Upper Peninsula Health Plan

Medicaid Certificate of Coverage

Table of Contents

MEDICAID
CERTIFICATE OF COVERAGE

Agreement delivered in: Michigan.

Read this entire Certificate carefully. It describes the rights and obligations of Members and Upper Peninsula Health Plan. It is the responsibility of the Member to understand the terms and conditions of this Certificate.

In some circumstances, certain medical services are not Covered or may require prior Certification by Upper Peninsula Health Plan.

SECTION 1: About this Certificate

This Certificate sets the terms and conditions of Coverage and describes the health care services that are Covered for Members under this Medicaid Plan.

This Certificate only covers Medically/Clinically Necessary services or supplies that are furnished while a person is a Member. It replaces and supersedes any Certificate we may have issued in the past.

Defined terms are capitalized when used in this Certificate. You may find these definitions in Section 15. The terms "We", "Us", and "Our" refer to Upper Peninsula Health Plan. The terms "You", "Your", and "Yourself" refer to the Member.

If You have any questions about Coverage, contact Customer Service in writing at Upper Peninsula Health Plan, 853 W. Washington Street, Marquette, MI 49855, or by telephone at (800) 835-2556.

SECTION 2: Obtaining Covered Services

A. Primary Care Provider (PCP)

Your PCP arranges Your medical care. He or she provides Your primary health care and refers You to and consults with Specialist Providers, Participating Providers, and Non-Participating Providers when necessary. Your PCP provides or coordinates such services as, among other things, ordering of lab tests and x-rays, prescribing medicine or therapies, and arranging hospitalization. You must talk with Your PCP about any issues concerning Your medical care. We will only Cover services that Your PCP provides or refers and that We Certify, unless we tell you otherwise in this Certificate.

When You enroll, You can choose a PCP. If You do not choose a PCP, one will be assigned to You. You have the right to change the PCP that was assigned. The Health Plan's Participating Providers are listed in the provider directory. Each member of your family may have a different PCP. If You need help choosing a PCP, call Customer Service at (800) 835-2556. When You change Your PCP, all medical treatment You are currently receiving must be pre-authorized and approved by Your new PCP.

You can voluntarily change Your PCP (and the Parent/Guardian may change the PCP of a minor or a Member who is incapable of choosing a PCP). To do this, contact Customer Service. The change will take effect on the first day of the month after We receive Your request. A PCP change cannot be made while You are in the Hospital.

B. Who Can be Your PCP?

You can choose from a list of doctors who specialize in family practice, general practice, OB/GYN, internal medicine, or pediatrics or a nurse practitioner or physician assistant in one of these offices. People with a chronic disease often need to see a Specialist to obtain care. In these limited cases, it may be better for the Specialist to be Your PCP. The Specialist must agree to be Your PCP. You should call Customer Service if You think You need a Specialist for a PCP.

C. You may obtain services from Federally Qualified Health Centers and Rural Health Clinics without prior approval from the Health Plan. These services include immunizations, family planning services, well child visits, and visits for illnesses or injuries.

D. Termination of Provider's Participation

A Participating Provider, or We, can terminate the provider's contract. They, or We, can also limit the number of Members the Participating Provider will accept as patients. We do not promise that You will be able to receive services from a specific Participating Provider the entire time You are Covered by Us. We will notify you if Your PCP stops acting as a PCP. You agree to choose another PCP with Our help, if needed.

A provider other than a PCP who provides services might stop acting as a Participating Provider. If that happens, You must work with Your PCP to choose another Participating Provider. Otherwise, any services You receive may not be Covered.

If You are being actively treated when a Participating Provider's contract with Us is terminated, You may continue to be treated by the provider for 90 days or until Your treatment is finished, whichever is first. If You are in Your second or third trimester of pregnancy, You can continue to see the provider until Your postpartum care directly related to Your pregnancy is over. If You have an advanced illness, You may continue to see the provider for the remainder of Your life for care directly related to treatment of Your advanced illness.

E. Referrals

At times, You may need services from a Participating Provider, a Specialist Provider, or a Non-Participating Provider. When that happens, Your PCP will direct the care you need. If a service you need is in the office of the Health Plan participating specialist, you do not need a written referral. Your PCP knows which services need to be authorized by us. All services from a Non-Participating Provider must be Certified by the Health Plan with a referral from your PCP before you see the Non-Participating Provider. Otherwise, You must pay for the services. You also must pay for those services beyond those Certified.

NOTE: If Your PCP suggests a service that is not Covered, You will be responsible for the cost of that service.

F. Care after Regular Office Hours

Your PCP must have telephone Coverage 24 hours a day, 7 days a week. If you become ill or are injured after regular office hours, You should call Your PCP's office and tell them You are a Member of the Health Plan. Your PCP or covering Participating Provider may give advice over the phone, prescribe medicine or therapy, ask You to come into the office, or refer You to an emergency room or another Participating Provider to receive help.

G. Review of Health Care Services and Supplies

We can review services and supplies that Health Professionals recommend to decide whether those services and supplies are Covered. If We decide that the services and supplies are not Covered, We will let You know. If You want Our decision reviewed, You must contact Us. See Section 11 for instructions.

H. Upon request, We can supply You with the licensing verification telephone number for the Michigan Department of Insurance and Financial Services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken against a health care provider in the immediately preceding three years.

SECTION 3: Enrollment

To enroll, You must have Medicaid eligibility, and you must have selected Our plan or have been assigned to Our plan by the State's Enrollment Broker.

We will Cover inpatient care for Your Newborn child from the child's date of birth. The Newborn will automatically be a Health Plan Member for at least the birth month. You can choose to change the health plan for a future date by contacting the State's Enrollment Broker.

A. Notification of Change in Status

You must let Us know about any changes that affect Coverage under this Certificate. You do that by calling Customer Service. You must also contact Your Department of Health and Human Services caseworker to update this information. That must be done if, for example, any of the following happens to anyone Covered under this Agreement:

(1) Change of address or telephone number;
(2) Eligibility for Medicare or enrollment in Medicare; or,
(3) Covered under other insurance.

Remember, these are just examples, and You must let Us know about any other change that, according to this Certificate, affects Coverage. You must let Us know about the change within 31 days after the change happens.

You do not need to contact the State when You want to make a PCP change. Contact Customer Service at (800) 835-2556, and We will assist You.

B. Loss of Eligibility

You will lose Your eligibility, and Your coverage will terminate, if You stop meeting the eligibility criteria as set forth by the Department of Health and Human Services.

SECTION 4: Effective Dates of Coverage

A. General Rules

Except as explained below in Subsection B, Your Coverage will begin on the first day of the month the State notifies Us of Your enrollment.

B. Non-Hospitalization Requirements

If You are hospitalized for treatment of an Illness or Injury when Coverage would otherwise begin, Your Coverage will not begin until that hospitalization ends. You should call Us to verify. The non-hospitalization rule does to apply to a Newborn if the mother was enrolled with Us on the date of delivery.

SECTION 5: Co-Pay Information

Some covered services may have a co-pay. We will tell you if you have a co-pay. You will never have a co-pay for family planning products or services, for pregnancy-related products or services, or for preventive services.

If you have any questions, call customer service at (800) 835-2256.

SECTION 6: Schedule of Covered Services

You are entitled to the Covered Services described below when those services are:

A. Medically/Clinically Necessary;

B. Provided by Your PCP, or provided by a Participating Provider and approved in advance by Us when we consider approval necessary, or provided by a Non-Participating Provider upon referral from Your PCP and Certified in advance by Us when We consider Certification necessary (except in a Medical Emergency); and,

C. Not excluded elsewhere in this Certificate. You should carefully review the rest of this Certificate information about the extent of Your Coverage.

Sometimes, Your PCP may refer You for or suggest a service that is not a Covered Service. If You receive a service that is not a Covered Service, You must pay for that service.

The Covered Services are:

A. PRIMARY CARE. Primary Care is the care provided by Your PCP.

(1) Health Maintenance and Preventive Care. The following services are Covered Services for each Member even though they are not provided in connection with the diagnosis and treatment of an illness or Injury:

a) Preventive and screening visits.
b) Routine child and adult immunizations for infectious diseases as recommended by the Advisory Committee on Immunization Practices (ACIP). Immunizations can be provided by the Health Department. No authorization is needed for immunizations.
c) One routine gynecological examination every 12 months.
d) Maternity care. Covered Services for maternity care are described in Subsection C.
e) Outreach for included services, especially pregnancy-related physicals.
f) Health Education services.
g) Speech services.
h) Parenting and birthing classes.
i) Tobacco cessation treatment, including pharmaceutical and behavioral support.
j) Therapies (speech, language, physical, and occupational).
k) Care related to the promotion of Healthy Behavior.

(2) Provider Care. All services listed above provided by Your PCP during an office visit, Hospital visit, or house call, for the diagnosis and treatment of illness or injury. In addition, a female Member has Coverage to access an OB/GYN Specialist for annual well woman exams and for routine obstetrical and gynecological services without prior authorization if the OB/GYN is a Participating Provider. Also, a minor Member does not need prior authorization to see a pediatrician who is a Participating Provider.

B. REFERRAL CARE. Referral Care is care provided by a Participating Provider, Specialist Provider, or Non-Participating Provider. It must be provided upon referral from Your PCP and Certified in advance by Us when We consider Certification necessary, except as noted. Most Covered Services require a referral from Your PCP unless noted. Additional visits may be covered when authorized by Us.

(1) Allergy testing, evaluations, and injections, including serum costs. See Section 7, exclusions from coverage under allergy testing for allergy testing that is not covered.

(2) **Ambulatory Surgical Services and Supplies.** Outpatient services and supplies furnished by a surgery center, along with a Covered surgical procedure, on the day of the procedure.

(3) **Breast Cancer Screening.** Procedures to aid in the diagnosis of breast cancer, including:

- One screening mammography every calendar year for women 40 years and older;
- Surgical breast biopsy;
- Treatment of breast cancer, including reconstructive plastic surgery, chemotherapy, and/or radiation therapy, physical therapy, and psychological and social support services, or other services when medically necessary and ordered by Your doctor.

(4) **Chiropractic Care.** Up to 18 visits per member every calendar year. Additional visits may be covered when authorized.

(5) **Contraceptive Medications and Devices.** These services and supplies to not require a referral and include, among other things, birth control pills, implantable contraceptive drugs, condoms, contraceptive foams or devices, I.U.D.s (including insertion and removal), contraceptive jellies and ointments, even if for a medical condition other than birth control. Condoms for members are to be dispensed in quantities no greater than 12 at one time and no more than 36 in a 30-day period.

(6) **Court-Ordered Services.** Services required by a court order, or as a condition of parole or probation, are only Covered when they are Medically/Clinically Necessary, and the services are provided according to Our procedures with the necessary Physician referrals.

(7) **Diabetic Services and Supplies.** Services and supplies for Members with diabetes including: (a) blood glucose monitors and 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) syringes that are used for the administration of insulin; (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 on the proper self-management and treatment of their diabetes condition. This also includes insulin as prescribed by a Physician, non-experimental medication for controlling blood sugar if prescribed by a Physician, and medications used to treat foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes if prescribed by a Physician, including a Podiatrist.

(8) **Durable Medical Equipment.** Equipment as outlined in the Michigan Department of Health and Human Services Medicaid Provider Manual and on their fee schedules.

(9) **End-Stage Renal Disease.** End-stage renal disease services, including dialysis, are Covered when authorized according to Our procedures with the necessary Physician referrals.

(10) **Family Planning.** The following are Covered Services and do not require a referral if You receive these services at an approved family planning center. The following are

Covered Services for each Member even if they are not provided in connection with the diagnosis and treatment of an illness or Injury;

(a) Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility. Examples of Covered Services are, among other things, sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.

(b) Diaphragms, including measurement and fitting.

(c) Advice on contraception and family planning, including child birth education.

(d) Treatment for sexually transmitted diseases (STDs).

Procedures to assist you in having children are excluded as described in Section 7.

(11) Hearing Care. Health services provided for the diagnosis and treatment of diseases of the ear. Hearing exams and hearing aid evaluations are available from a Participating Provider. We allow Coverage for the purchase and fitting of hearing aids, including batteries.

(12) Home Health Care. Intermittent skilled services, including hospice services, Certified in advance by Us and furnished in the home by a Home Health Agency or by a registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist, speech therapist, or other Health Professional as needed. Custodial care is not Covered even if You receive home health care services along with custodial care.

(13) Hospice Care. Both inpatient and outpatient.

(14) Hospital Care.

(a) Inpatient Care. Hospital inpatient services and supplies, including services performed by Health Professionals, semi-private room and board, general nursing care, and related services and supplies.

(b) Outpatient Care. Hospital services and supplies that You receive on an outpatient basis.

(15) Mental Health. Outpatient Care.

Evaluation, consultation, or treatment, including psychological testing necessary to make a diagnosis. No referral is necessary for mental health visits.

(16) FDA-Approved Drug Treatment. FDA-approved drugs used in antineoplastic therapy and the reasonable cost of administration. Coverage will be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the FDA if all of the following conditions are met.

(a) The drug is ordered by a Physician for the treatment of a specific type of neoplasm.

(b) The drug is approved by the FDA for use in antineoplastic therapy.

(c) The drug is used as part of an antineoplastic drug regimen.

(d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(e) The Physician has obtained informed consent from the patient for the treatment regimen, which includes FDA-approved drugs for off-label indications.

(17) Oral Surgery

(a) Reduction or manipulation of fractures of facial bones.

(b) Removal of tumors or cysts of the jaw, other facial bones, mouth, lip, tongue, accessory sinuses, salivary glands, or the ducts.

(c) Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury.

(18) Orthognathic Surgery. Orthognathic surgery is defined as oral surgical therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment. We will only Cover the following orthognathic surgery services and only when the services are Certified in advance by Our Chief Medical Officer in consultation with Your PCP (and if necessary, a dental consultant) as Medically/Clinically Necessary.

(a) Referral care for evaluation and orthognathic treatment.

(b) Cephalometric study and x rays.

(c) Orthognathic surgery and post-operative care (but Orthognathic Surgery will only be Covered if it is Medically/Clinically Necessary to correct a demonstrable bodily dysfunction).

(d) Hospitalization.

Orthodontic treatment is not a Covered Service.

(19) Outpatient Prescription Drugs. Prescription must be on Our formulary or prior authorized. Covered with a generic substitution process. Prescriptions will be dispensed in quantities prescribed by providers up to a 90-day supply, including Coverage for an off label use of an FDA-approved drug when Medically Necessary.

(20) Over-the-Counter Drugs and Supplies. The Health Plan covers these drugs and supplies in full with a Participating Provider's order and when dispensed by a participating pharmacy.

(21) Pain Management. Your PCP provides the evaluation and treatment of pain, or Your PCP can refer You to a pain Specialist or center. If Your pain is an emergency, call 911 or go to the nearest emergency room.

(22) Podiatry. The diagnosis and treatment of disorders of the foot, ankle, and lower leg.

(23) Reconstructive Surgery. Reconstructive surgery to correct congenital birth defects if We reasonably expect the surgery to correct the condition. We will only Cover the surgical services described above if You receive them within two years of the event that caused the impairment unless either of the following applies:

a. The impairment was not recognized at the time of the event. In that case, treatment must be given within two years of the time that the problem has been identified.

b. Your treatment needs to be delayed because of developmental or medical reasons.

(24) **Prosthetic and Orthotic/Support Devices.** Those devices as outlined in the Michigan Department of Health and Human Services Medicaid Provider Manual and on their fee schedules. Surgically implanted internal prosthetic devices and special appliances/devices that are worn externally, when the appliances or devices:

a. Temporarily or permanently replace all or part of the functions of an inoperative or malfunctioning internal body organ or an external body part lost or weakened/deformed as a result of Injury or illness (including breast replacement after mastectomy); and,
b. When prescribed by Your PCP or prescribed by a Participating Provider upon referral from Your PCP and Certified in advance by Us.

When appliance or device is Covered, We will repair or replace it if that need arises because of normal growth or normal wear and tear.

(25) **Provider Care.** All services listed in this Section provided by a Participating Provider or referral Provider during an office visit, Hospital visit, or house call, for the diagnosis and treatment of an Illness or Injury.

(26) **Radiology Examinations and Laboratory Procedures.** Diagnostic and therapeutic radiology services and laboratory tests not excluded elsewhere in this Certificate.

(27) **Short-Term Rehabilitative Therapy.** Physical therapy, cardiac rehabilitation, pulmonary therapy, and occupational therapy or speech therapy if due to: (a) an Injury; (b) an illness; or (c) a congenital defect for which You have received corrective surgery. These services are Covered if You receive them as an outpatient or in home if they can reasonably be expected to improve Your condition within 60 days of the date You begin therapy as determined by Our Medical Director in consultation with Your PCP. Also, the services are only Covered if a Participating Physician refers, directs, and monitors them and consults with Us in the process. Speech therapy for developmental delay and cognitive rehabilitative therapy are not Covered services. Services are not covered if provided by another public agency.

(28) **Skilled Nursing Facility.** Care or Inpatient Rehabilitation or Hospice Facility Care. Care and treatment, including physical therapy and room and board in semi-private accommodations, at a Skilled Nursing or Inpatient Rehabilitation or Hospice Facility, which the Health Plan has approved in advance.

(29) **Substance Abuse.** You are entitled to receive substance abuse services, which are provided by the local coordinating agency in Your area. Please call Customer Service at (800) 835-2556 for more information.

(30) **Temporomandibular Joint Syndrome (TMJS). "**Temporomandibular Joint Syndrome" or "TMJS" means muscle tension and spasm related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function, and neurological dysfunction. You have Coverage for the following services if they are Certified in advance by Us:

a. Office visits for medical evaluation and treatment of TMJS.
b. Specialty referral for medical evaluation and treatment of TMJS.
c. X-rays of the temporomandibular joint, including contrast studies but not dental x-rays.
d. Myofunctional therapy.
e. Surgery to the temporomandibular joint, such as condylectomy, meniscetomy, arthrotomy, and arthrocentesis.

(31) **Transplants.** Transplants of the following organs at a facility approved by US, but only when We have pre-approved the transplant as appropriate, Medically/Clinically Necessary, and non-experimental:

a. Cornea;
b. Heart;
c. Lung;
d. Kidney;
e. Bone marrow;
f. Liver;
g. Pancreas;
h. Small bowel.

We will cover the donor's medical expenses according to Michigan Medicaid policy if the person receiving the transplant is a Member and the donor's expenses are not Covered by another insurance carrier. The potential donor does not need to be a parent, child, or sibling of the Member proposed to receive the transplant in order to be covered. We will cover expenses for a donor search even if the Member ends up not finding a potential donor. We will Cover FDA-approved drugs used in antineoplastic therapy. We will also Cover expenses including allogenic, autologous, and peripheral stem cell harvesting and small bowel transplants. We will Cover computer searches and any subsequent testing necessary after the potential donor is identified unless Covered by another insurance carrier.

(32) **Transportation.** Ambulance and other emergency medical transportation are Covered. Hardship-based transportation service for medical services is also Covered when pre-authorized by the Health Plan.

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

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

Ophthalmic frames include a selection of approved ophthalmic frames. Repair or replacement of frames/lenses due to loss or breakage is a Covered benefit.

(34) Voluntary Sterilizations. These are tubal ligation and vasectomy, but We will only Cover a vasectomy if it is performed in a Physician's office or when in connection with other Covered inpatient or outpatient surgery. All members must sign the Sterilization Consent Form 30 days before the sterilization. The Member to be sterilized must be at least 21 years of age.

(35) Weight Loss Program. Medically Necessary weight reduction services, including bariatric surgery, are Covered when pre-authorized by the Health Plan.

C. MATERNITY CARE.

(1) **Hospital and Provider.** Services and supplies furnished by a Hospital or Provider (including a nurse midwife acting within the scope of his or her license or specialty certification) for prenatal care (including genetic testing), postnatal care, Hospital delivery, and care for the complications of pregnancy.

(2) **Newborn Child Care.** A Newborn child of a Member will automatically be enrolled with the Health Plan's program for the month of birth. If the parent or guardian wants to change the Newborn to another health plan, they must contact the State Enrollment Broker.

(3) **Home Care Services.** Is a Covered Service in conjunction with the Early Care Healthy Family Program.

(4) **Maternal Infant Health Program (MIHP).** This is available through a certified MIHP provider. Contact Customer Service to find out how to get access to these providers.

(5) **Dental Services.** Dental Services are covered for pregnant Members during pregnancy and until the last day of the third month after the expected due date. Dental Services include diagnostic, preventive, restorative, prosthodontics (removable only) and medically/clinically necessary oral surgery services, including extractions. The Department of Health and Human Services' website contains a list of covered Dental Services.

D. MEDICAL EMERGENCY AND URGENT CARE

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

You should contact your PCP's office before obtaining Urgent Care. If You are unable to contact Your PCP, call the Health Plan's After-Hours Line. If You use an Urgent Care Center for routine care, You will be responsible for the cost of that care.

The following are Covered Services:

(1) **Within the Service Area**

(a) Services and supplies that You receive for any condition that, following Our review of the proper medical records, We determine to have been a Medical Emergency.

(b) Emergency services includes stabilization of Your condition, meaning services are Covered until no further worsening of Your condition is likely to occur.
(c) Services and supplies that You receive for any condition that, following Our review of the proper medical records, We determine to have required Urgent Care at that time You received the services and supplies.
(d) Hospitalization for a Medical Emergency in a facility that is a Non-Participating Provider, until, in Our determination, it is appropriate for You to be transferred to a Participating Provider.

(2) **Outside the Service Area.** We will Cover as within the Service Area. We will not Cover services and supplies You receive during travel outside the Service Area if the only reason for the travel is to obtain medical services or supplies (unless We Certify, in writing, that We will Cover them).

(3) **Follow-Up Care.** Services You receive from, or upon referral from, Your PCP as follow-up care resulting from a Medical Emergency or Urgent Care situation. We will only Cover follow-up care received outside of the Service Area if we have Certified it in advance.

(4) **Ambulance Services.**
(a) In the case of a Medical Emergency, ambulance service to the nearest medical facility that can provide Medical Emergency care.
(b) Inter-facility ambulance transfers.

SECTION 7: Exclusions from Coverage

The following is a list of exclusions from Your Coverage. We will not Cover any service, treatment, or supply listed in the exclusions unless Coverage is required under applicable state or federal law.

1. **Abortions.** All services and supplies related to elective abortions to terminate pregnancy are not Covered unless a physician certifies that the abortion is Medically Necessary to save the life of the mother or is for a pregnancy that is the result of rape or incest. Treatment for medical complications occurring as a result of an elective abortion and for spontaneous, incomplete or threatened abortions and for ectopic pregnancies is Covered.
2. **Acupuncture and Other Non-Traditional Services.** Acupuncture and other non-traditional services, including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy, and Rolf therapy are not Covered.
3. **Adaptive Aids/Self-Help Items.** Services and supplies designed for self-assistance. Examples include, among other things, reachers, feeding, dressing, and bathroom aids.
4. **Against Medical Advice.** There is no Coverage for any service or treatment plan if You voluntarily deny that service or treatment plan, or any related service or treatment plan, against the advice of a Participating Provider. Also, there may be no Coverage for any service or treatment plan if You voluntarily discharge Yourself, or are otherwise discharged, against the advice of a Provider.
5. **Allergy Testing.** Any allergy testing and treatments that have not been proven to be effective are not Covered.
6. **Biofeedback.** Biofeedback for any diagnosis, including a mental health diagnosis.

7. **Clinical Ecology and Environmental Medicine.** Services and supplies provided to effect changes in, or treatment to, You and/or Your physical environment. When We say "clinical ecology" and "environmental medicine", We mean medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems.
8. **Court-Ordered Services.** Services required by a court order or as a condition of parole or probation are not Covered unless the services ordered by the court are Covered under this Certificate and are provided according to Our procedures.
9. **Cosmetic Services.** Cosmetic surgery or procedures done primarily to improve the way any part of the body looks. Coverage is excluded for Cosmetic Services including, but not limited to, surgery for sagging or extra skin, any procedure to increase or reduce the size of a portion of the body, such as, among other things, mammoplasty, liposuction, keloids, and rhinoplasty.
10. **Custodial Care.** Any care You receive if, in Our opinion, You have reached the maximum level of mental and/or physical function and you will not improve significantly more. This includes the provision of room and board, nursing care, home health aides, and personal care designed to help You in the activities of daily living. This also includes home care and adult day care that You receive, or could receive, from members of Your family.
11. **Dental Care.** Diagnostic, preventive, restorative, prosthodontics, and other dental services, except that some dental care is covered during pregnancy and until the end of the third month after the pregnancy due date.
12. **Durable Medical Equipment.** Equipment not outlined as Covered in the Michigan Department of Health and Human Services Medicaid Provider Manual, or equipment for which there is no code on the Michigan Medicaid Fee Schedule.
13. **Ear Plugs.**
14. **Educational Services and Services for Behavioral Disorders.** The Health Plan does not cover school-based services. These services can be obtained through Your local school system and include:
    (a) Services for remedial education, including treatment of learning disabilities, developmental and learning disorders, and behavioral training.
    (b) Services related to learning disabilities, developmental delays, or adult attention deficit disorders.
    (c) Education testing or training.
    (d) Services and supplies for mental retardation and senility.
    (e) Speech therapy for developmental delay.
    (f) Cognitive rehabilitation.
15. **Experimental, Investigational, or Unproven Services.** Any drug, device, treatment, or procedure that is experimental, investigational, or unproven. A drug, device, treatment or procedure is experimental, investigational, or unproven if one or more of the following applies:
    (a) The drug or device cannot be lawfully marketed in the United States without the approval of the Food and Drug Administration (FDA), and that approval hasn't been granted;
    (b) An institutional review board or other body oversees the administration of the drug, device treatment, or procedure, or approves or reviews research concerning safety, toxicity, or efficacy;
    (c) The patient informed consent documents describe the drug, device, treatment, or procedure as experimental or investigational, or in other terms that indicate the service is being evaluated for its safety, toxicity, or efficacy;

(d) Reliable Evidence shows that the drug, device, treatment, or procedure is:
    (i) The subject of ongoing Phase I or Phase II clinical trials;
    (ii) The research, experimental study, or investigational arm of ongoing phase of clinical trials; or,
    (iii) Otherwise under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or,

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

This exclusion for experimental services does not apply to off-label uses of FDA-approved anti-cancer drugs.

16. **Hair Analysis.** All services and products, including, but not limited to, wigs requested due to hair loss.
17. **Habilitative Services.** Services to help a person keep, learn or improve skills and functioning for daily living.
18. **Hypnotherapy.**
19. **Infertility and Abortion.** All services and supplies relating to infertility treatment and abortions, including, among other things, artificial insemination, in vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, prescription drugs designed to achieve pregnancy, elective abortions, and services to reverse voluntary sterilization.
20. **Leave of Absence.** Charges incurred when You are on an overnight or weekend pass during an inpatient stay.
21. **Marital Counseling.** Services and treatment related to marital or relationship counseling.
22. **Mental Health/Substance Abuse.** Only services listed in Section 6 are Covered.
23. **No Legal Obligation to Pay.** Any service or supply that You would not have a legal obligation to pay for without this Coverage. This includes, among other things, any service performed or item supplied by a relative of Yours if, in the absence of health benefits Coverage, You would not be charged for the service or item.
24. **Non-Participating Providers.** Services and supplies from a Non-Participating Provider. This exclusion does not apply in the case of:
    (a) Medical Emergency or when We have Certified the services and supplies in advance;
    (b) The treatment of communicable diseases such as TB or sexually transmitted diseases (STDs) at a local Health Department or Michigan Medicaid approved Family Planning Center;
    (c) Family planning services received at a Michigan Medicaid approved Family Planning Center or at a local Health Department;
    (d) Services provided at Child & Adolescent Health Centers (CAHCP), Federally-Qualified Health Centers (FQHC), or as otherwise stated in this Certificate; and,

(e) Immunizations.

25. **Not Medically/Clinically Necessary.** Services and supplies that We determine are not Medically/Clinically Necessary. If You disagree with Us about Medical/Clinical Necessity, You (with a Participating Provider if You wish) may appeal Our determination. But unless and until We agree with You that the services and supplies will be Covered Services, they will be excluded from Coverage. If We exclude Coverage because a service or supply was not Medically/Clinically Necessary, that is a determination about benefits and not a medical treatment determination or recommendation. You, with the Participating Provider, may choose to go ahead with the planned treatment at Your own expense and appeal Our denial of Your claim for Coverage under Our inquiry and grievance procedure.
26. **Not on Fee Schedule.** Any service, device, supply, or other item for which there is no code on the Michigan Medicaid Fee Schedule.
27. **Obstetrical Delivery in the Home.** Services and supplies related to obstetrical delivery in the home.
28. **Personal Comfort or Convenience Items, Household Fixtures, and Equipment.**
    (a) Services and supplies not directly related to Your care, such as, among other things, guest meals and accommodations, telephone charges, travel expenses, take-home supplies, and similar costs.
    (b) The purchase or rental of household fixtures, such as, among other things, escalators, elevators, swimming pools, and similar fixtures.
    (c) The purchase or rental of household equipment that have customary non-medical purposes, such as, among other things, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds, and similar equipment.
29. **Private Duty Nursing.**
30. **Provider Not Enrolled.** Services rendered, referred, or ordered by a provider who is not enrolled in Michigan Medicaid are not Covered Services. We will not pay for these services.
31. **Providers Barred from Reimbursement.** Services and supplies received from, or ordered or referred by, providers who have been: (a) terminated from our provider network for failing to meet our credentialing criteria; or (b) identified as sanctioned by Medicare or Medicaid.
32. **Relational, Educational, and Sleep Therapy.** Relational, educational, or sleep therapy and any related diagnostic testing. But this exclusion does not apply to therapy or testing provided as part of a Covered inpatient Hospital service.
33. **Religious Counseling.** Services and treatment related to religious counseling.
34. **Routine Foot Care.**
    (a) Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care.
    (b) Cleaning, soaking, and skin cream application for the feet.
35. **Self-Referral.** Services and supplies from any Health Professional upon self-referral by You. But this exclusion does not apply in the case of:
    (a) Medical Emergency or when We have certified the services and supplies in advance;
    (b) The treatment of communicable diseases such as TB or sexually transmitted diseases (STDs) at a local Health Department or Michigan Medicaid approved Family Planning Center;
    (c) Family planning services received at a Michigan Medicaid Family Planning Center or at a local Health Department;
    (d) Immunizations;

(e) Mental health services; and,
(f) As otherwise stated in this Certificate.

36. **Services Required by Third Parties.** Services required or recommended by third parties, including, but not limited to: (a) physical examinations in excess of one per year performed by Your PCP; (b) physical examinations performed by a Physician other than your PCP; (c) diagnostic services related to getting or keeping a job, getting or keeping any license issued by a governmental body, getting insurance coverage, foreign travel, or adopting children; (d) physical exams for school admission or attendance and participation in athletics outside of the normal schedule of well-child exams and/or by a Non-Participating Provider.
37. **Sex Therapy.** Services and treatment related to sex therapy.
38. **Transitional/Residential or Assisted Living.** Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help You in activities of daily living.
39. **Treatment in a Federal, State, or Governmental Entity.** The following is excluded to the extent permitted by law:
    (a) Services and supplies provided in a Non-Participating Hospital owned or operated by a federal, state, or other governmental entity unless authorized by Us.
    (b) Services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail, or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment. If you are incarcerated, you will be disenrolled from the Plan.
40. **Unauthorized Services and Supplies.** Services and supplies where prior authorization was required but was not obtained. We will not issue prior authorization after the services or supplies were already rendered. This exclusion does not apply to services necessary to treat a Medical Emergency, Urgent Care situation, family planning, the treatment of sexually transmitted diseases (STDs), immunizations, or as otherwise stated in this Certificate.
41. **Vocational Rehabilitation.** Work-related therapy, work hardening, and evaluations of the work site.
42. **Weight Control.** All services, supplies, and equipment related to weight control or reduction, whether or not prescribed by a physician or associated with illness, including, but not limited to, food, food supplements, gastric balloons, stomach stapling, jaw wiring, liposuction, physical fitness, or exercise programs. This would not include authorized Weight Control Programs.

SECTION 8: Limitations

You may only receive services from a Participating Provider or another Health Professional. Your PCP must approve or authorize those services, and they must be Certified by Us in advance when required, unless this Certificate says otherwise.

Some of the Covered Services are subject to maximum limitations, such as number of visits. Once You have reached a maximum for a Covered Service, You will be responsible for the cost of additional services.

A. Work-Related Illness or Injury.
We will not cover services for any work-related Illness or injury if the services are covered under any worker's compensation program or other similar program.

B. Services Received as a Member.
We will only pay for Covered Services You receive while You are Covered under the Agreement and you are a Member. A service is considered to be received on the date on which services, supplies, or materials are provided to the Member. We will only Cover services and supplies for the diagnosis or treatment of illness or Injury, except as specifically provided elsewhere in this document.

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

SECTION 9: Member Claims Responsibilities

Ordinarily, You are not responsible for the cost of services that You receive. However, You are responsible for the cost of any services You receive from Non-Participating Providers unless those services were arranged by Your PCP and Certified in advance by Us, or unless You need them to treat a Medical Emergency, Urgent Care situation, or as otherwise stated in this document.

Before We pay health care providers, We may require You to give Us more information or documentation to prove they are Covered Services. Our right to that information or documentation may be limited by state or federal law.

If you are not satisfied with any benefit determination We have made, You can dispute the decision under the inquiry and grievance procedure. Read Section 11 to find out more about that procedure.

SECTION 10: Termination of Coverage

A. Loss of Eligibility.
You will lose Your eligibility and Your enrollment will terminate if You stop meeting the eligibility criteria as required by the Department of Health and Human Services.

If you lost Your eligibility, Coverage will terminate at 11:59 p.m. on the date You lost Your eligibility.

B. Termination for Cause.
We cannot request termination of Your Coverage based on Your health or Your health care needs. Also, We will not request termination of Your Coverage just because You used the Agreement's grievance procedure to make a complaint against Us.

We can recommend the termination of Your Coverage to the State for any of the following reasons:

(1) We find out You have committed fraud against Us, or you have been dishonest with Us about some important or "material" matter. For example, We may request that the State terminate Your Coverage if We find out You gave Us wrong or misleading information,

You obtained a prescription under false pretenses, or You let someone else use Your ID Card. We can also collect from You the Reasonable and Customary Charges for Covered Services that You have received after the effective date of termination, plus Our cost of recovering those charges, including attorney's fees.

(2) You act so disruptively that You upset Our ordinary operations or those of a Participating Provider, including making verbal or physical threats against Us or a Participating Provider.

If We notify You that We intend to request termination of Your Coverage, You can ask for a grievance hearing within 30 business days. Read Section 11 to learn more about grievance hearings. If you ask for a grievance hearing, Your Coverage will remain in place until a final determination is made. If the final determination is in Our favor, We can terminate Your Coverage effective the date indicated by the State of Michigan.

SECTION 11: Member Complaint/Grievance and Appeals Procedure

Member Complaint/Grievance Procedure

A complaint/grievance is something you are unhappy with. You can call or write to the Health Plan when you have a problem. We would like to hear what you think so we can make our services better. We want to know if you have a complaint about a doctor's office. You can tell us if you think the office was not clean or safe. You can also tell us if there was not enough space in the waiting room or the exam room. In this case, Customer Service will help You.

To report a complaint/grievance, call Customer Service (800) 835-2556. They will help you fill out a form to begin looking into the problem.

The Health Plan has a process for complaints/grievances. A special person handles the complaints/grievances. We will get back to you within 90 calendar days unless waiting that long would hurt your health. In those cases, we will get back to you within three calendar days.

Member Appeals Procedure

If the Health Plan has decided to deny, terminate, or reduce any covered service, You can file an appeal. An appeal is a formal way of asking the Health Plan to review and change a coverage decision.

You have 60 calendar days from the date of the Health Plan denial notice to file an appeal. If the Health Plan is going to reduce or stop a service already approved, you can keep getting benefits during the appeals and state fair hearing process. You must meet the criteria to do so:

- The services were ordered by an authorized provider;
- The period covered by the original authorization has not ended; and
- The appeal was filed within 10 calendar days of the date the denial letter was mailed.

Services will stop if:

- You withdraw your appeal
- You do not ask for a State Fair Hearing within 10 calendar days from the Health Plan's appeal denial letter
- A State Fair Hearing decision is made against you

- The authorization expires or authorization service limits are met

You may have to pay for the care you got during the appeals process if:

- The decision to deny service is upheld
- You withdraw your appeal
- You fail to attend the state hearing

You can ask another person to appeal for you. You can do this by completing the Authorized Representative for Appeal Form that is included in your denial letter.

You can call or write to the Health Plan when You want to appeal a denial by calling Customer Service at (800) 835-2556 or writing to Upper Peninsula Health Plan, 853 W. Washington Street, Marquette, MI 49855. Our fax number is 906-225-7720. If you call the Health Plan to appeal, it must be followed by a written, signed appeal to the Health Plan. If the Health Plan does not receive your written, signed appeal within 60 calendar days of the denial letter, your appeal will be dismissed. Oral appeals will only be accepted for expedited appeal requests. If needed, Customer Service can help you file an appeal.

Internal Appeal Process:
A special committee will review your appeal. It will not be the same person who made the original decision to deny, reduce or stop services. The Health Plan will send you a letter letting you know of our decision within 30 calendar days of receipt. Expedited appeals will be handled within 72 hours of receipt. The Health Plan will let you know the decision by phone and by letter.

Once a decision has been made, you will get a letter with the Health Plan decision. The letter will explain further appeal rights and forms if the Health Plan does not completely approve your request during the internal appeal process.

External Review of Appeals:
If, after your appeal to Us, you are still unhappy with the decision that the Health Plan has made about your grievance, you can ask for an external appeal with the Department of Insurance and Financial Services. You must do this within 127 calendar days of receiving our appeal decision. Call Customer Service to get the form you need or contact the Department of Insurance and Financial Services at:

Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
530 W. Allegan Street, 7th Floor
P.O. Box 30220
Lansing, MI 48909-7220
Phone: (877) 999-6442
https://difs.state.mi.us/Complaints/ExternalReview.aspx
Fax: (517) 284-8848

Fair Hearing Process:
You may also request a State Fair Hearing with the Michigan Administrative Hearing Services (MAHS) for the Department of Health and Human Services. You may request this Hearing only after

receiving notice that We upheld our previous decision. You have 120 calendar days from the date of our decision to request a State Fair Hearing. Write to:

Michigan Administrative Hearing Services
Michigan Department of Health and Human Services
P.O. Box 30763
Lansing, MI 48909
Phone: (800) 648-3397
Fax: (517) 763-0146

SECTION 12: Extension of Benefits

We will continue paying for Your Covered Services if the Agreement is terminated while You are confined for medical treatment in a Hospital. After termination, We will pay for Covered Services only if You are hospitalized and only for the specific medical condition causing that confinement. As soon as one of the following happens, You will stop receiving benefits from the Health Plan:

A. The hospitalization is no longer Medically/Clinically Necessary or is for Non-Covered Services such as custodial care;

B. You have Coverage from another health plan or insurance carrier for the inpatient stay.

SECTION 13: Coordination of Benefits

A. Subrogation.

Subrogation means the Health Plan will have the same right as the Member to recover expenses for treatment of an illness or Injury for which another person or organization is legally liable. To the extent the Health Plan provided benefits for services in such situations, the Health Plan will be subrogated to the Member's right of recovery against the responsible person or organization. The Member is required to sign and deliver any documents and papers and do whatever is necessary to obtain these rights. The Member agrees not to take any action without the Health Plan's consent that would harm the rights and interests of the Health Plan. Any money received by suit, settlement, or otherwise for medical, Hospital, or other services provided by the Health Plan must be paid over to the Health Plan. When collection costs and legal expenses are included to recover sums benefiting both the Member and the Health Plan, a fair division of the collection costs and legal expenses will be made. Refusal or failure of a Member, without good cause, to cooperate with the Health Plan may result in Member's disenrollment or recovery by the Health Plan from the Member of costs for services provided under claim of subrogation, subject to the Member's grievance rights.

B. Right of Recovery.

Whenever benefits have been provided by the Health Plan under this Certificate, and another person or organization is responsible for payment, the Health Plan shall have the right to deny payment or to recover from the other responsible person or organization the reasonable cash value of the service.

C. Coordination of Benefits.

Coordination of Benefits shall be conducted in accordance with guidelines set forth by the Michigan Department of Health and Human Services and the Michigan Coordination of

Benefits Act, 1984, P.A. 64. These guidelines and laws determine how benefits are paid and by whom when you are covered by more than one health care plan or when auto insurance, worker's compensation insurance, or other payment sources exist. As a Medicaid health plan, we are always the payer of last resort. We will not pay for services that the primary payer denies because the rules of the primary payer were not followed. Please tell your doctors and Us when You have other health coverage.

SECTION 14: Medicare and Other Federal or State Government Programs

A. Non-duplication of Benefits.
Your benefits under this Certificate cannot be doubled up with any benefits You are or could be eligible for under Medicare or any other federal or state government program. If We Cover a service that is also Covered by one of those programs, any sums payable under that program for that service must be paid first.

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

(1) Election Against Coverage.
Despite any other provision under this Certificate, Medicare will always be the Primary Payer, and We will be the Secondary Payer.
(2) Members Eligible for Medicare ESRD Benefits.
Except as provided below, if You are entitled to, or are eligible for, end-stage renal disease (ESRD) Medicare benefits, the Primary Payer will be Medicare. If You have primary Coverage under Medicare by reason of age or Disability, and You later become eligible for Medicare ESRD Coverage, Medicare will remain primary to this Plan.
(3) Eligibility for Medicare.
In determining benefits payable under Medicare, You will be considered to be enrolled for and Covered by all Medicare (both Parts A and B) and other governmental benefits to which You are eligible, whether or not You are actually enrolled.
(4) Legislative and Regulatory Changes.
Despite any other provision of this Certificate, if any existing legislation or regulation is adopted or altered, or if any new legislation or regulation is enacted or adopted further permitting this Plan to be secondary to Medicare, the Health Plan will be secondary to Medicare as permitted by that legislation or regulation.

SECTION 15: Definitions

Agreement. The Group Agreement between the State of Michigan and the Health Plan. The Agreement is a contract for health benefits. The Agreement includes this Certificate, the enrollment form, any amendments, and any attachments. A copy of the Agreement is available upon request from Us and may also be obtained from the State of Michigan.

Certificate of Coverage. The document that Subscribers receive from Us that describes the rights and duties of both the Member and the Health Plan.

Certify or Certification. The process We use to determine whether services or supplies are Covered.

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

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

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

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

Health Plan. The Health Plan providing benefits under this Certificate of Coverage.

Health Professional. Someone who provides health care services provided that person is qualified under state law to provide those services.

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

ID Card. The Member Identification Card You receive from Us as evidence of your enrollment with Us.

Ill or Illness. A sickness or disease, including congenital defects or birth abnormalities.

Injury or Injured. Accidental bodily Injury.

Medical Director: A Michigan-licensed Physician We have designated to supervise and manage the medical aspects of Our health care delivery system.

Medical Emergency. A sudden onset of a medical condition so acute that if You don't receive immediate care or treatment, it could result in serious jeopardy to Your health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious jeopardy to a pregnancy.

Medically/Clinically Necessary. The services or supplies needed to diagnose, care for, or treat Your physical or mental condition. The Medical Director, or anyone acting at the Medical Director's request, in consultation with the PCP, determines whether services or supplies are Medically/Clinically Necessary. The services and supplies must be widely accepted professionally in the United States as effective, appropriate, and essential based upon nationally accepted standards of the health care Specialty involved. All of the following are considered not to be Medically/Clinically Necessary:

A. Those services rendered by a Health Professional that don't require the technical skills of such a provider;
B. Those services and supplies furnished mainly for the personal comfort or convenience of You, anyone who cares for You, or anyone who is part of Your family.

Medicaid. Title IX of the Social Security Act, as amended.

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

Member. A person enrolled with Us as a Subscriber.

Newborn. A child who is 30 days old or younger.

Non-Participating Provider. A Health Professional or other entity who hasn't contracted with Us to provide Covered Services to Members.

Orthognathic Surgery. Oral surgical therapy involving the repositioning (but not removal) of an individual tooth, arch, segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment.

Participating Hospital. A Hospital that contracts with Us to provide Covered Services to Members.

Participating Physician. A Physician who contracts with Us to provide Covered Services to Members.

Participating Provider. A Health Professional or other entity that contracts with Us to provide Covered Services to Members.

Physician. A state licensed doctor of medicine or osteopathy.

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

Prosthetics and Orthotics. Prosthetic devices are devices that aid body functioning or replace a limb or body part after accidental or surgical loss or to correct a birth defect. Orthotic appliances are appliances that are used to correct a defect to body form or function.

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

Reconstructive Surgery. Surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive surgery generally is done to improve function but may also be done to improve appearance.

Service Area. A geographical area designated by Us and approved by the proper regulatory authority. We publish precise Service Area boundaries, and You may obtain that information from Customer Service. Our Service Area is the Upper Peninsula of Michigan.

Skilled Nursing or Inpatient Rehabilitation or Hospice Facility. A facility that is licensed by the proper regulatory authority to provide inpatients with skilled nursing care and related services or short-term rehabilitative therapy.

Specialist Provider. A Participating Physician, other than a PCP, under contract with Us to provide Covered Services upon referral by the PCP and Certification in advance by Us.

Subscriber. A person who meets all applicable eligibility requirements of the State of Michigan and who has enrolled for coverage.

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

Urgent Care Center. A certified facility that provides Urgent Care for the immediate treatment only of an Injury or Illness.

You, Your, Yourself. The Member, whether enrolled with the Health Plan as a Subscriber or Covered Dependent.

We, Us, Our. The Health Plan.

SECTION 16: General Provisions

A. Independent Contractors.

We do not agree to directly provide any health care services under the Agreement, and We have no right or responsibility to make medical treatment decisions. Those decisions many only be made by health care providers in consultation with You. We are only obligated to provide Members a network of health care services. We alone are responsible for making benefit determinations under the Agreement and Our contracts with Participating Providers. Health care providers are responsible for making independent medical judgments.

Health care providers and You may choose to continue medical treatment even if We deny Coverage for those treatments. You will be responsible for the cost of those treatments. Health care providers and You may appeal any of Our benefit decisions. Any appeal must follow the inquiry and grievance procedure explained in Section 11.

B. Authorization to Release Medical Information.

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

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

C. Entire Agreement.
This Certificate of Coverage and your Member Handbook set forth the entire agreement between You and Us.

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

E. Truth in Application and Statements.
You agree to complete and submit to Us documentation that We reasonably request. You will ensure and warrant that all information contained in such documentation is true, correct, and complete.

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

G. General Obligations.
The Health Plan will not discriminate against Members because of race, color, ancestry, religion, age, sex, national origin, marital status, health status, or Disability.

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

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

J. State and Federal Law. We will apply this Certificate in accordance with state and federal laws and regulations. If any part of this Certificate violates state or federal law or regulations, we will change our procedures to agree with the laws and regulations.

K. Legal Actions. You have the right to bring an action for benefits under Section 500.3422 of the Michigan Compiled Laws. Before filing a lawsuit against Us, You must complete Our Grievance Procedure set forth in this Certificate. No lawsuit may be brought until at least 60

calendar days have passed since you received written proof of loss. No lawsuit may be brought after expiration of three years after the time written proof of loss was required to be furnished.

SECTION 17: Nondiscrimination

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

The Health Plan:

A. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   (1) Qualified sign language interpreters;
   (2) Written information in other formats (large print, audio, accessible electronic formats, other formats).

B. Provides free language services to people whose primary language is not English, such as:
   (1) Qualified interpreters;
   (2) Information written in other languages.

If you need these services, contact Customer Service.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: UPHP Customer Service, 853 W. Washington Street, Marquette, MI 49855, by phone at 1-877-349-9324 (TTY – 711), or by fax 1-906-225-7690. You can file a grievance in person, by mail, or fax. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-349-9324 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-349-9324 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-349-9324 (رقم هاتف الصم والبكم: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-349-9324（TTY：711）。

ܙܘܗܪܐ: ܐܢ ܐܢܫܘܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܝܬܘܢ ܕܡܟܠܝܬܘܢ ܝܠܦܬܐ ܕܡܫܢܝܬܐ ܕܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ
ܥܠ ܡܢܝܢܐ 1-877-349-9324 (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-349-9324 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-349-9324 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-349-9324 (TTY: 711) 번으로 전화해 주십시오.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-877-349-9324 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-349-9324 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-349-9324 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-349-9324 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-349-9324（TTY:711）まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-349-9324 (телетайп: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-349-9324 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-349-9324 (TTY: 711).