Member Handbook

and Certificate of Coverage

Phone: 1-800-390-7102 (TTY: 1-800-649-3777 or 711)
www.caresource.com

April 2011

MEMBER SERVICES

You may call Member Services at **1-800-390-7102** (TTY for the hearing impaired: 1-800-649-3777 or 711).
Si usted prefiere esta informacion en Espanol, favor de llamar a CareSource al 1-800-390-7102.

We can help if you:

- Have questions about benefits.
- Need a new ID card.
- Want to change primary care providers.
- Need a ride to a medical appointment.

We can help explain this information or provide it orally, in English or in your primary language. If you are visually or hearing-impaired, special help can be provided.

CARESOURCE 24 NURSE ADVICE LINE

With CareSource 24, you have **unlimited access to talk with a caring and experienced staff of registered nurses** through a toll-free number. You can call 24 hours a day, 7 days a week. CareSource 24 services are available at no cost to you. Our nurses can help you:

- Decide when self-care, a doctor visit or the emergency room is appropriate.
- Understand a medical condition or recent diagnosis.
- Prepare questions for doctor visits.
- Find out more about prescription or over-the-counter medicines.
- Get information on medical tests or surgery.
- Learn about nutrition and wellness topics.

To reach CareSource 24, call **1-866-206-0488**
(TTY: 1-800-649-3777 or 711).

CASE MANAGEMENT

CareSource has caring nurses and social workers who can help people with special health issues. Our case management staff is here to help you and your family stay healthy. Just call **1-800-390-7102**. Press the option for members, then the option for case management. They can help if you have:

- Complex health care needs
- Hospitalizations
- Chronic diseases like asthma, diabetes, heart failure or obesity
- Complicated pregnancy

DISEASE MANAGEMENT

We offer disease management programs for the following:

- Asthma
- Diabetes
- High blood pressure
- Quitting tobacco use

YOUR RIGHTS AND RESPONSIBILITIES

You have certain rights and responsibilities as a CareSource member. You can find these on page 16.

PLEASE CALL US

Please call Member Services at **1-800-390-7102**
(TTY: 1-800-649-3777 or 711) if:

- You have any questions or concerns.
- Your name, address or phone number changes.
- You have other insurance.
- You have to see a doctor for an illness or injury caused by someone else.
- You suspect someone is committing health care fraud.

OTHER PHONE NUMBERS

Vision Services Plan
1-800-877-7195

Comprehensive Behavioral Care
(mental health or counseling)
1-800-435-5348

Department of Community Health
(questions about the Medicaid program or services that are provided by fee-for-service Medicaid and not CareSource)
1-800-642-3195

TABLE OF CONTENTS

Contents **Page**

Quick Reference Guide **1**

Welcome to CareSource **4**
- — Member Services 4
- — CareSource 24 Nurse Advice Line 4
- — Provider Directory 4
- — Identification (ID) Cards 5
- — Health Assessment Form 5
- — CareSource Website 5
- — Ways to Participate in CareSource 5

Your Primary Care Provider (PCP) **6**
- — Choosing a PCP 6
- — Changing Your PCP 6
- — Specialists as PCPs 6
- — Making Appointments with Your PCP 6

Preventive Care **7**
- — EPSDT Program 7
- — Pregnancy Care 7
- — Babies First 8
- — Blood Lead Testing 8

Where to Get Medical Care **8**
- — Visits to Your PCP 8
- — Urgent Care 9
- — Emergency Care 9
- — Out-of-area Care 9
- — Visits to a Specialist 9

Covered Services **10**
- — Referrals and Prior Authorizations 12
- — Prescription Drugs 13

Other Benefits **13**
- — CareSource 24 Nurse Advice Line 13
- — Case Management 13
- — Disease Management 14
- — Transportation 14
- — Help to Quit Smoking 14
- — Health Information 14

Contents **Page**

Services Available Outside of CareSource **15**

Services Not Covered by CareSource **16**

Your Rights and Responsibilities **16**
- — Your Rights 16
- — Patient Advocate Law and Advance Directives 17
- — Your Responsibilities 18

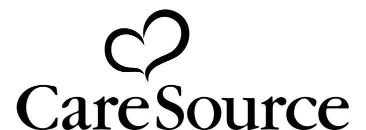
Quality Health Care **18**

Other Insurance **19**
- — Coordination of Benefits (COB) 19
- — Accidents 19

Fraud, Waste and Abuse **20**
- — Explanation of Benefits Statement 20
- — If You Suspect Fraud, Waste and Abuse 20
- — Protecting Your Privacy 21

How to File a Complaint **21**
- — Concerns 21
- — Complaints or Grievances 21
- — Appeals 22
- — Other Actions 22

Word Meanings **23**



WELCOME TO CARESOURCE

Welcome to CareSource. You are now a member of a health care plan for Medicaid consumers in many Michigan counties.

Please read this handbook from cover to cover. It will answer many questions you might have.

How To Reach Us

If you have a question or need to contact CareSource, please call us at:

1-800-390-7102 (toll free)
TTY for the hearing impaired
1-800-649-3777 or 711 (Michigan Relay Center)

Your family's health is important to us. Please let us know if you ever have a question or concern about your health care or our services. We want you to be a healthy and happy CareSource member.

We like to hear what you think of CareSource. Please call us with your suggestions for better service. Your ideas are important to us. Thank you.

Member Services

Our Member Services Department is open Monday through Friday, 8 a.m. to 5:30 p.m., except holidays. Our phone number is **1-800-390-7102**. Choose the menu option for Member Services. You can call to:

- Ask questions about CareSource eligibility and benefits.
- Request a new member ID card or other materials. We can provide some printed materials in some other languages or in different formats for special needs.
- Select or change your primary care provider (PCP).
- Let us know about a name or address change or a change in the size of your family.
- Ask about free interpreter services.
- Ask other questions about CareSource procedures or covered services.
- Ask about how to get a referral to a specialist.
- Ask questions about utilization management or prior authorization requests.
- Tell us how we can serve you better.
- Ask questions about a bill.
- Find out how to submit a claim.
- Submit a grievance or appeal (see page 21 of this handbook for details).
- Learn about CareSource services to help you live healthy.

Please give us a call. We want to make sure your concerns are taken care of and your questions are answered.

CareSource 24 Nurse Advice Line

With CareSource 24, you have **unlimited access to talk with a caring and experienced staff of registered nurses** through a toll-free number. You can call 24 hours a day, 7 days a week. CareSource 24 services are available at no cost to you. Our nurses can help you:

- Decide when self-care, a doctor visit or the emergency room is appropriate.
- Understand a medical condition or recent diagnosis.
- Prepare questions for doctor visits.
- Find out more about prescription or over-the-counter medicines.
- Get information on medical tests or surgery.
- Learn about nutrition and wellness topics.

To reach CareSource 24, call **1-866-206-0488** (TTY: 1-800-649-3777 or 711).

Provider Directory

The Provider Directory in your membership kit is a list of doctors and other health care providers who accept CareSource members. If you haven't chosen a PCP yet, please choose one from the directory or call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711) to see if any new PCPs have been added to it recently. It is important that you start to build a good doctor/patient relationship with your PCP as soon as you can.

Our directory is subject to change. Some providers may have been added or removed since it was printed. If you have a question or want to know which providers participate with CareSource, we can help. We can give you the most current information including more details about providers when you call, if you want to know more. We want to make sure you are aware of all of your options.

You can also look for doctors that accept CareSource members on our website at **www.caresource.com**. Just use the Find a Doctor tool. If you don't have access to our website, call Member Services to ask for a copy of our directory. After you choose your PCP, please let us know.

Identification (ID) cards

You will get two ID cards. The Michigan Department of Community Health (MDCH) sends your MiHealth Medicaid card to you. If you don't get your MiHealth card, please call MDCH at **1-800-642-3195**.

CareSource sends your CareSource member ID card with a separate letter. Each member of your household who has joined CareSource will receive his or her own card. Each card is good for as long as the person is a CareSource member.

Call CareSource Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711) if:

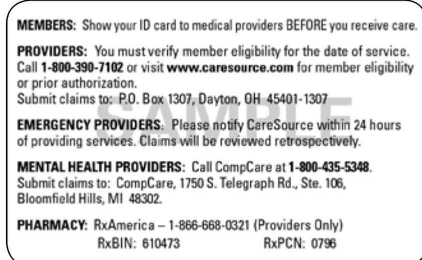
- You do not receive your member ID card within the next few days
- Any of the information on the card is wrong
- You lose your card

A new CareSource ID card will automatically be mailed to you whenever you change your PCP.

Always keep your ID cards with you, and remember to sign your CareSource ID card using a ball point pen. You will need both ID cards each time you get medical services or supplies.

Below is a sample member ID card:

Member Name Jane Doe
Date of Birth 01-01-1989
External ID 0012345678
Enrollment Date 01-23-2006
Group # C
Primary Care Provider Name Joseph Well
Primary Care Provider Phone (989) 555-5555
Member Services: 1-800-390-7102 (TTY: 1-800-649-3777 or 711)
CareSource 24, 24-hour nurse advice line: **1-866-206-0488**
www.caresource.com
SAMPLE
CareSource



MEMBERS: Show your ID card to medical providers BEFORE you receive care.
PROVIDERS: You must verify member eligibility for the date of service. Call **1-800-390-7102** or visit **www.caresource.com** for member eligibility or prior authorization.
Submit claims to: P.O. Box 1307, Dayton, OH 45401-1307
EMERGENCY PROVIDERS: Please notify CareSource within 24 hours of providing services. Claims will be reviewed retrospectively.
MENTAL HEALTH PROVIDERS: Call CompCare at **1-800-435-5348**.
Submit claims to: CompCare, 1750 S. Telegraph Rd., Ste. 106, Bloomfield Hills, MI 48302.
PHARMACY: RxAmerica – 1-866-668-0321 (Providers Only)
RxBIN: 610473 RxPCN: 0796
SAMPLE

Health Assessment Form

Inside your new member kit is a health care questionnaire. Please fill it out and return it to us in the enclosed envelope. This will help us understand your health care needs.

CareSource Website

You can find answers to many questions at the CareSource website. The website address is **www.caresource.com**. Choose Members, then click on Michigan Medicaid to learn more about:

- How to contact us
- Member benefits
- Staying well
- Member newsletters
- Your rights and responsibilities
- How to file a complaint
- And much more

You can also get copies of all our member materials such as fliers, brochures, handbooks and certificates of coverage.

Ways to Participate in CareSource

Apply to become a Board Member

CareSource has a Board of Directors. This board looks at the way CareSource does business and makes suggestions. Some people who serve on the board are members just like you. If you would like to become a board member, give us a call. Members vote on a new board member when a seat opens up or when a term is up. If you can't be on the board but have some ideas, we would still like to hear from you. Call us so we can get your suggestions.

CAHPS — Member Survey

Consumer Assessment of Health Plans and Systems (CAHPS) is a survey that randomly goes out to some of our members each year. If you receive a survey, please take time to fill out the questions. It will help us serve you better.

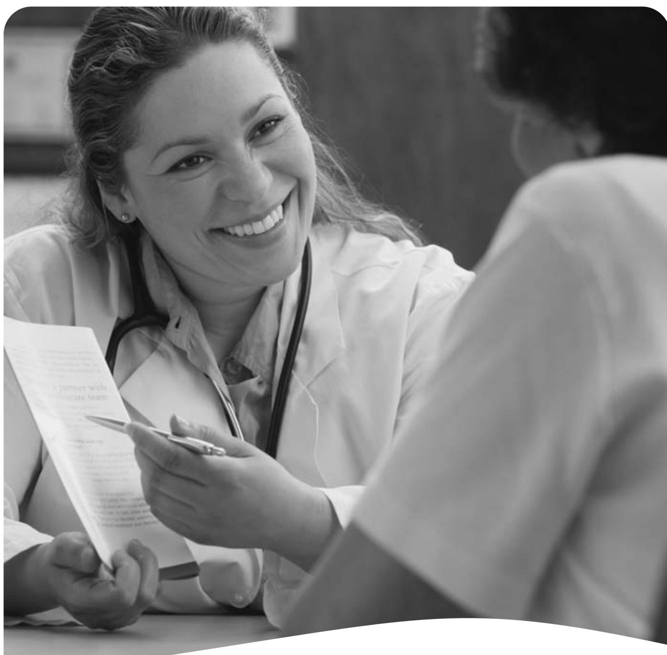
YOUR PRIMARY CARE PROVIDER (PCP)

Choosing A PCP

Each member of CareSource must choose a primary care provider (PCP) from CareSource's Provider Directory. Your PCP is an individual physician or physician group practice trained in family medicine, general practice, internal medicine or pediatrics.

Your PCP will work with you to direct your health care. Your PCP will do your checkups and shots and treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital. You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your CareSource ID card.

The Provider Directory in your membership kit is a list of doctors and other health care providers who accept CareSource members. If you haven't chosen a PCP yet, please choose one from the directory or call us to see if any new PCPs have been added to it recently. If you don't choose a PCP when you join, we will assign you to a PCP in your area. It is important that you start to build a good doctor/patient relationship with your PCP as soon as you can. For the names of the PCPs in CareSource, you may look in your Provider Directory, on our website at **www.caresource.com**, or you can call the CareSource Member Services Department at **1-800-390-7102** (TTY: 1-800-649-3777 or 711) for help.



If you are a new patient to your PCP, please call the office to schedule an appointment. This will help your PCP get to know you and understand your health care needs right away. You should also have all of your past medical records transferred to your new doctor.

Changing Your PCP

We hope you are happy with the PCP you have chosen, but we know that you may decide to choose a different PCP in the future. If for any reason you want to change your PCP, you must first call the Member Services Department to ask for the change. You can change your PCP as often as once a month, if needed. We will process your change the date of your call. CareSource will send you a new member ID card to let you know that your PCP has been changed and the date that you can start seeing the new PCP. Member Services can also help you schedule your first appointment, if needed.

For the names of the PCPs in CareSource, you may look in your Provider Directory, on our website at **www.caresource.com**, or you can call the CareSource Member Services Department at **1-800-390-7102** (TTY: 1-800-649-3777 or 711) for help.

Specialists as PCPs

Specialists are doctors who focus on one area of medicine or one part of the body. Some people have chronic health conditions and need to see a specialist a lot. In such cases, it may be better for the specialist to be your main doctor and act as your PCP. If you think you need a specialist as your PCP, please call Member Services.

Making Appointments with Your PCP

Schedule visits with your PCP as far in advance as possible. Always keep your scheduled appointments. If you need to reschedule, change or cancel an appointment, call your PCP at least 24 hours in advance. Please remember to call and cancel your transportation if you have made arrangements for a ride.

PREVENTIVE CARE

Your PCP will play a big part in your preventive care. This means making regular visits to your PCP even if you do not feel sick. Routine checkups, tests and screenings can help your doctor find and treat problems early before they become serious. Preventive care includes:

- Immunizations for children
- Well-child exams for children through age 20
- Blood tests and other screenings, when needed
- Yearly well-adult exams
- Pap smears
- Breast exams

For all preventive health guidelines for men, women, pregnant women, babies and children, please call Member Services at **1-800-390-7102** or visit our website at **www.caresource.com**.

EPSDT Program

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program provides preventive health care for CareSource members from birth through age 20. This is a series of well-child checkups.

CareSource covers EPSDT exams. They are recommended at the following ages:

- At birth
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 1 year
- 15 months
- 18 months
- 2 years
- 30 months
- Once a year from 3 through 20 years old

These visits include the following:

- Physical exam/checkup
- Immunizations/shots
- Eye exam
- Hearing test
- Diet evaluation and counseling
- Developmental and speech evaluations
- Height, weight and blood pressure checks
- Follow-up care for any problems found during exams
- Mental health and substance abuse screening, as needed
- Blood lead screening, as needed
- Other lab tests or care, as needed

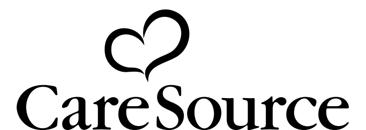
Call your child's PCP to schedule an appointment for an EPSDT exam. Take your child's shot records with you. If your child gets shots somewhere else, like the county health department, give a copy of the records to your child's PCP.

Pregnancy Care

It is important to see a doctor or nurse early in your pregnancy. You should visit your OB doctor regularly during and shortly after your pregnancy. This is the best way to have a healthy baby. Follow this schedule or go as often as your doctor tells you.

During the...	See your OB doctor...
1st-7th month of pregnancy	Once a month
8th month of pregnancy	Twice a month
9th month of pregnancy	Once a week
3-8 weeks after delivery	At least once for a checkup or as scheduled by your doctor

Michigan's Maternal and Infant Health Program (MIHP) provides preventive health services to qualifying pregnant women and infants. This program includes transportation.



Babies First

Babies First is a program for members of CareSource. This program is for moms-to-be and their babies. We want our members to have happy and healthy babies.

You can receive $10 gift cards to a store like Meijer or Wal-Mart just for keeping medical appointments. It's that simple. The information below shows the coupons you can get:

- **Coupon A** – Have your first prenatal appointment during your first 3 months of pregnancy. This is worth a $10 gift card.
- **Coupon B** – Keep all scheduled prenatal appointments during your second trimester. This is worth a $10 gift card.
- **Coupon C** – Keep all scheduled prenatal appointments during your third trimester. This is worth a $10 gift card.
- **Coupon D** – Keep your follow-up checkup with your doctor after your baby is born. Your checkup must be done by the doctor 3-8 weeks after delivery. This is worth a $10 gift card.
- **Coupons E-K** – You can receive a $10 gift card for each of your baby's well-child checkups. These are called EPSDT or Early and Periodic Screening, Diagnosis and Treatment.

Your baby must have a well-child checkup at 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, and 15 months of age. CareSource will send a brochure to you that explains the program.

Blood Lead Testing

Children should have their blood tested for lead poisoning at ages 1 and 2. Lead is found in the paint of many old homes, some tap water and dirt. Small children who are around lead may have learning or behavior problems. In high amounts, it can be deadly. An easy test can be done in the doctor's office and should be part of the well-child exam at ages 1 and 2. The test can also be done through the County Health Departments.

For more information, call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711).

WHERE TO GET MEDICAL CARE

We want to make sure you get the right care from the right health care provider when you need it. The following information will help you decide where you should go for medical care:

Is it safe to wait?

How to decide whether to go to an ER, urgent care or PCP

Ask yourself these questions:

- Is it safe to wait and call my doctor first?
- Is it safe to wait and schedule an appointment in the next day or two with my doctor?
- Is it safe to wait if I can get an appointment today with my doctor?
- If my doctor can't see me, is it safe to wait to be seen at an urgent care clinic as a walk-in?
- Could I die or suffer a serious injury if I don't get immediate medical help?

Remember, if you are not sure if your illness or injury is an emergency, call your doctor or call CareSource 24, our nurse advice line. Just dial **1-866-206-0488** to talk to a CareSource 24 nurse.

Visits to Your PCP

Your PCP will provide or arrange for the care you need. We suggest that you contact your PCP first for all health care covered by CareSource, except emergencies.

Please remember, you must receive all medically-necessary Medicaid-covered health care services from CareSource facilities and/or providers. The only time

you can use providers not on CareSource's panel is for emergencies, with an authorization, or if the service is provided by an FQHC, Child and Adolescent Health Center or family planning clinic.

You should have received a Provider Directory that lists all of our panel providers as well as other providers you can see. If you need a Provider Directory, contact Member Services at **1-800-390-7102** or go to our website at **www.caresource.com**. Remember, if you go to out-of-network providers for non-emergent routine care, you could be billed for the services by the provider, except as otherwise noted in this handbook or the Certificate of Coverage.

Some examples of conditions that can be treated by your PCP are:

- Routine checkups and screenings
- Cold/flu
- Earache
- Constipation
- Rash
- Sore throat
- Removal of stitches
- Pain management

Urgent Care

If your visit is urgent, it should be scheduled by your PCP's office staff within 2 days from the day you call to ask for the appointment. Urgent care is for an injury or illness that is serious, but symptoms will not cause lasting harm or loss of a limb.

If your PCP's office is closed, you can:

- Call your PCP for advice. You can reach your PCP, or a back-up doctor, 24 hours a day, seven days a week.
- Call our CareSource 24 nurse advice line at **1-866-206-0488** (TTY: 1-800-649-3777 or 711).

Emergency Care

Emergencies are sudden with very serious symptoms. Examples are uncontrolled bleeding or severe chest pain. If you have an emergency, you should be seen right away. You do not have to contact your PCP or CareSource before you get emergency services.

If you have an emergency, call 911 or go to the nearest emergency room (ER). If you are not sure whether you need to go to the ER, call your PCP or our CareSource 24 nurse advice line for help.

Let the ER know that your health plan is CareSource. After the visit, call your PCP within 24 hours to schedule follow-up care.

Out-of-area Care

If you travel outside of the county or state where you live, CareSource covers medically necessary services. If you have an emergency (as explained above) while you are away from home, call 911 or go to the nearest ER. Let them know you are a CareSource member. After the visit, call your PCP. He or she will help you arrange follow-up care.

If you need any other medical care, except emergencies, while you are away from home, call your PCP. Your PCP will help you arrange any services you need. You can also call CareSource 24, our nurse advice line. We can help you decide what to do.

Visits to a Specialist

Your PCP may want you to see a specialist if you need certain medical care or treatment. Each time you see a specialist, you will need a referral from your PCP. Without a PCP referral, CareSource cannot cover the cost of the visit.

Exceptions to this are visits to OB/Gyn and pediatric providers who participate with CareSource. They do not require a PCP referral. Participating specialists are listed in the Provider Directory.

COVERED SERVICES

CareSource will pay for the following services. Some of these services will require a referral or prior authorization. If you do not get a prior authorization or referral, you may be responsible for the bill. You can make sure that the service is covered or find out if you need a referral or authorization by calling Member Services at **1-800-390-7102.**

- Primary care provider services – You can visit your PCP as often as needed. PCP services include, but are not limited to:
  - — Routine office visits
  - — Preventive health screenings and physical exams (including well-child EPSDT services)
  - — Immunizations
  - — Blood lead follow-up services for members younger than 21
- Nurse practitioner services – You may go to any participating certified pediatric and family nurse practitioner.
- Services available at an FQHC – If there is a Federally Qualified Health Center (FQHC) in your area, you may choose to receive services from it. You do not need a referral from your PCP.
- Prescription drugs – Health care providers will write prescriptions for you. They can be filled at participating pharmacies. Prescriptions are filled with generic drugs, when available. See page 13 of this handbook or call CareSource for more details.
- Obstetric and gynecological services – You may go to any participating obstetrician or gynecologist (OB/Gyn) provider.
- Family planning services and supplies – You may receive services from your PCP, health department, family planning clinic, or participating OB/Gyn provider listed in your Provider Directory. Privacy is guaranteed. CareSource covers counseling, pregnancy tests, some birth control, HIV testing, and testing and treatment for sexually transmitted diseases. No referral is required.
- Hearing services – Hearing tests for all members. Hearing aids for members younger than 21.

- Communicable disease screening and services – These are from local health departments. No referral is required.
- Child and Adolescent Health Centers and Programs (CAHCP) – No referral is required for these services.
- Health education and outreach
- Parenting and birthing classes
- Emergency services – You do not have to go to a participating provider in an emergency. If you aren't sure where to go, call your PCP or our CareSource 24 nurse advice line at **1-866-206-0488**.
- Vision services – If you need vision services, contact Vision Services Plan at **1-800-877-7195**. VSP will arrange all of these services for you. Adults 21 years and older may receive one vision exam a year. Members under 21 may receive one exam every two years. Glasses are covered by CareSource for all members. There is a limited group of frames from which you may choose. If you choose a frame that is not in this group, you will have to pay for the total cost of the frame. Contact lenses are covered for members under 21 years of age if the member has a vision problem that cannot be corrected with eyeglasses. Contact lenses for adults age 21 and older are not a covered benefit. Members must use a CareSource provider for all of these benefits.
- Mental health services – CareSource covers 20 outpatient mental health visits a year. Inpatient and outpatient partial hospitalization care is provided through Community Mental Health Departments. Please call Comprehensive Behavioral Care at

1-800-435-5348 to arrange services. You will be referred to an appropriate mental health care provider.

- Medically necessary transportation – For emergency transportation, call 911. Please see page 14 for details about how to arrange non-emergency transportation.
- Ambulance and other emergency medical transportation
- Blood lead testing as recommended by the Medicaid EPSDT policy
- Pediatric services
- Immunizations
- Well-child visits up to 21 years of age
- Specialist services – These include visits to most participating specialists, such as a cardiologist (heart doctor) or a certified nurse midwife. Specialists are listed in the Provider Directory.
- Medical supplies – These require a prescription. They include diabetic supplies, surgical dressings, splints, casts and other items that cannot be reused.
- Diagnostic services – These include X-rays, lab work and medical imaging. Your PCP or a participating specialist may send you for these tests.
- Diagnostic tests – These include MRIs, PET scans and other medical imaging.
- Chiropractic services (back care) – You may go to any CareSource participating chiropractor without a referral or prior authorization. This is limited to 5 visits per year for members over 21 years of age.

- Podiatry services (foot care) – You may go to any CareSource participating podiatrist without a referral or prior authorization.
- Outpatient hospital services
- Medically necessary weight-loss services
- End-stage renal disease services (for kidney disease)
- Inpatient hospital services
- Durable medical equipment – This includes equipment such as wheelchairs, walkers or special devices. Your provider will get prior authorization and help you access these services.
- Home health care
- Home infusion services
- Hospice services – These are for end-of-life care. It is for the terminally ill such as cancer patients. Your provider will get prior authorization and help you access these services if you need them.
- Intermittent or short-term restorative or rehabilitative services in a nursing facility, up to 45 days
- Prescription drugs
- Non-participating specialist office visits – All services provided by non-participating specialists require prior authorization. A provider or member can call CareSource and request authorization to see a non-participating provider. Authorization is given for continuity of care services, or if there is no participating provider to render the services needed.
- Orthotics/prosthetics (artificial limbs)
- Pain clinic services
- Physical therapy, occupational therapy and speech therapy

CareSource

- Restorative or rehabilitative services – These services are in a place other than a nursing facility.
- Transplant services
- Therapies (special language, physical, occupational)

Please keep in mind that some services may need a referral, prior authorization or both.

Referrals

CareSource members may need a referral for some services. Your PCP or specialist will work with you to decide what care you need and where to get it. Your doctor will do one of the following:

- Arrange the services for you
- Give you a written okay to take with you when you get the service
- Tell you how to get the service

Please keep in mind that some services may require a referral.

Emergency care, transportation, vision services, mental health, routine OB/Gyn, pediatric care and family planning services do not need a referral from another doctor.

Prior Authorizations

A few services also need approval from CareSource. This is called prior authorization. Your PCP or specialist will help you if you need these services.

The following services require prior authorization:

- Inpatient care including nursing facility services
- All abortions
- Some home health services
- Nursing facility services
- Inpatient rehabilitative services
- Organ transplants
- Durable Medical Equipment over $750.00 billed charges
- The $750.00 rule does not apply to the below DME/ other items – these require prior authorization:
  - All powered or customized wheelchairs
  - Manual wheelchair rentals over 3 months
  - All miscellaneous codes (example E 1399)
- Plastic surgery and cosmetic procedures
- Non-formulary drug requests
- Ambulance and ambulette transportation – except for emergent or facility-to-facility transfers
- Services beyond benefit limits
- Diagnostic procedures
  - MRI's
  - PET scans
  - Gastrointestinal tract imaging (video capsule)
- Pain management/clinic
- Spinal injections and blocks
- All services provided by non-participating providers
- Rehabilitative services
  - Physical therapy over 18 visits per calendar year
  - Occupational therapy over 18 visits per calendar year
  - Speech therapy

- Food supplements/nutritional supplements

If you have any questions about referrals, call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711). You can find out how to get a referral. You can also ask how we decide whether to give prior authorization to your provider to perform a certain service.

Prescription Drugs

There is no co-pay for prescription drugs preferred by CareSource.

CareSource uses a Preferred Drug List. This is a list of drugs approved for your use. Generic drugs must be used when they are available. Most generic drugs and only the brand name drugs on the CareSource list are covered without prior authorization.

Certain drugs, even though they are on the list, may have special limits on the quantity that can be filled at your participating pharmacy. Some may require you to try other medications first. A pharmacist may request a 72-hour emergency fill of most medications by calling our Pharmacy Benefits Manager at **1-800-770-8014**. Anti-psychotic, HIV and anti-retroviral drugs are covered by your MiHealth Card. For additional information call our Member Services Department at **1-800-390-7102** or call Magellan at 1-877-624-5204. Some drugs are not covered, such as drugs for cosmetic purposes, infertility, erectile dysfunction drugs, and drugs used for international travel. Drugs not on the Preferred Drug List require a prior authorization.

Participating CareSource physicians have been notified in writing of:

- The drugs included on the list
- How to request a prior authorization
- Special procedures for urgent requests

If your doctor feels it is medically necessary for you to have a drug that is not on the list, he or she should request a prior authorization from CareSource. If CareSource does not authorize the request, we will tell you. We will give you information about the CareSource grievance and appeal process.

Please call Member Services:

- For more information or a list of preferred drugs
- To find out how to appeal a decision
- To ask if your drug is covered

OTHER BENEFITS

CareSource offers other benefits. They are available at no cost to you. They include:

CareSource 24 Nurse Advice Line

See page 4 of this handbook for more details about this service. To reach the 24-hour nurse advice line, call **1-866-206-0488** (TTY: 1-800-649-3777 or 711).

Case Management

CareSource has nurses and social workers who can work with you one-on-one. They can help you coordinate your health care needs. They will contact you:

- If your doctor requests it
- If you request help

- If our staff feels their services would be helpful to you or your family

Our staff is trained to help you and your family with any special medical issues like:

- Complex health care needs
- Hospitalizations
- Chronic diseases like asthma, diabetes, heart failure or obesity
- Complicated pregnancy

Disease Management

CareSource offers disease management programs. They can help you learn about your health and how you can better manage your specific health conditions. These programs are available to you at no cost. We have programs for:

- Asthma
- Diabetes
- High blood pressure
- Quitting tobacco use

Goals of our programs include:

- Helping you understand how to take good care of yourself
- Helping you adopt a healthy lifestyle
- Working with your doctor to reach your health goals

Transportation

If you need emergency transportation, please call 911.

If you do not have a way to get to your medical appointment, CareSource can help. If you meet the requirements here's how it works:

- For a ride to a medical appointment, call CareSource at **1-800-390-7102**. Choose the menu option for members, then the option for transportation.

Please call as soon as you know you need a ride. Please try to call at least five days ahead of your doctor's visit to arrange transportation or mileage reimbursement for medically necessary health care services.

Help to Quit Smoking

CareSource knows it's hard to quit smoking. We're here to help. We offer the Michigan Tobacco Quitline through the American Cancer Society. The Michigan Tobacco Quitline is free for you. It is a telephone coaching service to help tobacco users who are trying to quit. The Quitline is answered 24 hours a day, seven days a week.

Here's how it works:

- Call the Michigan Tobacco Quitline at **1-800-QUIT-NOW** (1-800-784-8669). During your first call, you will be asked questions about your tobacco use and your reasons for quitting. This will take about 20 minutes.
- You can choose to have a one-time session to help you plan how to quit on your own. Or, you can enroll in a five-session coaching program.
- If you choose the coaching program, you will be assigned a coach to help you. You will have the same coach help you throughout the program.
- You pick the best day and times for the coaching sessions. The coach will call you. You will also receive free printed information through the mail. It is filled with suggestions about how to cope with temptations to smoke.

CareSource also covers nicotine replacement therapy such as nicotine gum or patches, or medications like Zyban. All you need is a prescription from your physician.

Health Information

Preventive medical care is an important part of keeping your family healthy. Regular care helps your PCP find problems early so they can be treated before they get worse. CareSource sends members reminders about preventive care.

Knowing how to lead a healthy lifestyle also helps you stay well. CareSource offers information about many health care topics through brochures, fliers and newsletters. You can find copies of all health information for members on the CareSource website at **www.caresource.com**.

SERVICES AVAILABLE OUTSIDE OF CARESOURCE

Certain services are not covered by CareSource, but they are still available through Medicaid. They include:

- Dental services.
- Services provided by a school district and billed through the Intermediate School District.
- Maternal Infant Health Program (MIHP)
- Inpatient hospital psychiatric services. (Contact your local community mental health agency.)
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), after 45 days.
- Outpatient partial hospitalization psychiatric care.
- Mental health services in excess of 20 outpatient visits each calendar year. (Contact your local community mental health agency.)
- Mental health services for enrollees meeting the guidelines under Medicaid policy for severe and persistent mental illness or severe emotional disturbance. (Contact your local community mental health agency.)
- Substance abuse services through accredited providers. (Call Member Services at **1-800-390-7102**):
  - — Screening and assessment
  - — Detoxification
  - — Intensive outpatient counseling and other outpatient services
  - — Methadone treatment
- Services provided to persons with developmental disabilities and billed through Provider Type 21. (Contact your local community mental health agency.)
- Custodial care in a nursing facility.
- Home and Community based waiver program services.
- Personal care or home help services.
- Traumatic Brain Injury Program Services.
- Transportation for services not covered.
- Anti-psychotic and other behavioral health medications, HIV, hypnotics, stimulants, anti-Parkinsonism, and anti-retroviral drugs. (Call Member Services at **1-800-390-7102** or call Magellan at **1-877-624-5204.**) For these drugs, you must present your MiHealth Card when you get your medicine.

- WIC services, food and nutrition program for women, infants and children. Call your local health department for help.
- Drug and alcohol services – Call your local Substance Abuse Coordinating Agency or Comp Care. Drug and alcohol abuse is a disease. Some signs of abuse are:
  - — Using drugs or alcohol to get rid of stress, fear or shyness
  - — Money problems because of drug or alcohol abuse
  - — Lying or making excuses about the use of drugs or alcohol
  - — Missing school or work because of drug or alcohol use

If you need help contacting an agency, call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711).

SERVICES NOT COVERED BY CARESOURCE

CareSource does not pay for the following services:

- Services or items used only for cosmetic purposes
- Services that are experimental or for research
- An elective non-covered abortion and related services
- Abortions are not covered except in the case of rape, incest or when medically necessary to save the life of the mother
- Treatment for infertility services

This is not a complete list of non-covered services. If you have a question about whether or not a service is covered, please call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711).

YOUR RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of CareSource you have the following rights. CareSource and our participating providers will comply with all of these requirements.

- To receive information about CareSource, our services, our practitioners and providers and member rights and responsibilities.
- To be told how to ask about where a provider went to medical school, if they completed all of their training, and if they have a special certification in a certain part of medicine.
- To be treated with respect and with regard for your dignity and privacy.
- To receive quality health care.
- To have your medical information kept confidential.
- To say yes or no to having any information about you given out unless CareSource has to by law.
- To be given information about your health. You can ask your PCP for your medical records. You can also ask CareSource for information.
- To discuss information on any appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To get written materials in alternative formats if you have special needs.
- To get help with any special language needs you may have.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To be sure that others cannot hear or see you when you are getting medical care.
- To get an interpreter if you do not speak or understand the language of your provider. You can have an interpreter with you during a medical exam. This is a free service.
- To ask if CareSource has special payment arrangements with providers that could affect the services you may need or receive. Please call Member Services to get this information.
- To say you do not want certain care.
- To file a grievance (complaint) or appeal or to request a state hearing. See page 21 of this handbook for details.
- To make recommendations regarding CareSource's member rights and responsibility policy.

- To be able to get a second opinion from a qualified provider on CareSource's panel. If a qualified provider is not able to see you, CareSource must set up a visit with a provider not on our panel.
- To get medical care regardless of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Patient Advocate Law and Advance Directives

You have the right to make Advance Directives. This is covered under Michigan's Patient Advocate Law. These are documents you sign in case you become seriously ill. They are used if you become unable to communicate because of your illness or injury. They let your doctor and others know your wishes concerning medical treatment. You sign them while you are still healthy and able to make such decisions.

In these documents you can:

- Specify your wishes about future medical care.
- Give someone you trust the right to make decisions for you. The person you name is called your patient advocate.
- Or both. In this case, your patient advocate would agree to follow the wishes you have put in writing.

To learn more about advance directives, go to:
http://www.michbar.org/elderlaw/adpamphlet.cfm

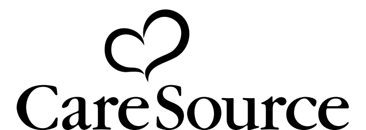
CareSource does not put any limits on your right to do this under state law. To file a complaint about how CareSource follows your wishes, please write or call:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, Third Floor
P.O. Box 30220
Lansing, MI 48909-7720
1-877-999-6442 or **www.michigan.gov/ofir**

To file a complaint about how your provider follows your wishes, please write or call:

Bureau of Health Professions,
Complaint and Allegation Division
P.O. Box 30670
Lansing, MI 48909-8170
(517) 373-9196 or **bhpinfo@michigan.gov**

The Bureau of Health Professions (BHP) complaint and allegation website is **www.michigan.gov/healthlicense**. Click on "file a complaint."



Your Responsibilities

As a CareSource member, you must be sure to:

- Notify CareSource and your Department of Human Services caseworker of a change in:
  - Your phone number
  - Name change – You get married or divorced
  - Your address – This could affect your CareSource enrollment
  - The number of people in your family. This could happen when a baby is born or an older child moves out.
- Use only participating health care providers.
- Always carry your ID cards and do not let anyone else use them.
- Keep scheduled health care appointments. Be on time. If you have to cancel, call 24 hours in advance. If you have scheduled transportation, please cancel transportation, too. If you do not keep scheduled appointments, or if you do not call your PCP to cancel your appointment, the provider may ask you to choose a different PCP. Your PCP has the right to request your discharge from their office if you miss appointments and do not notify them or if you break a treatment agreement.
- Follow the advice and instructions for care you have agreed upon with your doctors.
- Ask questions about your care.
- Give CareSource and your providers the information we need to provide care for you.
- Use emergency room services only when you believe an injury or illness could result in lasting injury or death.
- Let us know if you or your children with CareSource coverage have other health insurance.
- Let us know if you see a doctor for an injury or illness caused by another person or business, such as a car accident or a fall in a store.
- Understand as much as possible about your health issues. Take part in reaching goals that you and your providers agree upon. Let your providers know if you don't understand what they tell you.

- Consult our member website (**www.caresource.com**) annually for any updates to member rights and responsibilities.

QUALITY HEALTH CARE

Any decisions we make with your providers about the medical necessity of your health care are based only on how appropriate the care setting or services are. CareSource does not reward providers or our own staff for denying coverage or services. We do not offer financial incentives to our staff that encourage them to make decisions that result in underutilization.

You can contact us at any time about utilization management or prior authorization requests. Just call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711).

CareSource may decide that a new development not currently covered by Medicaid will be a covered benefit. This includes newly developed:

- Health care services
- Medical devices
- Therapies
- Treatment options

Coverage is based on:

- Updated Medicaid and Medicare rules

- External technology assessment guidelines
- Food and Drug Administration (FDA) approval
- Medical literature recommendations

You can contact CareSource to get any other information you want. This includes information about:

- Our structure and operations
- How we pay providers
- How we work with other health plans if you have other coverage
- Results of member surveys
- How many members disenroll from CareSource
- Benefits, eligibility, claims or participating providers

If you want to tell us about things you think we should change, please call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711). Our members' health is always our top priority.

OTHER INSURANCE

Other Health Insurance (Coordination Of Benefits – COB)

If you or anyone in your family has health insurance with another company, it is very important that you call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711) and your Department of Human Services (DHS) specialist about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent, then you need to call us to give us the information. Not giving us this information can cause problems with getting care and with bills. It can also be considered fraud.

Members with other insurance:

CareSource follows Michigan insurance guidelines for members with commercial insurance. Your commercial insurance is considered your primary coverage. CareSource is secondary coverage. You should follow the guidelines of your primary insurance when you get medical care. Be sure to show your providers both insurance ID cards. Providers will bill your primary insurance first. After your primary insurance pays its allowable amount, CareSource will be billed. CareSource pays the difference between the actual primary payment and the amount CareSource would have paid as primary.

You should let CareSource and your county caseworker know right away if your "other" insurance changes. Send us a copy of the Certificate of Coverage or policy from your other insurance. Let us know the carrier name, policy number, effective date and end date (where applicable).

Please send copies to:

CareSource
P.O. Box 8738
Dayton, OH 45401-8738
Attn: Member Services

Accidents

Please let us know if you or any CareSource member in your family has seen a doctor for an injury or illness caused by another person or business. Examples are:

- You are hurt in a car wreck
- You are bitten by a dog
- You fall and are hurt in a store

Call Member Services at **1-800-390-7102** to let us know. Another insurance company might have to pay the doctor or hospital bill. When you call, we need the name of:

- The person at fault
- His or her insurance company
- Any lawyers involved

Thank you for giving us this important information. It will help avoid delays in processing your CareSource benefits.

FRAUD, WASTE AND ABUSE

CareSource has a program designed to handle managed care fraud, waste and abuse committed by providers or members. We monitor and take action on any member or provider fraud, waste and abuse. Some examples are:

Provider fraud, waste and abuse:

- Prescribing drugs, equipment, or services that are not medically necessary
- Scheduling more frequent return visits than are medically necessary
- Billing for services not provided to you
- Billing for more expensive services than provided

Member fraud, waste and abuse:

- Sharing your CareSource ID card with another person
- Forging a doctor's signature on Babies First coupons, prescriptions, etc.
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Explanation of Benefits Statement

To help CareSource identify potential fraud or abuse in medical billing or medical identity theft, CareSource will send Explanation of Benefits Statements to randomly selected member households on a quarterly basis. **This statement is not a bill.** These statements will help you understand what medical services were billed to CareSource and how these benefits were paid. These statements tell you:

- The member who received the medical service(s).
- The name of the provider who billed the medical service(s).
- The date the medical service(s) was received.
- A description of the medical service(s) received.
- The amount paid for the medical service(s).

Please let us know if you or your family members did not receive the services shown on this statement by contacting our Special Investigations Unit using the contact information below.

If You Suspect Fraud, Waste and Abuse

If you think a doctor or a CareSource member is committing fraud, waste or abuse, you can report your concerns to us by:

- Calling **1-800-390-7102** (TTY: 1-800-649-3777 or 711) and choosing the menu option for reporting fraud.
- Sending an e-mail to **fraud@caresource.com**.
- Faxing us at 1-800-418-0248
- Visiting our website at **www.caresource.com** and using the Fraud, Waste and Abuse Reporting Form and mailing it to the address shown.

- Sending us a letter addressed to:

  CareSource
  Attn: Special Investigations Unit
  P.O. Box 1940
  Dayton, OH 45401-1940

OR

You may also report fraud directly to the Michigan Department of Community Health by:

- Calling **1-866-428-0005**
- Writing to:

  Medicaid Integrity Program Section
  Capitol Commons Center Building, 6th Floor
  P.O. Box 30479
  400 S. Pine Street
  Lansing, MI 48909-7979

When you report fraud, waste and abuse, please give us as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your report will be kept confidential to the extent permitted by the law.

Protecting Your Privacy

CareSource respects your right to privacy. Your New Member Kit has CareSource's Notice of Privacy Practices for your information. Please take the time to read it carefully.

The notice explains how, when and why we use or share the personal health information (PHI) we keep about you. Your PHI includes information used:

- To identify you
- To document your health
- To document your medical treatment
- To document payment for health care you receive

This notice also explains your rights with respect to your PHI. Information about your PHI is also on CareSource's website at **www.caresource.com**.

HOW TO FILE A COMPLAINT

We hope you are happy with CareSource and our services. If you are unhappy with anything about CareSource or our providers, please contact us as soon as possible. We want to hear about your concerns so we can improve our service to you.

Concerns

If you have a concern, call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711). We will try to solve the problem right away. If we can't, we will investigate the problem and work with other CareSource staff to resolve it. We will call you within 72 hours with a plan of action or proposed solution.

Complaints or Grievances

If you have a complaint, call Member Services at **1-800-390-7102** (TTY: 1-800-649-3777 or 711) and tell us your complaint. Complaints are resolved at the time of the call whenever possible. If we don't resolve the problem to your satisfaction, or if we don't resolve it within 72 hours, you can file a grievance. Just call **1-800-390-7102** (TTY: 1-800-649-3777 or 711) and tell us about your complaint.

Appeals

If you are not happy about a decision CareSource made about your health care, you can ask us to reconsider. This is called an appeal.

- You can file an appeal by calling **1-800-390-7102**.

OR

- You can file an appeal by writing:

  CareSource
  P.O. Box 1947
  Dayton OH 45401-1947

Appeals must be filed within 90 days of CareSource's decision, will be investigated by CareSource, and will be resolved in 30 days of receipt. You will receive a notice in writing telling you what CareSource has decided about your complaint.

Expedited appeals can be filed within 10 days of CareSource's decision. Expedited appeals are only for situations where a provider says or puts in writing that waiting for 30 days might jeopardize your life or health or would jeopardize your ability to regain maximum function. These types of appeals will be processed within 72 hours of receipt.

You may request a Private Informal Managerial Conference to explain your appeal and concerns directly to CareSource staff. Here you can present your views, let a lawyer or someone else speak for you, see all documents in the file, add new evidence, submit written comments, question the committee or ask for a neutral member of CareSource staff to help present your case for you.

If you do not choose to participate in the Private Informal Managerial Conference, your appeal will be submitted directly to the Appeals Committee for review. You will be notified of their decision within 30 days of filing your appeal.

We will send you a letter to let you know we received your appeal. Then we will send you a second letter telling you the appeal decision.

Other Actions

You can ask for a hearing with the Michigan Department of Community Health at any time within 90 days of the original letter denying your request. You do not have to go through the CareSource appeals process first. CareSource can provide you with the form you need to file this request. Or you can call the Administrative Tribunal at **1-877-833-0870**.

You can also ask for an independent review through the Office of Financial and Insurance Regulation (OFIR). You have to go through CareSource's appeals process first. You have 60 days after you receive the letter with the CareSource appeal decision to request a review through OFIR. CareSource can provide you with the form you need to file this request. Or, you can call OFIR at **1-877-999-6442** to get a form.

WORD MEANINGS

Advance Directives – Documents you sign in case you become seriously ill. They let your doctor and others know your wishes concerning medical treatment. You sign them while you are still healthy and able to make such decisions.

Appeal – Asking CareSource to reconsider a decision about your health care.

Co-payment – Amount the patient has to pay to a health care provider for services. CareSource members are not charged co-payments for any service provided by CareSource.

Covered Services – Medically necessary services, equipment or supplies that CareSource will pay for you to get.

Emergency Services – Services to treat an emergency. Emergencies are sudden with very serious symptoms. If an emergency is not treated by a doctor right away, you might die, suffer long-term health problems, or lose a limb.

Experimental Treatments – Procedures, drugs or supplies that are still being tested and have not been approved by the government.

Grievance – A complaint about CareSource or its services.

Hospice Services – End-of-life care for the terminally ill such as cancer patients.

Hospital Outpatient Services – Services at a hospital, but for people who are not staying at the hospital.

Inpatient Services – Services for people who have been admitted into a hospital, skilled nursing facility or rehabilitation center.

Long-term Care Facility – A facility licensed to provide inpatient nursing care for months or years at a time.

Medically Necessary Services – Procedures, drugs or supplies that are needed for your diagnosis, care or treatment.

Member – An eligible Medicaid recipient who has joined CareSource and receives health care services from participating providers.

Non-covered Services – Any services, equipment or supplies that are not medically necessary or that CareSource does not pay for.

Non-participating Provider – A doctor, hospital, pharmacy or other health care professional who has not signed a contract to provide services to CareSource members.

Participating Provider – A doctor, hospital, pharmacy or other health care professional who has signed a contract to provide services to CareSource members. They are listed in our Provider Directory.

Preventive Care – Taking care of your health so you can avoid serious illness.

Primary Care Provider (PCP) – A participating provider you have chosen to be your personal doctor. Your PCP works with you to coordinate your health care. He or she will treat you for most of your health care needs, send you to specialists, or admit you to the hospital, if needed.

Prior Authorization – For some services, participating providers must get approval from CareSource before you can get care. This is to make sure the service is the best care for your needs and that it will be covered. It is needed for services that are not routine, such as home health care and some surgeries.

Provider – Any person or business where you can get health care. Providers include doctors, nurses, specialists, hospitals and more. **Provider Directory** – A list of the doctors and other health care providers you can go to as a CareSource member.

Referral – A request from a PCP for his or her patient to see a specialist for care.

Specialist – A doctor who focuses on a particular kind of health care such as a surgeon or a cardiologist (heart doctor).

Urgent Care – Treatment for an injury or illness that is serious but will not cause lasting harm or loss of a limb.

Certificate of Coverage

CONTENTS **PAGE**

ARTICLE I. GENERAL CONDITIONS 26

1.1 Certificate 26
1.2 Rights and Responsibilities 26
1.3 Execution of Certificate 26
1.4 Waiver by CareSource, Amendments 26
1.5 Assignment 26

ARTICLE II. DEFINITIONS 26

ARTICLE III. ELIGIBILITY 30

3.1 Member Eligibility 30
3.2 Long-Term Care 30
3.3 Children's Special Health Care Services 30
3.4 Final Determination 30

ARTICLE IV. ENROLLMENT 30

4.1 Enrollment 30
4.2 Newborns 30
4.3 Change of Residency 30

ARTICLE V. EFFECTIVE DATE OF COVERAGE 30

5.1 Effective Dates of Enrollment 30
5.2 Notification 30

ARTICLE VI. RELATIONSHIP WITH PARTICIPATING AND NON-PARTICIPATING PHYSICIANS, PRACTITIONERS OR PROVIDERS 30

6.1 Selecting Primary Care Physicians, Practitioners or Provider 30
6.2 Role of Primary Care Physicians, Practitioners or Provider 31
6.3 Changing Primary Care Physicians, Practitioners or Provider 31
6.4 Specialist Providers and Other Participating Physicians, Practitioners or Provider 31
6.5 Non-Participating Physicians, Practitioners or Provider 31
6.6 Physician, Practitioner or Provider Prohibited from Discussing Treatment Options 31
6.7 Independent Contractors 31
6.8 Termination of a Physician, Practitioner or Provider's Participation 31
6.9 Inability to Establish or Maintain a Provider-Patient Relationship 32
6.10 Refusal to Follow Participating Physician's, Practitioner's or Provider's Orders 32

ARTICLE VII. MEMBERS RIGHTS AND RESPONSIBILITIES 32

7.1 Release and Confidentiality of Member Medical Records 32
7.2 Member Grievance Procedure 33
7.3 Membership Cards 33
7.4 Forms and Questionnaires 34
7.5 CareSource Board of Directors 34
7.6 Non-Covered Services 34

7.7 Regular Communication ... 34
7.8 CareSource Policies and Procedures ... 34
ARTICLE VIII. PAYMENT FOR COVERED SERVICES ... 34
8.1 Periodic Premium Payments ... 34
8.2 Members Covered ... 34
8.3 Copayments ... 34
8.4 Claims ... 34
8.5 Non-Participating Physicians, Practitioners or Providers ... 35
ARTICLE IX. COVERED SERVICES ... 35
ARTICLE X. EMERGENCY SERVICES OR URGENT CARE WITHIN THE SERVICE AREA ... 42
10.1 Emergency Services ... 42
10.2 Urgent Care ... 42
ARTICLE XI. OUT-OF-AREA SERVICES ... 43
11.1 Covered Services ... 43
11.2 Hospitalization ... 43
ARTICLE XII. EXCLUSIONS AND LIMITATIONS ... 43
12.1 Exclusions ... 43
12.2 Limitations ... 44
ARTICLE XIII. TERM AND TERMINATION ... 44
13.1 Term ... 44
13.2 Termination of Certificate by CareSource or the Department ... 45
13.3 Termination of Member Enrollment and Coverage by CareSource ... 45
13.4 Disenrollment by Member ... 46
ARTICLE XIV. COORDINATION OF BENEFITS ... 46
14.1 Purpose ... 46
14.2 Assignment ... 46
14.3 Order of Benefits ... 46
14.4 CareSource's Rights ... 47
14.5 Construction ... 47
ARTICLE XV. SUBROGATION ... 47
15.1 Assignment; Suit ... 47
15.2 Definition ... 47
ARTICLE XVI. MISCELLANEOUS ... 48
16.1 Governing Law ... 48
16.2 Policies and Procedures ... 48
16.3 Notice ... 48
16.4 Headings ... 48

ARTICLE I. GENERAL CONDITIONS

1.1 **Certificate.** This Certificate of Coverage (Certificate) is issued to Medicaid Program recipients who have enrolled in CareSource (CareSource). By enrolling in CareSource, the member agrees to abide by the terms and conditions of this certificate.

1.2 **Rights and Responsibilities.** This Certificate describes and states the rights and obligations of members and CareSource. It is the member's responsibility to read and understand this certificate. Section 9.2 of this certificate lists the covered services to which members are entitled under the terms and conditions of this certificate.
In some circumstances, certain medical services, equipment, and supplies are not covered or may require prior approval of CareSource.

1.3 **Execution of Certificate.** Members acknowledge and agree that a member's execution of the application shall be deemed to be his/her execution of this entire certificate. The application, this certificate, and the membership card(s) issued to the member constitute the member agreement between CareSource and the member.

1.4 **Waiver by CareSource, Amendments.** Only authorized officers of CareSource have authority to waive any conditions or restrictions of this certificate, to extend the time for making payment, or to bind CareSource by making a promise or representation or by giving or receiving any information. All changes to this certificate must be in writing and signed by an authorized officer of CareSource, and must be approved by the Office of Financial and Insurance Regulation (OFIR).

1.5 **Assignment.** All rights of a member to receive covered services under the member agreement are personal and may not be assigned to any other person or entity. Any attempts to assign the member agreement or any rights under the member agreement may result in termination of coverage for the member.

ARTICLE II. DEFINITIONS

2.1 **Applicability.** The definitions in this Article II are applicable throughout this certificate and any amendments, addenda, or appendices to this certificate.

2.2 **Application** means the membership application form that a Medicaid recipient is required to complete and sign to obtain Medicaid benefits.

2.3 **CareSource** is a non-profit corporation that has a Certificate of Authority issued by the state of Michigan as a health maintenance organization.

2.4 **Certificate** means this contract between CareSource and members, including all amendments, addenda and appendices.

2.5 **Communicable Disease** means a bacteria and virus or other agent resulting in a disease that can be passed on to other people in many different ways.

2.6 **Copayment** means the amount which a member is required to pay directly to a participating physician, practitioner or provider or a non-participating physician, practitioner or provider for certain covered services as set forth in Article IX of this certificate.

2.7 **Cosmetic Surgery** means those procedures which improve physical appearance, but which do not correct or materially improve a physiological function and are not medically necessary.

2.8 **Covered Services** mean the medically necessary services, equipment and supplies set forth in Section 9.2 of this certificate, which are subject to all of the terms and conditions of this certificate.

2.9 **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.

2.10 **Emergency Medical Care/Services** mean those services necessary to treat an emergency medical condition. 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 person or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

2.11 **Emergency Transportation** means a motor vehicle or rotary aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advance life support.

2.12 **Experimental, Investigational or Research Medical, Surgical or other Health Care Drug, Device, Treatment or Procedure** means a drug, device, treatment or procedure meeting one or more of the following criteria:

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 or as the experimental or research arm of a Phase III 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 to conventional alternatives.

e. It is described as experimental, investigational or research by informed consent or patient information documents.

f. It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HSS) or successor agencies, or of a human subjects (or comparable) committee.

g. The predominant opinion among experts as expressed in the published authoritative medical investigational or research settings.

h. 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.

i. 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. Coverage for drugs used in antineoplastic therapy are covered pursuant to MCL 500.3406e and MCL 500.3616a.

2.13 **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).

2.14 **Health Professional** means a health care physician, practitioner or provider who is appropriately licensed, certified or otherwise qualified to deliver health services pursuant to Michigan law.

2.15 **Hospice Services** means services provided by a licensed or Medicare certified hospice that are primarily furnished to provide pain relief, symptom management and supportive services to the terminally ill and their families. Hospice services may be provided in the home, adult foster care facility, home for the aged, long term care facility, alternative intermediate services home, or an inpatient hospice setting.

2.16 **Hospital** means an acute care facility licensed as a hospital by the state of Michigan that is primarily engaged in providing, on an inpatient basis, medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities.

2.17 **Hospital Services** mean those covered services that are provided by a hospital.

2.18 **Insurance Bureau, Office of Financial and Insurance Regulation (OFIR)** means office within DLEG or its successor agency that is duly authorized to regulate health maintenance organizations in the state of Michigan.

2.19 **Intractable Pain** is a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and by one or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

2.20 **Long-term Care Facility** means a facility licensed and certified by the Department of Community Health to provide inpatient nursing care services.

2.21 **Medicaid Agreement** is the contract between the state of Michigan and CareSource under which CareSource agrees to provide or arrange for covered services for members.

2.22 **Medicaid Program** means the Department of Community Health's program for medical assistance under Section 105 of Public Act 280 of 1939, as amended, MCL 400.105, and Title XIX of the Federal Social Security Act, 42 U.S.C. 1396 et seq.

2.23 **Medical Director** means a physician designated by CareSource to supervise and manage the medical aspects of CareSource's programs and services.

2.24 **Medically Necessary** means the services, equipment or supplies necessary for the diagnosis, care or treatment of a member's physical or mental condition as determined by the medical director in accordance with accepted medical practices and standards at the time of treatment. Medically necessary does not in any event include the following:

a. Services rendered by a health professional that do not require the technical skills of such a physician, practitioner or provider.

b. Services, equipment and supplies furnished mainly for the personal comfort or convenience of the member, any person who cares for the member, or any person who is part of the member's family.

c. Any part of the cost of a 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 participating physician, practitioner or provider in accordance with CareSource's procedures.

2.25 **Medicare** means the program established under Title XVIII of the Federal Social Security Act, 42 U.S.C. 1395 et seq.

2.26 **Member** means a Medicaid program recipient enrolled in CareSource and on whose behalf the Michigan Department of Community Health has paid a premium in accordance with the Medicaid agreement.

2.27 **Member Agreement** means this certificate, the member's application and the membership card issued by CareSource to the member.

2.28 **Non-covered Services** mean those medical and health care services, equipment and supplies that are not covered by CareSource.

2.29 **Non-participating Physician, Practitioner or Provider** means a health professional, hospital or other entity that has not contracted with CareSource to provide covered services to members.

2.30 **Participating Hospital** means a hospital that has contracted with CareSource to provide covered services to members.

2.31 **Participating Physician, Practitioner or Provider** means a health professional, hospital or other entity that has contracted with CareSource to provide covered services to members.

2.32 **Physician, Practitioner or Provider** means a health professional or other entity licensed by a state to practice medicine.

2.33 **Premium** means the amount prepaid by CareSource for members to secure covered services.

2.34 **Primary Care Physician**, practitioner or provider (PCP) means a participating physician, practitioner or provider who is responsible for providing, arranging, and coordinating all aspects of a member's health care.

2.35 **Service Area** means the areas in which CareSource has been licensed to provide services to its members.

2.36 **Specialist Physician, Practitioner or Provider** means a participating physician, practitioner or provider, other than a primary care physician, practitioner or provider, who provides covered services to members upon referral by the primary care physician, practitioner or provider and, if required, prior authorization by CareSource.

2.37 **State's Enrollment Broker** means an enrollment services contractor with the Michigan Department of Community Health who contacts and educates general Medicaid beneficiaries about managed care and how to enroll, disenroll and change enrollment.

2.38 **Urgent Care** means the treatment of a medical condition that requires prompt medical attention but a reasonable lapse of time before medical care is obtained would not place the patient's health in serious jeopardy, or cause serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

ARTICLE III. ELIGIBILITY

3.1 **Member Eligibility.** To be eligible to enroll in CareSource, a person must:

a. Be eligible for enrollment in the Medicaid Comprehensive Healthcare program as determined by the Department.
b. Reside within the plan's service area.

3.2 **Long-Term Care.** A Medicaid program recipient residing in a long-term care facility is not eligible to enroll in CareSource.

3.3 **Children's Special Health Care Services.** A Medicaid recipient covered for medical services on an active basis under the Children's Special Health Care Services, as defined by the Medicaid agreement, is not eligible to enroll in CareSource except as provided in the Medicaid agreement.

3.4 **Final Determination.** In all cases, the Michigan Department of Community Health shall make the final determination of a person's eligibility to enroll and continue enrollment in CareSource.

ARTICLE IV. ENROLLMENT

4.1 **Enrollment.** To enroll into CareSource, the eligible person must call or submit the appropriate form to the state's enrollment broker. They must be eligible for Medicaid and enrollment into a Medicaid MCO and reside in the CareSource service area.

4.2 **Newborns.** When the mother has CareSource coverage, the newborn child is automatically enrolled in CareSource from the date of birth. The member must notify the Department of Human Services (formally FIA) and CareSource of the birth of the newborn in accordance with the Medicaid agreement.

4.3 **Change of Residency.** A member must notify the Department of Human Services and CareSource when he or she changes residence. The Department of Community Health may terminate the member's health plan enrollment if the member moves outside the service area as provided in Article XIII of this certificate.

ARTICLE V. EFFECTIVE DATE OF COVERAGE

5.1 **Effective Dates of Enrollment.** A member's enrollment in CareSource and coverage under this certificate will become effective on the date determined by the Department of Community Health in accordance with the Medicaid agreement.

5.2 **Notification.** CareSource will notify a member of the effective date of coverage via a Member ID Card that is mailed to new members. A new member packet will follow that includes the member's CareSource Certificate of Coverage, CareSource member handbook and CareSource provider directory.

ARTICLE VI. RELATIONSHIP WITH PARTICIPATING AND NON-PARTICIPATING PHYSICIANS, PRACTITIONERS OR PROVIDERS

6.1 **Selecting a Primary Care Physician, Practitioner or Provider.** Each member must select a primary care physician, practitioner or provider (PCP). If the member is a minor or otherwise incapable of selecting a primary care physician, practitioner or provider on his or her own behalf, the adult responsible for the member must select a primary care physician, practitioner or provider on behalf of such member. CareSource reserves the right to select a primary care physician, practitioner or provider for the member in the event that he or she does not select a primary care physician, practitioner or provider. CareSource will use guidelines to make such a selection.

6.2 **Role of Primary Care Physician, Practitioner or Provider.** The member's primary care physician, practitioner or provider provides or coordinates, in conjunction with CareSource, health care services to the member, including but not limited to referrals to specialist physician, practitioner or provider; ordering lab tests and x-rays; prescribing medicines or therapies; arranging hospitalization; and generally coordinating the member's medical care as appropriate.

6.3 **Changing a Primary Care Physician, Practitioner or Provider.** A member may change his or her primary care physician, practitioner or provider by contacting CareSource's member services department. All changes must be approved by the member services department and will be processed the date of the request.

6.4 **Specialist Physicians, Practitioners or Providers and Other Participating Physicians, Practitioners or Providers.** A member must obtain referrals from his or her primary care physician, practitioner or provider and, when required, authorization from CareSource in order to receive covered services from specialist physicians, practitioners or providers, and other participating physicians, practitioners or providers, except as otherwise stated in this Certificate of Coverage. Members may access routine obstetrical, gynecological and pediatric services from participating Ob/Gyn and pediatric physicians, practitioners or providers without a referral pursuant to MCL 500.3406m and MCL 500.3406n. A member may be financially responsible for payment for medical services, equipment or supplies, except emergency services, if the member does not obtain the necessary referral or authorization from his or her primary care physician, practitioner or provider or CareSource.

6.5 **Non-Participating Physicians, Practitioners or Providers.** Members are financially responsible for payment for all medical services, equipment and supplies furnished by non-participating physicians, practitioners or providers, except for emergency services, Family Planning Services, Treatment of Communicable Diseases or other covered services authorized by CareSource, unless otherwise stated in the Medicaid contract or in this Certificate of Coverage. You must get prior authorization before seeing a non-participating provider, except as otherwise noted in this Certificate of Coverage.

6.6 **Physician, Practitioner or Provider** shall not be prohibited from discussing treatment options with members that may not reflect CareSource's position or may not be covered by CareSource. Physicians, practitioners or providers shall not be prohibited from advocating on behalf of a CareSource member in any grievance or utilization review process or in a prior authorization process to obtain necessary health care services in accordance with MCL 500.3407a.

6.7 **Independent Contractors.** CareSource does not itself undertake to directly furnish any health care services under this agreement. The obligations of CareSource are limited to arranging for the provision of covered services to members. Participating physicians, practitioners or providers and non-participating physicians, practitioners or providers are solely responsible for exercising independent medical judgments. CareSource is solely responsible for making benefit determinations in accordance with the member agreement, the Medicaid agreement and its contracts with participating physicians, practitioners or providers, but it expressly disclaims any right or responsibility to make medical treatment decisions. Such decisions may only be made by participating physicians, practitioners or providers in consultation with the member. A participating physician, practitioner or provider and a member may elect to continue medical treatments despite CareSource's denial of coverage for such treatments. Members may appeal any of CareSource's benefit decisions in accordance with CareSource's member grievance procedure.

6.8 **Termination of a Physician's, Practitioner's or Provider's Participation.** CareSource or a participating physician, practitioner or provider may terminate his or her contract or limit the number of members that the participating physician, practitioner or provider will accept as patients during the term of this agreement. CareSource does not represent or promise that a specific participating physician, practitioner or provider will be available to render services throughout the period that a member is enrolled in CareSource. If a participating physician, practitioner or provider who is rendering services to a member ceases to be a participating physician, practitioner or provider, the member must cooperate with his or her new primary care physician, practitioner or

provider or select another participating physician, practitioner or provider to render covered services.

6.9 **Inability to Establish or Maintain a Physician, Practitioner or Provider-Patient Relationship.** If a member is unable to establish or maintain a satisfactory relationship with a primary care physician, practitioner or provider or a specialist physician, practitioner or provider to whom the member is referred, CareSource may:

a. Ask the member to select another primary care physician, practitioner or provider.
b. Arrange to have the member's primary care physician, practitioner or provider refer the member to another specialist physician, practitioner or provider.
c. Request termination of the member's enrollment in accordance with Article XIII of this certificate.

6.10 **Refusal to Follow Participating Physician's, Practitioner's or Provider's Orders**. A member may refuse to accept or follow a participating physician's, practitioner's or provider's treatment recommendations or orders. The participating physician, practitioner or provider may request the member to select another participating physician, practitioner or provider if he or she cannot maintain a satisfactory relationship with the member because of the member's refusal to follow his or her orders.

If the member does not agree with a participating physician, practitioner or provider's treatment recommendations or orders, the member may request that CareSource designate another participating physician, practitioner or provider to render a second opinion.

a. If the second participating physician, practitioner or provider agrees that there is no acceptable alternative method of treating the condition, the member must either follow or refuse to follow the treatment recommendations or orders given by the first participating physician, practitioner or provider. If the member refuses to follow the treatment recommendations or orders and obtains any medical services, equipment or supplies not ordered by the first participating physician, practitioner or provider, the member shall be financially responsible for these medical services, equipment or supplies.

b. If the second participating physician, practitioner or provider disagrees with the treatment recommendations or orders given by the first participating physician, practitioner or provider, the medical director will resolve any disagreement between the first and second opinions concerning the treatment of a member's condition. Again, if the member obtains any medical services, equipment or supplies that are not ordered by the first participating physician, practitioner or provider or approved by the medical director, the member shall be financially responsible for these medical services, equipment or supplies.

c. If the member refuses to follow the treatment recommendations or order of a participating physician, practitioner or provider, but does not request a second opinion and obtains any medical services, equipment or supplies not ordered by the participating physician, practitioner or provider, the member shall be financially responsible for these medical services, equipment or supplies.

ARTICLE VII. MEMBERS RIGHTS AND RESPONSIBILITIES

7.1 **Release and Confidentiality of Member Medical Records.**

7.1.1 Clinical information from medical records of members and information received from participating and non-participating physicians, practitioners or providers shall be kept confidential by CareSource and not disclosed to third parties without the prior written consent of the member, except in connection with the bona fide use of anonymous data for medical research, education, or statistical studies, or as permitted or required by law, or in connection with CareSource's utilization review or quality management programs.

7.1.2 Pursuant to the authorization contained in and upon a member's or authorized person's signature on the application, CareSource shall have the right to receive from and release medical information to participating physicians, practitioners or providers and non-participating physicians, practitioners or providers regarding the member as necessary to implement and administer the Medicaid agreement, the member agreement, and CareSource's health plan, subject to the applicable requirements established by state and federal law.

7.1.3 Each member authorizes participating and non-participating physicians, practitioners or providers to disclose information concerning his or her care, treatment, and physical condition to CareSource on request and to permit copying of physician, practitioner or provider records by CareSource. Each member further agrees to cooperate with CareSource and its participating physicians, practitioners or providers by providing health history information and by assisting in obtaining prior medical records when requested. When necessary, the member shall cooperate with and assist in obtaining medical records.

7.1.4 Upon request, adult members, or authorized persons on behalf of members, may review their own medical records and those of minor members in their household in accordance with state and federal law. Such review shall take place at the offices of the participating physician, practitioner or provider during regular business hours and at a time reasonably specified by the participating physician, practitioner or provider.

7.2 **Member Grievance Procedure.** CareSource has procedures for receiving, processing, and resolving member concerns, complaints, and grievances relating to the benefits or the operation of CareSource. The member grievance procedure is fully described in the member handbook. If the grievance is not satisfactorily settled through this procedure, the enrollee has the right under Michigan law to an independent review through the state of Michigan, Office of Financial and Insurance Regulation, Division of Insurance, at 611 W. Ottawa, Third Floor, P.O. Box 30220, Lansing, MI 48909-7720.

Members may also ask for a hearing with the Michigan Department of Community Health. You can request a hearing form by contacting CareSource Member Services or the State Office of Administrative Hearing and Rules (SOAHR) at **1-877-833-0870**.

Members will receive a copy of the member handbook describing the member grievance procedure when they enroll with CareSource and may receive additional copies at any time by telephone request to CareSource's member services department.

7.3 **Membership Cards.**

7.3.1 CareSource will issue a membership card to each member. A member should present his or her membership card to a participating physician, practitioner or provider each time the member obtains covered services.

7.3.2 If a member permits the use of his or her membership card by any other person, CareSource may request termination of the member's enrollment in accordance with Article XIII of this certificate.

7.3.3 If a member's membership card is lost or stolen, the member must notify CareSource's member services department by the end of the next business day following the member's discovery of the loss or the date of the theft.

7.4 **Forms and Questionnaires.** Members shall complete and submit to CareSource such medical questionnaires and other forms as are requested. Members warrant that all information contained in questionnaires and forms completed by them is true, correct, and complete to the best of their knowledge. The intentional submission of false or misleading information or the omission of material information requested on such forms may be grounds for CareSource to request termination of enrollment.

7.5 **CareSource Board of Directors.** As provided by law, at least one-third of CareSource's Board of Directors shall consist of adult members ("enrollees") elected by adult members who are grantees as defined by the Medicaid agreement. Members may contact CareSource member services for information on becoming an enrollee member of the Board of Directors.

7.6 **Non-Covered Services.** Members are financially responsible for payment for all non-covered services that members request or receive from participating physicians, practitioners or providers or non-participating physicians, practitioners or providers.

7.7 **Regular Communication.** Members will receive CareSource's newsletter which will provide information regarding current policy, policy changes, and how best to take advantage of CareSource's services.

7.8 **CareSource Policies and Procedures.** Members are responsible for becoming familiar with and following the policies and procedures that CareSource adopts from time to time to promote the orderly and efficient administration of the Medicaid agreement, the member agreement and its health plan. The plan will provide information regarding its policies and procedures in the Plan's member handbook, newsletters, website and other written communications.

ARTICLE VIII. PAYMENT FOR COVERED SERVICES

8.1 **Periodic Premium Payments.** The Department of Community Health or its remitting agent will pay directly to CareSource, on behalf of each member, the premiums specified in the Medicaid agreement. The Department of Community Health or its remitting agent will pay the premiums on or before any due dates specified in the Medicaid agreement. The member understands that the premiums to be paid on his or her behalf by the Department of Community Health in return for covered services will be remitted in accordance with the Medicaid agreement.

8.2 **Members Covered.** Members for whom the premium has been received by CareSource are entitled to covered services under this certificate for the period to which the premium applies.

8.3 **Copayments.** Copayments are not currently required from CareSource members for any CareSource covered services. In the event CareSource elects to establish co-payments as allowed under the Medicaid Agreement with MDCH, members will be notified as required by MDCH.

8.4 **Claims.**

8.4.1 It is CareSource's policy to pay participating physicians, practitioners or providers directly for covered services furnished to members in accordance with the contracts between CareSource and participating physicians, practitioners or providers. However, if a participating physician, practitioner or provider bills a member for a covered service, the member should submit the bill to CareSource. If the member pays the bill, the member must submit a request for reimbursement to CareSource within sixty (60) days after the date the covered service was furnished to the member.

8.4.2 When a member receives emergency services or other covered services authorized by CareSource from a non-participating physician, practitioner or provider, the member should request the non-participating physician, practitioner or provider to bill CareSource. If the non-participating physician, practitioner or provider refuses to bill CareSource but bills the member, the member should submit any such bills to CareSource. If the non-participating physician, practitioner or 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 CareSource within sixty (60) days after the date the covered services were rendered.

8.4.3 Proof of payment acceptable to CareSource must accompany all requests for reimbursement. Failure to request reimbursement for covered services within the required time shall not invalidate or reduce any claim if it was not reasonably possible to provide acceptable proof of payment within such time and the member provides the required information to CareSource as soon as reasonably possible. However, in no event will CareSource be liable for reimbursement requests for which proof of payment is submitted to CareSource more than twelve (12) months following the date covered services were rendered. CareSource shall not be responsible for that part of a non-participating physician, practitioner or provider's charge that is in excess of the reasonable and customary charges.

8.4.4 CareSource may require a member to provide additional medical and other information or documentation to prove that services rendered were covered services before paying health care physicians, practitioners or providers or reimbursing the member for such services, subject to the applicable state and federal laws.

8.5 **Non-Participating Physicians, Practitioners or Providers.** Members are financially responsible for the cost of any services, equipment or supplies received from non-participating physicians, practitioners or providers unless those services are:

a. Included as covered services on Section 9.2 of this certificate.

b. Authorized in advance by CareSource.

c. Emergency services.

d. Specified in the member handbook or certificate of coverage as not requiring authorization (such as CAHCP and FQHC).

ARTICLE IX. COVERED SERVICES

9.1 A member is entitled to the services, equipment and supplies specified in Section 9.2 when they are specified as services covered by the Medicaid Program in the Medicaid Agreement:

a. Medically necessary.

b. Performed, prescribed, directed, or arranged in advance by the member's primary care physician, practitioner or provider, the network physician, practitioner or provider who is responsible for the provision, or arrangement for the provision, of health services to the member, except as otherwise noted in this Certificate of Coverage.

c. When required, authorized in advance by CareSource.

d. Provided by participating physicians, practitioners or providers, except for emergency services or as otherwise states in this Certificate of Coverage.

e. Supported by evidence based research literature and national quality of care standards.

9.2 The following are covered services when they meet the requirements stated above in Section 9.1:

a. Primary care physician, practitioner or provider office visits.

Each member must select a primary care physician, practitioner or provider who will be responsible for the member's health care needs, including coordination of specialist referrals and inpatient hospitalization.

b. Specialist physician, practitioner or provider office visits, with referral from the PCP.

The primary care physician, practitioner or provider will normally make referrals only to participating physicians, practitioners or providers, participating hospitals, and other participating physicians, practitioners or providers. The PCP may refer a member to non-participating physicians, practitioners or providers when it is medically necessary to do so and the service cannot be provided by a participating physician, practitioner or provider. However, any referral to a non-participating physician, practitioner or provider must be authorized in advance by CareSource.

A specialist physician, practitioner or provider may make further referrals to other participating physicians, practitioners or providers, participating hospitals, or other participating health professionals, but in each case must receive approval of the responsible participating primary care physician, practitioner or provider and authorization from CareSource.

Members are responsible for ensuring that referrals made by any participating physician, practitioner or provider have been pre-authorized by CareSource.

c. Preventive health services.

Services provided by a primary care physician, practitioner or provider or other participating physician, practitioner or provider to prevent illness, disease, disability or progression thereof, or to prolong life and promote physical and mental health are covered services by CareSource, including:

1. Health assessments and examinations as medically recommended for the age and sex of the member.

2. Pre-natal and post-natal care.

3. Pediatric examinations and well-baby care. Members may access routine pediatric services from a participating pediatrician without a referral.

4. Adult immunizations, except for travel or employment purposes. No referral is required if immunizations are received at the member's local health department.

5. Well-child visits and immunizations as covered by the EPSDT program. No referral is required if immunizations are received at the member's local health department.

6. Vision and hearing screenings, not including eye refraction testing.

7. Routine obstetrical and gynecological examinations. Members may access routine obstetrical/gynecological services from a participating Ob/Gyn without a referral.

8. Breast cancer mammography in accordance with MCL 500.3406d and MCL 500.3616:

   (a) One screening mammography examination for women 35 to 40 years old, during that 5 year period.

   (b) One screening mammography examination every calendar year for women 40 years of age or older.

   (c) Screenings ordered by a participating physician, practitioner or provider when medically indicated.

   (d) Definition: "Breast cancer screening mammography" means a standard two-view breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography in order to detect unsuspected breast cancer.

d. Family planning services.

Covered family planning services include information, instruction and medical counseling services on family planning issues, including the use of contraceptive devices and birth control medication. Other family planning services include:

1. Infertility diagnosis and testing.

2. Sterilization (tubal ligation and vasectomy).

3. Detection and treatment of sexually transmitted diseases (STDs).

e. Inpatient hospital services.

1. All inpatient hospital services, except for emergency services, must be provided at a participating hospital and must be arranged through the PCP and authorized in advance by CareSource.

2. Covered inpatient hospital services include semi-private room and board, general nursing care, intensive care and all other medically necessary services and supplies including:

   (a) Radiological services.
   (b) Laboratory and other diagnostic tests.
   (c) Pharmaceuticals.
   (d) Anesthesia.
   (e) Oxygen.
   (f) Chemotherapy and radiation therapy.
   (g) Blood products.
   (h) Obstetrical services.
   (i) Surgical treatment for morbid obesity. Services for morbid obesity are provided after conservative approaches and other services delivered by health professionals have proven ineffective and must follow CareSource guidelines and be prior authorized.

CareSource will not restrict benefits for any length of hospital stay in connection with childbirth for the mother or the newborn child following a normal vaginal delivery to less than 48 hours, or restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child following a Cesarean section to less than 96 hours; or require the physician, practitioner or provider to obtain authorization for any portion of the 48/96 hour hospital stay. The timeline does not apply if the provider and the mother determine a shorter length of stay may be appropriate.

f. Outpatient services.

1. Outpatient services must be provided or arranged by a PCP except as otherwise noted in this Certificate of Coverage, and pre-authorized by CareSource when prior authorization is required. Outpatient services may be provided in the outpatient department of a participating hospital or at another participating physician, practitioner or provider location.

2. Covered outpatient services include dialysis, chemotherapy, outpatient surgery and associated anesthesia services, diagnostic laboratory, diagnostic and therapeutic radiological services, short-term rehabilitative therapy, and other services delivered by health professionals, to include surgical procedures performed on an inpatient or outpatient basis. Reconstructive surgery, including breast reconstruction is a covered benefit pursuant to MCL 500.3406d.

g. Oral surgery.

Covered services include dental-related services not provided by dentists, such as prescription drugs, laboratory and radiology services, surgery and hospitalizations.

h. Rehabilitation and physical therapy services.

Covered services include short-term rehabilitative therapy limited to physical therapy for rehabilitation, occupational therapy, and speech and hearing therapy, performed or rendered on an inpatient or outpatient basis at a participating hospital or other participating physician, practitioner or provider when directed and monitored by a participating physician, practitioner or provider and authorized in advance by CareSource. "Short-term" is defined as a condition subject to a significant improvement in a relatively limited and predictable period.

i. Home health care.

Skilled home visits are covered without authorization by CareSource. Skilled home health services include home nursing services by a registered professional or licensed practical nurse, or care by a physical or occupational therapist in your home. Home health aide services may be covered if medically necessary with prior authorization. Drug and biological solutions, surgical dressings and related medical supplies, and equipment used during home health care visits will be covered so long as they are considered essential to the proper care and treatment of the home health care patient and are prescribed by the member's primary care provider.

j. Skilled nursing facility and hospice services.

1. Skilled nursing facility

   Covered services include care and treatment, including room and board, in semi-private accommodations at a skilled nursing facility when authorized in advance by CareSource. Skilled nursing facility services, (non-hospice care) must lead to rehabilitation and increased ability to function, be of a temporary nature, be supported by a treatment plan, and be authorized in advance by CareSource.

2. Hospice services

   Hospice services for members who have a prognosis of less than six (6) months to live are covered services. Hospice services may be provided in a variety of settings by a multi-disciplinary team of health professionals who attend to the member's physical, emotional, and spiritual needs. Hospice services for funeral arrangements and financial or legal counseling (including estate planning or drafting a will) are non-covered services.

k. Mental health services.

Mental health benefits through CareSource include 20 outpatient visits. Members must call a care manager at **1-800-435-5348** before visiting the therapist. The care manager will find out what services the member needs and will refer the member to a mental health physician, practitioner or provider. If a member has an emergency after business hours, he or she can call **1-800-435-5348**. Inpatient mental health services are provided through community mental health departments. Members can call a care manager at **1-800-435-5348** to help determine if they need inpatient services. Members will then need to contact their local Community Mental Health Department.

l. Prescription drugs.

Prescription and over-the-counter drugs, when included in CareSource's most current drug formulary, are covered when ordered by CareSource participating providers and obtained from a pharmacy in the CareSource network. Insulin, needles and syringes used in conjunction with the administration of injectable insulin are covered when ordered by a CareSource participating provider and obtained at a CareSource network pharmacy or supplier. All prescriptions are limited to a 30-day supply.

Coverage is specifically provided for antineoplastic therapy drugs in accordance with MCL 500.3616a and MCL 500.3406e:

1. The drug is ordered by a provider for the treatment of a specific type of neoplasm.
2. The drug is approved by the FDA for use in antineoplastic therapy.
3. The drug is used as part of an antineoplastic drug regimen.
4. Current medical literature substantiates the drug and recognized oncology organizations generally accept the treatment.

5. The provider has obtained informed consent from the patient for the treatment regimen which includes FDA-approved drugs for off-label indications.

CareSource does not cover drugs in the anti-psychotic classes and other behavioral health medications including substance abuse, HIV, hypnotics, stimulants, anti-Parkinsonism and anti-retroviral drug classes including protease inhibitors and reverse transcriptase inhibitors. These medications will be reimbursed by Magellan, MDCH's pharmacy benefits manager, through a point-of-service reimbursement system.

m. Durable medical equipment, prosthetics, and orthotics.

Special services such as durable medical equipment, prosthetics and orthotics, and other medical supplies, including, but not limited to, the cost and fitting of a prosthetic device following a mastectomy when authorized in advance by CareSource are covered services pursuant to MCL 500.3406a. CareSource reserves the right to require use of the least costly medically effective durable medical equipment and prosthetic or orthotic devices. Podiatric inserts for non-diabetic members that are 21 or older are not covered.

n. Emergency services.

Hospital care and other services delivered by health professionals for emergency treatment of a traumatic injury or medical emergency are covered by CareSource. Emergencies are defined as when something happens **suddenly** and with very serious symptoms, such as very bad pain, loss of blood, or chest pain. Emergencies are times when you could suffer serious injury, loss of limb or lasting damage to your body if you do not see a doctor at once.

Members should attempt to call their primary care provider before going to the emergency room if at all possible, unless delay might result in death or permanent impairment. In the event of a true emergency, members should seek help from the nearest emergency room or medical facility as soon as possible without attempting to contact their primary care provider first. Members should tell the emergency staff that they are a member of CareSource upon arrival if at all possible. Members should also inform the emergency personnel of their primary care provider's name, and request that he or she be contacted as soon as possible.

o. Medically necessary transportation.

For emergency transportation, members should call 911. Emergency transportation is covered in accordance with MCL 333.20902. The service must be medically necessary and the transportation must be to the nearest hospital capable of treatment and must be provided by a licensed ambulance service.

For non-emergency transportation, CareSource must ensure necessary transportation.

CareSource will help you get transportation if:

1. You need a ride to go to the doctor.
2. You need a ride to get medical items or services covered by CareSource. In some cases, the rides must be approved in advance.

Please call CareSource at 1-800-390-7102 as soon as possible when you think you may need transportation.

p. Vision services.

Routine eye examinations by a CareSource vision care participating physician, practitioner or provider to determine the need for vision correction are covered services. CareSource vision benefits are provided by Vision Services Plan (VSP). Members must contact VSP for services. One exam every two years is provided for members under the age of 21, unless otherwise authorized by CareSource. One exam every year is provided for members 21 and older, unless otherwise authorized by CareSource.

1. One pair of clear corrective lenses and eyeglass frames are covered every two years, unless new lenses are medically necessary due to a significant refraction change. Replacements for eyeglasses that are lost, broken or stolen are covered twice per year for members under the age of 21. Sunglasses are not a covered benefit. There is a limited group of frames from which you may choose. If you choose a frame that is not in this group, you will have to pay for the total cost of the frames. Members must use an approved CareSource/VSP vendor for vision/eyeglass services.

2. Contact lenses are covered only if the member has a vision problem that cannot adequately be corrected with eyeglasses. Contact lenses are not a covered benefit for members 21 and older.

q. Hearing examinations.

Hearing examinations to determine whether a hearing problem exists are covered services when performed or authorized by CareSource. These services do not require prior authorization and are a benefit for all CareSource members. Hearing aids are covered for members younger than 21 years of age.

r. Pregnancy terminations.

Medically necessary pregnancy terminations performed to save the life of the mother, or in cases of rape or incest, are covered services when authorized and pre-approved by CareSource.

s. Transplantation of tissue or organs.

Transplantation of tissue or an organ is a covered service if it is medically necessary, approved by the plan, and performed at a facility approved by the plan and member's primary care physician. Coverage includes costs associated with transplant surgery and care including organ procurement, donor searching and typing, harvesting of organs, and related donor medical costs. Cornea, kidney, and extra-renal organ transplants (heart, lung, heart-lung, liver, pancreas, bone marrow, and small bowel) are covered when determined to be medically necessary according to currently accepted standards of care. Drugs used in antineoplastic therapy are covered.

Transplantation will not be covered if:

1. The plan is not contacted for authorization prior to referral for transplant evaluation of the procedure.
2. The transplant procedure is performed in a facility that has not been designated by the plan as an approved transplant facility.
3. The transplant is experimental or investigational, as defined herein.

t. Diabetes (gestational, insulin-dependent, non-insulin dependent).

Diabetes-related services are covered according to sections 9.1 and 9.2 of this certificate.
Equipment coverage includes:

1. Blood glucose monitors and blood glucose monitors for the legally blind.
2. Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
3. Syringes.
4. Insulin pumps and medical supplies required for the use of an insulin pump.
5. Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

Outpatient pharmaceutical coverage includes:

1. Insulin.
2. Non-experimental medication for controlling blood sugar.
3. Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes.
4. Self-management training is limited to completion of a certified diabetes education program if considered medically necessary and if completed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge. Training will be conducted in group settings when possible.

u. Intractable pain. This will include participating health professionals who are board certified in the specialty of pain medicine and the evaluation and treatment of intractable pain, and who have reported all relevant professional degrees and information as a credentialed physician, practitioner or provider in the network.

v. Chiropractic. You may go to any participating CareSource chiropractor without a referral or prior authorization. CareSource members age 21 and older have a chiropractic benefit limit of 5 visits per year.

w. Podiatric (foot) services. You may go to any participating CareSource podiatrist without a referral or prior authorization.

x. Maternal and Infant Health Program (MIHP) services.

y. End-stage renal disease services.

ARTICLE X. EMERGENCY SERVICES OR URGENT CARE WITHIN THE SERVICE AREA

10.1 **Emergency Services.** A member should go directly to a hospital emergency room for emergency services. The member or a responsible party must notify his or her primary care provider within twenty-four (24) hours after seeking treatment at a hospital, or as soon thereafter as medically possible if the member is hospitalized due to the emergency.

10.2 **Urgent Care.** A member must call his or her primary care provider before obtaining urgent care from a participating physician, practitioner or provider. If the member is unable to reach his or her primary care provider, the member should call CareSource. CareSource's toll-free telephone number is provided in the member handbook. The member must contact his or her primary care provider for follow-up and continuing care.

ARTICLE XI. OUT-OF-AREA SERVICES

11.1 **Covered Services.** While the member is outside of the service area, all medical care, except urgent and emergency care, must be approved by the member's primary care physician, practitioner or provider.

11.2 **Hospitalization.** If an emergency situation requires hospitalization, the member or a responsible party must contact his or her primary care provider within twenty-four (24) hours after admission or as soon thereafter as medically possible. The member's primary care provider may require a member to move to a participating hospital when it is medically appropriate to do so.

ARTICLE XII. EXCLUSIONS AND LIMITATIONS

12.1 **Exclusions.** The following services, equipment and supplies are non-covered services:

a. Any service, equipment or supply not specified in Section 9.2.

b. Services, equipment or supplies not performed, provided, prescribed, directed, or arranged by the member's primary care provider except as otherwise noted in this Certificate of Coverage or, where required, not authorized in advance by CareSource.

c. Services, equipment and supplies that are not medically necessary.

d. Routine dental services, except as provided in Section 9.2.

e. Any examinations required by an employer as a condition of employment or for the purpose of obtaining employment or insurance.

f. Cosmetic surgery, except for reconstructive breast surgery or to correct a functional defect that is the result of a congenital and/or acquired disease or when performed to repair a part of the body that was previously altered due to injury or surgery.

g. Inpatient mental health and mental health services in excess of 20 outpatient visits per calendar year.

h. Items for personal cleanliness and grooming.

i. Substance abuse services, including screening and assessment, detoxification, outpatient services and methadone treatment. Substance abuse services including treatment for alcohol and drug dependency may be obtained through the community mental health agency in the member's county of residence. CareSource member service representatives or the member's primary care physician, practitioner or provider are available to assist in referral for these services.

j. Experimental, investigational or research medical, surgical or other health care drug, device, treatment or procedure as determined by the medical director and the department, as defined in Article II. This exclusion does not apply to therapies that include off-label uses of FDA-approved anti-cancer drugs if current medical literature substantiates their efficiency and recognized oncology organizations generally accept the treatment as defined in MCL 500.3406q.

k. Gender alteration operations or treatment related to the procedure.

l. Reversal of voluntarily induced infertility (sterilization).

m. Any service, equipment or supply usually given free of charge.

n. Abortions, except to save the life of the mother or for incest or rape.

o. Services for custodial or basic care in a long-term care facility.

p. Acupuncture.

q. Service unique to and provided only by the local school district and billed through the intermediate school district.

r. Services unique to and provided only by a community health services board as defined by the Medicaid agreement.

s. Services received in a veterans, Marine or other federal hospital, or care for conditions that federal, state or local law require be treated in a public facility.

t. Inpatient services provided by those institutions and nursing care facilities for the mentally retarded and mentally ill, or a mental hospital, as defined by the Medicaid agreement.

u. Over-the-counter medications not prescribed by participating physician, practitioner or provider except as otherwise specified in the member handbook or Certificate of Coverage.

v. Non-emergency services provided by non-participating physicians, practitioners or providers unless approved in advance by CareSource except as otherwise noted in this Certificate of Coverage.

w. Personal care services in a recipient's home, as defined by the Code of Federal Regulations on Public Health.

12.2 **Limitations.**

12.2.1 Covered services are subject to the limitations and restrictions described in Medicaid program physician, practitioner or provider manuals and Medicaid program bulletins and other directives.

12.2.2 CareSource has no liability or obligation for any services, equipment or supplies provided by a non-participating physician, practitioner or provider, except for emergency services, unless the services, equipment or supplies are authorized by CareSource before they are furnished to the member or as otherwise noted in this Certificate of Coverage.

12.2.3 A referral by a primary care physician, practitioner or provider for non-covered services does not make such services covered services.

ARTICLE XIII. TERM AND TERMINATION

13.1 **Term.** This certificate takes effect on the date specified in the Medicaid agreement and continues in effect from year to year thereafter unless otherwise specified in the Medicaid agreement or unless terminated in accordance with this certificate.

13.2 Termination of Certificate by CareSource or the Department.

13.2.1 This certificate will automatically terminate upon the effective date of termination of the Medicaid agreement. Enrollment and coverage of all members will terminate at 12 midnight on the date of the termination of this certificate, except as otherwise provided by the Medicaid agreement.

13.2.2 In the event of cessation of operations or dissolution of CareSource, this certificate may be terminated immediately by order of proper authority or by the Board of Directors. CareSource will be obligated for services for the remainder of the period for which premiums were paid or as otherwise prescribed by law or by the Medicaid agreement.

13.2.3 The Department of Community Health will be responsible for notifying members of the termination of this certificate. CareSource will not notify members of the termination of this certificate. The fact that members are not notified of the termination of this certificate shall not continue or extend a member's coverage beyond the date of the termination of the certificate.

13.3 Termination of Member Enrollment and Coverage by CareSource or the Department.

13.3.1 A member's enrollment and coverage under this certificate will terminate at the date and time provided in the Medicaid agreement when any of the following occurs:

a. The member moves out of the service area and is disenrolled from CareSource.

b. The member ceases to be eligible for the Medicaid program as determined by the Department of Community Health and is disenrolled from CareSource.

c. The member dies.

d. The member is given active eligibility status in Children's Special Health Care Services, (CSHCS) as provided in the Medicaid agreement.

e. The member is admitted to a long term care facility for custodial purposes or for more than 45 days of residential care unless the member is a hospice patient and has been disenrolled from CareSource.

f. The member is admitted to a state psychiatric hospital as defined in the Medicaid agreement.

g. The member becomes excluded for the purposes of Medicaid HMO enrollment as defined by the state.

13.3.2 The state may terminate a member's enrollment at the request of CareSource for any of the following reasons:

a. The member is unable to establish or maintain a satisfactory provider-patient relationship.

b. The member makes material misrepresentations or commits fraud in applying for enrollment.

c. The member misuses or commits fraud in the use of his or her membership card.

d. The member's conduct is abusive or obstructive to CareSource personnel, participating physicians, practitioners or providers or other members.

e. The member repeatedly and intentionally misuses CareSource's benefits and services.

f. The member fails to cooperate in coordinating benefits or subrogating the member's rights of recovery.

13.3.3 A member may appeal his or her termination under Section 13.3.2 through CareSource's member appeal procedure. CareSource will continue the member's coverage until a final decision is rendered under the member grievance procedure upon approval by the department.

13.3.4 CareSource will not terminate a member's enrollment and coverage on the basis of the status of a member's health, health care needs, or the fact that the member has exercised his or her rights under the member grievance procedure.

13.4 **Disenrollment by Member.**

13.4.1 A member may request to disenroll from CareSource with or without cause. The member must follow disenrollment procedures required by The Michigan Department of Community Health.

13.4.2 A member's coverage under this certificate ceases automatically on the effective date of the member's disenrollment. The effective date of disenrollment will be determined by the Department of Community Health.

ARTICLE XIV. COORDINATION OF BENEFITS

14.1 **Purpose.** CareSource will coordinate benefits for a member under this certificate with benefits available from health insurance carriers and other health benefit plans (payers) that also provide coverage for the member. CareSource will coordinate benefits to avoid duplication of benefits to members by CareSource and other payers. Upon CareSource's request, a member, or the authorized person acting on behalf of a member, must inform CareSource of all payers for the member. Each member, or authorized person, must also notify CareSource when any other payer becomes available to the member.

14.2 **Assignment.**

14.2.1 Upon CareSource's request, a member must assign to CareSource:

a. All insurance and other health care benefits, including Medicare and other private or governmental benefits (except Medicaid) payable for health care of the member.

b. All rights to payment and all money paid for any bills for health care received by the member.

14.2.2 Members shall not assign benefits or payments for covered services under this certificate to any other person or entity.

14.3 **Order of Benefits.** In establishing the order of payer responsibility for members, CareSource will follow coordination of benefits guidelines authorized by the Department of Community Health and Insurance Bureau. Benefits will be payable in accordance with applicable provisions of the Michigan Coordination of Benefits Act, Public Act 64 of 1984, as amended, MCL 550.251 et seq.

14.4 **CareSource's Rights.** CareSource is entitled to:

a. Determine whether and to what extent a member has indemnity coverage or other health benefit coverage for covered services.

b. Establish in accordance with Section 14.4, priorities for determining primary responsibility among the payers including CareSource, obligated to provide health care services or indemnity benefits.

c. Require a member or physician, practitioner or provider to file a claim with the primary payer before it determines the amount of CareSource's payment obligation, if any.

d. Recover from the member or physician, practitioner or provider, as applicable, the expense of covered services rendered to a member to the extent that such services are covered or indemnified by any other payer.

e. Recover from the member or physician, practitioner or provider, as applicable, the expense of services rendered to a member that are subsequently determined to be non-covered services and were incorrectly provided because of the member's error.

14.5 **Construction.** Nothing in this Article XIV shall be construed to require CareSource to make payment until it determines whether it is the primary payer or the secondary payer and what benefits are payable by the primary payer.

ARTICLE XV. SUBROGATION

15.1 **Assignment; Suit.** If a member has a right of recovery from any person or entity for the member's injury or illness, except from a member's health insurance or health benefit plan which is subject to Article XIV of this certificate, the member, as a condition to receiving covered services under this certificate, must do one of the following:

a. Pay or assign to CareSource all sums recovered by suit, settlement, or otherwise for the injury or illness up to the amount of CareSource's health care expenses for the injury or illness, but not in excess of monetary damages collected.

b. Authorize CareSource to be subrogated to the member's rights of recovery, including the right to bring suit in the member's name at the sole cost and expense of CareSource, up to the amount of CareSource's health care expenses for the injury or illness. In the event a suit instituted by CareSource on behalf of the member results in monetary damages awarded in excess of CareSource's actual health care expenses, CareSource shall have the right to recover the costs of suit and attorney fees out of the excess, to the extent of such cost and fees.

15.2 **Definition.** As used in this Article XV, **health care expense** means the amounts paid or to be paid by CareSource to participating physicians, practitioners or providers and non-participating physicians, practitioners or providers for covered services furnished to a member.

ARTICLE XVI. MISCELLANEOUS

16.1 **Governing Law.** This certificate is made and shall be interpreted under the laws of the state of Michigan.

16.2 **Policies and Procedures.** CareSource may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the member agreement, the group service Medicaid agreement and its health plan.

16.3 **Notice.**

16.3.1 Any notice required or permitted to be given by CareSource to a member under this certificate shall be in writing and either personally delivered or deposited in the U.S. mail with postage prepaid and addressed to the member at the address of record on file at CareSource's administrative offices.

16.3.2 Any notice required or permitted to be given by the member to CareSource shall be in writing and deposited in the U.S. mail with postage prepaid and addressed to CareSource at the following address:

CareSource
P.O. Box 23037
Lansing, MI 48909-3037

16.4 **Headings.** The headings and captions in this certificate are not to be considered as part of the certificate and are inserted only for convenience.

MI-M-01d
MDCH Approved 4/8/2011

© 2011 CareSource. All Rights Reserved.