

# UnitedHealthcare Community Plan

## Healthy Michigan Plan 2018 Certificate of Coverage (COC)

UnitedHealthcare Community Plan  
26957 Northwestern Hwy.  
Suite 400  
Southfield, MI 48033

**1-800-903-5253**



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## Article I: General Conditions

- 1.1 Certificate.** This Certificate of Coverage (Certificate) is issued to Healthy Michigan Plan Program recipients who have enrolled in UnitedHealthcare Community Plan, Inc. (UnitedHealthcare Community Plan). The terms and conditions of this certificate are governed by the compiled laws of the State of Michigan and the Healthy Michigan Plan benefits that UnitedHealthcare Community Plan is required to provide pursuant to its Healthy Michigan Plan Agreement with the State of Michigan. By enrolling in UnitedHealthcare Community Plan, 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 UnitedHealthcare Community Plan. 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 UnitedHealthcare Community Plan. It is also the Member's responsibility to understand your rights as a Member as set forth 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.** 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 Office of Insurance of Financial Services and Insurance Regulation.
- 1.5 Assignment.** All rights of a Member to receive Covered Services under the Member Agreement are personal. They may not be assigned to any other person or entity. Any attempts to reassign the any rights under the Member Agreement may result in termination of coverage for the Member.
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## Article II: Definitions

- 2.1 Applicability.** Article 11 defines words to help the understanding for Members. These definitions apply to this certificate and any changes or additions while it is effect.
- 2.2 Application.** Application means the Member Application form, which a Healthy Michigan Plan recipient must complete and sign. The Member 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.** 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 in the Healthy Plan of Michigan Agreement.
- 2.9 Department.** This term shortens the Michigan Department of Health and Human Services or its successor. This agency administers the Healthy Michigan Plan 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 department regulates 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.
- 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 experimental procedure: It cannot be lawfully marketed without the approval of the Food and Drug (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 to determine safety, efficiency in comparison to current treatments. It is described as experimental in nature. 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 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 Health Risk Assessment.** Protocol approved by DHHS to measure readiness to change and specific healthy behaviors of HMP enrollees.
- 2.16 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.
- 2.17 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.
- 2.18 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.
- 2.19 HMP.** Healthy Michigan Plan.
- 2.20 Hospice Services.** Hospice means services provided by a licensed or Medicare certified Hospice. They are primarily furnished to provide pain relief, symptom management and supportive services to the terminally ill and their families. 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 setting.
- 2.21 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.
- 2.22 Hospital Services.** These are those Covered Services which are provided by a Hospital.
- 2.23 HRA.** Health Risk Assessment.
- 2.24 Long Term Care Facility.** This facility licensed by the Department to give inpatient nursing care.
- 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 Healthy Michigan Plan 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 Handbook, and the Member 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.
- 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).** PCP is the Participating provider who is responsible for coordinates the care of their patients who are members.
- 2.38 Service Area.** 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.

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## Article III: Eligibility

- 3.1 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
    - Ages 19 – 64.
    - Not currently eligible for.
    - Not in or qualified for.
    - Not pregnant when applying for the Healthy Michigan Plan.
    - Earning up to 133% of the Federal Poverty Level.
    - Are residents of the State of Michigan.
  - B. Live in the Service Area.

- 3.2 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 Members 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.) Member 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. Member 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.
- 3.3 Newborn Eligibility.** Newborns of Members who were enrolled at the time of the child’s birth will be enrolled with UnitedHealthcare Community Plan.
- 3.4 Children’s Special Health Care Services (CSHCS).** These are health care and case management services for Members eligible for Michigan Healthy Michigan Plan – 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.
- 3.5 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.
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## Article IV: Enrollment

- 4.1 Newborns.** A Member’s newborn child is automatically enrolled in UnitedHealthcare Community Plan from the date of birth for at least the birth month. UnitedHealthcare Community Plan is required to notify the Department of the birth of the newborn within the time period required under the Healthy Michigan Plan Agreement.
- 4.2 Change of Residency.** A Member must notify the Department and UnitedHealthcare Community Plan when the Member changes his or her residence to a location outside of the Service Area. The Member will be eligible to receive Covered Services until he or she is disenrolled from UnitedHealthcare Community Plan as determined by the Department.
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## Article V: Effective Date of Coverage

- 5.1 Effective Dates of Enrollment.** A Member’s enrollment in UnitedHealthcare Community Plan and coverage under this Certificate will become effective on the date determined by the Department and UnitedHealthcare Community Plan in accordance with the Healthy Michigan Plan 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 minor's responsible adult 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 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. Vision services from any participating optometrist.
  - G. Chiropractic care visits from any participating chiropractor for up to eighteen (18) visits every calendar year for subluxation of the spine.
  - H. Short term outpatient 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).
  - I. Non-emergency transportation or gas reimbursement from a UnitedHealthcare Community Plan transportation provider.

- J. Federally Qualified Health Centers (FQHC's) Rural Health Centers (RHC's), Child and Adolescent Health Centers (CAHC's), Tribal Health Centers (THC's). 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. 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 Healthy Michigan Plan 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 decisions. There is a Grievance and Appeals 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 on-going 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 their current OB/GYN 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 Healthy Plan of Michigan 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 Providers agrees that there is no alternate treatment.

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## **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 the Health 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 Healthy Michigan Plan Application gives UnitedHealthcare Community Plan the right to get medical information from providers. This information exchange follows the Healthy Plan of Michigan 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 SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY.**

Effective January 1, 2018.

By law, we<sup>1</sup> 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 to access your HI.

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

HI is information about your health or health care services. We have the right to change our privacy practices for handling HI. If we change them, we will notify you by mail or email. We will also post the new notice at this website ([www.uhccommunityplan.com](http://www.uhccommunityplan.com)). We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

## **How We Use or Share Your Information**

**We must use and share your HI with:**

- You or your legal representative.
- Government agencies.

**We have the right to use and share your HI for certain purposes.** This must 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.** We may use or share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. 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.
- **For Plan Sponsors.** 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.** We may use your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may use your HI to send you appointment reminders and information about your health benefits.

**We may use or share your HI as follows.**

- **As Required by Law.**
- **To Persons Involved With Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with 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.** 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.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (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 if needed to give you services.** Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.
- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below.
  1. HIV/AIDS
  2. Mental health
  3. Genetic tests
  4. Alcohol and drug abuse
  5. Sexually transmitted diseases and reproductive health
  6. Child or adult abuse or neglect or sexual assault

We will follow stricter laws that apply. The attached "Federal and State Amendments" document describes those laws.

We will only use your HI as described here or with your written consent. We will get your written consent to share psychotherapy notes about you. 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 promotional mailings. If you let us share your HI, the recipient may further share it. You may take back your consent. To find out how, call the phone number on your ID card.

## Your Rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **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 when a disclosure could endanger you. We take verbal requests. 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. You can have your record sent to a third party. 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. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared 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 ([www.uhccommunityplan.com](http://www.uhccommunityplan.com)).



## Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or **TTY 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.

<sup>1</sup> This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Health Plan of Nevada, Inc.; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

## Financial Information Privacy Notice

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

Effective January 1, 2018.

We<sup>2</sup> 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.

### Questions About This Notice

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

<sup>2</sup> For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women’s and Children’s Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connexions HCI, LLC; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services LLC; UnitedHealthcare Services Company of the River Valley, 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.

**UNITEDHEALTH GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES:  
FEDERAL AND STATE AMENDMENTS**

Revised: January 1, 2018.

The first part of this Notice (pages 14 – 17) says how we may use and share your health information (“HI”) under federal privacy rules. Other laws may limit these rights. The charts below:

1. Show the categories subject to stricter laws.
2. Give you a summary of when we can use and share your HI without your consent.

Your written consent, if needed, must meet the rules of the federal or state law that applies.

**SUMMARY OF FEDERAL LAWS**

**Alcohol and Drug Abuse Information**

We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.

**Genetic Information**

We are not allowed to use genetic information for underwriting purposes.

**SUMMARY OF STATE LAWS**

**General Health Information**

We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, UT, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

### Prescriptions

We are allowed to disclose prescription-related information only  
(1) under certain limited circumstances, and/or  
(2) to specific recipients.

ID, NH, NV

### Communicable Diseases

We are allowed to disclose communicable disease information only  
(1) under certain limited circumstances, and/or  
(2) to specific recipients.

AZ, IN, KS, MI, NV, OK

### Sexually Transmitted Diseases and Reproductive Health

We are allowed to disclose sexually transmitted disease and/or  
reproductive health information only  
(1) under certain limited circumstances and/or  
(2) to specific recipients.

CA, FL, IN, KS, MI, MT, NJ,  
NV, PR, WA, WY

### Alcohol and Drug Abuse

We are allowed to use and disclose alcohol and drug abuse information  
(1) under certain limited circumstances, and/or disclose only  
(2) to specific recipients.

AR, CT, GA, KY, IL, IN, IA,  
LA, MN, NC, NH, OH, WA,  
WI

Disclosures of alcohol and drug abuse information may be restricted by  
the individual who is the subject of the information.

WA

### Genetic Information

We are not allowed to disclose genetic information without your  
written consent.

CA, CO, KS, KY, LA, NY, RI,  
TN, WY

We are allowed to disclose genetic information only  
(1) under certain limited circumstances and/or  
(2) to specific recipients.

AK, AZ, FL, GA, IA, IL, MD,  
MA, ME, MO, NJ, NV, NH,  
NM, OR, RI, TX, UT, VT

Restrictions apply to  
(1) the use, and/or  
(2) the retention of genetic information.

FL, GA, IA, LA, MD, NM,  
OH, UT, VA, VT

### HIV/AIDS

We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR

### Mental Health

We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

### Child or Adult Abuse

We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI
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# Member Rights and Responsibilities

## Your Rights.

- To be treated with respect no matter what your race, religion, color, age, sex, health condition, familial status, height, weight, disability or veteran's status.
- To get information about all health services and be explained how to obtain services.
- To choose a doctor from our list of UnitedHealthcare Community Plan Primary Care Providers (PCPs).
- To file a grievance, to request a fair hearing or have an external review under the Patient's Right to Independent Review Act.
- To voice grievances or appeals about UnitedHealthcare Community Plan or the care it provides.
- To make suggestions about UnitedHealthcare Community Plan's member's rights and responsibilities policies.
- To have your medical records and communications kept private.
- To expect UnitedHealthcare Community Plan staff and providers to comply with all member rights.
- To get full information from your PCP or health care provider about any treatment or test that may be needed for your health care.
- To participate in decisions on your health care.
- To accept or refuse treatment.
- To discuss medically necessary treatment options, regardless of cost or coverage.
- To get information about UnitedHealthcare Community Plan. Information is about services, business, and health care providers.
- To ask if UnitedHealthcare Community Plan has special financial arrangements with providers that can affect the use of referrals and services. Call UnitedHealthcare Community Plan to get this information.
- To see any UnitedHealthcare Community Plan OB/GYN for well-woman exams or obstetrical care without a referral from your PCP.
- To see any UnitedHealthcare Community Plan pediatrician if you are under the age of 18 without a referral from your PCP.
- To get a copy of these rights and responsibilities. To have them explained to you if you have any questions.

## Your Responsibilities.

- To be an informed member. Read your Member Handbook and call UnitedHealthcare Community Plan if you have any questions.
- To understand your health problems. To take part in setting health and treatment goals.
- To call UnitedHealthcare Community Plan for approval of all hospitalizations, except for emergencies or for urgent care.
- To tell UnitedHealthcare Community Plan of any other health insurance you have.
- To tell your PCP your full health history. To tell the truth about any changes in your health. To give the information that UnitedHealthcare Community Plan and its providers need to provide care.
- To listen and follow your PCP's advice for care you have agreed on. To help them plan what UnitedHealthcare Community Plan will work best for you.
- To know the names of your medications. To know what they are for and how to use them.
- To report any emergency care within 48 hours to your PCP. Report an emergency stay at a hospital soon after.
- To always carry your UnitedHealthcare Community Plan Member ID card.
- To respect the rights of other patients, doctors, office staff and staff at UnitedHealthcare Community Plan.
- To tell UnitedHealthcare Community Plan if you move or change phone numbers. To tell us about changes that affect your health, like childbirth. Call customer service and keep us informed.

**7.2 Member Complaints, Grievances and Appeals.** UnitedHealthcare Community Plan has procedures for processing and resolving member complaints, grievances. Those relating to the benefits or the operation of UnitedHealthcare Community Plan must follow MCL 500.3541 and Michigan's Independent Review Act. The Member Complaint, Grievance and Appeals Procedure is described in the Member Handbook. Complaints, Grievances and Appeals not settled through this procedure may be appealed to the Department of Insurance and Financial Services (DIFS), Office of General Counsel – Appeals Section, by mail, P.O. Box 30220 Lansing, MI 48909-7720, by courier/delivery, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933, Fax: 517-284-8838, Phone: 1-877-999-6442. DIFS Online External Review at <https://difs.state.mi.us/Complaints/ExternalReview.aspx>.

Members must exhaust UnitedHealthcare Community Plan Member, Complaint, Grievance Procedure before asking DIFS for review. Members must submit the request for DIFS review within 127 calendar days of the adverse decision. The exception is if a Member could seriously jeopardize life, health or function because of the expedited internal appeal time frame. Such condition must be confirmed by a doctor orally or in writing. Members also have the right to request a fair hearing with the Michigan Department of Health and Human Services Law tribunal. Members must exhaust UnitedHealthcare Community Plan Member, Complaint, Grievance Procedure before requesting a fair hearing with the MDHHS Law Tribunal. The request must be submitted within 120 calendar days of the adverse decision. Mail the request form sent with the denial notice to: Michigan Administrative

Hearings System For the Michigan Department of Health and Human Services, P.O. Box 30763, Lansing, MI 48909-7695. In conducting the review, the Resolving Analyst (RA) must review the Member's governing plan documents, Handbook, and as applicable, the state Medicaid contract, the previous adverse benefit determination and follows as documented on the CSA Member Appeals and Grievances processing grid.

1. The RA must apply the terms of the governing plan documents, unless a specific regulatory requirement applies, or the case requires a clinician's review of medical necessity or clinical criteria to determine applicability of coverage.
2. The RA is responsible for communicating the appeal decision to the member in writing after the completion of the review, in accordance with applicable regulatory requirements.

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](http://myuhc.com/communityplan). The Handbook describes the Complaint, Appeals and Grievance Procedure. They may get more copies at any time.

### **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** 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.

**7.3.3** 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 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.

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## 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 Provider, the Premiums specified in the Healthy Plan of Michigan 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.** Some covered services may have a copay. This means Members need to pay a fee to UnitedHealthcare Community Plan when they get those services.

Below tells what services need copays and how much to pay for members with income less than or equal to 100% FPL:

<b>Physician Office Visit</b>	\$2 per visit for Members 21 and older
<b>Pharmacy</b>	\$3 for each name brand of drugs for Members 21 and older; \$1 for each brand of drugs for Members 21
<b>Vision</b>	\$2 per visit for Members 21 and older; \$1 per visit for Members 21 and older
<b>Podiatry</b>	\$2 per visit for Members 21 and older
<b>ER Visit</b>	\$3 per visit for Members 21 and older
<b>Visit</b>	\$1 per visit for Members 21 and older
<b>Inpatient Stay</b>	\$50 for the first day of the stay for Members 21 and older
<b>Outpatient Hospital Visit</b>	\$4 per visit for Members 21 and older
<b>Inpatient Hospital Stay</b>	\$100 for the first day of the hospital stay for Members 21 and older

For members with income more than 100% of the FPL, copays are:

<b>Physician Office Visit</b>	\$4 per visit for Members 21 and older
<b>Pharmacy</b>	\$8 for each name brand of drugs for Members 21 and older; \$4 for each generic brand of drugs for Members 21
<b>Vision</b>	\$2 per visit for Members 21 and older
<b>Chiropractic</b>	\$3 per visit for Members 21 and older
<b>Podiatry</b>	\$4 per visit for Members 21 and older
<b>Hospital ER Visit</b>	\$8 per visit for Members 21 and older
<b>Outpatient Hospital Visit</b>	\$4 per visit for Members 21 and older
<b>Inpatient Hospital Stay</b>	\$100 for the first day of the hospital stay for Members 21 and older

- You only have to pay your copay if you are age 21 and older.
- You will not have a copay for family planning products or services.
- You will not have a copay for any pregnancy related products or services.
- You will not have copays for preventative services.

In addition to copays, you will be responsible for a contribution equal to 2% of your adjusted gross income if your income is between 100 – 133% of the Federal Poverty Level. This amount will be paid to UnitedHealthcare Community Plan.

A MIHealth Account will be set up for each Healthy Michigan Plan members. It will be your responsibility to pay required copays and premiums into your MIHealth Account. Customer Service (800) 903-5253 can answer any questions you have.

**8.4 Claims.** It is UnitedHealthcare Community Plan policy to pay Participating Providers directly for Covered Services rendered to Members in accordance with the contracts between UnitedHealthcare Community Plan and Participating Providers. However, if a Participating Provider bills a Member for a Covered Service, the member should submit the bill to UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will not reimburse Members for bills received by UnitedHealthcare Community Plan that exceed six (6) months from the date the services were rendered. If the Member pays the bill, the Member must submit a request for reimbursement for such Covered Services 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 request 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.

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## 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. When required, authorized in advance by UnitedHealthcare Community Plan; 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.
- C. Covered Services without a Referral from a PCP as set forth in Article VI, Section 6.5 of this Certificate.
- D. Preventative 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.
  - 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.
8. 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:
- a. 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.
  - b. Diaphragms and Intrauterine Devices (IUDs).
  - c. Advice on Contraception and Family Planning.
  - d. Abortion. Abortion is covered in the case of rape, incest or when medically necessary to save the life of the mother.
  - e. Infertility diagnosis and testing is covered when medically necessary, but any treatment for infertility is not a covered benefit.
- E. 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.

F. 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.

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

H. Rehabilitation and Physical Therapy Services. Short-term rehabilitative therapy is covered. This is limited to 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.

I. 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.

J. 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.

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

L. 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.

M. 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. 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.

N. 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.

- O. Emergency Service. 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 an 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.
- P. Ambulance Services. Ambulance services in the case of an emergency. They are covered if approved in advance by UnitedHealthcare Community Plan.
- Q. 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. Prescription lenses are covered only if the Member's vision cannot be corrected with glasses. Prescription lenses require advance approval.
- R. 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 for Members under 21 years of age. 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.
- S. Pregnancy Terminations. Medically necessary pregnancy terminations are covered to save the life of the mother or in cases of rape or incest.
- T. Bariatric Surgery. Bariatric surgery is covered only when medically needed. It must be approved in advance by UnitedHealthcare Community Plan. The Member must meet the Michigan Association of Health Plans Bariatric Surgery Guidelines.
- U. 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.



- V. The following medications for diabetes are covered. They must be ordered by a Participating Provider.
1. Insulin.
  2. Non-experimental medication for controlling blood sugar.
  3. Medications used for foot ailments, infections, and other medical conditions of the foot, ankle, or nails related to diabetes.
- W. Care related to the promotion of Healthy Behaviors.
- X. Dental Services i. Diagnostic, preventatives, restorative, prosthetic and medically/clinically necessary oral surgery services (including extractions) are covered. Visit [www.michigan.gov](http://www.michigan.gov) for a complete list of covered services.
- Y. Habilitative Services i. 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.
- Z. 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 temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

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## 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 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.
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## 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. Medical exams to confirm health status for third parties. This includes for employment, insurance, or for a court.
  - G. Surgery and care to improve appearance, unless needed medically.
  - H. Items for cleanliness and grooming.
  - I. Substance abuse services. Refer to UnitedHealthcare Community Plan Handbook for a list of outreach services.
  - J. Experimental medical, surgical or other health care drug, device or treatment. This is determined by the Medical Director and the Department.
  - K. Reproductive Services and Transsexual Surgery. Reversal of elective sterilization is excluded. Sex change surgery and all related costs in connection with such surgery are excluded. Reversal of elective sterilization is excluded. In-Vitro fertilization, GIFT, artificial insemination, ZIFT, intrauterine insemination (IUI), and any infertility treatments are excluded.
  - L. Any service, equipment or supply usually given free of charge.
  - M. Abortions, except to save the life of the mother or for incest or rape.
  - N. Inpatient services in a Long Term Care Facility. This does not include rehabilitation care for up to 45 days.
  - O. Acupuncture.
  - P. Services from a school-based provider per the Healthy Plan of Michigan Agreement.
  - Q. Services by a community health board per the Healthy Plan of Michigan Agreement.

- R. Care from a Veterans, Marine or other federal hospital. Or care that by law must be treated in a public facility.
- S. Inpatient services in facilities for the developmentally or intellectually disabled. Or care in a psychiatric hospital.
- T. Over-the-counter medications if not prescribed.
- U. Non-Emergency Services from a Non-Participating Provider, unless approved in advance by UnitedHealthcare Community Plan.
- V. Personal care services in a Member's home.
- W. Private duty nursing services covered by other Healthy Michigan Plan programs.
- X. 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).
  7. Comfort or convenience items.
  8. Exercise equipment, including, but not limited to, weight training.
  9. Back-up generators.
  10. Carve-out prescription medications paid through the Department of Community Health Fee-For-Service program.
- Z. 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.

## **12.2 Limitations.**

- 12.2.1** Covered Services are subject to the limits described in the UnitedHealthcare Community Plan Healthy Plan of Michigan Agreement, the Healthy Michigan Plan Program Provider Manuals and Healthy Michigan Plan 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 Healthy Plan of Michigan Agreement. It stays in effect from year to year unless stated in the Healthy Plan of Michigan Agreement or terminated.
- 13.2 Termination.** Termination of Certificate by UnitedHealthcare Community Plan or the Department.
- 13.2.1 Certificate.** This Certificate will terminate on the date of termination of the Healthy Plan of Michigan Agreement. Coverage will terminate at 12:00 Midnight on the date of the termination of this Certificate, unless stated in the Healthy Plan of Michigan 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 Healthy Plan of Michigan Agreement.
- 13.2.3** UnitedHealthcare Community Plan 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 Healthy Plan of Michigan Agreement when:
- A. The member moves out of the Service Area.
  - B. The member ceases to be eligible for the Healthy Michigan Plan 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 Appeals 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.

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## **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 Healthy Michigan Plan) 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 Healthy Michigan Plan coordination of benefits coverage and laws.

**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 Plan 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 Plan 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 HMP 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.  
26957 Northwestern Hwy, Suite 400  
Southfield, MI 48033
- 16.6 Headings.** The headings are not part of this Certificate.



UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
**UHC\_Civil\_Rights@uhc.com**

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:30 a.m. to 5:30 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:**

**<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**

Complaint forms are available at

**<http://www.hhs.gov/ocr/office/file/index.html>**

**Phone:**

Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

**Mail:**

U.S. Dept. of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, D.C. 20201

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:30 a.m. to 5:30 p.m.

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UnitedHealthcare Community Plan no da un tratamiento diferente a sus miembros en base a su sexo, edad, raza, color, discapacidad o origen nacional.

Si usted piensa que ha sido tratado injustamente por razones como su sexo, edad, raza, color, discapacidad o origen nacional, puede enviar una queja a:

Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
**UHC\_Civil\_Rights@uhc.com**

Usted tiene que enviar la queja dentro de los 60 días de la fecha cuando se enteró de ella. Se le enviará la decisión en un plazo de 30 días. Si no está de acuerdo con la decisión, tiene 15 días para solicitar que la consideremos de nuevo.

Si usted necesita ayuda con su queja, por favor llame al número de teléfono gratuito para miembros que aparece en su tarjeta de identificación del plan de salud, TTY 711, de lunes a viernes, de 8:00 a.m. a 5:30 p.m.

Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

**Internet:**

**<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**

Formas para las quejas se encuentran disponibles en:

**<http://www.hhs.gov/ocr/office/file/index.html>**

**Teléfono:**

Llamada gratuita, **1-800-368-1019, 1-800-537-7697** (TDD)

**Correo:**

U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, D.C. 20201

Si necesita ayuda para presentar su queja, por favor llame al número gratuito para miembros anotado en su tarjeta de identificación como miembro.

Ofrecemos servicios gratuitos para ayudarle a comunicarse con nosotros. Tales como, cartas en otros idiomas o en letra grande. O bien, puede solicitar un intérprete. Para pedir ayuda, por favor llame al número de teléfono gratuito para miembros que aparece en su tarjeta de identificación del plan de salud, TTY 711, de lunes a viernes, de 8:00 a.m. a 5:30 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-903-5253, TTY 711**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-903-5253, TTY 711**.

تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم **1-800-903-5253**، الهاتف النصي **711**.

注意：如果您說中文，您可獲得免費語言協助服務。請致電**1-800-903-5253**或聽障專線 (TTY) **711**。

MADETA: en maswtat lishana Aturaya, eten tishmiishta d lishana qa hayarta quray. Makhber **1-800-903-5253, TTY 711**.

LƯU Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **1-800-903-5253, TTY 711**.

VËMENDJE: Nëse flisni shqip, keni në dispozicion shërbime asistence gjuhësore pa pagesë. Telefono **1-800-903-5253, TTY 711**.

참고: 한국어를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-800-903-5253, TTY 711**로 전화하십시오.

মনোযোগ: যদি আপনি বাঙ্গালী ভাষায় কথা বলেন, তবে আপনার জন্য ভাষা সহায়তা পরিষেবা বিনামূল্যে লভ্য হবে। ফোন করুন **1-800-903-5253** নম্বরে, **TTY 711**.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z usługi bezpłatnej pomocy językowej pod numerem telefonu **1-800-903-5253, TTY 711**.

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie **1-800-903-5253, TTY-Gerät 711**.

ATTENZIONE: se parla italiano, Le vengono messi gratuitamente a disposizione servizi di assistenza linguistica. Chiami il numero **1-800-903-5253, TTY 711**.

ご注意:日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。電話番号**1-800-903-5253**、または**TTY 711**(聴覚障害者・難聴者の方用)までご連絡ください。

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел. **1-800-903-5253, TTY 711**.

PAŽNJA: Ako govorite srpsko-hrvatski, možete dobiti besplatnu pomoć za usluge jezika. Pozovite **1-800-903-5253, TTY 711**.

ATENSYON: Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-800-903-5253, TTY 711**.



**UnitedHealthcare Community Plan**

26957 Northwestern Hwy.

Suite 400

Southfield, MI 48033

1-800-903-5253

