Services at **1-866-316-3784**.

Your PRIRA review request can be sent by fax to **1-517-284-8838**, or you can mail it by UPS or U.S. Mail to:

DIFS, Healthcare Appeals Section Office of General Counsel P.O. Box 30220 Lansing, MI 48909-7720

Delivery Service to:

Office of General Counsel – Health Care Appeals Section Department of Insurance and Financial Services 530 W. Allegan St., 7th Floor Lansing, MI 48933-1521 Your PRIRA review request must include a copy of the Final Adverse Determination from Aetna Better Health of Michigan, any pertinent documentation about your case, such as bills, benefits explanations, medical records, correspondence, research materials that support your position, etc.

It's your responsibility to submit this documentation; DIFS does not contact medical providers for this information. You should always send copies; not the originals.

You do not need to hire a lawyer to request a PRIRA review. You can authorize someone to act on your behalf, such as a clergy, a friend, a family member, your doctor, or a lawyer.

DIFS will notify you within five business days of receiving your request for PRIRA review if they decide to review your case. If DIFS accepts your case for review, DIFS may tell you that it needs to get a recommendation from an Independent Review Organization. An Independent Review Organization is an entity that can perform an unbiased medical review of your case. If DIFS does not need to consult with an Independent Review Organization, you can expect to receive a decision from DIFS within 14 calendar days after your request was accepted by DIFS for review. If DIFS has to consult with an Independent Review Organization, the Independent Review Organization has 14 calendar days after it receives the case from DIFS to make a recommendation to DIFS. DIFS then has seven business days to issue its decision to you.

If you disagree with DIFS' decision, you can appeal to the Circuit Court of the county in which you live, or the Circuit Court of Ingham County.

PRIRA review does not apply to issues of termination or cancellation.

If you have questions about PRIRA reviews, you can call the Appeals Coordinator at **1-866-316-3784** or DIFS at **1-877-999-6442**.

# Section 11: Confidentiality and privacy

## Medical records

A Member, Parent, Guardian or Authorized Representative of a Member may review the records of the Plan relating solely to the Member, or a Minor Dependent of the Member who is also a Member, at the offices of the Plan. This review must be during regular business hours and be at an appointed time agreed to by the Plan and requested by the Member for that purpose. The Plan must reasonably grant such requests.

# Your child's privacy matters

We respect your privacy, we respect your child's privacy. As required by the Health Insurance Portability and Accountability Act (HIPAA), Aetna, and each member of the Aetna family of companies (an "Affiliate"), is sending you important information about how your medical and personal information may be used and about how you can access this information. **Please review the following Notice of Privacy Practices carefully.** If you have any questions, please call the Member Services number on the back of your membership identification card.

# **Notice of Privacy Practices**

Para recibir esta notificación en español por favor llamar al número gratuito de Member Services (Servicios a Miembros) que figura en su tarjeta de identificación.

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.

#### What do we mean when we use the words "health information?"

We use the words "health information" when we mean information that identifies you. Examples include your:

- Name
- Date of birth
- Health care you received
- Amounts paid for your care

### How we use and share your health information

**Help take care of you:** We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care. This could be doctors or drug stores. If you are no longer with our plan, with your okay, we will give your health information to your new doctor.

**Family and friends:** We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information, call us at **1-866-316-3784**.

If you are under 18 years of age and don't want us to give your health information to "your parents", call us at **1-866-316-3784**. We can help in some cases if allowed by state law.

**For payment:** We may give your health information to others who pay for your care. Your doctor must give us a claim form that includes your health information. We may also use your health information to look at the care your doctor gives you. We can also check your use of health services.

**Health care operations:** We may use your health information to help us do our job. For example, we may use your health information for:

- Health promotion
- Case management
- Quality improvement

- Fraud prevention
- Disease prevention
- Legal matters

A care manager may work with your doctor. They may tell you about programs or places that can help you with your health problem. When you call us with questions we need to look at your health information to give you answers.

# **Sharing with other businesses**

We may share your health information with other businesses. We do this for the reasons we explained above. For example, you may have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We will tell them if you are in a motorized wheelchair so they send a van instead of a car to pick you up.

## Other reasons we might share your health information

We also may share your health information for these reasons:

- Public safety To help with things like child abuse. Threats to public health.
- Research To researchers. After care is taken to protect your information.
- Business partners To people that provide services to us. They promise to keep your information safe.
- Industry regulation To state and federal agencies. They check us to make sure we are doing a good job.
- Law enforcement To federal, state and local enforcement people.
- Legal actions –To courts for a lawsuit or legal matter.

## Reasons that we will need your written okay

Except for what we explained above, we will ask for your okay before using or sharing your health information. For example, we will get your okay:

- For marketing reasons that have nothing to do with your health plan.
- Before sharing any psychotherapy notes.
- For the sale of your health information.

• For other reasons as required by law.

You can cancel your okay at any time. To cancel your okay, write to us. We cannot use or share your genetic information when we make the decision to provide you health care insurance.

### What are your rights

You have the right to look at your health information.

- You can ask us for a copy of it.
- You can ask for your medical records. Call your doctor's office or the place where you were treated.

You have the right to ask us to change your health information.

- You can ask us to change your health information if you think it is not right.
- If we don't agree with the change you asked for. Ask us to file a written statement of disagreement.

You have the right to get a list of people or groups that we have shared your health information with. You have the right to ask for a private way to be in touch with you.

- If you think the way we keep in touch with you is not private enough, call us.
- We will do our best to be in touch with you in a way that is more private.

You have the right to ask for special care in how we use or share your health information.

- We may use or share your health information in the ways we describe in this notice.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- We don't have to agree. But, we will think about it carefully.

You have the right to know if your health information was shared without your okay.

- We will tell you if we do this in a letter.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- We don't have to agree. But, we will think about it carefully.
- You have the right to know if your health information was shared without your okay.
- We will tell you if we do this in a letter.

#### Call us toll free at 1-866-316-3784 (TYY: 711) to:

- Ask us to do any of the things above.
- Ask us for a paper copy of this notice.
- Ask us any questions about the notice.

You also have the right to send us a complaint. If you think your rights were violated write to us at:

Aetna Better Health of Michigan Attn: Member Services 1333 Gratiot Avenue, Suite 400 Detroit, MI 48207

You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address.

If you are unhappy and tell the Office of Civil Rights, you will not lose plan membership or health care services. We will not use your complaint against you.

# **Protecting your information**

We protect your health information with specific procedures, such as:

- Administrative. We have rules that tell us how to use your health information no matter what form it is in written, oral, or electronic.
- Physical. Your health information is locked up and is kept in safe areas. We protect entry to our computers and buildings. This helps us to block unauthorized entry.
- Technical. Access to your health information is "role-based". This allows only those who need to do their job and give care to you to have access.

We follow all state and federal laws for the protection of your health information.

## Will we change this notice

By law, we must keep your health information private. We must follow what we say in this notice. We also have the right to change this notice. If we change this notice, the changes apply to all of your information we have or will get in the future. You can get a copy of the most recent notice on our web site at **www.aetnabetterhealth. com/michigan**.

# **Section 12: Certificate of Coverage**

# Aetna Better Health® of Michigan MIChild Program Certificate of Coverage

Effective October 1, 2015

Welcome to Aetna Better Health of Michigan.

We are extremely pleased to have You as a Member in Our health plan and look forward to serving You. We have built a strong network of area physicians, hospitals, and other providers to offer a broad range of services for Your medical needs.

As an Aetna Better Health of Michigan Member, it is important that You understand the way Your benefits and coverage operates. This Certificate of Coverage contains the information You need to know about Your coverage with Us. You should also review the enclosed MIChild Member Handbook, which contains important information about Your coverage with Us. The Certificate of Coverage and Member Handbook are also on our website at **www.aetnabetterhealth.com/michigan**.

Please take a few minutes to read these materials and to make Your covered family members aware of the provisions of MIChild coverage. Our Member Service Department is available to answer any questions You may have about Your coverage. You can reach Member Service at **1-866-316-3784**, Monday through Friday, 8 a.m. through 5 p.m., EST.

We look forward to serving You.

Bend S. Aller

Sincerely,

**Executive Director** 

# Aetna Better Health of Michigan MIChild Certificate of Coverage

The Agreement between Aetna Better Health of Michigan Inc. (hereafter called the "PLAN", "We", "Us", or "Our") and You and, if applicable, Your Dependents as Members of the PLAN (hereafter called "You" or "Member") is made up of this Certificate of Coverage, and any amendments (collectively "this Agreement" or "the Agreement").

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to this Agreement unless approved in writing by an officer of the PLAN, and the resulting waiver, change, or amendment is attached to the Agreement. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the rules and regulations of the PLAN.

**THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY.** Many of the provisions of this Agreement are related to each other; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement have special meanings. These words will appear capitalized and are defined for You in Section 1 of this Agreement, "Definitions." By using these definitions, You will have a clearer understanding of Your coverage.

From time to time, this Agreement may be amended. When that occurs, We will notify you by U.S. mail. The amended agreement or new Certificate of Coverage will be placed on our website at **www.aetnabetterhealth.com/michigan**. If you would like a copy mailed to you, you may contact Member Service at **1-866-316-3784**. You should keep this document in a safe place for Your future reference.

This Agreement and all riders attached to it contain the terms and provisions pursuant to which medical and hospital services will be arranged for by the PLAN to Members (as defined below) eligible for such Coverage (as defined below) under the Michigan MIChild program ("MIChild program").

# **SECTION 1.0 DEFINITIONS**

- **1.1 ADVERSE DETERMINATION** means the PLAN's denial or limited authorization of a requested service, or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Determination also includes (a) the failure to provide services in a timely manner, (b) any entire or partial reduction, suspension, or termination of a benefit or previously authorized service, or (c) failure to act within specified timeframes when addressing appeals and grievances. An Adverse Determination based, in whole or in part, on medical judgment includes the failure to authorize or cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate.
- **1.2** <u>APPEAL</u> means a Member's request, or a request on behalf of Member by an Authorized Representative, to review an Adverse Determination or a payment/reimbursement denial. For purposes of this Certificate of Coverage, Appeals due to Adverse Determinations and Appeals due to denial of payment shall all be referred to as "Appeals" and handled in the same manner.
- **1.3 ATTENDING PHYSICIAN** means any Physician responsible for managing the Member's care during a hospitalization or institutionalization.
- **1.4 BUSINESS DAY** means Monday through Friday, except those days identified by the state as a holiday.
- **1.5 CHRONIC** means a health condition that is prolonged or lingering in duration.
- **1.6 CO-PAYMENTS** mean those amounts that must be paid, if any, by a Member as a condition for receiving certain Covered Services according to this Agreement.
- **1.7 COSMETIC SERVICES AND SURGERY** means medical or surgical services (i) performed to reshape normal structures of the body in order to improve the Member's appearance and self-esteem; (ii) from which no significant improvements in physiological function could reasonably be expected; (iii) that do not meaningfully promote the proper function of the body (iv) that do not prevent or treat illness or disease; or (v) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.
- **1.8 COVERAGE or COVERED** means the entitlement of a Member to services provided in this Certificate of Coverage, subject to the terms, conditions, limitations, and exclusions herein, including the following: (i) health services must be provided when the Certificate of Coverage is in effect; (ii) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Certificate of Coverage occur; (iii) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Certificate of Coverage, and (iv) health services must be Medically Necessary, and must not be listed in Section 7 as an Exclusion.
- **1.9 COVERED SERVICES** means the health care services described at Section 6 of this Agreement and all supplemental benefits described in Attachments to this Agreement, if any, to the extent such services are required to be provided under policies of the Michigan MIChild program.

- **1.10 EFFECTIVE DATE** means the date when the Member is entitled to receive Covered Services under this Agreement, as determined by the MIChild program.
- **1.11 ELECTIVE SURGICAL PROCEDURE** means a treatment technique performed through surgery which is a Covered Service under Section 6.0 of this Certificate of Coverage and which is one of several optional medical treatments available, relative to the particular condition, which are acceptable under the current standards of Physicians or Health Professionals in the community.
- **1.12 EMERGENCY MEDICAL CONDITION** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the Member, or in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment of bodily function; or (c) serious dysfunction of any bodily organ or part.
- **1.13 EMERGENCY SERVICES** means those Covered Services, inpatient and outpatient that are rendered by a Provider qualified to provide services to treat an Emergency Medical Condition, and necessary to evaluate or stabilize an Emergency Medical Condition.
- **1.14 EXPERIMENTAL AND INVESTIGATIONAL** means those health products or services that meet one of the following conditions: (a) any drug or device that is not approved for use by the Food & Drug Administration ("FDA"); any drug classified by the FDA as investigational new drug ("IND"); any drug requiring preauthorization that is proposed for off-label prescribing; (b) any health product or service that is subject to Investigational Review Board ("IRB") review or approval; (c) any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III, as set forth by FDA regulations; or (d) any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer-reviewed medical literature and generally recognized by academic experts.
- **1.15 FORMULARY** means a listing of prescription drugs approved by the PLAN for coverage under this Agreement, dispensed by a pharmacy to Members. This list is subject to periodic review and change by the PLAN. The Formulary is available for review in Participating Providers' offices, on the PLAN's website, at **www.aetnabetterhealth.com/michigan**, or by contacting the PLAN'S Member Service department.
- **1.16 FRAUD** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself or some other person.
- **1.17 GRIEVANCE** means a formal statement of dissatisfaction about any matter other than an Adverse Determination as defined herein. Examples include, but are not limited to, (a) dissatisfaction regarding the availability, delivery, or quality of care of services provided to Member, or (b) aspects of interpersonal or contractual relationships such as rudeness of provider or employee, or failure to respect a Member's rights.
- **1.18 GRIEVANCE AND APPEAL PROGRAM** means the procedure under which a Member must file any Appeal or Grievance involving the PLAN, a Participating Provider Center, or any Participating Physician, Participating Health Professional, or other Participating Provider.

- **1.19 HEALTH PROFESSIONAL** means a podiatrist, dentist, nurse, optometrist, or other individual licensed or certified to practice a health care profession other than medicine or osteopathy by the state in which he or she is located.
- **1.20 HOSPITAL** means an institution, operated pursuant to law, which (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic, and surgical techniques by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVII of the Social Security Act (Medicare program). A facility that is primarily a place for rest, custodial care, or care of the aged, a nursing home, convalescent home, or similar institution is NOT a Hospital.
- **1.21 IDENTIFICATION CARD** means the card issued by the PLAN to each Member for purposes of identifying such individuals. The rights and responsibilities attendant to Members issued an Identification Card are set forth in Section 3.3 of this Certificate of Coverage.
- **1.22 INFERTILITY** means the inability of a woman to conceive a pregnancy after six (6) months of unprotected intercourse with a man, or the inability of a woman to carry a pregnancy to live birth as evidenced by three consecutive miscarriages (spontaneous abortions).
- **1.23 MEDICALLY NECESSARY** means those covered services that are required to identify, treat, or avoid illness or injury to a Member. The services must be (a) Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin; (b) Necessary to meet the basic health needs of the member as a minimum requirement; (c) Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service; (d) Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by the plan; (e) Consistent with the diagnosis of the condition; (f) Required for reasons other than the comfort or convenience of the covered person or his or her physician; and (g) Of demonstrated value based on clinical evidence reported by peer reviewed medical literature and by generally recognized academic medical experts; that is, it is not experimental (investigational or unproven).
- **1.24 MEMBER** means any person entitled to Covered Services under this Agreement in accordance with its terms and conditions.
- **1.25** <u>MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES OR MDHHS</u> means the administrative agency responsible for administering the MIChild program in Michigan.
- **1.26 NETWORK CENTER ASSOCIATION OR CENTER** means a partnership, corporation or association that has entered into a services arrangement or other arrangement with Physicians and Health Professionals (a majority being physicians) and which has additionally contracted with the PLAN to provide or arrange for the provision of Covered Services to Members.

- **1.27 NON-PARTICIPATING**, when used with Physician, Health Professional, Hospital or Skilled Nursing Facility, means an individual, facility or other health care entity with which the PLAN has made no arrangements to provide services to its Members either directly by employment or through an independent contract or indirectly through a Center and which, therefore, is not bound by a direct or indirect written agreement with the PLAN to provide services to Members. A Non-Participating Provider cannot bill Members for Covered Services when the Non-Participating Provider fails to obtain authorization from the PLAN.
- **1.28 DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES (DIFS)**. The agency that oversees financial institutions, insurance companies, and securities in the state of Michigan. DIFS can assist Members if they have questions, complaints, or concerns about credit unions, insurance companies, banks, securities, and health maintenance organizations ("HMOs").
- **1.29 OUT-OF-AREA SERVICES** means those Covered Services provided when a Member is temporarily absent from the Service Area that are immediately required as a result of an unforeseen illness, injury, or condition, and it is not reasonable for Member to obtain such Covered Services through the PLAN in the PLAN's Service Area due to the circumstances.
- **1.30 PARTICIPATING**, when used with Physician, Health Professional, Hospital or Skilled Nursing Facility or other individual, facility or health care entity means that the person or entity has entered into a direct or indirect written agreement with the PLAN to provide health services to Members. "Participating" refers only to those Providers included in the network of Providers described in the Provider Directory of Health Care Providers delivered to Members in connection with the Agreement. The participation status of Providers may change from time to time.
- **1.31 PHYSICIAN** means any doctor duly licensed and qualified to practice medicine (M.D.) or osteopathy (D.O.) in the State of Michigan.
- **1.32 PLAN** means Aetna Better Health of Michigan, Inc.
- **1.33 PRIMARY CARE PHYSICIAN or PCP** means a Physician who practices in the field of general, family, internal medicine, or pediatrics and who is primarily responsible, either directly or through coordination, for the provision or authorization of Covered Services to a Member. A PCP shall be designated as such by the PLAN.
- **1.34 PRIOR AUTHORIZATION/AUTHORIZATION** means that the PLAN has given approval for payment for certain Covered Services to be performed and an authorization number has been assigned. Upon Authorization, all inpatient Hospital stays are subject to concurrent review criteria established by the PLAN. If Member needs Specialty Services from a Non-Participating Provider, an Authorization means the Member's PCP or OB-GYN Physician has recommended a Non-Participating Provider for treatment of a specific condition, and the PLAN has assigned an authorization for a certain number of visits or days. Authorization does not guarantee payment if Member is not eligible for Covered Services at the time the service is provided.
- **1.35 PROVIDER** means a health care facility or person licensed, certified, or regulated under Michigan law.

- **1.36 RECONSTRUCTIVE SURGERY** means surgery that is performed on abnormal structures of the body which are caused by congenital defects, developmental abnormalities, trauma, infection, tumors or diseases and which is performed to improve function or to approximate a normal appearance.
- **1.37 SERVICE AREA** means the geographic area in which the PLAN has been authorized by the State of Michigan to provide or arrange for the provision of Covered Services to Members. Service Area is subject to change.
- **1.38 SKILLED NURSING FACILITY** means an institution that is licensed by the state in which it is located to provide skilled nursing services, and which has entered into an Agreement with the PLAN to provide such services to Members.
- **1.39 SPECIALIST PHYSICIAN** means any Physician who is not a Member's PCP, and who provides medical services to Members within the range of a particular medical specialty.
- **1.40 TRANSPLANT NETWORK** means the group of Providers designated by the PLAN to provide transplant services and treatment to Members. The Transplant Network is developed and managed by the PLAN's corporate parent, Aetna Better Health of Michigan.
- **1.41 URGENT/EXPEDITED APPEAL** means an Appeal that requires immediate attention, within seventy-two (72) hours of request because the time frame for the non-Urgent/non-Expedited Appeal process (i) could seriously harm the Member's life or health, or if the Member is pregnant, the life or health of the fetus; (ii) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain or health risk that could not be adequately managed without care or treatment.

## **SECTION 2.0 ELIGIBILITY**

- **2.1 MEMBER ELIGIBILITY.** MDHHS is responsible for making all determinations regarding who is eligible to enroll in MIChild managed care plans. The Michigan Department of Health and Human Services ("MDHHS") determines MIChild eligibility. Most changes by MDHHS will be made on a calendar month basis. The PLAN shall be responsible for Member until the date of disenrollment. To be eligible to enroll as a Member a person must:
  - **2.1.1** Meet the eligibility criteria established for MIChild as determined by MDHHS;
  - 2.1.2 Reside within Michigan; and
  - **2.1.3** Be determined by MDHHS to be appropriate for enrollment in a managed care plan, such as the PLAN
- **2.2 LOSS OF MICHILD ELIGIBILITY.** Effective on the date a Member covered by this Agreement loses his or her eligibility under the Michigan MIChild Program, coverage under this Agreement shall terminate. In the case of an inpatient hospital admission, payment for services will continue until the Member is discharged from the hospital. If the person regains MIChild eligibility within ninety (90) days from the date eligibility was terminated, the PLAN will accept automatic re-enrollment of the person on a prospective basis as determined by MDHHS.

## SECTION 3.0 ENROLLMENT AND COVERAGE EFFECTIVE DATES.

- **3.1 ENROLLMENT.** MDHHS is responsible for determining a person's eligibility for enrollment with the PLAN.
  - **3.1.1** ENROLLMENT PROCESS AND COLLECTED INFORMATION. MDHHS contracts with an enrollment services vendor to contact and educate general MIChild beneficiaries about MIChild managed care and to enroll and change enrollment for these beneficiaries. The PLAN does not administer the enrollment process, and a beneficiary is not deemed to be enrolled with the PLAN until the PLAN has received information from MDHHS. All enrollment and disenrollment determinations are made solely by MDHHS. A Member shall complete and provide to the PLAN or its Participating Physicians, Hospitals, Health Professionals or Skilled Nursing Facilities any forms (other than an Eligibility Application) that are reasonably requested, including medical questionnaires, and a Member shall assure that all information in such forms is true, correct and complete. At all times, the PLAN shall ensure that Member's health information is protected pursuant to state and federal law, including but not limited to the Health Insurance Portability and Accountability Act ("HIPAA").

#### 3.2 EFFECTIVE DATE OF COVERAGE

- **3.2.1** MDHHS DETERMINES EFFECTIVE DATE. Coverage is effective on the first day of the month MDHHS notifies the PLAN of the Member's enrollment. The member shall be "locked-into" the PLAN for twelve (12) months from the date of enrollment, as long as the member remains MIChild eligible. The member shall have the first ninety (90) calendar days of that period to change health plans.
- **3.2.2** NOTICE OF EFFECTIVE DATE. The PLAN will notify the Member of the Effective Date in writing.
- **3.2.3** NO COVERAGE PRIOR TO EFFECTIVE DATE. Consistent with MIChild requirements, Members are not eligible for Coverage for services provided before the Effective Date. If a Member is an inpatient at a hospital or other health facility on the Effective Date, no Coverage will be provided by the PLAN until the Member is no longer an inpatient in a hospital or facility.
- **3.3 IDENTIFICATION CARDS.** The PLAN will issue Identification Cards to Members, and such Identification Cards are to be used for identification purposes only and must be presented whenever the Member obtains Covered Services. The PLAN's non-emergency and emergency contact numbers are on the back of the Identification Card. Only the Member to whom the identification card is issued may use it. A person who is no longer eligible for Coverage or a person who is not designated as the Member on the Identification Card is not entitled to receive Covered Services and has no rights under the Identification Card. The Identification Card shall be returned to the PLAN at its request upon termination of Coverage or misuse. If a Member misuses, or

allows another person to use the Identification Card, or otherwise defrauds or attempts to defraud the PLAN, then the Member may be subject to prosecution and termination from the PLAN. The PLAN will report all suspected acts of fraud, waste and abuse to applicable state agencies, including MDHHS's Office of Health Services Inspector General (OHSIG).

## **SECTION 4.0 TERMINATION**

- **4.1** CANCELLATION OF THE PLAN/MDHHS CONTRACT. A Member's Coverage shall be subject to a transition plan in the event the contract between the PLAN and the State of Michigan under which this Coverage is provided is cancelled. If the contract between the PLAN and the State of Michigan is cancelled, then MDHHS is responsible for arranging for Members to be reassigned or enrolled in another comparable program. MDHHS is also responsible for setting a cancellation date.
- **4.2 <u>DISENROLLMENT BY MEMBER WITHOUT CAUSE</u>**. Disenrollment by a Member is allowed during the initial 90 calendar days of enrollment in the PLAN. The Member will need to choose another MIChild health plan after disenrolling from Us.
- **4.3 <u>DISENROLLMENT BY MEMBER FOR CAUSE</u>**. Disenrollment by a Member is only allowed at certain times under MDHHS policy. To request disenrollment, a Member must follow the procedures established by MDHHS. Member should contact the "MIChild Help Line" at **1-888-988-6300** to obtain information regarding the Disenrollment for Cause process. Hearing impaired call **1-888-263-5897**.
- **4.4 PLAN-INITIATED DISENROLLMENT.** The PLAN will petition MDHHS for disenrollment of a Member for the following reasons:
  - **4.4.1** Improper actions on the part of the Member or the Member's parent or guardian, including but not limited to fraud, waste and abuse, alteration or theft of prescriptions, misrepresentation of membership, or unauthorized use of benefits or other intentional misconduct.
  - **4.4.2** A Member, parent or guardian misuses the Identification Card as provided in Section 3.3.
  - **4.4.3** Member's/parent's/guardian's behavior towards either the PLAN or a Provider causes violent or life-threatening situations involving physical acts of violence, physical or verbal threats of violence, or stalking.

All disenrollments are subject to the prior approval of MDHHS. Before a Member is disenrolled under this section, the PLAN will attempt to resolve the problem with the Member. If the Member exercises their appeal right, the date of disenrollment shall be no later than thirty (30) days after resolution of the appeal, or on such other date as set by MDHHS. The Plan will be responsible for the Member until the date of disenrollment.

The PLAN will not request disenrollment based on the physical or mental health status of the Member. If the Member's physical or mental health is a factor in the violent behavior or action inconsistent with PLAN membership, the PLAN must provide proof of the PLAN'S actions to assist the Member in correcting the problem, including appropriate physical and mental health referrals. The PLAN will also document that continued enrollment seriously impairs the PLAN or providers to furnish services to the Member or other members. MDHHS may require additional information from the PLAN to determine the appropriateness of the disenrollment.

**4.5** MOVING OUT OF SERVICE AREA. If a Member moves out of the Service Area after the Effective Date, the PLAN Coverage will remain in effect until the Member is disenrolled by MDHHS from the PLAN which will be on the first day of the month following the implementation of the change of address. The PLAN will be responsible for Covered Services until the date of disenrollment. During such time, the Member may be required to return to the PLAN'S Service Area to seek Medically Necessary Covered Services from Participating Providers, or the PLAN may Authorize the Member to seek Medically Necessary Covered Services outside of the PLAN'S Service Area. The PLAN may not pay for otherwise Covered Services provided outside of the Service Area if no Prior Authorization was obtained, except when Covered Services were rendered in response to an Emergency Medical Condition.

# SECTION 5.0 SELECTION OF PARTICIPATING PROVIDERS & FEDERALLY QUALIFIED HEALTH CENTERS ("FQHC")

- **5.1 PRIMARY CARE PHYSICIAN & FQHC SELECTION.** Upon enrollment, the Member shall select a PCP or, as applicable, a FQHC. If the Member fails to select a PCP, the PLAN will automatically assign a PCP to the Member until the Member makes an alternate selection. After enrollment, a Member may choose a different PCP from a list provided by the PLAN by contacting the PLAN's Customer Care Call Center. If the PLAN cannot honor the Member's choice of PCP, the PLAN will contact the Member to assist the Member in making another choice. Member-initiated PCP changes will be permitted at any time, however the PLAN may limit such changes when they are being requested without cause.
- **5.2 PROVIDER DIRECTORY**. Participating Physicians, Health Professionals and other providers are subject to change, from time to time, with respect to individual practitioners or institutions. Accordingly, the PLAN neither warrants nor guarantees the length of service of any of its Participating Physicians or other Participating Providers.
- 5.3 PHYSICIAN/PATIENT RELATIONSHIP. When, after reasonable efforts are made, a Member and the Member's PCP are unable to establish or maintain a satisfactory relationship as physician and patient, a Member may be required to choose another PCP with not less than thirty (30) days notice, subject to the Member's rights under the Grievance and Appeal Program. A PCP must notify a Member of the reason for dismissal by means of a certified letter to the Member's current address of record. A copy must also be sent to the PLAN.

# **SECTION 6.0 COVERED SERVICES**

**6.1 COVERED SERVICES GENERALLY.** There are no co-payments or deductibles for MIChild Members. Enrollment in the PLAN entitles Members to receive the Covered Services set forth below, so long as such Covered Services are (a) provided, arranged and/or approved by the PCP (if required by the PLAN), (b) Medically Necessary, (c) subject to the limitations and exclusions set forth in this Agreement, and (d) required to be provided under contract with the Michigan MIChild program. The PLAN has the authority to arrange and/or Authorize those services that are Medically Necessary. Members and Providers must comply with the terms and conditions of the PLAN regarding Prior Authorization of services. Failure to secure Prior Authorization may result in the PLAN's denial of payment for otherwise Covered Services.

If a Member needs to see a Specialist, the Member's PCP will arrange the visit and provide Member with the appropriate documentation to take to the visit. Members are responsible for consulting with their PCP before receiving medical care from another Provider except as otherwise specified in this document. Members may only seek care from Specialists in the PLAN's network. If a Member seeks care from a Specialist without the required documentation from their PCP, the Member will be responsible for payment if the member is informed by the Specialist about the payment prior to receiving services. Visits to Providers who are not in the PLAN's network must first be approved by the PLAN's Health Services Department. For example, the PLAN may cover services provided by a Provider outside the PLAN network if no similar Provider is available in network, or the PLAN may cover services outside the network to ensure that a Member's care is not interrupted. Services received outside the network must be approved by the PLAN. Members with serious health conditions may need to see a Specialist to get the care they need. PCPs will refer their Members accordingly for such care. Some Members with special health conditions need to have a Specialist as their PCP, and should contact Customer Service for more information about this option.

- **6.2 PHYSICIAN AND HEALTH PROFESSIONAL SERVICES.** Physician services covered by the PLAN shall include:
  - **6.2.1** All office visits for diagnosis and treatment of illness and injuries provided by a Member's PCP and all related services, supplies and immunizations.
  - **6.2.2** Periodic physical examinations or health assessments as determined by the PCP.
  - **6.2.3** Pediatric care, including well-child care and certified pediatric nurse practitioner services. Prior Authorization is not required for access to a pediatrician who is a Participating Physician for general pediatric services, but Prior Authorization is required for pediatric services when provided by a Physician who is not a Participating Physician for such services.
  - **6.2.4** Gynecological and maternity care, including prenatal and postnatal care, delivery and other related obstetrical services, and nurse midwife services. Prior Authorization is not required for access to an obstetrician-gynecologist who is a Participating Physician for

annual well woman examinations and routine obstetrical and gynecological services, but Prior Authorization is required for the services of a Physician who is not a Participating Physician for such services.

- **6.2.5** Necessary inpatient and outpatient medical consultation and specialist care by a Participating Physician to whom a Member is referred by the PCP.
- **6.2.6** In-hospital and outpatient physician services, as deemed necessary for the care and treatment of the Member by the Attending Physician, including breast reconstruction surgery following a mastectomy.
- **6.2.7** Covered Services rendered by a Certified Nurse Midwife or Family Nurse Practitioner.
- **6.2.8** Private duty skilled care nursing charges, except such care if provided by a person who ordinarily resides in your home or who is a member of your family or the family of spouse.

## 6.3 WELL CHILD CARE/EARLY & PERIODIC SCREENING, DIAGNOSIS, & TREATMENT PROGRAM ("EPSDT").

These services are available to Members under the age of 19 to ensure access to health resources and assist parents/guardians in appropriately using health resources. No Prior Authorization is required if EPSDT services are rendered by a Participating Provider.

- **6.3.1** Screening Services shall include periodic well-child examinations, including assessment of health and developmental history; development & behavioral assessments; age appropriate unclothed physical examinations; height/weight/head circumference measurements; blood pressure examination for children aged 3 and over; immunization review and appropriate administration; health education including anticipatory guidance; nutritional assessment; hearing, vision, and dental assessment; blood lead testing for children under age 6; appropriate conference and counseling for parents/guardians; developmental, behavioral, hearing, and vision according to the periodicity schedule; laboratory services for tuberculin, hematocrit, hemoglobin, urinalysis; or other testing as may be ordered by Physician.
- **6.3.2** Vision Services will include diagnosis and treatment for defective vision, and may include eyeglasses as appropriate.
- **6.3.3** Dental Services shall include relief of pain and infections. The PLAN is responsible for screening and referral only. Fluoride varnish services administered by a physician up to four (4) times a year for children age 0 to 36 months.
- **6.3.4** Hearing Services shall include diagnosis and treatment for hearing defects, including hearing aids as appropriate.

- **6.3.5** Referral of children, as appropriate, to hearing and speech clinic; optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services; referral to community mental health services; and if a child is found to have elevated blood lead levels in accordance with MDHHS standards, the PLAN shall refer the child to the local health department for follow-up services that may include a study to determine the source of the lead poisoning.
- **6.3.6** Outreach Services by home visit, phone, or mail to those Members who are due or overdue for well-child visits.
- **6.4 SECOND OPINIONS.** The right of a Member to obtain a second medical opinion from a Participating Physician with respect to a given condition.
- **6.5 INPATIENT AND OUTPATIENT HOSPITAL SERVICES.** Inpatient admissions are covered up to 365 days per benefit year if it is provided and prescribed as Medically Necessary by the PCP or Attending Physician, and Authorized as such by the PLAN. Outpatient hospital care will be provided with no time limit, if it is provided and prescribed as Medically Necessary by the PCP or Attending Physician, and Authorized as such by the PLAN. Inpatient and Outpatient Hospital Services shall be obtained from a Participating Hospital or other participating facility and subject to the limitations and exclusions set forth in Sections 6.1, 7.0 and 8.0 of this Agreement. Inpatient and outpatient hospital services covered by the PLAN shall include:
  - **6.5.1** Semi-private room and board accommodations based upon availability. Such accommodations shall include general duty nursing care.
  - **6.5.2** Private room and board accommodations only with PLAN authorization.
  - **6.5.3** Inpatient therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units.
  - **6.5.4** Use of operating room, delivery room, birthing center and other surgical treatment rooms and equipment on an inpatient or outpatient basis.
  - **6.5.5** All laboratory and other diagnostic tests (X-rays, EKGs, nuclear isotopes, ultrasounds, CAT, MRI, MRA, PET) on an inpatient or outpatient basis as described at Section 6.6 below.
  - **6.5.6** Anesthetics, oxygen and other gas therapy, drugs, solutions and other biologicals.
  - **6.5.7** Radiation therapy, chemotherapy, hemodialysis, peritoneal services, short-term rehabilitation services and other forms of therapy only as described in Section 6.6 below.
  - **6.5.8** Additional services, supplies, equipment and special procedures, on an inpatient or outpatient basis, but excluding convenience items (e.g., telephone, television, etc.).

- **6.5.9** Skilled nursing care provided in a participating Skilled Nursing Facility to the extent required by MDHHS if the Member requires medical and skilled nursing care (not domiciliary care or custodial care), in the absence of which hospital confinement could be Medically Necessary.
- **6.5.10** Preadmission testing within 72 hours of inpatient admission.
- **6.5.11** Cosmetic or reconstructive surgery only for the correction of birth defects, conditions resulting from accidental injuries, deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.
- **6.5.12** Routine nursery care of the newborn when the mother is eligible for maternity care.
- **6.5.13** Emergency room services for accidental injuries treated within 48 hours of the injury or an illness or disease if the condition is life-threatening.
- **6.5.14** Surgery.
- **6.5.15** Termination of pregnancy when determined medically necessary to save the life of the mother, or in cases of rape and/or incest.
- **6.5.16** Special hospital programs including home hemophilia services and home hemodialysis services.
- **6.6 DIAGNOSTIC LABORATORY, X-RAY, AND IMAGING TESTS.** Diagnostic testing covered by the PLAN shall include:
  - **6.6.1** X-ray and laboratory tests, electrocardiograms and electroencephalograms.
  - **6.6.2** Radiology services, including diagnostic and therapeutic isotopes and other radioactive materials used for therapeutic purposes.
- **6.7 EMERGENCY MEDICAL SERVICES.** For purposes of this Agreement, Emergency Medical Services means those services that are required as a result of an Emergency Medical Condition as defined in Section 1.13 of this Certificate of Coverage.
  - 6.7.1 Emergency Medical Services include inpatient or outpatient services that are:
    (a) furnished by a provider qualified to furnish emergency services, including Non-Participating Physicians and Health Professionals in the Service Area or outside of the Service Area; and
    (b) necessary to evaluate or stabilize an Emergency Medical Condition found to exist using the prudent layperson standard.
  - **6.7.2** Emergency transportation for Members shall be Covered.

- 6.7.3 Where it is Medically Necessary that the Member receive medical attention immediately from a Non-Participating Physician or Health Professional, the Provider should contact the PLAN by telephone at the number listed on the Identification Card in this Agreement for Prior Authorization for subsequent follow-up care after the Emergency Medical Services have been provided. Treatment following screening and stabilization shall be deemed prior authorized if the PLAN does not respond within one (1) hour for a request for Prior Authorization being made by an emergency department. If the facility does not request prior authorization and the PLAN determines that services, other than those required to evaluate and/or stabilize the Member, were not required as the result of an Emergency Medical Condition, the PLAN will not be responsible for such care, payment or reimbursement for such services.
- **6.7.4** Accessing Emergency Medical and Urgent Care Services. Members requiring Emergency Medical Services and Urgent Care Services shall have access to such services through one of the following three available emergency service systems in addition to traditional 911 service.
  - 6.7.4.1 Emergency Nurse Line. Information services shall be available and accessible to each Member on a twenty-four (24) hour-a-day, seven (7) day-a-week basis at **1-866-711-6664**. The Emergency Nurse Line is in contact with Participating Physicians and Health Professionals, hospitals, ambulances and other Participating Providers to facilitate the provision of such services. Any person may contact the Emergency Nurse Line by calling the hot line telephone number listed on the Member Identification Card for purposes of seeking assistance on behalf of a Member in the event of an Emergency.
  - 6.7.4.2 Immediate Emergencies. In cases of an Emergency that requires immediate treatment before the PLAN's Emergency Triage System can be contacted and/ or before treatment can be secured through the PLAN, the Member may utilize a Non-Participating Physician, Health Professional, or other Provider within or outside the Service Area.
  - 6.7.4.3 Urgent Care Center System. In case of an accident, injury, or illness of a less serious nature in which the Member is not at risk of death or permanent impairment and in instances in which the Member is in the Service Area, the Member shall be required to seek services from a PLAN Urgent Care Center within 24 hours of such accident, injury, or illness. A list of Participating Urgent Care Centers and their locations is provided in the Provider Directory.
- **6.8 ORAL SURGERY.** Dental services, specifically provided in Sections 6.3.3 and the following limited dental services are covered by the PLAN:
  - **6.8.1** The treatment of a jaw fracture, dislocation, or wound.
  - **6.8.2** The treatment of cysts, tumors, or other disease tissues.

- **6.8.3** Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction.
- **6.8.4** The alteration of the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **6.8.5** Charges for office visits related to the above procedures.
- **6.8.6** Inpatient and outpatient hospital services and related medical services for surgical procedures required to be done in an operating room.

### **6.9 AMBULANCE/TRANSPORTATION.** The following are Covered Services:

- **6.9.1** Ambulance Services for a trip to or from the hospital, a skilled nursing facility, or Member's home.
- **6.9.2** Professional Ambulance Service when used to transport the Member from the place where injured or emergency occurred to the first hospital where treatment is given.

#### **6.10 HOSPICE CARE SERVICES.**

- **6.10.1** Hospice care services covered by the PLAN are limited to a maximum of 210 days—two periods of 90 days each and one period of 30 days—during the member's lifetime. Services are available to the extent (a) authorized by the PCP, (b) Authorized by the PLAN and (c) the hospice program is operated under the direction of a Participating Physician and meets the standards of the National Hospice Organization or similar standards.
- **6.10.2** Covered Hospice Care Services include:
  - <u>6.10.2.1</u> Nursing care by, or under the supervision of a Registered Nurse;
  - 6.10.2.2 Home health aide and homemaker services;
  - 6.10.2.3 Short-term inpatient care;
  - 6.10.2.4 Medical supplies and drugs;
  - 6.10.2.5 Physical, speech and occupational therapy.
  - 6.10.2.6 Bereavement counseling for the family for up to 30 days following the member's death.

- <u>6.10.2.7</u> Medical social services (including needs assessment, psychological and dietary counseling).
- **6.10.3** Children under 21 years of age may receive hospice care concurrently with curative treatment of the child's terminal illness. The need for hospice care must be certified by a physician and the hospice medical director.
- **6.11 HOME HEALTH SERVICES.** Home health services covered by the PLAN are limited to a maximum of one hundred twenty (120) days per member per calendar year. Services rendered at a Member's home that are Authorized by the PLAN, including:
  - **6.11.1** Professional medical care services deemed necessary for the Member's care and treatment, with the exception of private duty nursing as noted in Section 7.1.3.
  - **6.11.2** Subject to MDHHS limitations, intermittent home care nursing services by a registered nurse or a licensed practical nurse if the services of an registered nurse are not available, physical therapy services, occupational therapy services, speech therapy services, nutrition education and guidance and part-time home health aide services, not including housekeeping or long-term custodial care services.
  - **6.11.3** Home care medical supplies when deemed Medically Necessary by the PCP for the care and treatment of the Member during the Member's home confinement.
  - **6.11.4** Oxygen, laboratory services and drugs.
- **6.12 PREVENTIVE HEALTH SERVICES.** Preventive health services covered by the PLAN shall include:
  - **6.12.1** Periodic health assessment and screening by the PCP at intervals deemed appropriate for the age, sex and medical history of the Member, including well-child care. Well-child care is a clinical assessment of a child in the absence of illness to determine physical status and detect any abnormalities. (See EPSDT in Section 6.3)
  - **6.12.2** Routine periodic childhood and adult immunizations in accord with the Advisory Committee on Immunization Practices Guidelines for all Members, excluding immunizations that are required only for travel.
  - **6.12.3** Voluntary family planning service, including sexually transmitted disease testing and treatment. No Prior Authorization is required for these services.
  - **6.12.4** Vision and hearing screening to determine the need for vision and hearing correction.
  - **6.12.5** Health education and nutrition counseling services. Members may be responsible for a nominal fee for education services beyond what is provided in this Agreement.

#### 6.13 ORGAN AND TISSUE TRANSPLANTS.

- **6.13.1** All organ and tissue transplants must receive Prior Authorization, and be performed at a Participating Provider Authorized by the PLAN. The PLAN will pay for transplant-related hospital, surgical, laboratory, and X-ray services. Transplants such as heart, lungs, heart-lungs, liver, pancreas, small bowel, and bone marrow including allogeneic, autologous, and peripheral stem cell harvesting, are covered on a patient-specific basis when Medically Necessary according to accepted standards of care.
- **6.13.2** The PLAN will pay for hospital, surgical, laboratory and X-ray services incurred by a organ/tissue donor who is not a PLAN Member resulting from the transplant of an organ to a Member only to the extent such services are not covered by any other medical plan.
- **6.14 CHIROPRACTIC SERVICES.** Chiropractic services covered by the PLAN are limited to a maximum of twenty four (24) visits per member per calendar year. The following services of a Participating chiropractor are Covered when referred by the PCP: spinal manipulations, an initial office examination, x-rays relating to back and spine and first aid treatment of musculoskeletal injury.
- **6.15 HEARING AND SPEECH SERVICES.** Hearing and speech services covered by the PLAN are limited to a maximum of once every thirty-six (36) consecutive months. Services for the diagnosis or treatment of diseases or conditions of the ears when Authorized by the PCP, and audiometric examinations and hearing aid evaluation testing by a Participating Provider. The purchase and fitting of a hearing aid, including one follow-up visit, but not more frequently than 36 months after the Member's last hearing examination, hearing test or hearing aid was provided by the PLAN. Repairs, maintenance and batteries for hearing aids are not covered.
- **6.16 VISION SERVICES.** The care and treatment of diseases and conditions of the eye when provided by the PCP or referred by the PCP to a Participating optometrist or ophthalmologist, including:
  - **6.16.1** Annual examination of the eye, refraction and glaucoma testing; corrective lenses, single vision, multifocal, cataract or contact lenses; eye glass frames once every twenty-four (24) months or once every twelve (12) months with a prescription change. Contact lenses are covered when medically necessary or therapeutic to correct visual impairment when glasses are insufficient to correct a visual impairment.
- **6.17 REPRODUCTIVE CARE AND FAMILY PLANNING SERVICES.** Family Planning services, generally, are those medically approved diagnostic evaluations, drugs, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases ("STDs"). These services shall be provided confidentially to Members of child-bearing age, including minors who may be sexually active, who voluntarily choose not to risk pregnancy, or wish to limit the number and spacing of their children.

- **6.17.1** History, physical examination, laboratory testing, advice and supervision related to family planning in accordance with generally accepted medical practices.
  - **6.17.2** Contraceptive drugs, devices and supplies. Condoms shall be made available.
  - **6.17.3** Terminations of Pregnancy (abortions) and related services are covered only when (a) a Physician certifies that the abortion is Medically Necessary to save the life of the mother; (b) the pregnancy is a result of rape or incest; (c) treatment is for medical complications occurring as a result of an elective abortion; or (d) treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy. All terminations of pregnancy must be Prior Authorized by the PLAN.
  - **6.17.4** Family planning services. No prior authorization for family planning services is required at family planning clinics.
  - **6.17.5** Testing for Infertility; however, treatment for Infertility is not a Covered Service.
- **6.18 ALLERGY TESTING AND TREATMENT.** Allergy testing and treatment services must be authorized by the PCP and Authorized by the PLAN and are limited to the following:
  - **6.18.1** Routine testing procedures to determine or evaluate the source of an allergy.
  - **6.18.2** Treatment and procedures to contract the allergy or render the Member insensitive to an allergen, including the provision and administration of allergy serum.
- **6.19 DURABLE MEDICAL EQUIPMENT.** Durable Medical Equipment is defined as equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of injury; and (d) is appropriate for use in the home. Durable Medical Equipment is covered on a rental or purchase basis. In order for Durable Medical Equipment to be covered by the PLAN it must be prescribed by a Participating Physician or Health Professional as Medically Necessary to treat an existing injury or illness, it must be obtained from a supplier approved by the PLAN and the Durable Medical Equipment must be Authorized by the PLAN. The PLAN reserves the right to Authorize the least costly Durable Medical Equipment that is medically effective for the injury or illness. Repair of purchased Durable Medical Equipment is covered due to normal wear and tear. Replacement of purchased Authorized Durable Medical Equipment due to loss, irreparable damage of equipment, body growth or change as a result of normal usage, is covered, but replacement due to misuse or abuse is not a Covered Service. See Section 7.1.32 for Excluded Durable Medical Equipment.
- **6.20 PROSTHETIC AND ORTHOTIC DEVICES.** Coverage is provided for basic Prosthetic Devices and Orthotic Devices and specialized features authorized by the PCP and Authorized by the PLAN. Prosthetic and Orthotic Devices must be ordered by the Attending Physician and obtained from a PLAN-approved supplier. A Prosthetic Device is a device that replaces a missing part of the body or assists in the performance of a natural function of the body without necessarily replacing a missing part. Orthotic Devices are those external devices

that are designed to correct or assist in the prevention of a body defect, either of form or function. Breast prostheses are covered following a mastectomy.

- **6.20.1** Fitting, adjustment or repair is covered when due to normal usage or body growth or change. Replacement is covered when devices are damaged beyond repair, worn out or due to body growth or change, but excluded from coverage are replacement and/or repair of Orthotic and Prosthetic Devices due to intentional damage, misuse or abuse and comfort and convenience items.
- **6.20.2** Orthopedic shoe inserts when prescribed by a physician.
- 6.21 <u>DRUGS AND MEDICAL SUPPLIES</u>. Covered benefits are listed herein. Pharmacy is covered for each prescription drug or refill purchased up to a 34-day supply for acute medications and up to a 102-day supply for maintenance medications. Prescriptions are to be filled with a generic medication unless the prescribing physician has indicated "dispense as written" (DAW) on the prescription and prior authorization is obtained. Members may fill their prescriptions at over 50,000 pharmacies nationwide, and at over 1,900 in Michigan. The PLAN uses a closed Formulary, which means that only drugs listed on the Formulary are covered (except with prior approval in special circumstances). For more facts regarding the Formulary or drugs that require the PLAN's Prior Authorization, Members can call the PLAN at 1-866-316-3784. When filling a prescription, Members shall present their Aetna Better Health of Michigan MIChild ID card with the prescription at any Participating Pharmacy. The PLAN has contracted with Medco, a pharmacy benefit manager, to manage prescription drug coverage for Members.
  - **6.21.1** Prescription Drugs, which are those medicinal substances which under federal law are required to bear on the package label the statement: "Caution: Federal law prohibits dispensing without a prescription," are Covered.
  - **6.21.2** Selected over-the-counter analgesics, laxatives, antacids, non-supplement and family-planning drugs, devices or supplies are covered when prescribed by and Authorized by the PCP.
  - **6.21.3** Insulin, as well as necessary needles and syringes are covered when prescribed or Authorized by the PCP.
  - **6.21.4** FDA-approved drugs used in anti-neoplastic therapy and the reasonable cost of administration, whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received FDA-approval if the following conditions are met: (a) the drug must be ordered by a Physician for treatment of a specific type of neoplasm; (b) the drug must be approved by the FDA for use in anti-neoplastic therapy; (c) the drug is used as part of an antineoplastic drug regimen; (d) current medical literature substantiates the drug's efficacy and recognized oncology organizations generally accept the treatment; and (e) the Physician has obtained informed consent from the Member for the treatment regimen which includes FDA approved drugs for off-label indications.

- **6.21.5** Medically necessary medical supplies such as catheters, testtape, clinitest, and similar supplies; bag frames and supplies for colostomies, ileostomies, and ureterostomies; and dressings and dressing supplies are Covered Services when ordered or Authorized by the PCP.
- **6.21.6** Behavioral health and substance use disorder pharmacy services, including ADD/ADHD medications and other Psychotropic medications, are covered when listed on the PLAN's formulary and prescribed by (a) Participating Aetna Better Health of Michigan Providers; (b) the Behavioral Health and Developmental Disabilities Administration (BHDDA) or; (c) the Coordinating Agencies (CA). Some medications may require a prior authorization.
- **RESTORATIVE/REHABILITATIVE NURSING CARE.** Intermittent or short term restorative or rehabilitative nursing care, in a nursing facility while convalescing from general conditions and pulmonary TB, as Authorized by the PLAN, for a period of up to one hundred twenty (120) days per admission. After all benefit days have been exhausted, they are renewed when there has been a lapse of at least ninety (90) days from discharge date until the next admission date. The PLAN shall also cover restorative or rehabilitative nursing care outside of a nursing facility.
- **6.23 ESRD.** End Stage Renal Disease Services.
- **6.24 WEIGHT LOSS CLINIC.** Counseling is covered for morbid obesity when prescribed by a physician.
- **6.25 FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CENTERS.** Members may choose a Federally Qualified Health Center ("FQHC") or Rural Health Center ("RHC") as their Primary Care Physician. Members may also access Covered Services at Tribal Health Centers without prior authorization.
- **6.26 COMMUNICABLE DISEASES.** Members may receive treatment for communicable diseases such as AIDS/ HIV, Sexually Transmitted Diseases ("STDs"), tuberculosis, and vaccine-preventable communicable diseases.
- **6.27** CHILD & ADOLESCENT HEALTH CENTERS & PROGRAMS. Members may obtain Covered Services from Child & Adolescent Health Centers ("CAHCPs") without Prior Authorization from the PLAN.
- **6.28 PERSONS WITH SPECIAL NEEDS.** Members with special health care needs are entitled to (a) an assessment to identify any special conditions that require ongoing case management services and (b) direct access to specialists as appropriate for the Member's condition and identified needs.
- 6.29 **DIABETES EQUIPMENT, SUPPLIES, TRAINING, and SERVICES.** 
  - **6.29.1** The PLAN will cover the following equipment, supplies and educational training related to the treatment of diabetes if determined to be Medically Necessary and prescribed by the Member's PCP or a Specialist Physician to whom the Member is Appropriately Referred: (a) blood glucose monitors for

the legally blind; (b) test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices; (c) insulin syringes; (d) insulin pumps and medical supplies required for the use of an insulin pump; and (e) diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management training of their condition.

- **6.29.2** Coverage for diabetes self-management training shall be available subject to the following conditions:
  - (a) training is limited to completion of a certified diabetes education program should either of the following occur:
    - (i) training is considered Medically Necessary upon the diagnosis of diabetes by the Member's PCP or Specialist Physician to whom the Member is Appropriately Referred who is managing the Member's diabetic condition, and the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or
    - (ii) the Member's PCP or a Specialist to whom the Member is Appropriately Referred diagnoses a significant change with long term implications in the Member's symptoms or conditions that requires changes in the Member's self-management or a significant change in medical protocol or treatment modality.
  - (b) training shall be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the MDHHS. This training shall be conducted in a group-setting whenever practicable.
- **TOBACCO CESSATION TREATMENT.** The PLAN will cover Tobacco Cessation Treatment for all members, including pregnant women. The benefit includes diagnostic, therapy and counseling services and pharmacotherapy (including coverage of prescription and non-prescription tobacco cessation agents approved by the Federal Drug Administration (FDA). The PLAN may place a reasonable limit on the type and frequency of over-the-counter and prescription drugs covered under this benefit. Prior authorization is required.
- **6.31 OUT-OF-STATE SERVICES AUTHORIZED BY THE PLAN.** Prior authorization is required for the services of out-of-state hospitals and physicians, except for Emergency Medical Services necessary to evaluate or stabilize an Emergency Medical Condition found to exist using the prudent layperson standard.
- **6.32 ACUPUNCTURE THERAPY.** The PLAN will cover acupuncture therapy services up to a maximum of twenty (20) visits in a calendar year when performed by (not just under the directions of) a physician (M.D. or D.O.) for the treatment of any one of the following illnesses:
  - **6.32.1** Sciatica
  - **6.32.2** Neuritis

- **6.32.3** Post herpetic neuralgia
- **6.32.4** Tic douloureaux
- **6.32.5** Chronic headaches, e.g., migraine
- **6.32.6** Osteoarthritis
- **6.32.7** Rheumatoid arthritis
- **6.32.8** Myofascial complaints, e.g., neck and lower back pain
- **6.33 THERAPY (INPATIENT & OUTPATIENT).** Short-term physical therapy and medical rehabilitation services, including speech and functional occupational therapy from a Participating Provider, limited to restoring or improving functional loss caused by injury, illness, disease, or congenital anomaly. Physical, speech and occupational therapies are limited to a combined maximum of sixty (60) visits per member per calendar year. In order for such services to be covered by the PLAN, Member is required to obtain the prior approval and authorization of a PCP.

# **SECTION 7.0 EXCLUSIONS**

- **7.1 NON-COVERED SERVICES.** Services not listed in Section 6 are Excluded under the Agreement, unless required to be Covered by MIChild program or Michigan law. Under the provisions of this Agreement, the following services shall **not** be Covered by the PLAN:
  - **7.1.1** Services obtained by a member outside the PLAN Service Area and not authorized by the PLAN are not Covered, except for Emergency Medical Services as described in Section 6.7.
  - **7.1.2** Dental services except as specifically provided in Sections 6.3 and 6.8.
  - **7.1.3** Private duty nursing services if provided by a person who lives in the member's home or who is a member of the member's family or the family of the member's spouse.
  - **7.1.4** Non-medical ancillary services such as vocational rehabilitation and employee counseling.
  - **7.1.5** Cosmetic Services and Surgery; including but not limited to breast augmentation, refractive eye surgery, non-Medically Necessary reduction mammoplasty, rhinoplasty, spider or varicose vein repair.
  - **7.1.6** Services not required to be provided to MIChild beneficiaries under the terms of the Comprehensive Health Care Program for MIChild Program.
  - **7.1.7** Weight reduction whether by surgery or commercial or medical programs, except when Medically Necessary to treat morbid obesity, and authorized by the PLAN.
  - **7.1.8** Podiatric services.
  - **7.1.9** Faith healing.
  - **7.1.10** Elective termination of pregnancy (abortion) and related services, except as set forth in Section 6.
  - **7.1.11** Personal comfort items such as telephone, television and similar items.
  - **7.1.12** Any and all infertility treatment or related services. This exclusion applies, without limitation, to services performed in connection with any non-coital form of conception such as artificial insemination, intrauterine insemination, in vitro fertilization (IVF), intrafallopian transfers, donor egg/donor sperm programs, pre-implantation genetic testing, embryo transplantation, reversal of voluntary sterilization, and transsexual surgery and related preparatory treatments, and any related diagnostic and therapeutic services unique to these technologies.
  - **7.1.13** Services related in any way to surrogate parenthood, including, but not limited to, otherwise Medically Necessary obstetrical services.

- **7.1.14** Custodial or basic care (care that is or can be provided by individuals without specific health care skills, training, or licensure), including private duty, convalescent care services and general housekeeping services provided on an inpatient, outpatient or in-home basis.
- **7.1.15** Food and nutritional supplements and over-the-counter drugs available without prescription.
- **7.1.16** Non-prescribed dietary supplements, vitamins, minerals, and infant formula.
- **7.1.17** Except as prescribed as treatment for diabetes, routine foot care such as treatment or trimming of corns, calluses, toe nails, evaluation and treatment of subluxations of the feet and flat feet; and pedicures.
- **7.1.18** Home births.
- **7.1.19** Long-term rehabilitative treatment.
- **7.1.20** Fees, costs, and expenses incurred by a person who donates an organ or tissue, unless the recipient is a PLAN Member and the donor's own health benefit plan does not otherwise cover the expenses.
- **7.1.21** Speech therapy for foreign accent reduction or English as a second language.
- **7.1.22** Prosthetic hair, hair transplants or other services, procedures or supplies designed to enhance hair growth are excluded, regardless of diagnosis.
- **7.1.23** Testing to determine parentage or DNA testing.
- **7.1.24** Services Payable Under Other Programs. Services are excluded from coverage under the Agreement to the extent the services are provided, paid or payable:
  - 7.1.24.1 Under an extended benefit provision of any other health insurance or health benefits plan, policy, program or certificate.
  - <u>7.1.24.2</u> Under any policy, program, contract or insurance as provided under Section 8.2 of this certificate.
  - 7.1.24.3 Under any school district and billed through the Intermediate School District, veterans or public programs, including but not limited to Home & Community-Based Waiver Program Services.
  - <u>7.1.24.4</u> Substance Use Disorder Services such as screening, assessment, detoxification, intensive outpatient counseling, other outpatient services, methadone treatment and

medications presecribed specifically for the purpose of substance use disorders. Refer to the Member Handbook for instructions on how to access these services or call Member Service at **1-866-316-3784**.

- 7.1.24.5 Behavioral Health Services for Members, including prescriptions written by the Behavioral Health and Developmental Disabilities Administration (BHDDA), are provided by the local Community Mental Health Service Program. Refer to the Member Handbook for instructions on how to access these services or call the PLAN's Member Service at **1-866-316-3784**.
- 7.1.24.6 Inpatient hospital psychiatric services. The PLAN will not Cover physician costs related to providing psychiatric admission histories and physicals, but if medical services are needed for care other than psychiatric care during a psychiatric inpatient admission, the PLAN will pay for Prior Authorized and Medically Necessary Covered Services.
- 7.1.24.7 Outpatient Partial Hospitalization Psychiatric Care.
- 7.1.24.8 Services, including therapies (speech, language, physical, occupational), provided to persons with developmental disabilities and billed through Community Mental Health Services Program providers or Intermediate School Districts.
- **7.1.25** Non-emergent transportation.
- **7.1.26** Over-the-counter medicines (other than as provided in Section 6.21.2). Standard "medicine cabinet" items, including but not limited to, first aid supplies.
- **7.1.27** Disposable medical supplies (other than as provided in Section 6.21.5).
- **7.1.28** Experimental and investigational services, which include any drug treatment, device, procedure, service or benefit which is experimental or investigational, with the exception of anti-cancer drugs as defined in Section 6.21.4 of this Agreement. For the purposes of this Agreement, a drug, treatment, device, procedure, service or benefit may be considered to be experimental or investigational if it meets any one of the following criteria: (a) it cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and such approval of the FDA was not granted at the time of the use or proposed use; (b) it is the subject of a current investigational new drug or new device application on file with the FDA; (c) it is being provided pursuant to a research, investigational or experimental stage or phase of a clinical trial as established, monitored or regulated by any state or federal government or agency; (d) it is being provided pursuant to a written protocol which describes among its objectives, determination of safety, efficacy, efficacy in comparison to conventional alternatives or toxicity; (e) it is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services; (f) the predominant opinion among experts as expressed in the published

authoritative literature is that usage should be substantially confined to research settings; (g) if the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to determine safety, toxicity, efficacy, or efficacy in comparison to conventional alternatives; or (h) it is not investigational in itself pursuant to any of the foregoing criteria, and would not be Medically Necessary, but for the provision of a drug, device, treatment, or procedure which is "investigational or experimental." Without limiting the above the following are considered experimental or investigational and therefore are not Covered Services:

- 1. Fees associated with the care, services, supplies, devices or procedures, which are investigational or are in conjunction with research studies.
- 2. Medical services which are generally regarded by the medical community to be unusual, infrequently provided, and not necessary for the protection of health.
- 3. Services associated with organ or tissue transplantation that is considered experimental.
- **7.1.29** Organ donor related services, except as stated in Section 6.13.
- **7.1.30** All health services rendered as a result of a court order, unless otherwise medically necessary, or during Member's incarceration in any jail or prison to extent services are payable by the court or jail or prison authorities.
- **7.1.31** Health services or prescription drugs not provided by a Participating Provider except approved referrals, Emergencies, and as otherwise stated herein.
- **7.1.32** Durable Medical Equipment. (a) Deluxe equipment such as motorized wheelchairs and beds, unless Medically Necessary; (b) Items not medical in nature; (c) Physicians' equipment such as stethoscopes and sphygmomanometers; (d) Comfort and convenience items such as bed boards, overbed tables, telephone arms and air conditioners; (e) Exercise and hygiene equipment such as exercycles, toilet seats and tub or shower seats; (f) Self-help devices not primarily medical in nature such as saunas, elevators, ramps and special telephone or communication devices; (g) Experimental or research equipment. Replacement of Durable Medical Equipment due to intentional damage by any individual is not a Covered Service.
- **7.1.33** Parenting and Birthing classes.
- **7.1.34** Sterilization procedures unless Prior Authorized by the PLAN.
- **7.1.35** Intermittent or short term restorative or rehabilitative nursing care, in a nursing facility after a period of one hundred twenty (120) days except as described in Section 6.22.
- **7.1.36** Traumatic Brain Injury Program Services.

- 7.1.37 Maternal and Infant Health Program ("MIHP").
- **7.1.38** Transplants of artificial organs.
- **7.1.39** Repairs and replacement of parts (including batteries and ear molds) for hearing aids. Replacement of lost or broken hearing aids are not covered unless the thirty-six (36) month coverage limitation does not apply.

#### 7.2 OTHER EXCLUSIONS

- **7.2.1** Care rendered by Member or a Member's family member or by a business entity that Member or a family member of Member controls.
- **7.2.2** Any service or supply, or portion of a charge thereof, for which Member has no financial liability, or that was provided free of charge.
- **7.2.3** Services and/or supplies obtained fraudulently.
- **7.2.4** Services and/or supplies rendered prior to Member's Effective Date.
- **7.2.5** Charges resulting from Member failing to appropriately cancel a scheduled appointment.
- **7.2.6** Services and/or supplies prohibited from being rendered by law or regulation.
- **7.2.7** Procedures to repair or remove varicose veins unless Medically Necessary.

# SECTION 8.0 COORDINATION OF BENEFITS AND SUBROGATION

- **8.1** COORDINATION IN GENERAL WITH OTHER INSURANCE. By federal and state law, the Covered Services provided under this Agreement are secondary to benefits available under any other health benefit plan or plans (such as individual, group, employer-related, self-insured or self funded plan or commercial carrier) to which a Member is eligible, the PLAN will identify and seek recovery from all other liable third parties.
- **8.2 PLAN'S SUBROGATION RIGHTS.** The PLAN shall be subrogated and shall succeed to any Member's rights of recovery from a third party (such as automobile insurance, liability insurance, and worker's compensation insurance) for incurred services provided under this contract.

The Member shall reimburse the PLAN to the extent of the amounts recovered by said Member as a result of any lawsuit, settlement, or otherwise, less the PLAN's pro-rated share of attorney fees and costs sustained by the Member in obtaining such a recovery. If the attorney fees of the Member are to be paid on a contingency basis, the PLAN's right of subrogation will be reduced by its pro-rata share of attorney fees which do not exceed twenty-five (25) percent of any recovery. The Member shall, upon request by the PLAN, execute and deliver such instruments and papers as may be required to do whatever else may be necessary and reasonable to carry out this Section 8.2.

**8.3 COORDINATION WITH MEDICARE.** Members who become eligible for both MIChild and Medicare coverage are ineligible for enrollment in the PLAN. The PLAN shall initiate disenrollment with MDHHS. When a Member is also enrolled in Medicare, Medicare will be the primary payer ahead of the PLAN. The PLAN will pay or otherwise cover all cost-sharing amounts incurred by the Member such as coinsurance and deductibles required by Medicare. Members who are eligible for Medicare must apply for Medicare coverage.

# **SECTION 9.0 MEMBER RIGHTS**

- **9.1 INSPECTION OF RECORDS.** A Member, parent, guardian or authorized representative of a Member may review the records of the PLAN relating solely to the Member or a minor Dependent of the Member who is also a Member, at the offices of the PLAN during regular business hours and at an appointed hour reasonably granted on request by the Member for that purpose.
- **9.2 REFUSAL TO ACCEPT TREATMENT.** A Member may for personal or religious reasons refuse to accept the recommended treatment or procedures recommended by a Participating Physician (or Health Professional). Such refusal to accept treatment may be regarded as incompatible with the physician/patient relationship and as an impediment to the rendering of proper health care. If a Member refuses to accept recommended treatment and no reasonable alternative for treatment exists, the Member shall be so advised. If the Member still refuses recommended treatment, neither the PLAN nor the Physician shall have further responsibility to provide care for the condition being treated. The foregoing is subject to the Member's right to file a grievance in accordance with the Grievance and Appeal Program.
- **9.3 MEMBER'S RESPONSIBILITY FOR PAYMENT.** If the member receives any services from a Non-Participating hospital, Physician, Health Professional, Skilled Nursing Facility or other entity and is informed of the responsibility to pay prior to receiving services, the member is responsible for payment except in the case of a Medical Emergency or Urgent Care situation. If the services are authorized by the Member's PCP and approved by the Plan, the member is not responsible for payment.
- 9.4 NON-PARTICIPATING PROVIDERS. The PLAN shall reimburse Non-Participating Providers for Covered Services if the services (a) were Medically Necessary, (b) were Authorized by the PLAN, and (c) could not reasonably have been obtained from a Participating Provider, inside or outside of the state of Michigan on a timely basis. This shall be applicable to Non-Participating Providers located in and out of the state of Michigan. The PLAN shall pay qualifying claims from Non-Participating Providers at established Michigan MIChild fees in effect on the date of service. If Michigan MIChild has not established a specific rate for the Covered Service, the PLAN will follow Medicaid policy for the determination of the correct payment amount.
- **9.5 NOTICE OF CHANGE OF ADDRESS, OTHER COVERAGE, CHANGE IN ELIGIBILITY, LOSS OR THEFT OF IDENTIFICATION CARD.** Member agrees to notify the PLAN promptly, either in writing or by telephone, of any change in address or if the Identification Card is lost or stolen. Member agrees to give the PLAN notice of any other health benefit coverage under which the Member is covered at the time of enrollment or at any time thereafter while this Coverage is in effect, or any change in eligibility.
- **9.6 AUTHORIZED FOR RELEASE AND RECEIPT OF INFORMATION.** Member agrees to allow the PLAN to obtain information from any provider of services that provides Covered Services to Member as may be reasonably necessary to administer Covered Services under this Agreement. By accepting Coverage under this Agreement, Member agrees to authorize such providers to provide reports and information to the PLAN and to other providers in connection with the care, treatment and physical condition of Member. This consent

will terminate when Coverage terminates and all claims for Covered Services have been processed. Member agrees to provide a signed authorization to release medical records upon request by the PLAN. By signing the application for MIChild coverage, Member has granted the PLAN permission to use Member health information consistent with the HIPAA Privacy Rule.

**9.7 CONFIDENTIALITY.** Confidentiality of Member information maintained by the PLAN will be protected in accordance with applicable state and federal statutes including HIPAA. Please refer to the PLAN's Notice of Privacy Practices.

# SECTION 10.0 GRIEVANCE AND APPEAL PROCEDURES

We take Your concerns seriously and we have procedures for responding to them. You can voice Your concerns, misunderstandings and/or dissatisfaction with any aspect of Our policies and procedures or care rendered by a Participating Provider, or if You are displeased with a decision We made regarding services you requested. At any time within ninety (90) days after our initial Adverse Determination, or action we took that You are dissatisfied with, You may file a Grievance/Appeal with Us, or You may request a Patient Right to Independent Review Act PRIRA Review through DIFS to resolve Your Appeal. All Grievance/Appeal information will be provided to You in Your prevalent language. TTY/TDD (Teletypewriter/Telecommunication Device for the Deaf) and interpretive services will also be made available upon request.

**10.1 GRIEVANCES/APPEALS.** You may file a Grievance/Appeal if You are upset about the quality of services that You received, or the relationship that You have with Us, or Your Provider, or if You are concerned about Your rights as a Member. You may also file a Grievance/Appeal due to an Adverse Determination or denial of payment that We made such as when we:

- Deny or limit authorization of a service that You or Your Provider requests.
- Fail to make payment or provide, in whole or in part, a benefit to You.
- Fail to provide services in a timely manner.
- Reduce, either entirely or partially, suspend, or terminate a benefit or previously authorized service (except when reduction, suspension, or termination result from state or federal action).
- Fail to act within specified timeframes when We handle your Appeal.
- Fail to authorize or Cover services because We think that the services are experimental, investigational, cosmetic, or not Medically Necessary or appropriate.

By filing a Grievance/Appeal with Us, You are asking Us to reconsider the decision that We made because You, or Your Authorized Representative, think that You are entitled to receive the requested service or have the service paid for, or have us do something differently. Your Provider may also file a Grievance/Appeal on Your behalf, provided that You complete and send to Us an Authorized Representative Form that gives Your permission for Your Provider to act on Your behalf. In the event of an Urgent/Expedited Grievance/Appeal, Your treating provider can file a Grievance/Appeal on Your behalf without submitting an Authorized Representative Form.

You can file a Grievance/Appeal before You receive the requested service. This is called a Pre-Service Grievance/Appeal. You can also file a Grievance/Appeal after You receive the requested service. This is called a Post-Service Grievance/Appeal. You or Your Provider can also file an Urgent/Expedited Grievance/Appeal if You think that the timeframes of the Grievance/Appeal process could seriously jeopardize Your life or health, or if You are pregnant, the life or health of Your fetus, or Your ability to attain, maintain, or regain maximum function. Please read below for more information about the Grievance and Appeals Process.

If you need help filing a Grievance/Appeal, We are here to help You. Please contact the Appeals Coordinator at **1-866-316-3784**. If You send Your Grievance/Appeal to Us in writing, We will send You a letter acknowledging Our receipt of Your Grievance/Appeal within three (3) days of Our receiving it. We will contact You within

thirty (30) days to let You know how Your Grievance/Appeal was resolved. If you need Your Grievance/Appeal reviewed on an Expedited basis because it involves a medical condition that requires an immediate response from Our Health Services Department, We will respond to Your Grievance/Appeal within forty-eight (48) hours of receiving it. The PLAN staff reviewing Your Grievance will not have been previously involved in any prior decisions about Your Grievance/Appeal. The PLAN will make sure that the staff reviewing Your Grievance/Appeal has the necessary qualifications to review Your Grievance/Appeal.

#### 10.2 THE GRIEVANCE/APPEAL PROCESS

- **10.2.1** If You receive an Adverse Determination or denial of payment from Us, or if We did something you're dissatisfied with, You can dispute it using the Grievance/Appeal process described below. You can also have Your Provider act on Your behalf. To do that, You must complete an Authorized Representative form, which You can receive by calling Member Service.
- **10.2.2** Your Grievance/Appeal must be filed within ninety (90) calendar days of the date of Our Adverse Determination or denial of payment, or action that You are dissatisfied with. Requests for Grievances/ Appeals received after ninety (90) calendar days will not be eligible for review under Our internal Grievance/Appeal process. At any time, you can contact the Appeals Coordinator at **1-866-316-3784**.
- **10.2.3** You, or Your Authorized Representative, need to send Us a written request that includes Your name, the name of the treating Provider, the date of service (if it already took place), a description of the service that was requested or received and denied by Us, or the action We took that You are dissatisfied with. Your (or Your representative's) mailing address, an explanation of why We should reverse Our decision, and a copy of any information that will support Your request. You may also provide Us with any additional documents, records or information that is relevant to Your Grievance/Appeal.
- **10.2.4** If You have an Authorized Representative, You should also send us the completed Authorized Representative form. Such requests should be addressed to: Aetna Better Health of Michigan 1333 Gratiot Ave. Suite 400, Detroit, MI 48207. Attn: Appeals Coordinator. If You would like to have an Authorized Representative act on Your behalf, We cannot begin to review Your Grievance/Appeal until We receive the Authorized Representative form. If We receive Your Grievance/Appeal without an Authorized Representative Form, We will not start to process Your Grievance/Appeal until We get this form. You may submit an Authorized Representative Form at any time before the end of the ninety (90) day period in which You are entitled to submit an Grievance/Appeal to Us. Our timeframe to review Your Grievance/Appeal will begin on the day that We receive the Authorized Representative Form from You.
- **10.2.5** If You or Your representative cannot file a written Grievance/Appeal, You may contact Us so that We can obtain the above information and fill out the necessary documents to start Your Grievance/Appeal. You or your representative may request access to and copies of documents, records and information relevant to the Grievance/Appeal. We will provide you with that information free of charge. We will also provide You with assistance, if You need it, with completing the paperwork and other steps of Your Grievance/Appeal, for example, if You need an interpreter or a TTY/TTD capability.

- **10.2.6** Within five (5) working days of Our receipt of Your Grievance/Appeal, the Appeal Coordinator will send a letter to You or Your Authorized Representative confirming receipt of the Grievance/Appeal. The notice will also notify You or Your Authorized Representative of Your rights during the Grievance/Appeal process, including: information on how to contact the Appeal Coordinator who has been appointed to assist in resolving formal Grievance/Appeals; Your right to appear before the Appeal Committee; Your right to request a representative to act on Your behalf; Your opportunity to participate in the hearing in person, via conference call, or other appropriate technology; and the right of reasonable access before and during the Grievance/Appeals process, upon request and free of charge, to all documents, records and other information considered during the Appeal process. You should contact the Appeal Coordinator if You or Your Authorized Representative would like to participate in the hearing. The Appeal Coordinator may also notify You or Your Authorized Representative expresses a desire to participate in the hearing, the Appeal Coordinator will send an additional letter to You or Your Authorized Representative with details about the hearing including the time, date, location and/or conference call telephone number into which You or Your Authorized Representative should dial.
- **10.2.7** If We determine that We need an extension in order to obtain additional information from your treating Provider, and it is in Your best interest, We will extend Our time period once during the Grievance/Appeal process for up to ten (10) calendar days with Your permission.
- **10.2.8** Depending on whether Your Grievance/Appeal involves a medical or non-medical issue, the Appeal Committee will be made up of the PLAN's senior managers and/or the PLAN's Medical Director, and other health professionals. No one on the Appeal Committee was involved in making the original decision about Your care, or reports to the person who madethe original decision about Your care.
- **10.2.9** We will render a final decision within five (5) business days of the Appeal Committee meeting and within thirty (30) calendar days after the date the Grievance/Appeal was received. We will send written notice of Our decision to You or Your Authorized Representative within thirty (30) calendar days after your Grievance/Appeal is received. The notification will include:
  - The specific reason(s) for the determination;
  - Reference to the specific Coverage provision on which the determination was based (i.e., reference to the specific section in Your Evidence of Coverage);
  - Notice if an internal rule, guideline or protocol was utilized in making the determination, and if an internal rule, guideline or protocol was utilized in making the determination, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;
  - If the Grievance/Appeal decision is based on medical necessity, experimental treatment or a similar exclusion (i.e., investigational, cosmetic, etc.), the specific clinical rationale for the determination;

- Notice of any further Grievance/Appeal rights
- A list of the persons on the Appeal Committee;
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to Your Grievance/Appeal; and
- A statement of Your rights to appeal to the Michigan Department of Insurance and Financial Services (DIFS) under the Patient Right to Independent Review Act (PRIRA)

#### 10.3 URGENT/EXPEDITED GRIEVANCES/APPEALS

- **10.3.1** You or Your Authorized Representative (which may include the treating Provider) may file an Urgent/Expedited Grievance/Appeal in writing or orally. The Urgent/Expedited Grievance/Appeal may be submitted verbally or in writing to: Aetna Better Health of Michigan Attn. Appeals Coordinator, 1333 Gratiot Ave. Suite 400 Detroit, MI 48207 or verbally by calling The PLAN at **1-866-316-3784**. Once You have filed Your Urgent/Expedited Grievance/Appeal due to Adverse Determination with the PLAN and the medical documentation supports the need for an Urgent/Expedited external review, you can also request an Urgent/Expedited PRIRA Review with DIFS. You do not have to wait for the PLAN to make a decision on Your Grievance/Appeal (See Section 10.5 below for more information).
- **10.3.2** If You would like to have an Authorized Representative, other than Your treating Provider, act on Your behalf during an Urgent/Expedited Grievance/Appeal, and You are unable to submit an Authorized Representative Form to Us because of Your incapacity or an emergency circumstance, We may proceed with Your Grievance/Appeal and communicate with the purported Authorized Representative if it is in Your best interest and if the information disclosed is directly relevant to Your Grievance/Appeal.
- **10.3.3** To request an Urgent/Expedited Grievance/Appeal, You or Your Authorized Representative must give Us Your name, Your Provider's name, the date of service (if it already took place), a description of the service that was requested or received and denied by Us, or the action We took that You are dissatisfied with. Your (or Your Authorized Representative's) mailing address and telephone number, an explanation of why We should reverse our decision, and a copy of any information that will support Your request.
- **10.3.4** If there is insufficient information provided with the Urgent/Expedited Grievance/Appeal, We will notify You or Your Authorized Representative immediately by telephone of the information needed. If the necessary information is not received, the Appeal committee will make a decision based on the information available.
- **10.3.5** If a physician with knowledge of Your medical condition determines that a Grievance/Appeal involves Urgent/Expedited, We will treat your Grievance/Appeal as an Urgent/Expedited Grievance/Appeal. If You request an Urgent/Expedited Grievance/Appeal, but Your Provider does not also state that Your Grievance/Appeal should be handled on an Urgent/Expedited basis, Our Medical Director will review Your Grievance/Appeal to determine if Your Grievance/Appeal qualifies as an Urgent/Expedited

Grievance/Appeal. If We decide that Your Grievance/Appeal is not an Urgent/Expedited Grievance/Appeal and that it should be processed as a standard Grievance/Appeal, We will verbally notify You as soon as possible, and send You a letter within two (2) days.

- **10.3.6** If We proceed with Your Urgent/Expedited Grievance/Appeal, a hearing will be scheduled with an Appeal Committee to take place within forty-eight (48) hours of Your request, and Your Grievance/Appeal will be resolved within seventy-two (72) hours of Your request. You and/or Your Authorized Representative may participate in the hearing. If You or Your Authorized Representative request an extension during the Urgent/Expedited Grievance/Appeal, the Grievance/Appeal will have to be moved to the standard thirty (30) day timeframe for Us to decide Your Grievance/Appeal. We will provide You with written confirmation of the transfer to the standard Grievance/Appeal timeframes within two (2) days of Your request for extension. If You or Your Authorized Representative chooses to withdraw the request for the extension, We will consider Your Grievance/Appeal on an urgent/expedited basis, within seventy-two (72) hours.
- **10.3.7** None of the individuals on the Appeal Committee will be someone who was involved in the original Adverse decision or who reports to someone who was involved in the original Adverse decision. You or Your Authorized Representative will be offered the opportunity to attend and participate in the Appeals Committee Meeting when your Appeal is considered by the Committee.
- **10.3.8** We will render a final decision and provide verbal and written notice of that decision within seventy-two (72) hours after the date the Grievance/Appeal was received. The notification will include:
  - The specific reason(s) for the determination;
  - Reference to the specific Coverage provision on which the determination was based (i.e., reference to the specific section in Your Evidence of Coverage);
  - Notice if an internal rule, guideline or protocol was utilized in making the determination, and if an internal rule, guideline or protocol was utilized in making the determination, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;
  - If the Grievance/Appeal decision is based on Medical Necessity, experimental treatment or a similar exclusion (i.e., investigational, cosmetic, etc.), the specific clinical rationale for the determination;
  - Notice of any further Grievance/Appeal rights;
  - A list of the persons on the Appeal Committee;
  - A statement that You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to Your Grievance/Appeal; and
  - A statement of Your rights to appeal to DIFS through the PRIRA process.
- **10.4 CONTINUATION OF BENEFITS DURING APPEAL.** During the time that We are processing Your Grievance/Appeal due to an Adverse Determination or while You are waiting for Your DIFS review, You may be entitled to continuation of benefits pursuant to the following:

- **10.4.1** As used in this section, "timely" filing means filing on or before the later of the following: (a) within ten (10) days of Us mailing the Adverse Determination, or (b) the intended effective date of Our proposed Adverse Determination.
- **10.4.2** We will continue Your benefits during the time of the Grievance/Appeal due to an Adverse Determination process or DIFS review when:
  - 10.4.2.1 You or Your Authorized Representative files the Grievance/Appeal due to an Adverse Determination on a timely basis;
  - 10.4.2.2 Your Grievance/Appeal due to an Adverse Determination involves the termination, suspension, or reduction of a previously authorized course of treatment;
  - 10.4.2.3 Your services were ordered by an authorized provider;
  - 10.4.2.4 The original period covered by the original authorization has not expired; and
  - 10.4.2.5 You request extension of the benefits.
- **10.4.3** If, at Your request, We continue or reinstate Your benefits while the Grievance/Appeal due to an Adverse Determination is pending, the benefits must be continued until one of the following occurs:
  - 10.4.3.1 You withdraw the Grievance/Appeal.
  - 10.4.3.2 The time period or service limits of a previously authorized service has been met.
- **10.4.4** If the final resolution of the Grievance/Appeal due to an Adverse Determination upholds the original action, We may recover the cost of the services furnished to You while the Grievance/Appeal was pending, to the extent that such services were furnished solely because of the requirements of this section. You may be required to pay for these services.
- **10.4.5** If We decide in Your favor and reverse a decision to deny, limit, or delay services that were not furnished while the Grievance/Appeal was pending, We must authorize or provide the disputed services promptly and as expeditiously as Your health condition requires.
- **10.4.6** If We reverse a decision to deny authorization of services, and You received the disputed services while the Grievance/Appeal was pending, We must pay for those services.
- **10.5** YOUR RIGHTS UNDER THE PATIENT RIGHT TO INDEPENDENT REVIEW ACT ("PRIRA"). You can request an Expedited PRIRA Review within ten (10) days of filing an Urgent/Expedited Grievance/Appeal with Us when it involved a medical condition for which a physician certifies that the time frame for completing a standard PRIRA review would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum

function. In the case of a Non-Urgent/Expedited Grievance/Appeal, you can request PRIRA Review within sixty (60) days **after** we have issued Our final decision through the Plan's Grievance and Appeal process. You should use the "Health Care Request for External Review Form" that We provide to You. This form can also be found at **http://www.michigan.gov/documents/cis ofis fis 0018 25078 7.pdf**.

To qualify for PRIRA review:

- You must have received an Adverse Determination and a final decision from Us
- You must have been covered by Us on the date of service in question
- The service You requested must reasonably appear to have been a Covered Service under this Agreement and
- You must have exhausted your appeal rights with Us except in the case of an Urgent/Expedited Grievance/Appeal.
  - **10.5.1** If an Expedited PRIRA Review is necessary, it will be completed within seventy-two (72) hours after Your written request was submitted.
  - 10.5.2 Your PRIRA Review request must be sent by fax to 1-517-284-8838 or by UPS or U.S. mail to:

DIFS, Healthcare Appeals Section Office of General Counsel P.O. Box 30220 Lansing, MI 48909-7720

Delivery Service to:

Office of General Counsel – Health Care Appeals Section Department of Insurance and Financial Services 530 W. Allegan St., 7th Floor Lansing, MI 48933-1521

and must include a copy of the Final Adverse Determination from the PLAN, any pertinent documentation about Your case, such as bills, benefits explanations, medical records, correspondence, research materials that support your position, etc. IT IS YOUR RESPONSIBILITY TO SUBMIT THIS DOCUMENTATION; DIFS DOES NOT CONTACT MEDICAL PROVIDERS FOR THIS INFORMATION. YOU SHOULD ALWAYS SEND COPIES; NOT THE ORIGINALS.

- **10.5.3** You do not need to hire a lawyer to request a PRIRA Review. You can authorize someone to act on Your behalf, such as a clergy, a friend, a family member, Your doctor, or a lawyer.
- **10.5.4** DIFS will notify You within five (5) business days of receiving Your request for PRIRA Review if DIFS can handle Your case. If Your case is accepted by DIFS, DIFS will determine whether it needs to

get a recommendation from an Independent Review Organization, which is an entity that can perform an unbiased medical review of Your case. If DIFS does not need to consult with an Independent Review Organization, You can expect to receive a decision from DIFS within fourteen (14) calendar days after Your request was accepted by DIFS for review. If DIFS has to consult with an Independent Review Organization, the Independent Review Organization has fourteen (14) calendar days after it receives the case from DIFS to make a recommendation to DIFS. DIFS then has seven (7) business days to issue its decision to You.

- **10.5.5** If You disagree with DIFS' decision, You can appeal to the Circuit Court of the county in which You live, or the Circuit Court of Ingham County.
- **10.5.6** If the PLAN disagrees with DIFS' decision, the PLAN may appeal within sixty (60) days of the date of the decision to the circuit court for the county in which You reside or the Circuit Court of Ingham County. However, the PLAN may seek other remedies available under applicable state law.
- **10.5.7** PRIRA Review cannot be requested for complaints by Providers regarding claims payment or handling of reimbursement for services. PRIRA Review does not apply to issues of termination, cancellation, or the amount You have to pay for Coverage.
- **10.5.8** If You have questions about PRIRA Reviews, You can call the Appeals Coordinator at **1-866-316-3784**, or DIFS at **1-877-999-6442**.

# **SECTION 11.0 GENERAL CONDITIONS**

- **11.1 ASSIGNMENT.** Assignment by a Member is prohibited.
- 11.2 <u>CIRCUMSTANCES BEYOND THE PLAN'S CONTROL</u>. In the event that, due to circumstances not reasonably within the control of the PLAN, including but not limited to complete or partial destruction of facilities, a major natural disaster, epidemic, war, riot, civil insurrection, labor dispute, disability of a significant part of a hospital or a disability of the PLAN personnel, or similar causes which delay or render impractical the rendition of services described in this Agreement, neither the PLAN nor any Participating Provider shall be liable for such delay or failure to provide services as a result of such circumstances. For purposes of this Section, the term "epidemic" shall mean an outbreak of a contagious disease that spreads rapidly by infection among a population throughout a particular geographic area.
- **11.3 NOTICE.** Any notice required or permitted to be given by the PLAN hereunder shall be deemed to have been duly given if in writing and personally delivered, or if in writing and deposited in the United States Mail with postage prepaid, addressed to the Member at the last address of record on file at the principle office of the PLAN; such notice by the Member shall be deemed to have been given when so personally delivered or mailed, addressed to the PLAN at:

Aetna Better Health of Michigan 1333 Gratiot Ave., Suite 400 Detroit, Michigan 48207

- **11.4 HEADINGS.** The catchline headings and captions in no way shall be considered to be a part of this contract, but are inserted only for the convenience of reference.
- **11.5 GOVERNING LAW.** This contract is made and shall be interpreted under the laws of the State of Michigan and federal law, where applicable.
- **11.6 EXECUTION OF CONTRACT.** The parties acknowledge and agree that the Member's signature or execution on a MIChild Eligibility Application form shall be deemed to be the Member's execution of this Agreement.
- **11.7 SEVERABILITY.** If any provision of the Agreement, on its effective date or thereafter, is determined to be in conflict with Federal or Michigan law or applicable rules and regulations of the Michigan Department of Insurance and Financial Services (DIFS), such provision shall be fully severable and the remaining provisions of the Agreement shall continue in full force and effect.
- **11.8 WAIVER.** The waiver by either party of any breach of any provision of the Agreement shall be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right under this Agreement shall not operate as a waiver of such right.

**11.9 DISCLAIMER.** The PLAN contracts with independent physician groups who provide health care to Members and other patients. The PLAN does not directly furnish medical care, make medical judgments, or assume any responsibility for the physician's medical treatment of the Members.

**11.10 AMENDMENTS.** This Agreement may be amended from time to time, in writing in the form of a rider to this Agreement, as required due to changes in MIChild program policies or coverages, or state and federal regulations.

