



UnitedHealthcare Community Plan

**Medicaid Program
Healthy Michigan Plan
2025 Certificate of Coverage (COC)**

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Table of contents

Article I: General conditions	6	2.15 Healthy Michigan Plan	8
1.1 Certificate	6	2.16 Healthy Michigan Plan Agreement	8
1.2 Rights and Responsibilities	6	2.17 Healthy Michigan Plan Program	8
1.3 Execution of Certificate	6	2.18 HMP	8
1.4 Waiver by UnitedHealthcare Community Plan, Amendments	6	2.19 Hospice Services	8
1.5 Assignment	6	2.20 Hospital	9
Article II: Definitions	7	2.21 Hospital Services	9
2.1 Applicability	7	2.22 Long-Term Care Facility	9
2.2 Application	7	2.23 Medicaid Agreement	9
2.3 Behavioral Health	7	2.24 Medicaid Program	9
2.4 UnitedHealthcare Community Plan	7	2.25 Medical Director	9
2.5 Certificate	7	2.26 Medically Necessary	9
2.6 Copayment	7	2.27 Medicare	9
2.7 Cosmetic Surgery	7	2.28 Member	9
2.8 Covered Services	7	2.29 Member Agreement	9
2.9 Department	7	2.30 Non-Covered Services	9
2.10 DIFS	7	2.31 Non-Participating Provider	9
2.11 Emergency Services	7	2.32 Participating Hospital	10
2.12 Experimental, Investigational or Research Medical, Surgical or Other Health Care Drug, Device, Treatment or Procedure	8	2.33 Participating Physician	10
2.13 Family Planning Services	8	2.34 Participating Provider	10
2.14 Health Professional	8	2.35 Physician	10
		2.36 Premium	10
		2.37 Primary Care Provider (PCP)	10
		2.38 Service Area	10

Medicaid Certificate of Coverage (COC)

2.39 Specialist Provider	10	6.6 Non-Participating Providers	14
2.40 Urgent Care.	10	6.7 Independent Contractors	14
Article III: Eligibility	11	6.8 Termination of Provider’s Participation	15
3.1 Medicaid Member Eligibility	11	6.9 Inability to Have a Provider-Patient Relationship	15
3.2 HMP Member Eligibility	11	6.10 Refusal to Follow Provider’s Orders . .	15
3.3 Effective Date of Eligibility	11	Article VII: Members rights and responsibilities	16
3.4 Newborn Eligibility.	12	7.1 Release and Confidentiality of Member Medical Records	16
3.5 Children’s Special Health Care Services (CSHCS).	12	Health Plan Notices of Privacy Practices	17
3.6 Final Determination	12	Member rights and responsibilities. .	23
Article IV: Enrollment	12	7.2 Member Complaints, Grievances and Appeals.	24
4.1 Newborns.	12	7.3 Member Identification (ID) Cards . .	25
4.2 Change of Residency	12	7.4 Forms and Questionnaires.	25
Article V: Effective date of coverage . . .	12	7.5 UnitedHealthcare Community Plan Board of Directors	25
5.1 Effective Dates of Enrollment.	12	7.6 Non-Covered Services	25
5.2 Notification.	12	7.7 Regular Communication	25
Article VI: Relationship with providers. .	13	7.8 Your Rights as a Member	25
6.1 Choosing a Primary Care Provider (PCP)	13	7.9 UnitedHealthcare Community Plan Policies and Procedures	25
6.2 Role of Primary Care Provider.	13	7.10 Continuity of Care	25
6.3 Changing a Primary Care Provider. .	13	7.11 Pain Medicine	25
6.4 Specialist Physicians and Other Participating Providers.	13		
6.5 Self-Referral to Participating Providers Without Authorization . . .	13		

Medicaid Certificate of Coverage (COC)

Article VIII: Payment for covered services	26	Article XIV: Coordination of benefits . . .	41
8.1 Periodic Premium Payments	26	14.1 Purpose	41
8.2 Members Covered	26	14.2 Assignment	41
8.3 Copayments	26	14.3 Claims	41
8.4 Claims	26	14.4 Order of Benefits	41
Article IX: Covered services	27	14.5 UnitedHealthcare Community Plan Rights	42
9.1 Member eligibility	27	14.6 Construction	42
9.2 Covered services	27	14.7 Medicare and Other Federal or State Government Programs	42
Article X: Emergency or urgent care in the service area	37	Article XV: Subrogation	42
10.1 Emergency Services	37	15.1 Assignment; Suit	42
10.2 Urgent Care	37	15.2 Definition	43
Article XI: Out-of-area services	37	Article XVI: Miscellaneous	43
11.1 Covered Services	37	16.1 Governing Law	43
11.2 Hospitalization	37	16.2 Contract	43
Article XII: Exclusions and limitations . .	37	16.3 Period of Time for Legal Claims	43
12.1 Exclusions	37	16.4 Policies and Procedures	43
12.2 Limitations	39	16.5 Notice	43
Article XIII: Term and termination	39	16.6 Headings	43
13.1 Term	39		
13.2 Termination of Certificate	39		
13.3 Termination of Enrollment	40		
13.4 Disenrollment by Member	41		

Article I: General conditions

- 1.1 Certificate.** This is the Certificate of Coverage (Certificate) for the Medicaid Program and the Healthy Michigan Plan program recipients who have enrolled in UnitedHealthcare Community Plan, Inc. (UnitedHealthcare Community Plan). The terms and conditions of this certificate follow the compiled laws of the State of Michigan and Medicaid. UnitedHealthcare Community Plan must provide these benefits. The benefits are required to uphold a Medicaid Agreement with the State of Michigan. By enrolling in UnitedHealthcare Community Plan, the Member agrees to follow the terms and conditions of this Certificate.
- 1.2 Rights and Responsibilities.** This Certificate defines the rights and obligations of Members and UnitedHealthcare Community Plan. It is the Member's responsibility to understand this Certificate. Section 9.2 of this Certificate lists the Covered Services. Members are entitled to service under the terms and conditions of this Certificate. Some medical services, equipment, and supplies are not covered. Some service needs prior authorization by UnitedHealthcare Community Plan. Members have a responsibility to understand the rights of Members. These are listed in the Member Handbook.
- 1.3 Execution of Certificate.** Members agree that submitting a Member Application makes them subject to the rules of this Certificate. By accepting this Certificate, Members are entering into an agreement with UnitedHealthcare Community Plan. That Member agreement includes: the Application, the Certificate, the Member Handbook and the Plan ID cards.
- 1.4 Waiver by UnitedHealthcare Community Plan, Amendments.** Only officers of UnitedHealthcare Community Plan have authority to waive any conditions of this Certificate. That includes timing of payment, and exchange of information. All changes to this Certificate must be in writing. Changes are signed by an officer of UnitedHealthcare Community Plan. Changes are approved by the Department of Insurance and Financial Services (DIFS).
- 1.5 Assignment.** All rights of a Member to get Covered Services under the Member Agreement are personal. They may not be assigned to any other person or entity. Any attempts to reassign rights of the Member Agreement may result in termination of coverage.

Article II: Definitions

- 2.1 Applicability.** Article II defines words to clarify understanding for Members. These definitions apply to this certificate and any changes or additions while it is in effect.
- 2.2 Application** means the Member Application form which a Medicaid or Healthy Michigan Plan recipient must complete and sign. The Application begins eligibility process and enrollment in the State of Michigan Medical Assistance Program. The Michigan Department of Health and Human Services manages this program.
- 2.3 Behavioral Health.** Behavioral health is a term that may refer to a mental health disorder and/or substance abuse issues.
- 2.4 UnitedHealthcare Community Plan** is a for-profit corporation. It operates as a health maintenance organization under the authority of the State of Michigan's Department of Insurance and Financial Services (DIFS).
- 2.5 Certificate.** This means this contract or Member Agreement between UnitedHealthcare Community Plan and Members. This includes all amendments, addenda, appendices and riders.
- 2.6 Copayment.** This means the amount a Member may have to pay directly to a Provider for some services. These are listed in Article IX.
- 2.7 Cosmetic Surgery.** This means procedures which improve physical appearance, but which do not improve a physical function, and are not Medically Necessary.
- 2.8 Covered Services.** This means the Medically Necessary services, equipment and supplies listed in Section 9.2. These are subject to the terms of this Certificate. UnitedHealthcare Community Plan must follow the service guidelines in the Medicaid Agreement.
- 2.9 Department.** This term shortens the Michigan Department of Health and Human Services or its successor. This agency administers the Medicaid Program in the State of Michigan. This agency monitors the health maintenance organizations, like UnitedHealthcare Community Plan for the State.
- 2.10 DIFS.** The letters stand for Department of Insurance and Financial Services or its successor. This agency monitors the health maintenance organizations like UnitedHealthcare Community Plan for the State.
- 2.11 Emergency Services.** These are services needed to treat an emergency medical condition. This means a condition with serious symptoms. This includes severe pain. It means that without fast medical care, a person would think (i) jeopardy to the person's health or the health of an unborn child; (ii) serious harm to bodily functions; or (iii) dysfunction of any body organ or part.

Medicaid Certificate of Coverage (COC)

- 2.12 Experimental, Investigational or Research Medical, Surgical or Other Health Care Drug, Device, Treatment or Procedure.** This means a drug, device, treatment that meets at least one of the following conditions that make it an experimental procedure: It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and approval has not been granted at the time of its use. It is the part of a current new drug or new device application on file with the FDA. It is part of a Phase I or Phase II clinical trial. This includes a research arm of a Phase III clinical trial. It is being provided with the objective of determining safety, efficiency in comparison to existing treatments. It is described as experimental in nature by patient information documents. It is subject to the approval of an Institutional Review Board (IRB) as needed by federal regulations. Rules of the FDA, the Department of Health and Human Services (HSS), or a human subjects committee is most important. It is experimental if medical experts deem it so. That expert opinion can be published medical journals. That opinion can warn of more information to determine safety and effectiveness. At the time of use, it is not generally accepted by the medical community. Coverage for drugs used in antineoplastic therapy is covered pursuant to MCL §500.3406e of the Michigan Insurance Code.
- 2.13 Family Planning Services.** These are services to prevent pregnancy or treat sexually transmitted diseases. This includes medically approved evaluations, drugs, supplies, devices, or counseling.
- 2.14 Health Professional.** This is a health care provider who is qualified to give health services under Michigan law.
- 2.15 Healthy Michigan Plan.** Program operated under a 1115 Waiver approved by CMS to provide Medicaid coverage to all adults in Michigan with incomes up to and including 133 percent of federal poverty level.
- 2.16 Healthy Michigan Plan Agreement.** The Agreement is the contract between the State of Michigan and UnitedHealthcare Community Plan under which UnitedHealthcare Community Plan agrees to arrange for the delivery of Covered Services for Members.
- 2.17 Healthy Michigan Plan Program.** Program means the Department'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., as amended.
- 2.18 HMP.** Healthy Michigan Plan.
- 2.19 Hospice Services.** This means support services for the terminally ill and their families. They must be from a licensed or Medicare certified Hospice. They are mainly for pain relief and to manage symptoms. The services may be in the home or a facility setting.

Medicaid Certificate of Coverage (COC)

- 2.20 Hospital.** This means a care facility licensed as a hospital by the State of Michigan. It provides inpatient medical care. It has medical, diagnostic, and surgical facilities.
- 2.21 Hospital Services.** These are those Covered Services which are provided by a Hospital.
- 2.22 Long-Term Care Facility.** This facility is licensed by the Department to give inpatient nursing care.
- 2.23 Medicaid Agreement.** This is a contract between the State of Michigan and UnitedHealthcare Community Plan. It states that UnitedHealthcare Community Plan agrees to the administration of Covered Services for Members.
- 2.24 Medicaid Program.** Name for the Department's program for Medical Assistance. This is set forth in 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., as amended.
- 2.25 Medical Director.** This is a Physician chosen by UnitedHealthcare Community Plan to oversee the medical aspects of UnitedHealthcare Community Plan services.
- 2.26 Medically Necessary.** Covered Services from a provider that is needed to identify, treat or avoid an illness or injury. This is determined by UnitedHealthcare Community Plan Medical Director or UnitedHealthcare Community Plan Utilization Management representative. For approval of payment the following are considered: The service must match the symptoms, diagnosis and treatment of Member's condition. The service meets the standards of medical practice. The service is not a matter of convenience. The service is safely provided to Member. Not all Medically Necessary services are Covered Services.
- 2.27 Medicare.** A program under Title XVIII of the Federal Social Security Act, 42 U.S.C. 1395 et seq.
- 2.28 Member.** This person is a Medicaid recipient enrolled in UnitedHealthcare Community Plan. The Department has paid a Premium for service to be given to this person.
- 2.29 Member Agreement.** The understanding of responsibility between the Member and UnitedHealthcare Community Plan as presented in this Certificate, the Member's Application, the Member Handbook, and the UnitedHealthcare Community Plan ID Card.
- 2.30 Non-Covered Services.** Health care services, equipment and supplies which are not Covered Services.
- 2.31 Non-Participating Provider.** Provider or Hospital that has not contracted with UnitedHealthcare Community Plan to provide Covered services to Members.

Medicaid Certificate of Coverage (COC)

- 2.32 Participating Hospital.** Hospital that contracts with UnitedHealthcare Community Plan to provide Covered services.
- 2.33 Participating Physician.** Doctor who contracts with UnitedHealthcare Community Plan to provide Covered Services.
- 2.34 Participating Provider.** Any Health Provider or Hospital that contracts with UnitedHealthcare Community Plan to provide Covered Services.
- 2.35 Physician.** Doctor of Medicine (MD) or Doctor of Osteopathy (DO) licensed in the State of Michigan.
- 2.36 Premium.** Money prepaid by the Department for Members to get Covered Services.
- 2.37 Primary Care Provider (PCP)** is the Participating Provider who is responsible for coordinating the care of their patients who are members.
- 2.38 Service Area** means the areas in which UnitedHealthcare Community Plan is allowed by DIFS and MDHHS to provide services.
- 2.39 Specialist Provider.** Participating Provider, other than a PCP, who provides services with referral. These services may need prior approval by UnitedHealthcare Community Plan.
- 2.40 Urgent Care.** The care needs to be given right away. The condition or illness does not risk health of person, or unborn baby. The condition or illness does not risk body or organ dysfunction means services that are not Emergency Services, but are required right away.

Article III: Eligibility

- 3.1 Medicaid Member Eligibility.** To enroll in UnitedHealthcare Community Plan a person must:
- A. Be eligible for the Medicaid Program which is done by the Department of Health and Human Services; and
 - B. Live in the Service Area.
- 3.2 HMP Member Eligibility.** To enroll in UnitedHealthcare Community Plan a person must:
- A. Be eligible for the Healthy Michigan Plan Program which is done by the Department of Health and Human Services; and
 - Are age 19–64 years
 - Have income at or below 133% of the federal poverty level* (\$16,000 for a single person or \$33,000 for a family of four)
 - Do not qualify for or are not enrolled in Medicare
 - Do not qualify for or are not enrolled in other Medicaid programs
 - Are not pregnant at the time of application
 - Are residents of the State of Michigan
 - * Eligibility for the Healthy Michigan Plan is determined through the Modified Adjusted Gross Income methodology
 - B. Live in the Service Area
- 3.3 Effective Date of Eligibility.** If a Member becomes eligible during a month, he or she is eligible for the whole month. In some cases, covered services used before Member knows eligibility may be covered. Actual eligibility occurs on the first day of the month after the Member is determined eligible. (This does not apply to newborns.) UnitedHealthcare Community Plan is not responsible for paying for health care services before the date of enrollment, except for newborns. (Refer to II-G6.) If the Member is an inpatient in a hospital on the date of enrollment (first day of the month), UnitedHealthcare Community Plan will not be responsible for the inpatient stay or any charges prior to discharge. UnitedHealthcare Community Plan will be responsible for all care from the date of discharge forward. If a Member is disenrolled from UnitedHealthcare Community Plan while in a hospital, UnitedHealthcare Community Plan will cover all charges until the date of discharge.

Medicaid Certificate of Coverage (COC)

- 3.4 Newborn Eligibility.** Newborns of Members who were enrolled at the time of the child's birth will be enrolled with UnitedHealthcare Community Plan.
- 3.5 Children's Special Health Care Services (CSHCS).** These are health care and case management services for Members eligible for Michigan Medicaid – Children's Special Health Care Services (CSHCS).
- CSHCS is a state of Michigan program that serves children and some adults with special health care needs. CSHCS covers more than 2,700 medical diagnoses.
- 3.6 Final Determination.** In all cases, the Department shall make the final decision on eligibility. The Department makes the final decision about enrollment status in UnitedHealthcare Community Plan.

Article IV: Enrollment

- 4.1 Newborns.** A Member's newborn child is enrolled in UnitedHealthcare Community Plan from the date of birth. UnitedHealthcare Community Plan must notify the Department of the birth of the newborn. The birth notice must be within the guidelines of the Medicaid Agreement.
- 4.2 Change of Residency.** A Member must notify the Department and UnitedHealthcare Community Plan when the Member moves outside of the Service Area. The Member will be able to get Covered Services until he or she is disenrolled from UnitedHealthcare Community Plan.

Article V: Effective date of coverage

- 5.1 Effective Dates of Enrollment.** A Member's enrollment in UnitedHealthcare Community Plan and coverage will be effective on the date determined by the Department and UnitedHealthcare Community Plan Guidelines for effective date are in the Medicaid Agreement.
- 5.2 Notification.** UnitedHealthcare Community Plan will notify a Member of the effective date of coverage.

Article VI: Relationship with providers

- 6.1 Choosing a Primary Care Provider (PCP).** Each Member must select a Primary Care Provider. If the Member is a minor or cannot choose a PCP, the adult responsible for the Member must choose their PCP. UnitedHealthcare Community Plan may choose a PCP for the Member if he or she does not choose one within thirty (30) days of joining UnitedHealthcare Community Plan. UnitedHealthcare Community Plan may also choose a PCP if the contract between UnitedHealthcare Community Plan and the PCP is revoked. If a provider is no longer the Member's PCP, is assigned by mistake or will not provide medical services, UnitedHealthcare Community Plan may choose another PCP.
- 6.2 Role of Primary Care Provider.** The Member's PCP provides or manages the Member's health care services along with UnitedHealthcare Community Plan. This includes referrals to Specialists, ordering lab tests and X-rays, prescribing medicines or therapies, and arranging hospital stays. The PCP generally coordinates a Member's medical care as appropriate.
- 6.3 Changing a Primary Care Provider.** A Member may change his or her PCP by contacting UnitedHealthcare Community Plan Customer Service. All changes must be approved in advance by the Customer Service Department. They will notify the Member of the effective date of the change.
- 6.4 Specialist Physicians and Other Participating Providers.** Members must get referrals from their PCP. In some cases these services need authorization from UnitedHealthcare Community Plan. In the event that a Participating Provider is not available, UnitedHealthcare Community Plan will consider approving another provider.
- 6.5 Self-Referral to Participating Providers without Authorization.** If a Member does not get a PCP referral or prior approval from UnitedHealthcare Community Plan, he or she may have to pay for services. This does not include Emergency Services. A Member may only get medically necessary services without a referral from a PCP for:
- A. Well woman care from a participating OB/GYN.
 - B. Certified Nurse Midwife Services.
 - C. Certified pediatric and family nurse practitioner services.
 - D. Family Planning from any family planning clinic.
 - E. Immunizations from the Health Department.
 - F. Pediatrician visits made by a child under the age of eighteen (18) to any participating pediatrician.

Medicaid Certificate of Coverage (COC)

- G. Vision services from any participating optometrist.
- H. Chiropractic care visits from any participating chiropractor for up to eighteen (18) visits every calendar year for subluxation of the spine.
- I. Non-emergency transportation or gas reimbursement from a UnitedHealthcare Community Plan transportation provider.
- J. **Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Child and Adolescent Health Centers (CAHCs), Tribal Health Centers (THCs).** Members may go to any FQHC, RHC, CAHC, or THC without being sent by their PCP even if it is not a UnitedHealthcare Community Plan provider. They will not have an extra copay.
- K. Behavioral health care from any participating behavioral health provider or at any Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Child and Adolescent Health Center (CAHC) or Tribal Health Center (THC).
- L. Dental visits for diagnostic, preventative, restorative, prosthetic and medically/clinically necessary oral surgery services (including extractions) from any UnitedHealthcare dentist.

6.6 Non-Participating Providers. Members do not have to pay for Covered Services from Non-Participating Providers, if:

- A. The provider has not informed the Member in writing that the services are not covered by UnitedHealthcare Community Plan;
- B. The provider did not get prior approval from UnitedHealthcare Community Plan. Or the provider did not submit a claim to UnitedHealthcare Community Plan within one (1) year of the date of service; and
- C. There is a difference between the provider's charge and the UnitedHealthcare Community Plan payment.

6.7 Independent Contractors. UnitedHealthcare Community Plan does not directly provide any health care service under this Agreement. UnitedHealthcare Community Plan arranges Covered Services for Members. Providers are solely responsible for medical judgments. UnitedHealthcare Community Plan is solely responsible for benefit determinations. All decisions follow the Member Agreement and the Medicaid Agreement and contracts with Participating Providers. It disclaims any right or responsibility to make medical decisions. Such decisions may only be made by Providers in consultation with the Member. A Provider and a Member may elect to continue treatments despite UnitedHealthcare Community Plan denial of coverage. Members may appeal any of UnitedHealthcare Community Plan benefit decisions. There is a Grievance and Appeal process for Members.

6.8 Termination of Provider's Participation. UnitedHealthcare Community Plan or a Provider may terminate their contract or limit the number of Members that the Provider will accept. UnitedHealthcare Community Plan does not promise that a Provider will be able to render services. If a Member's PCP no longer acts as a PCP, the Member must choose another PCP. If a Provider is no longer a Participating Provider, the Member must work with his or her PCP to pick another.

To make sure care a Member started can be finished, UnitedHealthcare Community Plan will work with the Member's doctor. The Member can continue treatment for up to 90 days if:

- A new member is in an ongoing course of care with a non-UnitedHealthcare Community Plan provider
- UnitedHealthcare Community Plan ends a contract with a provider for reason other than cause
- A Member who is less than 13 weeks pregnant must see a UnitedHealthcare Community Plan provider for all her care
- A Member who is over 13 weeks pregnant can continue to see her current OB/GYN provider until the end of postpartum care

6.9 Inability to Have a Provider-Patient Relationship. If a Member is unable to have a good relationship with a PCP or a Specialist, UnitedHealthcare Community Plan may:

- A. Ask the Member to pick another PCP; or
- B. Arrange to have the Member's PCP refer the Member to another Specialist; or
- C. Allow Member's disenrollment, meeting the guidelines of the Medicaid Agreement.

6.10 Refusal to Follow Provider's Orders. A Member may refuse to follow a Provider's orders. The Provider may then ask the Member to pick another Provider.

The Member may ask the Medical Director to arrange a second opinion. The Medical Director will resolve any disagreement between the first and second opinions from another Provider. The Member must pay for any medical services, equipment or supplies not ordered by the first Provider:

- A. If the Member refuses to follow a Provider's orders.
- B. If the Member does not request a second opinion.
- C. If the second Provider agrees that there is no alternate treatment.

Article VII: Members' rights and responsibilities

7.1 Release and Confidentiality of Member Medical Records.

- 7.1.1** Member's medical information and personal health information (PHI) must be kept private by UnitedHealthcare Community Plan. It shall not be shared with third parties without the prior written consent of the Member. See exceptions in the UnitedHealthcare Community Plan Notice of Privacy Practices.
- 7.1.2** The Member's signature on the Medicaid Application gives UnitedHealthcare Community Plan the right to get medical information from providers. This information exchange follows the Medicaid Agreement, Member Agreement and state and federal laws.
- 7.1.3** Each Member authorizes providers to share PHI with medical records with UnitedHealthcare Community Plan. Each Member agrees to provide health history. Each Member agrees to help get prior medical records when needed; the Member authorizes release of his or her medical records.
- 7.1.4** Members may request to look at their own medical records per state and federal law. The review will be done at the Provider's offices during business hours.
- 7.1.5** **UnitedHealthcare Community Plan Privacy Notice.**
 - Privacy Practices Notice for Medical Information**
 - Privacy Practices Notice for Financial Information**
 - Member Rights and Responsibilities**

Health Plan Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

By law, we¹ must protect the privacy of your health information (“HI”). We must send you this notice. It tells you:

- How we may use your HI.
- When we can share your HI with others.
- What rights you have for your HI.

By law, we must follow the terms of this notice.

HI is information about your health or medical services. We have the right to make changes to this notice of privacy practices. If we make important changes, we will notify you by mail or e-mail. We will also post the new notice on our website. We will notify you of a breach of your HI.

How we collect, use, and share your information

We collect, use, and share your HI with:

- You or your legal representative.
- Certain government agencies. To check to make sure we are following privacy laws.

We have the right to collect, use and share your HI for certain purposes. This may be for your treatment, to pay for your care, or to run our business. We may use and share your HI as follows.

- **For Payment.** To process payments and pay claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** To help with your care. For example, we may share your HI with a hospital you are in, to help them provide medical care to you.
- **For Health Care Operations.** To run your business. For example, we may talk to your doctor to tell him or her about a special disease management or wellness program available to you. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.

Medicaid Certificate of Coverage (COC)

- **For Plan Sponsors.** If you receive health insurance through your employer, we may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** To make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may send reminders about appointments you have and information about your health benefits.
- **For Communications to You.** We may contact you about your health insurance benefits, healthcare or payments.

We may collect, use, and share your HI as follows:

- **As Required by Law.** To follow the laws that apply to us.
- **To Persons Involved with Your Care.** A family member or other person that helps with your medical care or pays for your care. This also may be to a family member in an emergency. This may happen if you are unable to tell us if we can share your HI or not. If you are unable to tell us what you want, we will use our best judgment. If allowed, after you pass away, we may share HI with family members or friends who helped with your care or paid for your care.
- **For Public Health Activities.** For example, to prevent diseases from spreading or to report problems with products or medicines.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with certain entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** For example, to answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** To public health agencies or law enforcement, for example, in an emergency or disaster.
- **For Government Functions.** For military and veteran use, national security, or certain protective services.
- **For Workers' Compensation.** If you were hurt at work or to comply with labor laws.
- **For Research.** For example, to study a disease or medical condition. We also may use HI to help prepare a research study.
- **To Give Information on Decedents.** For example, to a coroner or medical examiner who may help to identify the person who died, why they died, or to meet certain law. We also may give HI to funeral directors.

Medicaid Certificate of Coverage (COC)

- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody, for example: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates.** To give you services, if needed. These are companies that provide services to us. They agree to protect your HI.
- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
 1. Alcohol and Substance Use Disorder
 2. Biometric Information
 3. Child or Adult Abuse or Neglect, including Sexual Assault
 4. Communicable Diseases
 5. Genetic Information
 6. HIV/AIDS
 7. Mental Health
 8. Minors' Information
 9. Prescriptions
 10. Reproductive Health
 11. Sexually Transmitted Diseases

We will only use or share your HI as described in this notice or with your written consent. We will get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your health insurance ID card.

Your rights

You have the following rights.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.** Your request to limit our use or sharing must be made in writing.

Medicaid Certificate of Coverage (COC)

- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request as allowed by state and federal law. We take verbal requests but may ask you to confirm your request in writing. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. We will respond to your request in the time we must do so under the law. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of when we shared your HI in the six years prior to your request. This will not include when we shared HI for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website.
- **In certain states, you may have the right to ask that we delete** your HI. Depending on where you live, you may be able to ask us to delete your HI. We will respond to your request in the time we must do so under the law. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

Using your rights

- **To Contact your Health Plan.** If you have questions about this notice, or you want to use your rights, **call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or TTY/RTT **711**.
- **To Submit a Written Request.** Mail to:
UnitedHealthcare Privacy Office
MN017-E300, P.O. Box 1459, Minneapolis MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

You may also notify the Secretary of the U.S. Department of Health and Human Services. We will not take any action against you for filing a complaint.

¹ This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to <https://www.uhc.com/privacy/entities-fn-v2>.

Financial Information Privacy Notice

THIS NOTICE SAYS HOW YOUR FINANCIAL INFORMATION MAY BE USED AND SHARED. REVIEW IT CAREFULLY.

Effective January 1, 2024

We² protect your “personal financial information” (“FI”). FI is non-health information. FI identifies you and is generally not public.

Information we collect

- We get FI from your applications or forms. This may be name, address, age and social security number.
- We get FI from your transactions with us or others. This may be premium payment data.

Sharing of FI

We will only share FI as permitted by law.

We may share your FI to run our business. We may share your FI with our Affiliates. We do not need your consent to do so.

- We may share your FI to process transactions.
- We may share your FI to maintain your account(s).
- We may share your FI to respond to court orders and legal investigations.
- We may share your FI with companies that prepare our marketing materials.

Confidentiality and security

We limit employee and service provider access to your FI. We have safeguards in place to protect your FI.

Medicaid Certificate of Coverage (COC)

Questions about this notice

Please **call the toll-free member phone number on health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-633-2446**, or TTY/RTT **711**.

² For purposes of this Financial Information Privacy Notice, “we” or “us” refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Health Care Solutions, Inc.; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. For a current list of health plans subject to this notice go to <https://www.uhc.com/privacy/entities-fn-v2>.

Member rights and responsibilities

You have rights and responsibilities as our member. Our staff will respect your rights. We will not discriminate against you for using your rights. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the right to:

- Receive information about your health care services
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private
- Participate in decisions regarding your health care, including the right to refuse treatment and express preferences about treatment options
- Have a candid discussion on appropriate or medically necessary treatment options for your conditions, regarding of cost or benefit coverage
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected
- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you
- To file a grievance, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand
- Receive Federally Qualified Health Center and Rural Health Center services
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
- To request information on the structure and operation of the UnitedHealthcare Community Plan
- To make suggestions about our services and providers
- To make suggestions about member rights and responsibilities policy
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval

Medicaid Certificate of Coverage (COC)

You have the responsibility to:

- Review this handbook and UnitedHealthcare Community Plan Certificate of Coverage
- Make and keep appointments with your UnitedHealthcare Community Plan doctor
- Treat doctors and their staff with respect
- Protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your health plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior
- Apply for Medicare or other insurance when you are eligible
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to <https://newmibridges.michigan.gov/>.

7.2 Member Complaints, Grievances and Appeals. UnitedHealthcare Community Plan has implemented a system to handle member appeals and grievances regarding benefits or the plan's operations. Detailed information about this process can be found in the UnitedHealthcare Community Plan Medicaid Member Handbook.

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. If you have any questions, please call Customer Service at 1-800-903-5253.

Members can request a Member Handbook by phone or writing to Customer Service (1-800-903- 5253) or can access an online version at myuhc.com/communityplan. The Handbook describes the Complaint, Appeals and Grievance Procedure. They may get more copies at any time.

Medicaid Certificate of Coverage (COC)

7.3 Member Identification (ID) Cards.

- 7.3.1** UnitedHealthcare Community Plan will issue a UnitedHealthcare Community Plan ID card to each Member. A Member should present his or her UnitedHealthcare Community Plan ID card to a Provider each time the Member gets services.
- 7.3.2** UnitedHealthcare Community Plan will issue a Dental ID care to each adult Medicaid ages 21 and over and all Healthy Michigan Plan members.
- 7.3.3** If a Member lets another person use his or her UnitedHealthcare Community Plan ID card, UnitedHealthcare Community Plan may reclaim Plan ID card. It may terminate the Member's enrollment. It may terminate the enrollment of all Members in the Member's household.
- 7.3.4** If a Member knows that his or her UnitedHealthcare Community Plan ID card is lost or stolen, the Member must notify UnitedHealthcare Community Plan Customer Service by the end of the next business day.
- 7.4 Forms and Questionnaires.** Members must complete any UnitedHealthcare Community Plan medical questionnaires and other forms. Members warrant that all information in them is true and complete to the best of their knowledge.
- 7.5 UnitedHealthcare Community Plan Board of Directors.** At least one third of UnitedHealthcare Community Plan Board of Directors must be Members elected by Members. Members may ask for a list of UnitedHealthcare Community Plan Board of Directors showing the enrollee board members. Changes in board membership are listed in the UnitedHealthcare Community Plan newsletter. Members may contact UnitedHealthcare Community Plan about becoming a member of the Board of Directors.
- 7.6 Non-Covered Services.** Members must pay for of all Non-Covered Services if they agree to this in writing before the service is given. Non-Covered Services from Participating Providers can also be Member's responsibility.
- 7.7 Regular Communication.** Members will get a UnitedHealthcare Community Plan newsletter. It tells about policy, policy changes, and how best to use UnitedHealthcare Community Plan services.
- 7.8 Your Rights as a Member.** Each Member has rights as required by law. Details on rights are in the Member Handbook.
- 7.9 UnitedHealthcare Community Plan Policies and Procedures.** Members must read and comply with the terms of the Member Agreement.
- 7.10 Continuity of Care.** Each Member may continue treatment if the Primary Care Provider's participation ends during the course of the treatment. This is subject to the limitations set forth in MCL 500.2212b.
- 7.11 Pain Medicine.** Each Member may ask for information on the credentials of providers.

Article VIII: Payment for covered services

- 8.1 Periodic Premium Payments.** The Department or its agent will pay UnitedHealthcare Community Plan, on behalf of each Member, the Premiums specified in the Medicaid Agreement. These will be paid on or before their due dates.
- 8.2 Members Covered.** Members for whom the Premium has been received by UnitedHealthcare Community Plan are entitled to Covered Services for the period to which the Premium applies.
- 8.3 Copayments.** Copayments are not currently due for any Covered Services.
- 8.4 Claims.** It is UnitedHealthcare Community Plan policy to pay providers directly for services. If a Provider bills a Member for a Covered Service, the Member should send the bill to UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will not reimburse Members for bills received by UnitedHealthcare Community Plan more than six (6) months from the date of service. If the Member pays the bill, the Member must submit a request for reimbursement in writing to UnitedHealthcare Community Plan immediately after paying the bill.
- 8.4.1** When a Member receives Emergency Services or other Covered Services authorized by UnitedHealthcare Community Plan from a Non-Participating Provider, the Member should request the Non-Participating Provider to bill UnitedHealthcare Community Plan. If the Non-Participating Provider refuses to bill UnitedHealthcare Community Plan but bills the member, the Member should submit any such bills to UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will not reimburse Members for bills received by UnitedHealthcare Community Plan that exceed twelve (12) months from the date the services were received. If the Non-Participating Provider requires the member to pay for the Covered Services at the time they are rendered, the member must submit a for reimbursement for such Covered Services in writing to UnitedHealthcare Community Plan immediately after paying the bill.
- 8.4.2** Proof of payment acceptable to UnitedHealthcare Community Plan must accompany all requests for reimbursement for Covered Services. 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 UnitedHealthcare Community Plan as soon as reasonably possible. However, in no event will UnitedHealthcare Community Plan be liable for reimbursement requests for which proof of payment is submitted to UnitedHealthcare Community Plan more than twelve (12) months following the date Covered Services were rendered. Neither UnitedHealthcare Community Plan nor the member shall be responsible for

that part of a Non-Participating Provider's charge that is in excess of the Reasonable and Customary Charges.

- 8.4.3** UnitedHealthcare Community Plan 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 providers or reimbursing the for such services, subject to the applicable state and federal laws.

Article IX: Covered services

9.1 Member eligibility.

A Member is entitled to the services, equipment and supplies specified in Section 9.2 when they are:

- A. Medically Necessary;
- B. Performed, prescribed or arranged by the Member's PCP or another provider;
- C. Authorized in advance by UnitedHealthcare Community Plan, if needed; and
- D. Consistent with UnitedHealthcare Community Plan obligations to provide such services pursuant to the Healthy Michigan Plan Agreement.

9.2 Covered services.

The following are Covered Services when they meet the requirements stated above in Section 9.1:

- A. Primary Care Provider (PCP) office visit.
Each member must select a Primary Care Provider who will be responsible for the Member's health care needs, including coordination of specialist referrals and inpatient hospitalization.
- B. Specialist Provider office visits, with referral from the PCP.
The Primary Care Provider (PCP) will normally make referrals only to Participating Physicians, Participating Hospitals, and other Participating Providers. The PCP may refer a Member to Non- Participating Providers when it is Medically Necessary to do so and the service cannot be provided by a Participating Provider. However, any referral to a Non-Participating Provider must be authorized in advance by UnitedHealthcare Community Plan. A Specialist Provider may make further Referrals to other Participating Physicians, Participating Hospitals, or other Participating Health Professionals, but in each case must receive prior approval of the responsible Participating Primary Care Provider (PCP) and authorization in advance from UnitedHealthcare Community Plan.

Medicaid Certificate of Coverage (COC)

C. Covered Services without a Referral from a PCP as set forth in Article VI, Section 6.5 of this Certificate.

D. Preventive Health Services.

Services provided by a Primary Care Provider or other Participating Provider to prevent illness, disease, disability or progression thereof, or to prolong life and promote physical and behavioral health are Covered Services by UnitedHealthcare Community Plan, including:

1. Health assessments and examinations as medically recommended for the age and sex of the Member.
2. Prenatal and post-partum care.
3. Adult immunizations, except for travel or employment purposes. Routine child and adult immunizations for infectious diseases, as recommended by the Advisory Committee on Immunization Practices (AACIP). Immunizations can be provided by the Health Department and do not require authorization from the PCP or UnitedHealthcare Community Plan.
4. Vision and hearing screenings, not including eye refraction testing.
5. Routine gynecological examinations.
6. Member educational programs as described in the Member Handbook.
7. Breast cancer screening mammography in accordance with MCL §500.3406d of the Michigan Insurance Code.
 - a. One screening mammography examination for women 35 -40 years of age during that five (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 when medically indicated.
 - d. Definition: "Breast cancer screening mammography" means a standard 2-view breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

Medicaid Certificate of Coverage (COC)

- e. Hospital, medical or surgical expenses incurred for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy are covered benefits when medically necessary, coordinated with the UnitedHealthcare Community Plan provider and approved in advance by UnitedHealthcare Community Plan as appropriate. This coverage includes services an individual receives for reconstructive surgery following a mastectomy or who is fitted with a prosthetic device when medically necessary, coordinated with the UnitedHealthcare Community Plan provider and approved in advance by UnitedHealthcare Community Plan as appropriate. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this section.
- E. Family Planning Services such as contraception counseling and associated physical exams and procedures are covered. The following are covered services even if they are not provided in connection with the diagnosis and treatment of an illness or injury:
 - 1. Voluntary Sterilizations. Tubal ligations and vasectomies are covered for Members over the age of 21. Vasectomies are only covered when performed in a Physician's office. Any time a sterilization procedure is performed a consent form must be signed 30 days in advance of the procedure and submitted to the Plan. Sterilization reversals are excluded.
 - 2. Diaphragms and Intrauterine Devices (IUDs).
 - 3. Advice on Contraception and Family Planning.
 - 4. Abortion. Abortion is covered in the case of rape, incest or when medically necessary to save the life of the mother.
 - 5. Infertility diagnosis and testing is covered when medically necessary, but any treatment for infertility is not a covered benefit.
- F. Food Services:

Starting June 1, 2025, UnitedHealthcare Community Plan will offer two food services to help improve your health: Medically Tailored Home Delivered Meals (MTM) and Produce Prescription. MTM provides up to two healthy meals a day for up to three months, along with advice from a dietitian. Produce Prescription gives vouchers to buy fruits and vegetables for up to three months. These services are available to members in certain counties who meet specific health and nutrition criteria. You can only use one service at a time, and your Medicaid coverage will not change whether you use these services or not. For more details, check your Member Handbook or call 1-800-903-5253.

Medicaid Certificate of Coverage (COC)

G. Inpatient Hospital Services.

1. All inpatient Hospital Services, except for Emergency Services, must be at a Participating Hospital. They must be set up by the PCP. They must be approved in advance by UnitedHealthcare Community Plan except as set forth in Article VI, Section 6.4.
2. Covered inpatient Hospital Services include semi-private room and board, general nursing care, intensive care and all other Medically Necessary services and supplies. These include radiological services, laboratory and other diagnostic tests, pharmaceuticals, anesthesia, oxygen, chemotherapy and radiation therapy, blood products, obstetrical services and other services by Health Professionals.

H. Outpatient Services.

1. Outpatient services must be given or set up by a PCP. They must be approved in advance by UnitedHealthcare Community Plan. They may be done in the outpatient department of a Participating Hospital. Or they may be done at another Participating Provider location except as set forth in Article VI, Section 6.4.
2. Covered outpatient services include dialysis, chemotherapy, outpatient surgery and related anesthesia services, diagnostic laboratory, diagnostic and therapeutic radiological services, short-term rehabilitative therapy, and other services by Health Professionals.

I. Oral Surgery.

Dental services not done by dentists are covered with prior approval. This includes prescription drugs, laboratory and radiology services, anesthesia and hospitalizations.

J. Rehabilitation and Physical Therapy Services.

Short-term rehabilitative therapy is covered. This is limited to physical therapy for rehabilitation, occupational therapy, language, speech and hearing therapy. This must have prior approval. "Short-term" is a condition which can improve in a limited period.

Medicaid Certificate of Coverage (COC)

K. Transplant Services.

Tissue or organ transplants, if medically necessary. These must have prior approval. All costs for surgery and care 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 if medically necessary. Drugs used in antineoplastic therapy are covered.

1. Transplants will not be covered if:

- a. UnitedHealthcare Community Plan does not give approval prior to evaluation;
- b. The transplant is done in a facility that is not approved by UnitedHealthcare Community Plan;
- c. The transplant is experimental;
- d. If other insurance or benefit program is responsible for paying for the services; or
- e. The donor has not first exhausted all possible insurance services before UnitedHealthcare Community Plan is billed.

2. Once the transplant is approved, UnitedHealthcare Community Plan will tell PCP which facilities are approved for that type of transplant.

L. Home Health Care.

Home health care will be given when a Member is confined to their home. Home health care visits are covered when set up by the PCP. They must be approved in advance. Home health care includes: home care nursing services, skilled nursing care, and home health aides. Drug and biological solutions, surgical dressings and related medical supplies, and equipment used during home health care visits will be covered when essential to proper care and prescribed by the PCP.

M. Skilled Nursing Facility and Hospice Services.

1. Skilled Nursing Facility.

Care and treatment, including room and board, in a semi-private room at a Skilled Nursing Facility for up to forty-five (45) days per twelve (12) month period. This must be set up by a PCP. It must be approved in advance by UnitedHealthcare Community Plan. Skilled nursing facility services (non-Hospice care) must lead to increased ability to function. It must be of a temporary nature. It must be supported by a treatment plan. It must be approved in advance by UnitedHealthcare Community Plan.

Medicaid Certificate of Coverage (COC)

2. Hospice Services.

Hospice services for Members who have a prognosis of less than six (6) months to live are covered. These may be in a variety of settings. They are given by a team who attend to physical, emotional, and spiritual needs. A Referral must be made by the PCP. UnitedHealthcare Community Plan must approve services in advance.

Hospice services are not based on medical need. It is an option for Members diagnosed as having less than six (6) months to live.

Skilled Nursing Facility and Hospice Services in connection with custodial care, domiciliary care, drug addiction, chronic organic brain syndrome, alcoholism, intellectually disabled, senility or any behavioral health disorder are not covered.

Hospice Services for funerals and financial or legal counseling are not covered. This includes planning estates or wills.

N. Prescription Drugs.

Drugs from the most current UnitedHealthcare Community Plan drug formulary are covered. They must be ordered by a Participating Provider. They must be obtained from a Participating Pharmacy. Insulin, needles and syringes used for injectable insulin are covered. They must be ordered by a Participating Provider. They must be obtained at a Participating Pharmacy. Prescriptions are limited to a thirty (30) day supply. Prior authorization is required for off-label use of an US FDA approved drug and the reasonable cost of supplies medically necessary to administer the drug. "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the US FDA.

Coverage is provided for antineoplastic therapy drugs if:

1. The drug is ordered by a doctor for the treatment of a specific type or neoplasm.
2. The drug is approved by the Food and Drug Administration for use in antineoplastic therapy.
3. The drug is used as part of an antineoplastic drug regimen.
4. Current medical literature and oncology boards accept the treatment.
5. The patient has given informed consent.

Medicaid Certificate of Coverage (COC)

O. Durable Medical Equipment, Prosthetics and Orthotics.

Special services such as durable medical equipment, prosthetics and orthotics, and other medical supplies are covered when ordered by the PCP. They must be approved in advance by UnitedHealthcare Community Plan. They must be provided by a Participating Durable Medical Equipment Provider. UnitedHealthcare Community Plan may require use of the least costly device.

P. Emergency Services.

Hospital care and other services for an emergency are covered.

Members should call their PCP before going to the emergency room. If a true emergency, a delay might result in death or permanent impairment. In event of a true emergency, Members should seek help from the nearest emergency facility right away. They do not need to call their PCP first. Members should tell the emergency personnel the name of their PCP. They should ask that he or she be contacted as soon as possible.

Q. Ambulance Services.

Ambulance services in the case of an emergency. Non-emergent ambulance services are covered if medically necessary and approved in advance by UnitedHealthcare Community Plan.

R. Vision Services.

Routine eye exams by Participating Providers are covered. A Referral is not needed for a Participating Optometrist. Eye exams, prescription lenses and frames are covered. All members may have one eye exam and one pair of glasses every twenty-four months. Members under 21 may get two pairs of replacements for lost, broken or stolen glasses every twelve months. Members age 21 or older may get one pair of replacement glasses.

1. The Member may apply the cost allowed by UnitedHealthcare Community Plan for eyeglass frames towards the cost of any pair of frames. The Member must pay any difference between the cost allowed and the cost charged.
2. Sunglasses are not covered.
3. Contact lenses are covered only if the Member's vision cannot be corrected with glasses. Contact lenses require advance approval.

Medicaid Certificate of Coverage (COC)

S. Hearing Examinations and Hearing Aids.

Hearing exams are covered if done or approved by the PCP. UnitedHealthcare Community Plan will cover one single hearing aid unit per ear. They must be from a licensed hearing aid dealer. This includes hearing aids and delivery. The hearing aid unit must be FDA approved. Hearing aid repairs and adjustments; replacement earmolds; and hearing aid supplies, accessories and batteries are covered.

T. Pregnancy Care.

Prenatal and postpartum care are covered by any OBGYN provider.

Maternal Infant Health Program (MIHP) is a home visiting program for women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include:

- Prenatal teaching
- Childbirth education classes
- Nutritional support, education and counseling
- Breastfeeding or formula feeding support
- Help with personal problems that may complicate your pregnancy
- Newborn baby assessments
- Referrals to community resources and help finding baby cribs, car seats, clothing, etc.
- Support to stop smoking
- Help with substance abuse
- Personal care or home health services

Doula Services.

Doula support during the perinatal period is covered and may include, but is not limited to:

- Prenatal services
- Labor and delivery services
- Postpartum services

Medicaid Certificate of Coverage (COC)

U. Bariatric Surgery.

Bariatric surgery is covered only when medically needed. It must be approved in advance by UnitedHealthcare Community Plan. The request must meet the Michigan Medicaid policy.

V. Diabetes Treatment Services.

The equipment, supplies, and educational training for diabetes listed below are covered. They must be prescribed by a Participating Provider:

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 needed for the use of an insulin pump.
5. Diabetes self-management training.

The following medications for diabetes are covered. They must be ordered by a Participating Provider.

- Insulin
- Non-experimental medication for controlling blood sugar
- Medications used for foot ailments, infections, and other medical conditions of the foot, ankle, or nails related to diabetes

W. Targeted Case Management (TCM)

Recuperative Care (RC) is covered short-term for members who are homeless and being discharged from an inpatient hospital stay. The program provides case management and coordination of medical care and Medicaid services for up to 90 days per hospital discharge.

X. Behavioral Health Services.

Behavioral Health Visits are unlimited. UnitedHealthcare members can see a Participating Provider without a referral from a PCP. Behavioral Health information is provided by Optum Behavioral Health Services at 1-800-903-5253. For long term mental health treatment UnitedHealthcare will work with Community Mental Health to get member the needed care.

Medicaid Certificate of Coverage (COC)

Y. Dental Services.

Dental services for adults age 21 and older are covered. Services include diagnostic, preventative, minor restorative and oral surgery.

Temporomandibular Joint Syndrome (TMJ).

“Temporomandibular Joint Syndrome” or “TMJ” means muscle tension and spasm related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction. The following services are covered when approved in advance by UnitedHealthcare Community Plan:

1. Office visits for medical evaluation and treatment of TMJ.
2. Specialty referral for medical evaluation and treatment of TMJ.
3. X-rays of the temporomandibular joint including contrast studies, but not dental X-rays.
4. Myofunctional therapy.
5. Surgery to the temporomandibul.

Z. Telemedicine.

Telemedicine services are covered and must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his health care profession in the state where the patient is located.

AA. Healthy Michigan Plan Only: Habilitative Services.

Habilitative Services are services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech language pathology and other services.

Article X: Emergency or urgent care in the service area

- 10.1 Emergency Services.** A Member should go to a Hospital emergency room for emergency care. The Member's PCP must be notified within twenty-four (24) hours after treatment. If the member is hospitalized, the PCP should be notified as soon as possible.
- 10.2 Urgent Care.** A Member must call his or her PCP before getting Urgent Care. The Member must contact the PCP for all follow-up care.

Article XI: Out-of-area services

- 11.1 Covered Services.** Emergency Services are covered by UnitedHealthcare Community Plan if the Member is only temporarily out of the Service Area. Routine medical care outside of the Service Area is covered with prior authorization from UnitedHealthcare Community Plan.
- 11.2 Hospitalization.** If an Emergency visit requires hospitalization, the Member's PCP must be contacted within twenty-four (24) hours. The PCP may require the Member to move to a Participating Hospital when possible.

Article XII: Exclusions and limitations

- 12.1 Exclusions.** These services, equipment and supplies are Non-Covered Services:
- A. Any service, equipment or supply not listed in Section 9.2.
 - B. Personal or comfort items.
 - C. Services, equipment or supplies not directed by the PCP or provider or not approved in advance by UnitedHealthcare Community Plan.
 - D. Sports-related physicals, surgery, related services and durable medical equipment.
 - E. Services, equipment and supplies which are not Medically Necessary.
 - F. Routine dental services for Medicaid members enrolled in the Healthy Kids Dental program.
 - G. Medical exams to confirm health status for third parties. This includes for employment, insurance, or for a court.
 - H. Surgery and care to improve appearance, unless needed medically.
 - I. Items for cleanliness and grooming.

Medicaid Certificate of Coverage (COC)

- J. Substance abuse services. Refer to UnitedHealthcare Community Plan Member Handbook for a list of outreach services.
- K. Experimental medical, surgical or other health care drug, device or treatment. This is determined by the Medical Director and the Department.
- L. Reproductive Services. Reversal of elective sterilization is excluded. Reversal of elective sterilization is excluded. In-Vitro fertilization, GIFT, artificial insemination, ZIFT, intrauterine insemination (IUI), and any infertility treatments are excluded.
- 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. Inpatient services in a Long-Term Care Facility. This does not include rehabilitation care for up to 45 days.
- P. Acupuncture.
- Q. Services from a school-based provider per the Medicaid Agreement.
- R. Services by a community health board per the Medicaid Agreement.
- S. Care from a Veterans, Marine or other federal hospital. Or care that by law must be treated in a public facility.
- T. Inpatient services in facilities for the developmentally or intellectually disabled or care in a psychiatric hospital.
- U. Over-the-counter medications if not prescribed.
- V. Non-Emergency Services from a Non-Participating Provider or unless approved in advance by UnitedHealthcare Community Plan.
- W. Personal care services in a Member's home.
- X. Private duty nursing services covered by other Medicaid programs.
- Y. Durable Medical Equipment benefits do not include:
 - 1. Deluxe equipment that is not Medically Necessary.
 - 2. Environmental control equipment including, but not limited to, air conditioners.
 - 3. Bathing or hygienic equipment including, but not limited to, swimming pools and hot tubs.
 - 4. Hypo-needle injectors.
 - 5. Seat cushions.
 - 6. Support garments (including cervical collars).

Medicaid Certificate of Coverage (COC)

7. Comfort or convenience items.
8. Exercise equipment, including, but not limited to, weight training.
9. Back-up generators.
10. Dental braces and appliances.

The following dental service are excluded from coverage:

Orthodontics, Gold Crowns, Gold Foil Restorations, Inlay/Onlay restorations, Fixed Bridges, Bite Splints, Mouthguards, sports appliances, Services or Surgeries that are experimental in nature, Dental Devices not approved by the GDA, Analgesia, Inhalation of Nitrous Oxide, Dental prostheses, Dental braces and appliances.

11. Carve-out prescription medications paid through the Department of Community Health Fee-For-Service program.

12.2 Limitations.

- 12.2.1** Covered Services are subject to the limits described in the UnitedHealthcare Community Plan Medicaid Agreement, the Medicaid Program Provider Manuals and Medicaid bulletins and directives.
- 12.2.2** UnitedHealthcare Community Plan has no liability or obligation for any services from a Non-Participating Provider unless these are approved in advance by UnitedHealthcare Community Plan. This does not include emergency care.
- 12.2.3** A Referral by a PCP for Non-Covered Services does not mean they are covered.

Article XIII: Term and termination

- 13.1 Term.** This Certificate takes effect on the date stated in the Medicaid Agreement. It stays in effect from year to year unless stated in the Medicaid Agreement or terminated.
- 13.2 Termination of Certificate by UnitedHealthcare Community Plan or the Department.**
 - 13.2.1** This Certificate will terminate on the date of termination of the Medicaid Agreement. Coverage will terminate at 12:00 Midnight on the date of the termination of this Certificate, unless stated in the Medicaid Agreement.
 - 13.2.2** In the event of cessation of operations by UnitedHealthcare Community Plan, this Certificate may be terminated immediately. UnitedHealthcare Community Plan will be obligated for services for period for which premiums were paid or as prescribed by law or by the Medicaid Agreement.

Medicaid Certificate of Coverage (COC)

13.2.3 UnitedHealthcare Community will notify members of the termination of this Certificate. The fact that Members are not notified will not extend Members' coverage.

13.3 Termination of Enrollment and Coverage by UnitedHealthcare Community Plan or the Department.

13.3.1 A Member's enrollment and coverage will terminate per the Medicaid Agreement when:

- A. The Member moves out of the Service Area.
- B. The Member ceases to be eligible for the Medicaid Program.
- C. The Member dies.
- D. The Member is given active eligibility status as a child with special health care needs.
- E. The Member is admitted to a Long-Term Care Facility. This does not include rehab care (45 days) or Hospice.
- F. The Member is admitted to a state psychiatric hospital.

13.3.2 UnitedHealthcare Community Plan may disenroll a Member for cause. This includes:

- A. The Member cannot keep a relationship with a PCP after two tries;
- B. The Member misrepresents or commits fraud in applying for enrollment; or
- C. The Member misuses or commits fraud in the use of his or her UnitedHealthcare Community Plan ID card; or
- D. The Member's conduct is abusive or obstructive to UnitedHealthcare Community Plan personnel, Participating Providers or other Members; or
- E. The Member repeatedly misuses UnitedHealthcare Community Plan benefits and services; or
- F. The Member fails to cooperate in coordinating benefits or subrogating the Member's right of recovery.

13.3.3 UnitedHealthcare Community Plan will not terminate a Member's enrollment on the basis of health or health care needs. A Member will not be terminated for using the Complaint, Grievance and Appeal process.

13.4 Disenrollment by Member.

- 13.4.1** A Member may disenroll from UnitedHealthcare Community Plan with or without cause. To do so, a Member should contact the UnitedHealthcare Community Plan Customer Service Department. The Member must follow disenrollment.
- 13.4.2** A Member's coverage stops on the date of the Member's disenrollment. The date of disenrollment will be determined by the Department.

Article XIV: Coordination of benefits

- 14.1 Purpose.** UnitedHealthcare Community Plan will coordinate benefits for a Member with benefits from health insurance carriers and other health benefit plans who also provide coverage for the Member. A Member, or their agent, must inform UnitedHealthcare Community Plan of all health insurance carriers and other health benefit plans for the Member. Each Member, or agent, must certify that the health insurance carriers and other health benefit plans listed in his or her application are the only ones from whom the Member has any rights to payment of health care. Each Member, or agent, must also notify UnitedHealthcare Community Plan when any other health insurance carrier and other health benefit plan becomes available to the Member. The Member agrees that any misrepresentation may result in disenrollment.
- 14.2 Assignment.**
- 14.2.1** Upon UnitedHealthcare Community Plan request, a Member must assign to UnitedHealthcare Community Plan:
- A. All insurance and other health care benefits, and other private or governmental benefits (except Medicaid) for health care of the Member; and
 - B. All rights to payment and all money paid for any claims for health care received by the Member.
- 14.2.2** Members shall not assign benefits or payments for Covered Services to any other person or entity.
- 14.3 Claims.** Upon UnitedHealthcare Community Plan request, a Member must authorize UnitedHealthcare Community Plan to submit claims for the Member to Medicare and other health insurance carriers and other health benefit plans.
- 14.4 Order of Benefits.** UnitedHealthcare Community Plan will follow Medicaid coordination of benefits guidelines and laws.

Medicaid Certificate of Coverage (COC)

- 14.5 UnitedHealthcare Community Plan Rights.** UnitedHealthcare Community Plan is entitled to:
- A. Determine to what extent a Member has health benefit coverage; and
 - B. Determine responsibility among the health insurance carriers and other health benefit plans; and
 - C. Require a Member or provider to file a claim with the primary health insurance carrier or other health benefits plan; and
 - D. Recover costs from the Member or provider for services covered by any other health insurance carriers and other health benefit plans; and
 - E. Recover costs from the Member or provider for Non-Covered Services that were provided due to the Member's error.
- 14.6 Construction.** UnitedHealthcare Community Plan does not have to make payment until it determines what benefits are payable by the primary health insurance carrier and other health benefit plan.
- 14.7 Medicare and Other Federal or State Government Programs.** If the member obtains Medicare, they will be disenrolled from the Healthy Michigan Plan. Until disenrollment the following will apply:
- A. Non-duplication of Benefits.

Your benefits under this Certificate cannot be doubled up with any benefits. You are, or could be, eligible for under Medicare or any other federal or state government program. If we cover a service that is also covered by one of those programs, any sums payable under that program for that service must be paid first.

Article XV: Subrogation

- 15.1 Assignment; Suit.** If a Member has a right of recovery for an injury or illness, other than a health plan, the Member must:
- A. Pay or assign to UnitedHealthcare Community Plan all sums recovered up to the amount of UnitedHealthcare Community care expenses; or
 - B. Authorize UnitedHealthcare Community Plan to get all medical records relating to the injury or illness.
 - C. Authorize UnitedHealthcare Community Plan to be subrogated to the Member's rights of recovery up to the amount of UnitedHealthcare Community care expenses for the injury or illness. UnitedHealthcare Community Plan also has the right to recover suit and attorney fees.

- 15.2 Definition.** Health care expense means the amounts paid or to be paid by UnitedHealthcare Community Plan to providers for services given 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 Contract.** This Certificate shall be construed as a Contract under the laws of the State of Michigan.
- 16.3 Period of Time for Legal Claims.** Any dispute regarding this Certificate shall be made within a reasonable time. The time period should be no later than three years from the dispute.
- 16.4 Policies and Procedures.** UnitedHealthcare Community Plan may adopt policies, procedures and rules to administer this Certificate, the Member Agreement, and the Medicaid Agreement.
- 16.5 Notice.**
- 16.5.1** Any notice required from UnitedHealthcare Community Plan to a Member shall be in writing. It will be delivered or deposited in the U.S. Mail. It will be sent to the Member's address on file with UnitedHealthcare Community Plan.
- 16.5.2** Any notice required by the Member to UnitedHealthcare Community Plan shall be in writing. It should be sent to:
- UnitedHealthcare Community Plan, Inc.
3000 Town Center
Southfield, MI 48075
- 16.6 Headings.** The headings are not part of this Certificate.

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