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(313) 871-2000

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CERTIFICATE OF COVERAGE

Medicaid

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ARTICLE I. TOTAL HEALTH CARE, INC.

Total Health Care, Inc. is a non-profit company licensed as an HMO in the State of Michigan. Total Health Care, Inc. has a contract with the State of Michigan to provide health care services to Michigan Medicaid recipients.

ARTICLE II. DEFINITIONS

- 2.1** "Affiliated Hospital" means any hospital that has a contract with the Plan to provide hospital services to Members.
- 2.2** "Affiliated Physician" means an individual licensed to practice medicine or osteopathy (MD or DO) and who has a contract with the Plan or an Individual Practice Association (IPA) to provide services to Members.
- 2.3** "Affiliated Provider" means a health professional, a Hospital, licensed pharmacy, or any other institution, organization, or person who has a contract with the Plan or an Individual Practice Association (IPA) to render one or more health maintenance services to Members.
- 2.4** "Authorized Benefits and Services" are those health care benefits and services available to Members under this Certificate when provided by health care providers authorized to provide such care under this Certificate.
- 2.5** "Beneficiary" means any person deemed eligible for the Medical Assistance Program.
- 2.6** "CHCP" means the Comprehensive Health Care Program, the health services program for Medicaid beneficiaries in Michigan, administered by the Department of Community Health, Medical Services Administration.
- 2.7** "Contract Year" means the 12-month period from the date that coverage was initially effective under the contract with the State of Michigan and each 12-month period thereafter, unless otherwise stated and agreed upon.
- 2.8** "Covered Services" means all Medicaid services, as defined in this Certificate.
- 2.9** "DCH" means the Department of Community Health of the State of Michigan.
- 2.10** "Enrollee" is any Medicaid Beneficiary that is a member of Total Health Care.
- 2.11** "Health Center" means a health care facility that is operated by an Individual Practice Association (IPA).
- 2.12** "Hospice" means a licensed health care program that has a contract with the Plan to provide a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

- 2.13** "Hospital" means state-licensed acute care facility that provides inpatient, outpatient, and emergency medical, surgical or psychiatric services, treatment and care of injured or acutely sick persons, by or under the supervision of a staff of physicians and that continuously provides a twenty-four (24) hour-a-day nursing service by registered nurses, and which is not, other than incidentally, a place for the treatment of pulmonary tuberculosis, a place for the treatment of drug abuse, a place for the treatment of alcoholism, nor a nursing home.
- 2.14** "Individual Practice Association" or "IPA" means a partnership, corporation, association or other entity that has a contract with a Plan to provide and arrange for services to Members, has as its primary objective the delivery, or arrangement for the delivery, of health care services, and employs or has entered into written service agreements with health professionals, a majority of whom are physicians.
- 2.15** "Medical Emergency or Accidental Injury":
- 1.) "Medical Emergency" means a medical condition manifested by severe symptoms occurring suddenly and unexpectedly that could reasonably be expected to result in serious physical impairment or loss of life if not treated immediately.
 - 2.) "Accidental Injury" means a traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a Member's health or result in loss of life.

Examples of Medical or Accidental Injury include, but are not limited to:

- Heart attacks,
- Hemorrhaging,
- Poisonings,
- Loss of consciousness or respiration,
- Trauma, and
- Convulsions

- 2.16** "Member" means a Subscriber eligible to receive services under this Group Contract, who is enrolled in the plan.
- 2.17** "Open Enrollment Period" means that limited period of time during which eligible persons are given the opportunity to enroll in the Plan.
- 2.18** "Plan" means Total Health Care, Inc.
- 2.19** "Primary Care Provider" (PCP) means those providers within the Plan who are designated as responsible for providing for or arranging health care for specified enrollees. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist or pediatric physician when appropriate for an Enrollee. Other physician specialists may be designated when appropriate for an Enrollee's health condition.
- 2.20** "Referral Facility" means any legally qualified and state-licensed intermediate care facility, skilled nursing facility, Hospice, or Hospital that provides services to members under the orders of an Affiliated Physician and the Plan's Medical Director or his/her designee.

- 2.21** “Referral Physician” means a physician other than an Affiliated Physician who is licensed to practice medicine or osteopathy and who delivers medical specialty care to a Member on the referring order of an Affiliated Physician.
- 2.22** “Service Area” means the geographic area in which the Plan is authorized by the Michigan Department of Labor and Economic Growth and Michigan Department of Community Health to provide health care services to members.
- 2.23** “Subscriber” means an individual:
- 1) Who meets all eligibility criteria established by this Medicaid Certificate of Coverage; and
 - 2) Who has been enrolled with the Plan through the State’s enrollment broker.

ARTICLE III. ENROLLMENT: ELIGIBILITY AND ENROLLMENT

3.1 Eligibility

The State has the sole authority for determining whether persons are eligible for the Comprehensive Health Care Program (CHCP) and enrollment in the Plan.

3.2 Enrollment

- 1) Initial Enrollment: Medicaid beneficiaries eligible for the CHCP have the full choice of available Medicaid Health Plans within their county of residence. Beneficiaries must select the Plan they wish to enroll in within thirty (30) days from the date of approval of Medicaid eligibility. If they do not voluntarily choose a Plan within thirty (30) days of approval, DCH will automatically assign the Beneficiaries to Plans within their county of residence.
- 2) Enrollment Lock-in: Except as stated in this subsection, enrollment into the Plan will be for a period of 12 months with the following conditions:
 - Enrollees will be provided with an opportunity to select any Plan approved for their area during this open enrollment period;
 - Enrollees will be notified that if they do nothing, their current enrollment will continue;
 - Enrollees who choose to remain with the same Plan will be deemed to have had their opportunity for disenrollment without cause and declined that opportunity;
 - Enrollees who change enrollment within the 90-day period will have another 90 days within which they may change Plans without cause and this may continue throughout the year;
 - An Enrollee who has already had a 90-day period within the year with the same plan;
 - Enrollees who disenroll from a Plan will be required to change enrollment to another Plan;
 - Such changes will be approved and implemented by DCH on a calendar month basis.
- 3) Enrollment date: If a Beneficiary is deemed eligible during a month, he or she is eligible for an entire month starting from the first day of the next available month. Newborn enrollees may be retroactively determined eligible.
- 4) Newborn enrollment: Newborns of eligible CHCP mothers who were enrolled at the time of the child’s birth will be automatically enrolled with the mother’s Plan. At a minimum, newborns are eligible for the month of their birth and may be eligible for up to one year longer.

- 5) Open enrollment: Open enrollment will occur for all Beneficiaries at least once every 12 months. Enrollees will be offered the choice to stay in the health plan they are in or to change to another Plan within their county at the end of the 12-month lock-in.
- 6) Automatic Re-enrollment : Enrollees who are disenrolled from a Plan due to loss of Medicaid eligibility will be automatically re-enrolled or assigned to the same Plan should they regain eligibility within two months. If more than two months have elapsed, Beneficiaries will have full choice of available Plans within their county of residence.

ARTICLE IV. : GENERAL CONDITIONS

4.1 Selection of a Primary Care Physician

Each Member will select a Primary Care Physician (PCP) and Health Care location. The Health Center and PCP name and phone number is located on the Member's identification card. If a Member does not select a PCP at the time of enrollment, he or she will be assigned to a PCP and Health Center by the Plan based on the geographic location of his or her address. **All Authorized Benefits and Services must be provided by or authorized and arranged through this designated PCP, except in the event of a Medical Emergency or Accidental Injury or as otherwise stated in this Certificate of Coverage. If a Member needs PCP information or other help, the member should contact the Plan's Member Services Department at (313) 871-2000 or toll free at (800) 826-2862.**

4.2 Plan's Right to Transfer a Member

If a Primary Care Physician (PCP) or Individual Practice Association (IPA) is unable, fails, neglects, or refuses to provide Authorized Benefits and Services, the Plan can transfer Members covered from a PCP to another PCP during such inability, failure, neglect and/or refusal. The Plan's right to transfer Members will be exercised in the best interest of the Member's health care needs and within the legal limitations dealing with termination of medical care to patients. In the event of such a transfer, the Plan does not guarantee that transferred Members will return to the former PCP in the future.

4.3 Patient/Physician Relationship

Nothing contained within this Certificate shall interfere with the professional relationship between the Member and the physician providing care. Each Member shall have the right to choose, to the extent feasible and appropriate, the Affiliated Physician and other health care professionals responsible for his/her primary care. Each Individual Practice Association (IPA) maintains medical records at the designated Health Center for each Member receiving services. The medical records are available for inspection and review during regular business hours upon request by the Member.

4.4 Changes to this Agreement

No officer, agent, or representative of the Plan except the Executive Director is authorized to vary the terms or conditions of this Certificate in any way to make any promises or agreements supplemental to this Certificate. Any supplemental agreements or variances to the terms or conditions of this Certificate must be in writing signed by the Executive Director of the Plan.

4.5 Benefits are Solely for the Member

The authorized Benefits and Services provided under this Certificate are solely for the individual benefit of the Members and cannot be transferred or assigned. If any Member aids, attempts to aid or knowingly permits any other person not a Member of the Plan to obtain benefits or services from or through the Plan, the Plan will report such actions to DCH for appropriate action. The theft or wrongful use, delivery or circulation of a Member's identification card may constitute a felony under Michigan law.

4.6 Lost Identification Cards

If a Member's identification card is lost or stolen, the Member must contact the Plan's Member Services Department at (313) 871-2000 or toll free at (800) 826-2862 by the close of the business day following the discovery of the theft or loss.

4.7 Grievances/Appeals

A grievance/appeal may be filed due to a denial of payment, an adverse determination, or other dissatisfaction with the Plan. An adverse determination means health care services have been reviewed and denied, reduced or terminated. An untimely response to a request becomes an adverse determination. The Member or authorized representative has ninety (90) days from the date of the adverse determination letter to file a grievance/appeal. An authorized representative must have written permission to represent the Member. The consent must be sent with the grievance/appeal.

A Member has the right to have benefits continue pending resolution of the grievance/appeal. The Member may also authorize a representative to act on their behalf in the grievance/appeal process. The Member has the right to send additional documentation with the grievance/appeal.

At the Member's request, as a part of the grievance/appeal rights, the Plan can arrange a meeting with the Appeal Review Committee. The Member can discuss the grievance/appeal with the committee. The Member or authorized representative may attend a meeting in person or by telephone. A person not involved in the first decision can review the grievance/appeal. No one who reports to the person involved in the initial decision can review the grievance/appeal. The person who reviews the grievance/appeal will be of similar specialty.

A medical grievance/appeal will be completed within thirty (30) calendar days after it is received. An administrative or denial of grievance/appeal will be completed within thirty-five (35) calendar days after it is received. The time frame may be extended up to ten (10) business days if the Member requests an extension or if the Plan can show that there is need for additional information and can demonstrate that the delay is in the Member's best interest. If the Plan utilizes the extension, the Member will receive written notice of the reason for the delay. The Member will be notified in writing of the final decision. If the decision upholds the denial, an external appeal can be filed. The final letter informs the Member of the external appeal rights and how to file the appeal.

Expedited Grievance/Appeal

Sometimes, a time delay may increase the risk of harm to the Member's health or life. A grievance/appeal is considered expedited (quick), when a doctor notifies the Plan verbally or in writing that waiting 30 days would cause the Member to have severe pain or put their life at risk. The doctor must have knowledge of the Member's medical condition and be able to support the claim. The Plan will not punish a provider who requests or supports an expedited grievance/appeal. The grievance/appeal

must be received within ten (10) days of the denial.

If we deny a request for an expedited grievance/appeal it is changed to a thirty (30) day grievance/appeal. After filing an expedited internal grievance/appeal with the Plan, the Member may file an appeal to request an expedited external review with the Office of Financial and Insurance Regulation (OFIR).

A decision about an expedited grievance/appeal is made no later than seventy-two (72) hours after it is received. The Plan will notify the Member of the decision by phone. The Plan will also mail the decision to the Member within two (2) business days. The Member can request an extension of the decision time. The request moves the grievance/appeal to a thirty (30) day grievance/appeal.

If the decision upholds the denial, the Member will receive the reasons for the final denial. The notification letter will include the benefit provision, guideline, protocol or other criteria used. Upon request, the Member will be provided access to and copies of all papers related to the grievance/appeal.

External Appeal Rights

The Member or authorized representative has the right to ask for an Administrative Fair Hearing. The Member must file within ninety (90) days after receiving the denial letter. If the Member is receiving benefits and asking for a hearing, there will be no action taken against the Member. A hearing can be requested even if the Member is appealing to the Plan.

A request for an Administrative Fair Hearing must be in writing. An Administrative Fair Hearing request form will be sent with the denial letter. The form must be signed by the Member, or a person authorized to sign on the Member's behalf.

IMPORTANT: An Authorized representative must have written permission to represent the Member. The representative can request a hearing for the Member and represent the Member at the hearing. A hearing may be delayed, dismissed or denied if the Member does not provide written proof to the Department of Community Health that the Member authorized this person to act on the Member's behalf. A letter or a copy of a court order naming this person as the Member's guardian or conservator meets the requirement. A representative does not need written permission if this person is the Member's spouse or attorney.

The Administrative Fair Hearing starts an appeal directly to the State of Michigan Department of Community Health.

Members needing assistance completing the form should call 1-800-642-3195. Members with questions about the hearing process can call 1-877-833-0870 for information. Mail the form to:

State Office of Administrative Hearings and Rules
Michigan Department of Community Health
Administrative Tribunal
P.O. 30763
Lansing, Michigan 48909

The Member or authorized representative also has the right to request an external review of OFIR. The request can be made after the Plan notifies the Member of the final decision. Notification of the final decision completes the Plan's internal appeal process.

The Member or authorized representative must file the OFIR, Health Care-Request for External Review from OFIR. The request can be made after the Plan notifies the Member of the final decision. Notification of the final decision completes the Plan's internal appeal process.

The Member or authorized representative must file the OFIR, Health Care-Request for External Review Form to be given an external review. A copy of the Health Care-Request for External Review Form will be sent with the final decision letter. The Member may also call OFIR at 1-877-999-6442 to have a form mailed. The form should be filed no later than sixty (60) days after receipt of the final decision letter.

When appropriate, OFIR obtains the recommendation of an independent review organization. The independent review organization is not part of the Plan. This organization reviews the grievance/appeal as stated in the Patients Right to Independent Review Act.

To ask questions about the external review process, contact our Grievance Coordinator at (313) 871-2000 or 1-800-826-2862 ext. 889.

To request an independent review, contact OFIR at:

Office of Financial and Insurance Regulation
Health Plans Division
P.O. Box 30220
Lansing, Michigan 48909-7720

Phone number: Toll free at (877) 999-6442 or (517) 241-4168

4.8 When a Member enrolls in the Plan, such Member shall be deemed to have:

- 1) Authorized any physician, Hospital, or any other previous providers of health services to furnish to the Plan's Medical Director, Affiliated Physician, Affiliated Provider, Referral Physician, or Referral Facility, information related to all previous conditions and treatment except as otherwise provided by law.
- 2) Agreed to use Affiliated or Referral Physicians and Affiliated or Referral Facilities and other Affiliated Providers only, except in case of a Medical Emergency or Accidental Injury or as otherwise stated in this Certificate of Coverage.

4.9 This Certificate supercedes all previous contracts or certificates between the Plan and the Members.

4.10 Notices by Plan or Member

Any notice required to be given by the Plan or a Member shall be deemed to have been duly given if in writing and personally delivered, or deposited in the United States mail with postage prepaid, addressed, as applicable, to the Remitting Agent, to the member at the last address on record at the Plan's principal office, or to the Plan at 3011 W. Grand Blvd., Suite 1600, Detroit, MI 48202.

4.11 Confidentiality

The Plan will not disclose information concerning Members and/or their medical treatment or conditions to persons other than the Plan's Medical Director, Affiliated Providers, Referral Physicians, and Referral Facilities, except when authorization of the Member or as otherwise required by legal process or state or federal regulatory agencies.

4.12 Truth in Application and Statements

The Member agrees to complete and submit to the Plan any enrollment forms or other forms as may be requested by the Plan. The Member ensures and warrants that all information contained in these forms is true, correct, and complete.

4.13 Change of Address Notification

The Enrollee must notify the Plan if there is a change of address. The Enrollee can either notify the Plan in writing at 3011 W. Grand Blvd., Suite 1600, Detroit, MI 48202 or by calling the Member Services Department at (313) 871-2000 or toll free at (800) 826-2862 to inform the Plan of a change of address.

4.14 Subrogation and COB

The Plan has the same right as the Member to recover expenses for the treatment of an injury or illness for which another person or organization is legally liable. To the extent that the Plan provides services in such situations, the Plan will be subrogated to the Member's right to recovery against any responsible person or organization, including any other health plan or insurers on policies of insurance including those issued to and in the name of the Member.

By acceptance of an ID card from the Plan, the Member agrees as a condition to receiving Authorized Benefits and Services under this Certificate, that the Member will make a good faith effort to pursue recovery from any liable person or organization and upon collection of any recoveries for any Authorized Benefits and Services provided by the Plan, will reimburse the Plan.

Benefits under the Certificate will be coordinated with all group health insurance and/or other HMO benefits available to the Member under any policy or certificate which also has a coordination of benefits provision. The priority of responsibility under the coordinating policies or certificates will be determined in accordance with State laws and the Medicaid Program.

4.15 Affiliated Provider Termination

In the event of termination, Members in an ongoing course of treatment with an Affiliated Physician or Referral Physician shall be permitted to continue such treatment with Plan authorization as follows:

- 1) For a period of ninety (90) days from the date the Member is notified of the termination;
- 2) If the Member is in the second or third trimester of pregnancy, treatment shall continue through post-partum care;
- 3) If it is determined that the Member is terminally ill, as defined in Section 5653 of the public health code, treatment will continue for the remainder of the Member's life for care directly related to the treatment of terminal illness.

ARTICLE V. COVERED BENEFITS AND SERVICES

Services are limited to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Covered benefits and services are consistent with the Michigan Medicaid Program and are operated consistently with applicable Medicaid provider manuals and publications for coverage limitations.

The services provided to Enrollees under this Contract include the following:

- Inpatient and outpatient hospital services
- Emergency services
- Practitioners' services (such as those provided by physicians, optometrists, and dentists enrolled as Medicaid Provider Type 10)
- Chiropractic services for beneficiaries under the age of 21
- Podiatry services
- Immunizations
- Well Child/ EPSDT for persons under age 21
- Transplant services
- Tobacco cessation treatment, including pharmaceutical and behavioral support
- Family planning services
- Pharmacy services
- Prosthetics & orthotics
- Durable medical equipment and supplies
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Hospice services (if requested by the Enrollee)
- Transportation - ambulance and other emergency medical transportation, non-emergent medical transportation for necessary covered services
- Vision services for beneficiaries under the age of 21
- Low vision services for beneficiaries age 21 and older
- Hearing & speech services
- Hearing Aids for beneficiaries under the age of 21
- Therapies (speech, language, physical, occupational; excluding services provided to persons with developmental disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or intermediate school districts)
- Diagnostic lab, x-ray and other imaging services
- Health education
- Home health services
- Intermittent or short-term restorative or rehabilitative services in a nursing facility up to 45 days
- Parenting and birthing classes
- Medically necessary weight reduction services
- End stage renal disease services
- Mental health care up to 20 outpatient visits per calendar year
- Outreach for included services, especially pregnancy related and well-child care
- Out-of-state services authorized by the Plan
- Treatment for sexually transmitted disease (STD)
- Blood lead testing and follow-up services for individuals under the age of 21
- Restorative and rehabilitation services in a place of service other than a nursing facility
- Well-Woman Exam
- Breast cancer screening
- Reconstructive surgery and prosthetics following mastectomy
- Antineoplastic drug coverage (Chemotherapy)
- Preventative health services

Specific coverage policies apply to certain types of services as follows:

5.1 Emergency Care

Emergency Services as well as medical screening exams are covered consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (41 USCS 1395 dd(a)). Emergency services for medical emergencies or accidental injuries are available 24 hours a day, 7 days a week.

“Medical Emergency” means a medical condition manifested by severe symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life if not treated immediately.

“Accidental Emergency” means a traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a Member’s health or result in loss of life.

Heart attacks, hemorrhaging, poisonings, loss of consciousness or respiration, trauma and convulsions are some examples of Medical Emergencies or Accidental Injuries.

Transportation is covered for all emergencies. Any medically necessary and appropriate transportation is covered by the Plan.

Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered at the Member’s designated Health Center only, unless specifically authorized in writing by the Plan’s Medical Director or designee.

5.2 Out-of-Network Services

Out-of-network emergency services are covered and do not require authorization. All other out-of-area or out-of-network services must be authorized by the Plan, an affiliated physician, or as otherwise stated in this Certificate of Coverage.

5.3 Family Planning Services

Family planning services include any medically approved diagnostic evaluation, 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). Services are to be provided in a confidential manner to individuals of child bearing age including minors who may be sexually active, who voluntarily choose not to risk initial pregnancy, or wish to limit the number and spacing of their children.

- 1) Members have full freedom of choice of family planning provider, both in-plan and out-of-plan.
- 2) Family planning services do not include treatment for infertility.
- 3) No prior authorization is required for Family Planning Services.

5.4 Federally Qualified Health Centers (FQHCs)

Members may receive medically necessary services from a Federally Qualified Health Center (FQHC) if the Member resides in the FQHC’s service area (Wayne, Oakland, Macomb and Genesee Counties) and if the Member requests such services.

5.5 Co-Payments

Medicaid beneficiaries do not have any co-payments.

5.6 Abortions

Medicaid funds cannot be used to pay for elective abortions (and related services) to terminate pregnancy unless a physician certifies that the abortion is medically necessary to save the life of the mother. Elective abortions are also covered if the pregnancy is a result of rape or incest. Treatment for medical complications occurring as a result of an elective abortion are covered. Treatment for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies are covered.

5.7 Pharmacy

Prescription drugs are covered benefits. Some over-the-counter products such as insulin syringes, reagent strips, psyllium, and aspirin are also covered. Condoms are also available to eligible Members.

5.8 Well Child Care/Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program

Well Child/EPSDT is a Medicaid child health program of early and periodic screening, diagnosis and treatment services for children, adolescents, and young adults under the age of 21. It supports two goals: to ensure access to necessary health resources, and to assist parents and guardians in appropriately using those resources.

The screening component includes a general health screening most commonly known as a periodic well-child exam. The required well child/EPSDT screening guidelines include:

- Health and developmental history
- Developmental/behavioral assessment
- Age appropriate unclothed physical examination
- Height and weight measurements, and age appropriate head circumference
- Blood pressure for children 3 and over
- Immunization review and administration of appropriate immunizations
- Health education including anticipatory guidance
- Nutritional assessment
- Hearing, vision and dental assessments
- Blood lead to testing for children under 6 years of age
- Interpretive conference and appropriate counseling for parents or guardians
- Age-appropriate screening, testing, and vaccinations

Additionally, objective testing for developmental behavior, hearing and vision must be performed in accordance with the periodicity schedule included in Medicaid policy. Laboratory services for tuberculin testing, hematocrit, urinalysis, hemoglobin, or other needed testing as deemed by the physician will be provided.

5.9 Immunizations

All Enrollees are eligible for vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. The Plan participates with the Vaccine for Children (VFC) program for children 18 years old and younger. The Plan also participates in the locally accessed Michigan Care Improvement Registry (MCIR).

Enrollees can also obtain immunizations from the local health department without prior authorization.

5.10 Transportation

The Plan provides emergency transportation for enrollees. The Plan provides non-emergency transportation to authorized, medically necessary covered services.

5.11 Transplant Services

Transplant services are covered benefits. Transplant surgery and care is covered, including organ procurement, donor searching and typing, harvesting of organs, related donor medical costs. Cornea and kidney transplants and related procedures are covered services. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologous and peripheral stem cell harvesting, and small bowel) are covered on a patient-specific basis when deemed medically necessary.

5.12 Post-Partum Stays

The Plan covers maternity and nursery care of at least forty-eight (48) hours following childbirth (96 hour minimum stay in the case of a cesarean section).

5.13 Communicable Disease Services

Communicable diseases under this section are HIV/AIDS, STDs, tuberculosis, and vaccine-preventable communicable diseases. Enrollees may receive treatment services for communicable diseases from local health departments without prior authorization by the Plan.

5.14 Restorative Health Services

Restorative health services means intermittent or short-term “restorative” or rehabilitative nursing care that may be provided in or out-of-licensed nursing facilities. Up to forty-five (45) days of restorative health care services in a nursing facility are covered as long as medically necessary and appropriate. The 45-day maximum does not apply to restorative health services provided in place of service other than a nursing facility.

5.15 Child and Adolescent Health Center (CAHC)

Enrollees may choose to obtain services from a Child and Adolescent Health Center (CAHC) without prior authorization from the Plan.

5.16 Well-Woman Exam

Female enrollees may obtain routine OB/GYN services from in-plan and out-of-plan providers without prior authorization from the Plan.

5.17 Breast Cancer Screening

Mammography breast cancer screening services are covered by the Plan. Coverage is for one mammography screening every calendar year for women 40 years of age or older, and for one mammogram during the five-year period for women between 35 and 40 years of age. Any other medically indicated mammography is covered.

5.18 Other Breast Services and Treatment Following a Mastectomy

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction on the breast to produce a symmetrical appearance
- Prosthesis (breast implant); and
- Treatment for physical complications of the mastectomy, including lymphedema

5.19 Diabetic Services

The Plan shall provide coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary, meets established criteria, and is prescribed by a licensed allopathic or osteopathic physician:

- Blood glucose monitors
- Blood glucose monitors for the legally blind
- Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices
- Syringes
- Insulin pumps and medical supplies required for the use of an insulin pump
- Diabetes self-management training to ensure the Members with diabetes are trained as to the proper self-management and treatment of the diabetic condition
- Insulin and other medications for the treatment of diabetes and associated conditions

5.20 Antineoplastic Drug Coverage (Chemotherapy)

The Plan covers drugs used in antineoplastic therapy and the reasonable cost of its administration. Coverage for drugs in antineoplastic therapy is 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 Federal Food and Drug Administration, 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 Federal Food and Drug Administration 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 that includes Federal Food and Drug Administration approved drugs for the off-label indications.

5.21 Pediatric Care

Members may see a pediatrician for Well Child Care within the Plan's network without a referral or prior authorization from either the Plan or the PCP.

5.22 Intermediate and Outpatient Substance Abuse Services

For intermediate and outpatient substance abuse services, the Member should contact the Plan's Member Services Department at (313) 871-2000 or toll free at (800) 826-2862 for instructions.

ARTICLE VI: EXCLUSIONS AND LIMITATIONS

- 6.1** All benefits and services not specifically described as Authorized Benefits and Services in this Certificate are excluded under this certificate.
- 6.2** Medical, surgical, Hospital, and related services (except for an Emergency) obtained by a Member from providers other than Affiliated Providers, are not covered unless they are authorized in writing by the Plan's Medical Director or designee before the services are rendered, unless otherwise stated in this Certificate of Coverage.
- 6.3** Services which are not medically necessary are not covered. The final determination of medical necessity is made by the Plan's Medical Director or designee.
- 6.4** Services ordered by a court of competent jurisdiction are not covered, unless they are otherwise Authorized Benefits and Services.
- 6.5** Services provided during police (county or state) custody are not covered, unless they are otherwise Authorized Benefits and Services.
- 6.6** Surgery and other services for cosmetic purposes, as deemed by Medicaid's policies and procedures, are not covered.
- 6.7** Medical, surgical, and other health care procedures deemed by Medicaid's policies and procedures to be experimental (including research studies) are not covered.
- 6.8** Services of private duty nurses are not covered unless they are authorized by the Plan's Medical Director or designee before services are rendered.
- 6.9** Personal care services to provide assistance with daily living activities are not a covered benefit. Examples of personal care include: assistance in bathing, dressing, eating, walking, getting in and out of bed and taking medicine.

- 6.10** General housekeeping services and personal convenience items, including but not limited to, television and telephone services are not covered.
- 6.11** Reversal of voluntary, surgically induced sterilization is not covered.
- 6.12** Hospital, medical and surgical services for the primary purpose of sex transformation are not covered.
- 6.13** Services for treatment of infertility are not covered.

ARTICLE VII: TERMINATION OF A MEMBER'S COVERAGE

- 7.1** The Plan will be responsible for the Member's medical care until the State of Michigan Department of Community Health notifies the Plan that its responsibility for the Member is no longer in effect.
- 7.2** Coverage for an Enrollee shall terminate whenever any of the following occurs:
 - 1) The Contract between the Plan and the State is terminated for any reason.
 - 2) The Enrollee is no longer eligible for Medicaid and does not regain eligibility within two (2) months.
 - 3) The Enrollee dies.
 - 4) The Enrollee moves outside the Plan's service area and the State has disenrolled the member from the plan.
 - 5) The Enrollee is medically eligible under CSHCS and has elected to enroll in CSHCS.
 - 6) The Enrollee is eligible for long-term custodial services in a nursing facility following discharge from an acute care inpatient facility, the health plan has requested disenrollment, and the State has approved the disenrollment.
 - 7) The Enrollee is admitted to a state psychiatric hospital.
 - 8) The Enrollee is granted a disenrollment by DCH for medical exceptions.
 - 9) The Member is moved into a Medicaid eligible group that is excluded from enrolling in the CHCP.
 - 10) The Member is in a Medicaid eligible group that may voluntarily enroll in a CHCP and chooses to disenroll.
 - 11) Other circumstances where the State Medicaid Program dictates.
- 7.3** The Plan may request disenrollment of an Enrollee by DCH, when actions by the Enrollee are inconsistent with the Plan's membership, including fraud, abuse of the Plan's services, or other intentional misconduct; or if, in the opinion of the PCP, the Enrollee's behavior makes it medically infeasible to safely or prudently render Covered Services. Such termination is subject to the grievance procedures as set forth in this Certificate. The notice of intent to terminate shall be immediately communicated to the Enrollee whose enrollment is terminated, along with procedures for expeditious review pursuant to Article 4 Section 7.

