



PRO CARE HEALTH PLAN, INC.

MEDICAID

CERTIFICATE OF COVERAGE

**Pro Care Health Plan, Inc.
3956 Mount Elliott
Detroit, Michigan 48207**

Pro Care Health Plan, Inc. is a licensed health maintenance organization. Pro Care is a for-profit corporation whose business office is at 3956 Mount Elliott Street, Detroit, Michigan 48207. Pro Care is accredited by the Utilization Review Accreditation Commission.

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ARTICLE 1 - GENERAL CONDITIONS

- 1.1 **Certificate.** This Certificate of Coverage is issued to you because you are eligible for the Medicaid Program and you are enrolled in Pro Care Health Plan (“Pro Care”). If you are the head of the house and others in your house are also enrolled in Pro Care this Certificate is issued to you as the head of the house. In this Certificate you are called the “Member”. Others in your house who are also enrolled in Pro Care are also called the “Member”.
- 1.2 **Rights and Responsibilities.** This Certificate describes and states the Member’s rights and responsibilities and Pro Care’s rights and responsibilities. **It is the Member’s responsibility to read and understand this Certificate.** By enrolling in Pro Care, the Member agrees to comply with this Certificate.
- 1.3 **Changes.** All changes to this Certificate must be in writing and signed by an authorized officer of Pro Care. Verbal changes to this Certificate are not permitted even if an employee of Pro Care tells the Member differently.
- 1.4 **Assignment.** The Member’s rights to receive Covered Services under the Certificate are personal to the Member. The Member may not give or sell these rights to any other person. If the Member gives or sells, or tries to give or sell, his or her rights to any other person, the Member’s enrollment in Pro Care may be terminated under Article 9.

ARTICLE 2 - DEFINITIONS

- 2.1 **“Applicability”** This part of the Certificate tells the meaning of words that are used throughout this Certificate. If a word is defined in this part of the Certificate, that word has the same meaning throughout this Certificate.
- 2.2 **“CAHCP”** means Child and Adolescent Health Centers and Programs.
- 2.3 **“Certificate”** means this Certificate of Coverage between Pro Care and the Member, and all changes and attachments to this Certificate.
- 2.4 **“Communicable Diseases”** means HIV/AIDS, sexually transmitted diseases, tuberculosis and vaccine-preventable communicable diseases.
- 2.5 **“Contract Year”** means a 12-month period ending on an anniversary of the Member’s effective date of coverage.
- 2.6 **“Copayment”** means the amount of money that the Member is required to pay directly to a Participating or Non-Participating Provider for certain Covered Services.
- 2.7 **“Covered Services”** means the Medically Necessary services, equipment and supplies set forth in **Appendix A** of this Certificate which are covered health care benefits under this Certificate.

- 2.8 **“Department”** means the Michigan Department of Community Health or its successor agency which is duly authorized to administer the Medicaid Program in the State of Michigan.
- 2.9 **“Emergency Medical Condition”** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment of bodily functions; or (iii) serious dysfunction of any bodily organ or part.
- 2.10 **“Emergency Services”** means the services which are Medically Necessary to treat an Emergency Medical Condition. Emergency Services includes medical screening exams and stabilization consistent with the federal Emergency Medical Treatment and Active Labor Act.
- 2.11 **“Experimental”** means a supply, drug, device, item, procedure or treatment that meets one of more of the following standards:
- A. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
 - B. It is the subject of a current investigational new drug or new device application on file with the FDA.
 - C. It is being provided pursuant to a Phase I or Phase II clinical trial.
 - D. It is being provided pursuant to a written protocol which describes among its objectives the determination of safety, efficacy or efficiency in comparison of conventional alternatives.
 - E. It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS) or successor agencies, or of a human subjects or comparable committee.
 - F. The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to medical investigational or research settings.
 - G. The predominant opinion among experts as expressed in the published authoritative medical or scientific literature is that further experiment,

investigation or research is necessary in order to define safety, toxicity, effectiveness or efficiency compared with conventional alternatives.

- H. At the time of its use or proposed use, it is not routinely or widely employed or is otherwise not generally accepted by the medical community.
- I. It is not investigative in itself pursuant to any of the foregoing criteria, and would not be Medically Necessary, but for the provision of a drug, device, treatment, procedure or equipments which meets any of the foregoing criteria.
- J. It is deemed experimental, investigational or research under Pro Care's insurance or reinsurance agreements.

An antineoplastic drug which is a covered benefit in accordance with Section 3406e of the Insurance Code is not an Experimental drug.

- 2.12 **“Family Planning Services”** are 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.
- 2.13 **“Health Professional”** means an individual licensed, certified or authorized in accordance with Michigan law to practice a health profession in Michigan.
- 2.14 **“Hospital”** means a facility licensed as a hospital under Michigan law, except for a facility licensed or operated by the State of Michigan as a mental health or psychiatric hospital.
- 2.15 **“Hospital Services”** mean those Covered Services which are provided by a Hospital.
- 2.16 **“Insurance Code”** means the Michigan Insurance Code of 1956, as amended, MCL 500.101 et seq.
- 2.17 **“Medicaid Contract”** is the contract between the Department and Pro Care under which Pro Care agrees to arrange for Covered Services for Members.
- 2.18 **“Medicaid Program”** means the medical assistance program established by Michigan and federal law to provide comprehensive health care services for eligible individuals.
- 2.19 **“Medical Director”** means a Physician designated by Pro Care to supervise and manage the quality of care aspects of Pro Care's programs and services.
- 2.20 **“Medically Necessary”** means the services, equipment or supplies necessary for the diagnosis, care or treatment of the Member's physical or mental condition as determined by the Medical Director in accordance with accepted medical practices and standards of

care at the time of treatment. Medically Necessary does not in any event include any of the following:

- A. services rendered by a Health Professional that do not require the technical skills of the Health Professional; or
- B. services, equipment or supplies furnished mainly for the personal comfort or convenience of the Member, any individual who cares for the Member, or any individual who is part of the Member's family; or
- C. that part of the cost of service, equipment or supply which exceeds that of any other service, equipment or supply that would have been sufficient to safely and adequately diagnose or treat the Member's physical or mental condition, except when rendered by, or provided upon the referral of, a PCP, or otherwise authorized by Pro Care, in accordance with Pro Care's procedures.

- 2.21 **“Medicare”** means the health benefits program primarily for elderly and disabled individuals established under Title XVIII of the federal Social Security Act, 42 U.S.C. 1395 et seq.
- 2.22 **“Member”** means a Medicaid Program beneficiary enrolled in ProCare and on whose behalf the Department has paid a Premium in accordance with the Medicaid Contract.
- 2.23 **“Non-Covered Service”** means a health care service which is not a covered health care benefit under this Certificate.
- 2.24 **“Non-Participating Provider”** means a Health Professional, a Hospital, pharmacy, laboratory, or any other health care provider or supplier who does not have a contract with ProCare to render Covered Services to Members.
- 2.25 **“Office of Insurance”** means the Michigan Office of Financial and Insurance Services, or its successor agency, which is duly authorized to regulate health maintenance organizations in Michigan.
- 2.26 **“Participating Hospital”** means a Hospital, which has a contract with ProCare to provide Covered Services to Members.
- 2.27 **“Participating Physician”** means a Physician who has a contract with ProCare to provide Covered Services to Members.
- 2.28 **“Participating Provider”** means a Participating Physician, Participating Hospital, or any other Health Professional or health care provider or supplier which has a contract with ProCare to render Covered Services to Members.

- 2.29 **“PCP”** means the Participating Provider who is responsible for providing primary care Covered Services for the Member and arranging and coordinating all aspects of the Member’s health care.
- 2.30 **“Physician”** means a doctor of allopathic or osteopathic medicine licensed to practice medicine in the State of Michigan.
- 2.31 **“Pro Care ”** means Pro Care Health Plan, Inc. a Michigan for profit corporation licensed by the State of Michigan as a health maintenance organization.
- 2.32 **“Premium”** means the amount of money paid by the State of Michigan to Pro Care to secure Covered Services for Members under the Medicaid Contract.
- 2.33 **“Service Area”** means the geographic area in which Pro Care is authorized by the Office of Insurance and Department to operate as a health maintenance organization and Medicaid health plan.
- 2.34 **“Specialist”** means a Participating Physician, other than a PCP, who provides Covered Services to Members upon referral by the PCP and, if required, prior authorization by Pro Care.
- 2.35 **“Urgent Care”** means the treatment of a medical condition that requires prompt medical attention but is not an Emergency Medical Condition.

ARTICLE 3 - ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

- 3.1 **Eligibility.** The Department has sole authority to determine the eligibility of individuals or families for the Medicaid Program. Pro Care does not have any authority to determine whether an individual is eligible for the Medicaid Program.
- 3.2 **Enrollment.** An individual may enroll in Pro Care only if the individual is eligible for the Medicaid Program and lives within the Service Area. The Department or its Enrollment Services Contractor has sole authority for enrolling individuals in Pro Care . An eligible individual may choose Pro Care, or the Department may choose Pro Care for the eligible individual. Pro Care will not deny enrollment to, expel, or refuse to re-enroll any individual because of the individual’s health status or need for services.
- 3.3 **Effective Date of Coverage.** The effective date of the Member’s coverage by Pro Care is the first day of the month after the Department notifies Pro Care in writing of the enrollment. However, if the Member is in any inpatient setting on this date, Pro Care is not responsible for arranging or paying for any health care services for the Member, including the inpatient stay and any charges connected with that stay. Pro Care is responsible only for arranging and paying for Covered Services after the date of the Member’s discharge from the inpatient setting. Pro Care is not responsible for arranging or paying for any health care services for an individual before the effective date of coverage in Pro Care, except for newborns as set forth below. Pro Care is not responsible

for arranging or paying for any health care services for an individual during a period of retroactive eligibility (as determined by the Department), except for newborns as set forth below. Pro Care or the Department will notify the Member of the effective date of enrollment in ProCare and coverage under this Certificate.

- 3.4 **Newborns.** The Member's newborn child is eligible for the Medicaid Program for the month of birth, and may be eligible for up to one-year longer as determined by the Department. The newborn child is automatically enrolled in Pro Care if the child's mother is eligible for the Medicaid Program and is enrolled in Pro Care at the time of the child's birth. The newborn is entitled to Covered Services retroactive to the date of birth. The Member must notify the Member's Michigan Department of Human Services caseworker as soon as possible after the birth of a newborn. The Department has sole authority to determine the continued eligibility and enrollment of a newborn.
- 3.5 **Change of Residence.** The Member must notify Pro Care when the Member moves to a residence outside of the Service Area. If the Member moves outside of the Service Area, the Member's enrollment in Pro Care may be terminated under Article 9. However, the Member is entitled to Covered Services until the Member is disenrolled from Pro Care. The Member must notify Pro Care either by telephoning or writing to the Member Services Department. Pro Care will notify the Department of changes in accordance with Department procedures.
- 3.6 **Change in Family Size.** The Member must notify Pro Care as soon as possible of changes in the Member's family such as a divorce, an adoption or change in child custody. The Member must notify Pro Care either by telephoning or writing to the Member Services Department. Pro Care will notify the Department of changes in accordance with Department procedures.
- 3.7 **Final Determination.** In all cases, the Department will make the final determination of an individual's eligibility for the Medicaid Program and the individual's enrollment and right to continue enrollment in Pro Care.

ARTICLE 4 - MEMBER RIGHTS AND RESPONSIBILITIES

- 4.1 **Certificate Compliance.** This Certificate describes and states the Member's rights and responsibilities and Pro Care's rights and responsibilities. It is the Member's responsibility to read and understand this Certificate. By enrolling in Pro Care, the Member agrees to comply with this Certificate. The Member's rights and responsibilities are described and stated throughout this Certificate and in the Member Handbook in addition to the general provisions described and stated in this Article 4.
- 4.2 **Medical Questionnaires and Other Forms.** The Member must complete and submit medical questionnaires and other forms that are reasonably requested by Pro Care. The Member must provide true, correct and complete information on these questionnaires and forms. If the Member intentionally provides false or misleading information or omits a

material fact on a questionnaire or form, the Member's enrollment in Pro Care may be terminated under Article 9 of this Certificate.

- 4.3 **Identification Card.** Pro Care will issue an Identification Card to the Member. The Member must present the Identification Card to Participating Providers each time the Member obtains Covered Services. The Identification Card is the property of Pro Care and Pro Care may request the Member to return an Identification Card at any time.
- 4.4 **Misuse of Identification Card.** If the Member misuses the Identification Card, permits another person to use the Card, or otherwise defrauds (or tries to defraud) Pro Care, Pro Care may immediately request the Member to return the Identification Card to Pro Care. The Member's enrollment in Pro Care, and the enrollment of any other Members in the household, may be terminated under Article 9 if the Member misuses the Card, permits another person to use the Card, or otherwise defrauds or tries to defraud Pro Care,
- 4.5 **Loss or Theft of Identification Card.** The Member must promptly notify Pro Care of the loss or theft of the Member's Identification Card. The Member must notify Pro Care either by telephoning or writing to the Member Services Department.
- 4.6 **Member Handbook.** The Member will receive a copy of the Member Handbook when the Member enrolls in Pro Care. Pro Care will notify the Member of any changes to the Member Handbook. The Member may request additional copies of the Member Handbook at any time by telephoning or writing to the Member Services Department.
- 4.7 **Grievance and Appeal Procedures.** Pro Care has internal procedures for receiving, processing and resolving Member concerns relating to any aspect of health services or administrative services, including authorizations for medical services. An external grievance and appeal procedure administered by the Office of Insurance and a Medicaid Fair Hearing Process are also available to Members. The Member Handbook describes Pro Care's internal grievance and appeal procedure, the Office of Insurance external grievance procedure, and the Medicaid Fair Hearing Process. The Member may call Pro Care's Member Services Department if the Member has a question concerning Pro Care's internal grievance procedures or the external processes. The telephone number of the Member Services Department is in the Member Handbook.
- 4.8 **Fraud and Abuse.** Pro Care has a compliance program for identifying, addressing and reporting instances of fraud and abuse. The Member should report to Pro Care any suspected fraud or abuse involving the Medicaid Program. The Member Handbook has information about reporting suspected fraud and abuse to Pro Care or government agencies. Abuse includes health care provider or Member practices that result in unnecessary costs to the Medicaid Program or in reimbursement for services that are not medically necessary. Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to the person or some other person, including any act constituting fraud under federal or state law.

- 4.9 **Reasonable Accommodation.** Pro Care will make reasonable accommodation for Members with hearing and/or visual impairments.
- 4.10 **Advance Directives.** Pro Care has policies and procedures for the use and handling of Members' advance directives. Pro Care's Member Handbook describes the Members' right to have and exercise advance directives under Michigan law. An advance directive is a Member's written instruction, such as a living will or durable power of attorney for health care as recognized under Michigan law, relating to the provision of health care if the Member is incapacitated.
- 4.11 **Member Inclusion.** Pro Care has written guidelines and a process to reasonably ensure that Members are provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, physical or mental handicap, residence in the Service Area, or lawful occupation.
- 4.12 **Member Health and Other Information.** Pro Care must keep the Member's protected health information confidential under Michigan and federal laws, including HIPAA. Pro Care must not use or disclose the Member's protected health information to other persons if the use or disclosure violates state or federal laws. Pro Care will provide the Member a Notice of Privacy Practices that describes the Member's rights and obligations and Pro Care's rights and obligations regarding the Member's protected health information. The Department and the federal Centers for Medicare and Medicaid Services will have access to Members' medical records without obtaining Members written approval before requesting the medical records. Pro Care must comply with state and federal law regarding the Member's right to access and review the Member's medical record. Pro Care will protect from unauthorized disclosure all Member information collected, maintained or used in the administration of the Medicaid Contract.
- 4.13 **Pro Care's Board of Directors.** As required by law, at least one-third of the Directors on Pro Care's Board of Directors must be adult Members elected by subscribers. Pro Care will notify all subscribers of the date of subscriber elections and each subscriber will have the right to vote for Member nominees for the Board of Directors. Nominations and elections of Directors will be reported in Pro Care's periodic newsletter. The Member may contact Pro Care's Member Services Department for information on becoming a Director.
- 4.14 **Protection Against Liability for Payment and Balance Billing.** The Member will not be liable for payment to Pro Care or health care providers for Covered Services provided to the Member, except as specifically stated in this Certificate.
- 4.15 **Pro Care's Policies and Procedures.** The Member is responsible for becoming familiar with and following the policies and procedures which Pro Care adopts from time to time to administer the Medicaid Contract, the Certificate and Pro Care . Pro Care will provide copies of its policies and procedures to the Member upon request, and will provide information regarding policies and procedures in Pro Care 's newsletter and other written communication to Members.

4.16 **Member Request for Information.** The Member should refer to Pro Care's Provider Directory for a listing of current Participating Providers, including names and locations of Participating Providers by specialty or type and which Participating Providers will not accept new Members. This Certificate and the Member Handbook describe limitations of accessibility and referrals to specialists, prior authorization requirements and Non-Covered Services. In addition, as required by the Insurance Code, upon request of the Member, Pro Care will provide a description of any of the following information requested by the Member:

- A. Professional credentials of Participating Physicians and other health professionals who are Participating Providers;
- B. The licensing verification telephone number for the Michigan Department of Community Health that can be accessed for information regarding disciplinary actions or open complaints against a health professional Participating Provider;
- C. The financial relationship between Pro Care and any Participating Provider; or
- D. A telephone number and address to obtain additional information concerning the Provider Directory, limitations of accessibility and referrals to specialists, prior authorization requirements, Non-Covered Services or any of the items described above in paragraphs A through C.

ARTICLE 5 - RELATIONSHIPS WITH PARTICIPATING AND NON-PARTICIPATING PROVIDERS

5.1 **Choosing a PCP.** At the time of enrollment in Pro Care, the Member should choose his/her PCP from Pro Care's Provider Directory. The Provider Directory lists all Participating Physicians who are primary care Physicians. The Member may choose a clinic as a PCP if the clinic is listed in the Provider Directory as a PCP. If a Member is a minor or otherwise incapable of selecting a PCP, an authorized person may select a PCP on behalf of the Member. An authorized person may select a pediatrician who is a Participating Physician as the PCP for a Member who is a minor. Pro Care will allow a Specialist to be the Member's PCP if it is necessary for the Specialist to manage the Member's medical condition. This might be necessary for a medical condition such as diabetes, end-stage renal disease, HIV/AIDS or other chronic disease or disability. If Pro Care cannot honor the Member's choice of a PCP, Pro Care will notify the Member to allow the Member to choose an alternate PCP or to disenroll. Disenrollment will be determined by the Department. Pro Care will select a PCP for a Member if the Member (or an authorized person on behalf of the Member) does not select a PCP within ten days of the effective date of enrollment. Pro Care will notify the Member of the PCP that Pro Care selected for the Member. Pro Care will inform the Member of the hours of operation and office locations of the PCP that the Member has chosen or that Pro Care has selected for the Member.

- 5.2 **Changing a PCP.** The Member may change to a different PCP by making a verbal or written request to Pro Care 's Members Services Department. A PCP change is effective on the first day of the following month if requested by the 25th day of the current month. The member should verify the effective date of change when the Member requests the change.
- 5.3 **Role of PCP.** The Member's PCP provides primary care services and arranges and coordinates the provision of other health care services for the Member, including referrals to specialists, ordering lab tests and x-rays, prescribing medicines, and arranging hospitalization.
- 5.4 **Specialists and other Participating Providers.** Except as otherwise expressly stated in this Certificate, the Member must obtain a referral from the PCP or, when required, authorization from Pro Care, **before** the Member receives Covered Services from a Specialist or other Participating Provider. If the Member does not obtain the necessary referral or authorization from the PCP or Pro Care, Pro Care will not pay for any of the medical services, equipment, and supplies that the Member receives from the Specialist or other Participating Provider. It is not necessary to obtain a referral or authorization to receive the following services from Participating Providers: (i) Emergency Services; (ii) Family Planning Services; (iii) outpatient mental health services for up to 20 visits per Contract Year; (iv) covered vision services; or (v) an annual well-woman examination and routine obstetrical and routine gynecological services from an obstetrician-gynecologist.
- 5.5 **Non-Participating Providers.** The Member may occasionally require Covered Services from Non-Participating Providers. On these rare occasions, the Member must obtain authorization from Pro Care **before** the Member receives any Covered Services from the Non-Participating Provider, except as otherwise specifically stated in this Certificate. If the Member does not receive authorization from Pro Care, Pro Care will not pay or reimburse the Non-Participating Provider or the Member for any of the medical services, equipment and supplies received from the Non-Participating Provider, except under the following circumstances: (i) the services are Medically Necessary Covered Services; **and** (ii) the services could not reasonably be obtained from a Participating Provider; **and** (iii) Pro Care did not respond to a the request for authorization within 24-hours after the request was made. If Pro Care does not have a Participating Provider available for a second opinion within its provider network, the Member may obtain a second opinion from a Non-Participating Provider at no cost to the Member with Pro Care's prior authorization. It is not necessary to obtain authorization from Pro Care before receiving the following services from Non-Participating Providers: (i) Emergency Services; (ii) treatment of Communicable Diseases at the Member's local health department; (iii) Family Planning Services; and (iv) Covered Services from a CAHCP provider. If there is not a Participating Provider Federally Qualified Health Center in the county where the Member resides, the Member may obtain routine health care services from a Non-Participating Federally Qualified Health Care Center without prior authorization from Pro Care.

- 5.6 **Independent Contractors.** Pro Care contracts with Participating Providers who provide Covered Services to Members. The Participating Providers are independent contractors. They are not employees, agents, partners or co-venturers of Pro Care. Participating Providers are solely responsible for exercising independent medical judgments. A Participating Provider and the Member may initiate or continue medical services despite Pro Care 's decision that the services are Non-Covered Services. Pro Care will not pay or reimburse the Participating Provider or the Member for any of these Non-Covered Services. The Member may appeal Pro Care 's decision on whether services are Covered Services by following the grievance and appeal procedures described in the Member Handbook.
- 5.7 **Availability of Participating Providers.** Pro Care does not represent or promise that a specific PCP or other Participating Provider will be available to render services throughout the period that the Member is enrolled in Pro Care. Pro Care or the Participating Provider may terminate the provider contract or limit the number of Members that the Participating Provider will accept as patients. If the Participating Provider contract of the Member's PCP is terminated, the Member must select another PCP. Pro Care will notify the Member of the termination of the PCP's Participating Provider contract and will assist the Member in choosing a new PCP before termination of the contract. If a Specialist who is rendering services to a Member ceases to be a Participating Provider, the Member must cooperate with the Member's PCP or Pro Care in referring the Member to another Specialist to render the Covered Services.
- 5.8 **Inability to Establish or Maintain a Physician-Patient Relationship.** If the Member is unable to establish or maintain a satisfactory relationship with a PCP or a Specialist, Pro Care may request the Member to select another PCP, or may arrange to have the Member's PCP refer the Member to another Specialist. If the Member is unable to establish or maintain a satisfactory relationship with Participating Physicians, the Member's enrollment in Pro Care may be terminated under Article 9.
- 5.9 **Refusal to Accept or Follow Treatment.** For personal or religious reasons, a Member may refuse to accept or follow the treatment(s) or procedure(s) recommended as necessary by a Participating Physician. The Participating Physician may request that the Member select another Participating Physician if a satisfactory relationship with the Member cannot be maintained because of the Member's refusal to follow such treatment recommendations or orders.

ARTICLE 6 - PAYMENT FOR COVERED SERVICES

- 6.1 **Periodic Premium Payments.** The State of Michigan will pay the Premium directly to Pro Care, on behalf of the Member. The State of Michigan will pay the Premium on or before the due date specified in the Medicaid Contract. The Member is entitled to Covered Services under this Certificate for the period to which the Premium applies.
- 6.2 **Copayments.** A Member must pay or arrange for payment of Copayments at the time a Covered Service is provided. Copayments, if any, are set forth in **Appendix D** of the

Certificate. A Participating or Non-Participating Provider may require the Member to pay the Copayment in cash at the time of delivery of the Covered Services. A Participating or Non-Participating Provider may not deny Covered Services to the Member due to the Member's inability to pay the Copayment.

6.3 **Claims.**

- 6.3.1 It is Pro Care 's policy to pay Participating Providers directly for Covered Services provided to Members in accordance with the provider contracts between Pro Care and Participating Providers. However, if a Participating Provider bills the Member for a Covered Service, the Member should contact the Member Services Department upon receipt of the bill. If the Member pays a bill for Covered Services, Pro Care will require the Participating Provider to reimburse the Member.
- 6.3.2 If the Member receives Emergency Services, Family Planning Services, treatment of Communicable Diseases or CAHCP Covered Services from a Non-Participating Provider, the Member should request the Non-Participating Provider to bill Pro Care. If the Non-Participating Provider refuses to bill Pro Care but bills the Member, the Member should submit the bill to Pro Care. If the Non-Participating Provider requires the Member to pay for the Emergency Services, Family Planning Services, Communicable Disease treatment services or CAHCP Covered Services at the time they are rendered, the Member must submit a request for reimbursement for such Covered Services in writing to Pro Care within 60 days after the date the Covered Services were provided to the Member.
- 6.3.3 If Pro Care authorizes the Member to receive Covered Services from a Non-Participating Provider, the Member should request the Non-Participating Provider to bill Pro Care. If the Non-Participating Provider refuses to bill Pro Care but bills the Member, the Member should submit the bill to Pro Care. If the Non-Participating Provider requires the Member to pay for the Covered Services at the time they are rendered, the Member must submit a request for reimbursement for such Covered Services in writing to Pro Care within 60 days after the date the Covered Services were provided to the Member.
- 6.3.4 If the Member requests reimbursement for Covered Services, the Member must submit acceptable proof that the Member paid the Non-Participating Provider for the Covered Services. The Member should submit the proof of payment at the same time as the request for reimbursement. If the Member is not reasonably able to submit proof of payment at the same time the Member makes a request for reimbursement, Pro Care will reimburse the Member for the Covered Services if the Member provides proof of payment as soon as reasonably possible. However, ProCare will not be obligated to reimburse the Member if the Member submits proof of payment more than 12 months after the date Covered Services were provided to the Member.

- 6.3.5 ProCare may require the Member to provide additional medical and other information or documentation to prove that services rendered were Covered Services before paying Non-Participating Providers or reimbursing the Member for such services, subject to applicable state and federal law.
- 6.4 **Non-Participating Providers.** Pro Care will not pay a Non-Participating Provider or reimburse the Member for any services, supplies or equipment provided by a Non-Participating Provider that are not authorized in advance by Pro Care except under the following circumstances: (i) the services are Medically Necessary Covered Services; **and** (ii) the services could not reasonably be obtained from a Participating Provider; **and** (iii) Pro Care did not respond to a the request for authorization within 24-hours after the request was made. Pro Care will pay Non-Participating Providers for Emergency Services, Family Planning Services, treatment of Communicable Diseases at the Member's local health department and Covered Services by a CAHCP provider as set forth in this Certificate.
- 6.5 **Non-Covered Services.** Pro Care will not pay a Participating Provider or a Non-Participating Provider, or reimburse the Member, for any Non-Covered Services received by the Member if the Member knew or reasonably should have known that the services were Non-Covered Services at the time the services were rendered. Pro Care may recover from the Member the expenses for Non-Covered Services.

ARTICLE 7 - COVERED SERVICES

- 7.1 **Covered Services.** The Member is entitled to the Covered Services specified in Appendix A when **all of the following conditions are met:**
- 7.1.1 The Covered Services are specified as services covered by the Medicaid Program in the Medicaid Contract at the time that services are rendered, as those services are changed, limited and deleted from time to time by the Medicaid Program. All changes, limitations and deletions from Medicaid coverages will automatically apply to the Member. The details of all current Medicaid coverages are contained in Medicaid Program policy manuals and publications. Members are only entitled to Covered Services consistent with the current Medicaid coverages.
- 7.1.2 The Covered Services are Medically Necessary. Except as otherwise required by law, a Participating Provider's determination that a Covered Service is medically necessary is not binding on Pro Care.
- 7.1.3 The Covered Services are performed, prescribed, directed or arranged in advance by the Member's PCP, except when a Member may directly access the services of a Specialist or other Participating Provider or a Non-Participating Provider under the express terms of this Certificate.
- 7.1.4 The Covered Services are authorized in advance by Pro Care, when required.

- 7.1.5 The Covered Services are provided by Participating Providers, except for services authorized in advance by Pro Care or as otherwise expressly set forth in this Certificate.
- 7.2 **Emergency Services.** In case of an Emergency Medical Condition, the Member should go directly to a Hospital emergency room. The Member, the Hospital or a responsible person must notify Pro Care as soon as possible after the Member receives Emergency Services. All follow-up and continuing care that are not Emergency Services must be authorized in advance by Pro Care or the Member's PCP. Pro Care will not deny payment for Emergency Services up to the point of stabilization because of the final diagnosis or lack of prior authorization.
- 7.3 **Urgent Care.** Urgent Care must be authorized in advance by the Member's PCP. All follow-up and continuing care must be authorized in advance by the Member's PCP.
- 7.4 **Out-of-Network Services.** Except as otherwise expressly stated in this Certificate, Covered Services by Non-Participating Providers must be authorized in advance by Pro Care.
- 7.5 **Out-of-Area Services.**
- 7.5.1 **Covered Services.** Emergency Services are covered by Pro Care while the Member is temporarily out of the Service Area. The Member, the Hospital or a responsible person must notify Pro Care as soon as possible after the Member receives Emergency Services. Urgent Care and other Covered Services must be authorized in advance by Pro Care. If the Covered Services are Medically Necessary and could not be reasonably obtained from a Participating Provider, the Covered Services are considered authorized by Pro Care if Pro Care does not respond to a request for authorization within 24 hours of the request.
- 7.5.2 **Hospitalization.** If an Emergency Medical Condition requires hospitalization, the Member, the Hospital or a responsible person must notify Pro Care as soon as possible after the emergency hospitalization begins. Pro Care may require the Member to move to a Participating Hospital when it is physically possible to do so.
- 7.6 **Coordination of Care Services.** Pro Care will refer Members to agencies or others for certain services, such as certain behavioral health and developmental disability service, which the Member may be eligible to receive, but which are not Covered Services under this Certificate. These services are set forth on **Appendix B**. The State of Michigan or other agency or entity will be responsible for paying for these services.

ARTICLE 8 - EXCLUSIONS AND LIMITATIONS

8.1 **Exclusions.** The services, equipment and supplies listed on **Appendix C** are Non-Covered Services. In addition, any health care services provided before the effective date of coverage or after the coverage under this Certificate has terminated are Non-Covered Services, except as otherwise expressly stated in this Certificate.

8.2 **Limitations.**

8.2.1 Pro Care has no liability or obligation for payment for any services, equipment or supplies provided by Non-Participating Providers unless the services, equipment or supplies are Covered Services **and** are authorized in advance by Pro Care, except when this Certificate otherwise specifies that the Member may obtain Covered Services from Non-Participating Providers without prior authorization.

8.2.2 A referral by a PCP for Non-Covered Services does not make such services Covered Services.

8.2.3 ProCare will not cover services, equipment or supplies not performed, provided, prescribed, directed or arranged by the Member's PCP or, where required, not authorized in advance by Pro Care, except when this Certificate otherwise specifies that Pro Care will cover such services.

8.2.4 ProCare will not cover services, equipment or supplies that are not Medically Necessary.

ARTICLE 9 - TERM AND TERMINATION

9.1 **Term.** This Certificate takes effect on the effective date of coverage as specified in Article 3. This Certificate continues in effect from year to year thereafter unless otherwise specified in the Medicaid Contract or unless terminated in accordance with this Certificate.

9.2 **Termination of Certificate by Pro Care or the Department.**

9.2.1 This Certificate will automatically terminate upon the effective date of termination of the Medicaid Contract. Enrollment and coverage of all Members will terminate at 12:00 Midnight on the date of the termination of this Certificate, except as otherwise provided by the Medicaid Contract.

9.2.2 If Pro Care stops operating or dissolves, this Certificate may be terminated immediately by court or administrative agency order or by the Board of Directors of Pro Care. Pro Care will be responsible for Covered Services for the Member to the extent that Premiums were paid on behalf of the Member or as otherwise prescribed by law or by the Medicaid Contract.

9.2.3 The Department will be responsible for notifying Members of the termination of this Certificate. ProCare will not notify Members of the termination of this Certificate. The fact that Members are not notified of the termination of this Certificate will not continue or extend Members' coverage beyond the date of termination of this Certificate.

9.2.4 The enrollment and coverage of all Members terminates on the effective date of termination of this Certificate under this Section 9.2.

9.3 **Department Disenrollment of the Member.**

9.3.1 The Department may disenroll the Member when any of the following occurs:

- A. the Department erroneously enrolled the individual in Pro Care; or
- B. the Member ceases to be eligible for the Medicaid Program as determined by the Department; or
- C. the Member dies; or
- D. the Member moves out of the Service Area.

9.3.2 In all cases, the Department will make the final decision concerning disenrollment of the Member under this Section 9.3. The effective date of disenrollment will be determined by the Department.

9.3.3 The Member's coverage under this Certificate terminates automatically on the effective date of the Member's disenrollment, except as provided in Section 9.6.

9.4 **Pro Care Request for Disenrollment of the Member.**

9.4.1 Pro Care may request the Department to disenroll the Member for any of the following reasons:

- A. the Member becomes medically eligible for the Children's Special Health Care Services program and the family chooses to enroll in the CSHCS program; or
- B. the Member is admitted to a nursing facility for custodial care or remains in a nursing facility for rehabilitative care for longer than 45 days; or long-term care facility unless the Member is a hospice patient; or
- C. the Member is admitted to a State of Michigan psychiatric hospital or an intermediate care facility for the mentally retarded as defined by the Medicaid Contract; or.

- D. the Member is incarcerated in a correctional facility; or
- E. the Member is served under the Home & Community Based Elderly Waiver; or
- F. the Member is unable to establish or maintain, after reasonable attempts by two Participating Physicians, a satisfactory physician-patient relationship; or
- G. the Member makes material lies, omits facts, or otherwise commits fraud in completing medical questionnaires or other forms requested by ProCare or the Department; or
- H. the Member's circumstances change such that the Member no longer meets the criteria for enrollment in ProCare as defined by the Department;
- I. the theft or alteration of prescriptions, the misuse or fraud in the use of the Member's Identification Card, or other fraud or misrepresentation in the Member's use of ProCare's benefits and services; or
- J. the Member's physical or verbal conduct is violent, threatening, abusive or obstructive to ProCare's personnel, Participating Providers or other Members; or
- K. the Member is non-compliant with or misuses Pro Care's benefits and services, including failure to follow treatment plan, unauthorized repeated use of Non-Participating Providers, repeated use of Hospital emergency rooms for conditions that are not Emergency Medical Conditions, and other non-compliant situations that impede care; or
- L. the Member fails to cooperate in coordinating benefits or subrogating the Member's rights of recovery.

9.4.2 ProCare will not request the Department to terminate the Member's enrollment and coverage on the basis of the Member's physical or mental status or the fact that the Member has exercised the Member's rights under Pro Care's Grievance Procedure.

9.4.3 In all cases, the Department will make the final decision concerning disenrollment of the Member under this this Section 9.4. The effective date of disenrollment will be determined by the Department.

9.4.4 The Member's coverage under this Certificate terminates automatically on the effective date of the Member's disenrollment, except as provided in Section 9.6.

9.5 **Member Request for Disenrollment.**

9.5.1 The Member will remain enrolled in ProCare for 12 months after the effective date of enrollment, except as follows:

- A. If the Member has changed enrollment from another Medicaid health plan to ProCare, the Member may request the Department to disenroll the Member without cause from Pro Care at any time during the first 90 days after the effective date of enrollment in Pro Care; or
- B. The Member may disenroll from Pro Care during an annual open enrollment period as determined by the Department. The Department will notify the Member of the annual open enrollment period; or
- C. At any time, the Member may request the Department to disenroll the Member from Pro Care because of poor quality of care, lack of access to providers or necessary specialty Covered Services, or other good reason as determined by the Department.

9.5.2 After enrollment in Pro Care for 12 months, the Member may request the Department to disenroll the Member from Pro Care as follows:

- A. The Member may disenroll from Pro Care during an annual open enrollment period as determined by the Department. The Department will notify the Member of the annual open enrollment periods; or
- B. At any time, the Member may request the Department to disenroll the Member from Pro Care because of poor quality of care, lack of access to providers or necessary specialty Covered Services, or other good reason as determined by the Department.

9.5.3 The Member's coverage under this Certificate terminates automatically on the effective date of the Member's disenrollment. The effective date of disenrollment will be determined by the Department.

9.6 **Continuation of Benefits.** If the Member is an inpatient at a Hospital on the date that the Member's enrollment in Pro Care terminates, Pro Care is responsible for payment for the inpatient Hospital stay until the date of discharge, subject to exceptions for disenrollments based on Children's Special Health Care Services enrollments.

ARTICLE 10 - COORDINATION OF BENEFITS

- 10.1 **Purpose.** In order to avoid duplication of benefits to Members by Pro Care and other Payers, Pro Care will coordinate benefits for the Member under this Certificate with benefits available from other Payers that also provide coverage for the Member.
- 10.2 **Notification.** The Department will furnish Pro Care with notice of all other Payers providing health care benefits to the Member. The Member must notify Pro Care of any health insurance or health plan benefits, rights to payment and money paid for any claims for health care when the Member learns of them. The Member must also notify Pro Care when payment of health care benefits from any other Payer becomes available to the Member.
- 10.3 **Order of Benefits.** In establishing the order of Payer responsibility for health care benefits, Pro Care will follow coordination of benefits guidelines authorized by the Department and Office of Insurance and applicable provisions of the Michigan Coordination of Benefits Act, Public Act 64 of 1984, as amended, MCL 550.251 et seq. For Members with Medicare coverage, Medicare will be the primary payer ahead of Pro Care.
- 10.4 **ProCare's Rights.** ProCare will be entitled to:
- A. determine whether and to what extent the Member has health insurance or other health benefit coverage for Covered Services; and
 - B. establish, in accordance with this Article, priorities for determining primary responsibility among the Payers obligated to provide health care services or health insurance; and
 - C. require the Member, a Participating Provider or a Non-Participating Provider to file a claim with the primary Payer before it determines the amount of ProCare's payment obligation, if any; and
 - D. recover from the Member, Participating Provider or Non-Participating Provider, as applicable, the expense of Covered Services rendered to the Member to the extent that such Covered Services are covered or indemnified by any other Payer.
- 10.5 **Construction.** Nothing in this Article shall be construed to require ProCare to make a payment until it determines whether it is the primary Payer or the secondary Payer and the benefits that are payable by the primary Payer, if any.
- 10.6 **Definition.** As used in this Article 10, "Payer" means all insurance and other benefit plans, policies, and programs that may be liable for payment or reimbursement for health care services rendered to the Member, including Medicare, employer-sponsored health plans, self-funded and self-insured plans, commercial health insurance carriers,

automobile insurance and workers compensation and other private and governmental plans, policies and programs.

ARTICLE 11 - SUBROGATION

- 11.1 **Subrogation.** Subrogation means that ProCare will have the same right as the Member to recover expenses for treatment of an injury or illness for which another person or entity is legally liable. To the extent ProCare incurs Health Care Expenses in such situations, ProCare will be subrogated to the Member's right of recovery against any responsible person, including a Payer as defined in Article 10.
- 11.2 **Assignment; Suit.** If the Member has a right of recovery from any person or entity for the Member's injury or illness, the Member, as a condition to receiving Covered Services under this Certificate, must do the following:
- A. pay or assign to Pro Care all sums recovered by suit, settlement, or otherwise for the injury or illness up to the amount of Pro Care 's Health Care Expenses for the injury or illness, but not in excess of monetary damages collected; or
 - B. authorize Pro Care to be subrogated to the Member's rights of recovery, including the right to bring a lawsuit in the Member's name at the sole cost and expense of Pro Care, up to the amount of Pro Care 's Health Care Expenses for the injury or illness.
- 11.3 **Attorney Fees and Costs.** In the event that a suit instituted by Pro Care on behalf of the Member, or a suit by the Member in which ProCare joins, results in monetary damages awarded in excess of Pro Care's actual Health Care Expenses, Pro Care shall have the right to recover the costs of suit and attorney fees out of the excess, to the extent of such costs and fees.
- 11.4 **Settlement.** The Member shall not compromise or settle a claim or take any action that would prejudice the rights or interests of Pro Care without Pro Care's prior written consent.
- 11.5 **Definition.** As used in this Article 11, "Health Care Expenses" means the amounts paid or to be paid by ProCare to the Member, Participating Providers and Non-Participating Providers for Covered Services furnished to the Member.

ARTICLE 12 - MISCELLANEOUS

- 12.1 **Governing Law.** This Certificate is made and shall be interpreted under the laws of the State of Michigan.
- 12.2 **Notice.** Except as otherwise provided in any other section of this Certificate, any notice required or permitted to be given by Pro Care to the Member under this Certificate must

be in writing and either personally delivered or deposited in the U.S. Mail, first class, with postage prepaid and addressed to the Member at the address of record on file at Pro Care 's administrative offices. Except as otherwise provided in any other section of this Certificate, any notice required or permitted to be given by the Member to Pro Care under this Certificate must be in writing and either personally delivered or deposited in the U.S. Mail, first class, with postage prepaid and addressed to Pro Care at the following address:

Pro Care Health Plan, Inc.
Attn: Member Services
3956 Mount Elliott
Detroit, Michigan 48207

APPENDIX A - BENEFIT DETAIL OF COVERED SERVICES

The following are Covered Services under the Certificate. All Covered Services are subject to the terms, conditions, limitations and exclusions set forth in the Certificate. Covered Services must be Medically Necessary. All Covered Services must be provided by the Member's PCP or authorized in advance by the Member's PCP or ProCare, except as otherwise specifically stated in the Certificate.

1. Allergy testing, evaluations and injections, including serum costs.
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. Ambulance Services. Professional ambulance services for the following situations or conditions:
 - a. ambulance transportation to the emergency department of a Hospital due to an Emergency;
 - b. ambulance transportation from a Hospital to another facility, including a skilled nursing facility (participating or non-participating);
 - c. transportation from a non-participating Hospital to a Participating Hospital; and
 - d. round trip ambulance transportation from the Hospital or facility of the patient's confinement to another facility for tests or other necessary services that cannot be provided at the facility in which the patient is confined.
4. Antineoplastic Drug Therapy. Antineoplastic drugs are covered in accordance with the Insurance Code.
5. Blood Lead Testing. Blood lead testing services are covered for Member's under the age of 21 in accordance with the Medicaid policy.
6. Cardiac Rehabilitation Therapy. Coverage for a cardiac rehabilitation program is provided for one series of classes after one of the following events:
 - a. myocardial infarction;
 - b. post-coronary artery bypass surgery;
 - c. angina;
 - d. post-coronary angioplasty; or
 - e. high cardiac risk factors such as high blood pressure, high cholesterol or elevated stress level.

7. Chiropractic Services for Members Under Age 21.
8. Communicable Diseases treatment.
9. Contraceptive Medications and Devices. These services and supplies are covered. Over-the-counter family planning drugs and supplies are covered with a prescription.
10. Diagnostic Tests. Medically Necessary diagnostic laboratory tests, x-rays and other tests are covered if the Member's PCP performs the tests or refers the Member to a Participating Provider for the tests.
11. Dietary/Nutritional Services. Dietary/nutritional counseling services are covered when provided by a Participating Provider and authorized by Pro Care .
12. Disposable Items and Other Medical Supplies.
 - a. Disposable items are covered when replacing a normal body function (e.g., ostomy and urology supplies).
 - b. The following diabetic supplies are covered: insulin, syringes, reagents, standard glucometers and lancets. Insulin pumps may be covered for Type I uncontrolled insulin dependent diabetes.
13. Durable Medical Equipment and Supplies. Durable medical equipment is covered in accordance with Department guidelines.
14. Emergency Services.
15. End Stage Renal Disease Services.
16. Family Planning Services. Family planning services such as contraception counseling and associated physical exams and procedures are covered.
17. Health Education.
18. Hearing Services. Hearing exams and hearing aids and supplies for Members under age 21 are covered. Maintenance and repair of hearing aids and hearing aid batteries are covered. Batteries are distributed in one-month supplies.
19. Home Health Services. Home health care visits are covered. Covered Services include home care nursing visits by a registered professional or licensed practical nurse and home health aides under certain circumstances.
20. Hospice Services. All Medically Necessary and prior authorized hospice services are covered when provided in a nursing home or hospital and requested by the Member.
21. Hospital Services.

- a. Inpatient Services. Hospital inpatient services and supplies including professional services, semi-private room and board, general nursing care and related services.
 - b. Outpatient Services. Facility and professional services and supplies which are furnished on an outpatient basis.
 - c. Diagnostic and Therapeutic Services. Services and supplies for laboratory, radiologic and other diagnostic tests and therapeutic treatments.
22. Immunizations.
23. Infusion Therapy.
24. Maternity Care.
- a. Participating Provider. Services and supplies furnished by a Participating Provider for prenatal care, genetic testing, delivery and postnatal care.
 - b. Certified Nurse Midwife Services.
 - c. Newborn Child Care. A newborn child of a Member is entitled to Covered Services for the month of birth, and may be entitled to services for up to one-year as determined by the Department.
 - d. Length of Stay. The Member and newborn child are entitled to a minimum of 48 hours of inpatient Hospital Services following a vaginal delivery and a minimum of 96 hours of inpatient Hospital Services following a caesarian section. A Member is entitled to receive a home health visit if the Member leaves the Hospital before the expiration of the minimum length of stay.
 - e. Maternal and Infant Support Services. Services for high risk mothers and infants to ensure healthy deliveries, which may include home visits, social services and transportation.
 - f. Parenting and Birthing Classes.
25. Mental Health Services. Short-term outpatient therapy is covered for up to 20 visits per Contract Year. The outpatient mental health benefit is not meant to cover severe and/or persistent mental disease or illness of children or adolescents with severe emotional disturbances.
26. Oral and Maxillofacial Surgery.
- a. Oral and Maxillofacial Surgery and Related X-Rays. Oral and maxillofacial surgery and related x-rays are a Covered Service when performed by a Participating Provider, in accordance with Pro Care's referral policies, for the following conditions:

- (1) emergency repair and treatment of fractures of the jaw and facial dislocation of the jaw;
 - (2) emergency repair of traumatic injury resulting from a non-occupational injury to sound natural teeth, provided treatment occurs within 24 hours of the initial injury (only the initial visit for treatment will be covered); and
 - (3) multiple extractions, when concurrent with a medical condition which requires the procedure to be performed in a hospital (only hospital incurred charges, supplies and anesthesia will be covered for this situation).
- b. Temporomandibular Joint Syndrome (TMJ). TMJ surgery is covered.
 - c. Orthognathic Surgery. Orthognathic surgery (surgery to correct the relationship or positions of the bones and soft tissues of the jaw) for congenital syndromes which directly affect the growth, development and function of the jaw and surrounding structures are covered.
27. Outreach for Covered Services.
28. Pharmacy Services.
- a. Formulary drugs are covered, but are limited to a 30-day supply.
 - b. Non formulary or off-label drugs are covered when prior authorized by ProCare, but are limited to a 30-day supply.
 - c. Insulin syringes, reagent strips, psyllium, aspirin and condoms are covered. Other over-the-counter drugs and medical supplies must have a prescription to be covered.
29. Plastic and Reconstructive Surgery. Plastic and reconstructive surgery to improve function or to approximate a normal appearance is covered when the surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery of the breast on which a mastectomy for cancer was performed is covered. Some plastic and reconstructive surgery must meet specific criteria before being covered.
30. Podiatry Services for Members Under Age 21.
31. Practitioner Services. Professional services by Physicians and other practitioners such as physicians assistants, certified pediatric nurse practitioners, and certified family nurse practitioners are covered when they render Covered Services.
32. Prosthetic Devices and Orthotics. Standard prosthetic and orthotic supports and devices are covered in accordance with Department guidelines. Prosthetic devices are custom

made artificial devices used to replace all or a portion of a functional part of the body (e.g. artificial limb). Breast prosthesis after mastectomy is covered.

33. Radiology Services. Therapeutic radiology services are covered unless they are excluded elsewhere in the Certificate.
34. Rehabilitative and Restorative Services. Coverage of intermittent or short-term restorative or rehabilitative nursing care in a nursing facility is limited to 45 days. The 45-day limit does not apply to intermittent or short-term restorative or rehabilitative nursing care in other places of service.
35. Therapies. Short-term, restorative physical, occupational, speech and language therapy is covered. Short-term therapy is treatment that is expected to significantly improve the Member's condition within 60 days from the date therapy begins. Coverage is as follows:
 - a. Physical Therapy. Physical therapy provided in a Hospital outpatient department, Physician's office or the Member's home is covered.
 - b. Occupational Therapy. Occupational therapy provided in a Hospital outpatient department or Physician's office is covered.
 - c. Speech and Language Therapy. Speech and language therapy provided in a Hospital outpatient department or Physician's office is covered.
36. Screening Mammography. Breast cancer screening mammography is covered in accordance with the Insurance Code.
37. Sexually Transmitted Diseases treatment.
38. Transportation Services. Non-emergency transportation services, including travel expenses, are covered for transport to and from authorized Covered Services in accordance with Pro Care's non-emergency transportation policies and procedures.
39. Transplants. Cornea and kidney transplants and related procedures are covered benefits. External 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 Member-specific basis when determined Medically Necessary. Pro Care has a policy to evaluate, document and act upon a Member's request for an external transplant. A Member may obtain a copy of the policy upon request to Pro Care .
40. Vision Services.
 - a. Routine eye exams by a Participating Provider to determine the need for vision correction are covered. One exam is covered every two years. No referral is required.

- b. One pair of clear corrective lenses of any focal type and approved eyeglass frames are covered at Plan participating vision providers every two years. Sunglasses are not covered.
 - c. Orthoptics are covered.
 - d. Contact lenses are covered only if the Member has a vision problem that cannot be adequately corrected by eyeglasses (monocular aphakia; keratoconus, anisometropia or antimetropia that results in aniseikonia; or other medical conditions which have no alternative treatment).
 - e. Members may not upgrade to contact lenses or to non-approved frames.
 - f. Other vision care related to eye injury, medical diagnosis, etc. is covered.
41. Well-Child/EPSTD. Well-child and EPSTD services for persons under the age of 21 are covered.
42. Weight Reduction Services. Weight reduction services are covered only when Medically Necessary.

APPENDIX B - COORDINATION OF CARE SERVICES

The following services are the coordination of care services provided by Pro Care to Members under the Certificate:

1. **Dental Services.** Most dental services are not covered by the Certificate, but are available under the Medicaid Program through dentists approved by the Department. Pro Care will provide Members with the names of dentists in their area who are available to provide dental services.
2. **Mental Health Services.** Members may be eligible to receive mental health services that are not covered by the Certificate but may be covered benefits for Medicaid beneficiaries. Upon request, ProCare will provide Members with information regarding these services from mental health providers or agencies in their area, may refer Members for these services, and will coordinate the Member's services with the provider or agency as appropriate.
3. **Developmental Disability Services.** Developmental disability services are not covered by the Certificate but may be covered benefits for Medicaid beneficiaries. Members may be eligible to receive developmental disability services from development disability providers or agencies in their area. ProCare will provide Members with information regarding these services upon request, may refer Members for these services and will coordinate the Member's services with the provider or agency as appropriate.
4. **Substance Abuse Services.** Substance abuse services are not covered by the Certificate but may be covered benefits for Medicaid beneficiaries. Members may be eligible to receive substance abuse services through substance abuse providers or agencies in their area. Pro Care will provide Members with information regarding these services upon request, may refer Members for these services, and will coordinate the Member's services with the provider or agency as appropriate.
5. **Coordination with Local Health Department.** Pro Care will coordinate certain services with the Member's local health department and will make certain referrals as appropriate. Pro Care may require Members to receive certain services, including certain Covered Services, through the Member's local health department.

APPENDIX C - EXCLUDED SERVICES AND LIMITATIONS

Any services, equipment or supplies not specified in **Appendix A**, even when recommended by a PCP or Participating Provider or written on a Pro Care referral form are excluded from coverage under the Certificate. Exclusions and limitations include the following:

1. **Abortions.** Elective abortions and related services are excluded unless one of the following conditions is met: (i) a physician certifies that the abortion is medically necessary to save the life of the mother; (ii) the pregnancy is the result of rape or incest; (iii) treatment is for a medical complication occurring as a result of an elective abortion; or (iv) treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy..
2. **Alternative Procedures and Treatments.** Alternative procedures and treatments which are not generally recognized or accepted by the medical community are excluded. Also excluded are procedures and treatments which are primarily educational in nature.
3. **Ambulance Services.** Use of an ambulance for transportation for any reason other than an Emergency or because the Member's medical condition necessitates use of an ambulance is excluded.
4. **Cognitive Evaluation and/or Retraining and Related Services.** Cognitive services, training and/or retraining, and any related care, supplies or procedures, are excluded regardless of who provides them.
5. **Cosmetic Surgery/Procedures.** Elective cosmetic surgery, medications, injections, procedures and related services are excluded. Examples include elective rhinoplasty, spider/varicose vein removal and elective breast reduction. Cosmetic alteration done simultaneous to surgery for a medical condition is not covered. Wigs, prosthetic hair or hair transplants are not covered. As provided in **Appendix A**, breast reconstructive surgery following a mastectomy is covered.
6. **Court-Ordered Services.** Services ordered by a court of law are excluded unless they are otherwise Medically Necessary and all ProCare requirements are met.
7. **Custodial or Personal Care.** Custodial or personal care, including such care in a skilled nursing facility, is excluded.
8. **Dental Services.** Routine dental services, including tooth repair/restoration/extraction, dental x-rays, wisdom teeth extractions, root canals and gingivectomies are excluded. Orthodontia, supplies and appliances including splints and braces are excluded. Also excluded are services and supplies due to damage of any tooth due to the natural act of chewing. Dental implants/mandibular bone staples are excluded.

9. Developmental Disability Services. Development Disability Services provided to the Member with a developmental disability and billed through a Provider Type 21 are excluded.
10. Experimental Drugs, Devices, Supplies, Treatments, Procedures or Equipment.
11. Forms. Physician and professional staff charges for completing forms or medical records are excluded. Postage, handling and medical record transfer charges are excluded.
12. Government-Provided Medical Care. Medical expenses incurred in any government Hospital or other facility, or for services of a government Physician or other government Health Professional are excluded.
13. Hair Analysis.
14. Home and Community Based Waiver Program Services.
15. Home Help Services.
16. Hospital Confinement. Days of confinement for non-medical reasons are not covered.
17. Hypnotherapy. Hypnotherapy is excluded.
18. Long-Term Therapies. Long-term therapies which exceed the defined benefit are not covered.
19. Medical Care for Illegal Activity. ProCare excludes coverage for injuries or illnesses sustained by a Member if the Member's action contributes to or causes the injury or illness during the commission of a felony, or attempt to commit a felony, or the Member's activity in an illegal occupation. Care rendered while the Member is in police custody for any felony, attempted felony, or illegal activity is excluded.
20. Medical Equipment and Supplies. Excluded from coverage are: replacement or repair of any covered item due to misuse, loss or abuse; experimental items; batteries; comfort and convenience items such as over-bed tables, heating pads, protective helmets, adjustable beds, telephone arms, air conditioners, sauna baths, whirlpool baths, hot tubs and elevators.
21. Mental Health Services. Excluded from coverage are: inpatient hospital psychiatric services and outpatient partial hospitalization services; court ordered examinations to determine competence and expenses for expert witness' testimony as to the mental condition of a Member; court ordered treatment for chemical dependency or mental conditions unless treatment is otherwise Medically Necessary and all Plan requirements are met; diagnosis and treatment of mental illnesses not classified in the current Diagnostic Statistical Manual; marital and relationship counseling; and job counseling.

22. **Military Service Connected Disability.** Care for injuries, illnesses or disabilities for which the Member is legally entitled to military health care is excluded. Any injury or sickness resulting from war or an act of war or service in the Armed Forces of any country is excluded from coverage.
23. **Missed or No-show Appointments.** Fees imposed by a Physician, Health Professional or other health care provider for a missed or no-show appointment are not covered by ProCare and are the financial responsibility of the Member.
24. **Non-Medical Services.** Non-medical services such as on-site vocational rehabilitation and training or work evaluations, school, home or work site environmental evaluations, or related employee counseling are excluded.
25. **Oral splints and appliances.** Oral splints and appliances associated with TMJ, orthognathic, and oral and maxillofacial surgeries are excluded.
26. **Other Coverages.** Treatment is excluded for any injury or sickness for which and to the extent any benefit, settlements, awards or damages are received or payable under Worker's Compensation, an insurance policy, state or federal law, or any other third party payer.
27. **Personal and Convenience Items.** Personal and convenience items, including household fixtures and equipment, are excluded.
28. **Prescription Drugs.** The following prescription drugs are excluded from coverage:
 - a. Medications prescribed for cosmetic purposes;
 - b. Experimental, Investigational or Research Drugs;
 - c. Drugs prescribed to treat infertility;
 - d. Nicotine nasal spray and inhalers;
 - e. Vitamin and mineral combination drugs; and
 - f. Drugs prescribed for weight loss are excluded unless medically necessary.
29. **Private Duty Nursing Services.** Private duty nursing services, inpatient or outpatient, are excluded.
30. **Reproductive Services and Transsexual Surgery.** Reversal of elective sterilization is excluded. Sex-transformation surgery and all expenses in connection with such surgery are excluded. In vitro fertilization, GIFT, artificial insemination, ZIFT, intrauterine insemination (IUI), surrogate parenthood and any infertility treatments are excluded.

31. Routine Foot Care. Routine foot care, e.g., treatment of corns, calluses, toenails, etc. is excluded.
32. School District Services. Services provided by a school district and billed through the school district are excluded.
33. Services and Supplies Not Prescribed by a Physician.
34. Services Rendered by a Family Member. Services, care, treatment and referrals rendered by the Member's family, including self, spouse, mother, father, grandmother, grandfather, aunt, uncle, cousin, brother, sister, son, daughter, niece, nephew, grandson, granddaughter or any person who resides with the Member.
35. Services Required by Third Parties. Services required by third parties are excluded including: physical examinations, diagnostic services, prescriptions and immunizations in connection with obtaining and continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; securing insurance coverage; and school admissions or attendance examinations to participate in athletics. Medical and/or psychiatric evaluations for any legal determinations are excluded.
36. Special Food and Nutritional Supplements. Food and food supplements are not covered, except for enteral and parenteral feedings when they are the only means of nutrition.
37. Speech Therapy. Therapy to treat delays in speech development is excluded.
38. Substance Abuse. Substance abuse services including screening and assessment, detoxification, intensive outpatient counseling, other outpatient services and methadone treatment are excluded. Members may be eligible to receive substance abuse services through providers or agencies in their area as indicated in Appendix B of the Certificate.
39. Telephone/Internet/E-Mail Consultations. Charges for services consisting of telephone and/or Internet and e-mail conversations are not covered.
40. Vision Correction Procedures. Radial keratotomy, Lasik and other infractive keratoplasties or vision correction procedures are excluded.
41. Weight Reduction. Weight reduction or control procedures and programs are excluded unless Medically Necessary.

APPENDIX D – COPAYMENTS

The following Covered Services are subject to Copayments as set forth in this Appendix D:

<u>Covered Service</u>	<u>Copayment</u>
N/A	N/A