UnitedHealthcare Community Plan
Member Handbook

Aged, Blind or Disabled Program, Covered Families and Children Program (Healthy Families and Healthy Start)

1-800-895-2017 (TTY: 711)
www.myuhc.com/communityplan
**Important Telephone Numbers**

**Member Services**
(7 a.m. to 7 p.m. Monday through Friday) 1-800-895-2017
Hard-of-hearing 711

**24/7 Nurse Line**
(available 24 hours a day, 7 days a week) 1-800-542-8630
TTY 1-800-855-2880

**Healthy First Steps (for mothers-to-be)** 1-800-599-5985

**Care Management** 1-800-895-2017

**Fraud and Abuse Hotline**
UnitedHealthcare 1-877-766-3844
Ohio Department of Insurance 1-800-686-1527
1-614-644-2671

**Pharmacy Questions**
Ohio Medicaid Consumer Hotline 1-800-324-8680
TTY 1-800-292-3572
[http://jfs.ohio.gov/ohp/bhpp/meddrug.stm](http://jfs.ohio.gov/ohp/bhpp/meddrug.stm)

**Website** [www.myuhc.com/communityplan](http://www.myuhc.com/communityplan)

**Your Health Providers**

Name: ___________________________ Phone: ___________________________

Name: ___________________________ Phone: ___________________________

Name: ___________________________ Phone: ___________________________

Name: ___________________________ Phone: ___________________________

Emergency Room: ___________________________ Phone: ___________________________

Pharmacy: ___________________________ Phone: ___________________________

NurseLineSM is a service mark of UnitedHealth Group, Inc.
Health plan coverage provided by UnitedHealthcare Community Plan of Ohio, Inc., a licensed HIC in the state of Ohio.
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Welcome to UnitedHealthcare Community Plan. You are now a member of a health care plan, also known as a managed care plan (MCP). UnitedHealthcare Community Plan provides health care services to Ohio residents eligible for Aged, Blind, or Disabled, Covered Families and Children (including Healthy Start and Healthy Families), and adult extension Medicaid benefits. As a member, you are now eligible for exciting benefits at no cost to you. In addition, we have disease and care management programs for conditions such as asthma and diabetes and Healthy First Steps™ Pregnancy Program.

If your UnitedHealthcare Community Plan member identification (ID) card has not come in the mail yet, it will arrive soon. Remember to take this card to all your doctor visits and show your card to your doctor’s staff.

This Is Your Member Handbook.

Please take time to read this Handbook. Your Member Handbook will answer many questions you may have. If you have any problems in reading or understanding this or any other UnitedHealthcare Community Plan information, please contact our Member Services at 1-800-895-2017 (TTY 711) for help at no cost to you. We can help to explain the information or provide the information orally, in English or in your primary language. We may have the information printed in certain other languages or in other ways. If you are visually or hearing-impaired, special help can be provided. Our Member Services staff will help you to use UnitedHealthcare Community Plan. You can reach Member Services Monday through Friday from 7 a.m. to 7 p.m.

Member Services 1-800-895-2017 (TTY: 711)
Monday – Friday, 7 a.m. – 7 p.m.

Our office is closed on these major holidays:

- New Year’s Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day

Member Services can help you with the following: finding a provider, benefit questions, how to access services, filing a complaint, changing PCPs, language help, etc. You can call when you are unsure of something or if you have any questions about UnitedHealthcare Community Plan. We may monitor calls to train new team members or see how our team is doing. This means a supervisor may listen in when you call.
You can also write to us:

Member Services
UnitedHealthcare Community Plan
9200 Worthington Rd.
Westerville, OH 43082

Please visit our website which includes an up-to-date member information, health education, list of providers, and much more.

www.myuhc.com/communityplan

UnitedHealthcare Community Plan may not discriminate on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services in the receipt of health services.

Language Help

If you have a problem reading or understanding this information or any other UnitedHealthcare Community Plan information, please contact our member services at 1-800-895-2017 for help at no cost to you. We can explain this information, in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

Members with hearing loss, please call 711. This is a free Telecommunications Relay Service (TRS) that allows persons with hearing or speech disabilities to place and receive telephone calls. Ask to be connected to UnitedHealthcare Community Plan and give them the Member Services number 1-800-895-2017.

If needed, member information and literature can be made available in a different language, large print, Braille and audio tapes. Interpreters are also available for visual or hearing impaired members. If you need this information in Braille or large print, please call Member Services at 1-800-895-2017.

Si desea recibir una copia de esta información en español, por favor llame al numero 1-800-895-2017.

Ohio Department of Medicaid (ODM) Eligibility Review

You will receive a notice about renewing your Medicaid eligibility in the mail every 12 months (sometimes sooner). When you receive the notice, you must contact your local Ohio Department of Medicaid. If you don’t, your Medicaid will stop. Tell your caseworker if you move. If the Ohio Department of Medicaid has the wrong address, you might not receive the notice on time.
UnitedHealthcare Community Plan is a state approved health care plan. UnitedHealthcare Community Plan has Primary Care Providers, also called PCPs. These are doctors that can take care of most of your health care needs. We also have other providers (doctors) who are specialists; for example, heart doctors or surgeons.

UnitedHealthcare Community Plan contracts with providers who meet UnitedHealthcare Community Plan’s quality standards. We want you to get the best care possible.

**Identification (ID) Cards**

You should have received a UnitedHealthcare Community Plan Membership ID card. Each member of your family who has joined UnitedHealthcare Community Plan will receive their own card. These cards replace your monthly Medicaid card. Each card is good for as long as the person is a member of UnitedHealthcare Community Plan. You will not receive a new card each month as you did with the Medicaid card. Your Member ID card may only be used for your care and should not be given to anyone for their use.

If you are pregnant, you need to let UnitedHealthcare Community Plan know when your baby is born so we can send you a new ID card for your baby.

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**Always Keep Your ID Card(s) With You**

You will need your ID card each time you get medical services. This means that you need your UnitedHealthcare Community Plan ID card when you:

- See your Primary Care Provider (PCP)
- See a specialist or other provider
- Go to an emergency room
- Go to an urgent care facility
- Go to a hospital for any reason
- Get medical supplies
- Get a prescription
- Have medical tests
- Receive non-emergency transportation service (i.e. trips to and from your PCP)

Call your UnitedHealthcare Community Plan Member Services as soon as possible at 1-800-895-2017 (hard-of-hearing: 711) if:

- You have not received your card(s) yet
- Any of the information on the card(s) is wrong
- You lose your card(s)
- You have a baby
UnitedHealthcare Community Plan Providers

UnitedHealthcare Community Plan contracts with providers who meet UnitedHealthcare Community Plan’s quality standards.

It is important to remember that you must receive services covered by UnitedHealthcare Community Plan from facilities and/or providers on UnitedHealthcare Community Plan’s panel. See pages 20 – 23 for information on services covered by UnitedHealthcare Community Plan. The only time you can use providers that are not on UnitedHealthcare Community Plan’s panel is for:

- Emergency services
- Federally qualified health centers/rural health clinics
- Qualified family planning providers
- Ohio Department of Mental Health certified community mental health centers
- An out of panel provider that UnitedHealthcare Community Plan has approved you to see

You should have received a Provider Directory that lists all of our panel providers as well as other non-panel providers you can use to receive services. You can also visit our website at www.myuhc.com/communityplan to view up to date provider panel information.

What Is a Medical Home?

If you go to the same provider or medical practice all the time, this provider is your medical home.

Why Would I Want a Medical Home?

There are lots of reasons for you and your family to have a medical home.

- A medical home will already have your medical records. This lets the doctor see you faster.
- A medical home will know what shots, illnesses and prescriptions you have had and what works best.
- A medical home will know what your allergies and other health issues are.
- A medical home will know what behavior and health is normal for you.
- A medical home can answer your questions about previous treatment.

Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is your personal doctor. Think of your PCP office as your medical home. When you enroll in UnitedHealthcare Community Plan, you pick a PCP for yourself. Some PCPs may have medical residents, nurse practitioners, nurse midwives and physician assistants who will provide care to you under the direction of your PCP. All providers listed in UnitedHealthcare Community Plan’s Provider Directory have agreed to take care of UnitedHealthcare Community Plan members. All of our providers have met UnitedHealthcare Community Plan’s high quality standards.
How Do I Find a Provider?

Use our provider directory. It lists the names, locations, telephone numbers, and languages other than English spoken by our plan providers. If you do not have a Provider Directory and would like us to send you one, please call Member Services 1-800-895-2017. We can help you find a provider close to where you live. We can also help you find participating specialists, home health care and durable medical equipment suppliers.

Visit us online at www.myuhc.com/communityplan. New providers join the UnitedHealthcare Community Plan network all the time. The most up-to-date directory is on our website.

For most of your medical care, you must go to your Primary Care Provider.

Choosing a Primary Care Provider (PCP)

Each member of UnitedHealthcare Community Plan must choose a Primary Care Provider (PCP) from UnitedHealthcare Community Plan’s Provider Directory. Your PCP is your personal doctor. You can find our most up-to-date listings of UnitedHealthcare Community Plan providers on our website at www.myuhc.com/communityplan.

If you do not have access to the internet, call Member Services at 1-800-895-2017 (hard-of-hearing: 711) to ask about a provider or request a printed directory.

Your PCP is an individual physician, physician group practice, advance practice nurse or advance practice nurse group practice trained in pediatrics, family medicine (general practice), internal medicine or pediatrics. If you are pregnant, you can choose a PCP trained in obstetrics/gynecology (OB/Gyn).

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

Some Primary Care Provider sites may have medical residents, nurse practitioners and provider assistants who will provide care to you under the supervision of your PCP.

If your Primary Care Provider stops working with UnitedHealthcare Community Plan, we will let you know. We will help you pick a new provider.
Getting Care

Get to Know Your PCP – Time for a Wellness Visit!

It’s important for all UnitedHealthcare Community Plan members to have regular wellness visits. This way your PCP can help you stay healthy. See your PCP as soon as you become a UnitedHealthcare Community Plan member. You don’t have to wait until you are sick.

Some questions you can ask are:
- What are the office hours?
- What if I need night or weekend care?
- Who takes calls if your office is closed?
- Do you need an “O.K.” from me to get my records from another office?
- Am I due for any tests or check-ups?

It is important to know all the staff at your PCP’s office. They will help you with medical advice and much more. It is best to call during regular business hours if you want to speak to someone from the office.

Making an Appointment to See Your PCP

When you call or go to the office to make an appointment, be sure to tell them you are a UnitedHealthcare Community Plan member and why you need an appointment.

When you go to your appointment, be sure to take
- Your UnitedHealthcare Community Plan card.
- Your card for any other insurance coverage you may have.

How Long Should It Take to Get a PCP Appointment?

Here are some general guidelines on how long it takes to get an appointment with your PCP.

**Emergency appointments:**
Immediately or referred to an emergency facility

**Urgent (but not an emergency) appointments:**
Within 24 hours

**Routine symptomatic appointments:**
Within 48 hours

**Routine asymptomatic appointments:**
Within 6 weeks

**Preventive, well-child, and regular appointments:**
Within 6 weeks
Changing Your PCP

If for any reason you want to change your PCP, you must first call the Member Services Department to ask for the change. Members can change their PCP monthly. PCP changes within the first month of membership will be effective the date of the request. If you request a PCP change after your first month of membership, the change will be effective on the first day of the next month. UnitedHealthcare Community Plan will send you a new ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP.

For the names of the PCPs in UnitedHealthcare Community Plan, you may look in your Provider Directory, on our web site at www.myuhc.com/communityplan, or you can call the UnitedHealthcare Community Plan Member Services Department at 1-800-895-2017 (hard-of-hearing: 711) for help.

If you did not select a PCP at the time you enrolled with UnitedHealthcare Community Plan, UnitedHealthcare Community Plan will assign a PCP for you. We will notify you that you can change to another PCP if you wish during the first month of your enrollment with UnitedHealthcare Community Plan, or monthly thereafter.

Seeing Another Doctor or Specialist

When you and your PCP (Primary Care Provider) agree you need to go to another doctor (specialist), he/she will refer you to that doctor. This is means the doctor selects or recommends another doctor for you to see.

If you have a complicated illness or condition, frequent visits to a specialist may be necessary. If you require frequent visits to a specialist, UnitedHealthcare Community Plan can help you coordinate your health care. You may see your specialist as often as needed.

Sometimes there may be a reason that a specialist may need to be your PCP. A specialist serves as a PCP for members with very complex healthcare needs. If you and/or your specialist believe that they should be your PCP, you should call the Member Services Department to discuss. The specialist will be able to serve as your PCP and will be available to you 24 hours a day, 7 days a week.

If you have a complicated illness or condition, please call Member Services at 1-800-895-2017 (hard-of-hearing: 711). We will help you. Member Services can also provide you with a list of specialists.

Out-of-Network Providers

Your PCP may decide you need medical care that you can only get from a doctor or other health care provider that does not participate with UnitedHealthcare Community Plan. Your PCP will need to call us to get an okay or Prior Authorization from UnitedHealthcare Community Plan for these services before they will be covered.

Second Opinions

If you would like a second opinion from another doctor, contact Member Services at 1-800-895-2017 (hard-of-hearing: 711). They can help you.
Medical Advances
When UnitedHealthcare Community Plan receives requests to cover newly developed medical equipment or procedures, our national Technology Assessment Committee reviews them. This committee includes physicians and other health care professionals. The Committee uses national guidelines and scientific evidence from medical literature to help decide whether UnitedHealthcare Community Plan should approve the use of the equipment or procedures.

After Hours Care or Care When Traveling Outside the UnitedHealthcare Service Area
Sometimes you may need your Primary Care Provider when the office is closed or when you are traveling outside the UnitedHealthcare Community Plan service area. If you need urgent or non-emergent care, call your PCP’s office. You will receive directions on how to access care. There is someone to help you 24 hours a day, seven days a week. If your PCP tells you to go to the nearest emergency room, call UnitedHealthcare Community Plan within 24 hours or as soon as possible.

You can also call UnitedHealthcare Community Plan’s NurseLine services. NurseLine nurses are available to answer your health-related questions 24 hours a day and 7 days a week. Call NurseLine at 1-800-542-8630 (TTY: 1-800-855-2880).

NurseLine℠ Services
As a member of UnitedHealthcare Community Plan, you can take advantage of our NurseLine services. NurseLine provides you with 24 hours a day and 7 days a week access through a toll-free telephone number to experienced registered nurses who understand your health care needs and concerns.

You can rest easy knowing registered nurses with NurseLine have an average of 15 years of experience. NurseLine uses trusted, physician-approved information to help you make the right decisions. All at no cost to you!

Getting the best health care begins with asking questions and understanding the answers, NurseLine can help you make health-related decisions. A NurseLine nurse can even give you tips on eating healthy and staying fit. The nurse can also help you:

• Decide if the emergency room or a doctor visit is right for you.
• Find a doctor or hospital.
• Understand your treatment options.
• Teach you about important health screenings and shots.
• Answer your health-related questions.
• Learn how to save money on prescriptions.
• Teach you how to take medications safely.

Call NurseLine services at 1-800-542-8630 (TTY: 1-800-855-2880).

(For information purposes only. Nurses can’t diagnose problems nor recommend specific treatment. They are not a substitute for your doctor’s care.).
Urgent Care

Urgent care is when you need care, treatment, or advice within 24 hours.

If you need urgent care, you can visit an urgent care center. You do not need to get prior authorization before you do so. If you need help locating an urgent care center near you, call Member Services at 1-800-895-2017 (hard-of-hearing: 711) and we will help you.

If you do not know whether you need to visit an urgent care center, you can call your PCP or our 24/7 NurseLine services at 1-800-542-8630 (TTY: 1-800-855-2880) and your PCP or NurseLine Representative will help you. To make sure you receive the best care, tell your PCP about any visits to an urgent care center. By doing this, your PCP can help coordinate your health care.

Emergency Services

Emergency services are for a medical problem that you think is so serious that it must be treated right away by a doctor. We cover care for emergencies both in and out of the county where you live. Further, UnitedHealthcare Community Plan considers emergency services to be those covered inpatient and outpatient services that are:

(a) Furnished by a qualified provider; and
(b) Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency services are needed when you need immediate medical care because of the sudden onset of a medical condition or severe pain that the average person feels would:

- Place the person’s health or the health of an unborn baby at serious risk;
- Result in serious harm to bodily functions; and/or,
- Result in serious harm to an organ or body part.

If you are not sure whether you need to go to the emergency room, call your Primary Care Provider or our 24/7 NurseLine services at 1-800-542-8630 (TTY: 1-800-855-2880). Your PCP or the 24/7 NurseLine Representative can talk to you about your medical problem and give you advice on what you should do.

Some examples of when emergency services are needed include:

- Miscarriage/pregnancy with vaginal bleeding
- Heart attacks
- Severe chest pain
- Severe bleeding that does not stop
- Serious breathing difficulties
- Possible stroke

You do not have to contact UnitedHealthcare Community Plan for an okay before you get emergency services. If you have an emergency, call 911 or go to the NEAREST emergency room (ER) or other appropriate setting.
Remember, if you need emergency services:

• Go to the nearest hospital emergency room or other appropriate setting. Be sure to tell them that you are a member of UnitedHealthcare Community Plan and show them your ID card.
• If you need emergency transportation, contact 911 or your local emergency service.
• If the provider that is treating you for an emergency takes care of your emergency but thinks that you need other medical care to treat the problem that caused your emergency, the provider must call UnitedHealthcare Community Plan.
• You will need to call your Primary Care Provider as soon as possible after the emergency is under control. Your Primary Care Provider is available 24 hours a day, seven days a week to help you.
• If the hospital has you stay, please make sure that UnitedHealthcare Community Plan is called within 24 hours or as soon as possible. Please call Member Services at 1-800-895-2017 (hard-of-hearing: 711). This number is listed on your UnitedHealthcare Community Plan Member ID Card.

Prior Authorization

Prior authorization is for services that must be approved by UnitedHealthcare Community Plan. Your doctor must call Utilization Management (UM) at 1-800-366-7304 before you obtain a service or procedure that is listed as requiring a prior authorization. Our UM team is available Monday through Friday 8 a.m. to 5 p.m. On-call staff is available 24 hours a day, 7 days a week for emergency prior authorizations.

UnitedHealthcare Community Plan also reviews some of your services and care as they are happening. This is called concurrent review. Examples are when you are:

• A patient in the hospital
• Receiving home care by nurses
• Certain outpatient services such as speech therapy and physical therapy

UnitedHealthcare Community Plan reviews your progress with your doctor to be sure you still need those services or if other services would be better for you.

UnitedHealthcare Community Plan has policies and procedures to follow when they make decisions regarding medical services. The UM doctors and nurses make their decision based on your coverage and what you need for your medical condition. The goal is to make sure that services are medically necessary, that they are provided in an appropriate setting, and that quality care is provided.

We want to help you stay well. If you are sick we want you to get better.

• UnitedHealthcare Community Plan does not pay employees extra for limiting your care.
• Our network doctors do not receive extra money or rewards if they limit your care.

If you have questions about UM decisions or processes, call Member Services at 1-800-895-2017 (hard-of-hearing: 711).
**Hospital Care**

When you go to the hospital:
- If your hospital care is not an emergency, your Primary Care Provider (PCP) will make the plans for you to go.
- If your hospital care is an emergency, you, a family member, or a friend must tell UnitedHealthcare Community Plan within 24 hours or as soon as possible.

Why do you need to tell UnitedHealthcare Community Plan if you go to the hospital in an emergency?
- So UnitedHealthcare Community Plan will pay for covered services.
- So UnitedHealthcare Community Plan sees that you get follow-up care.

**Informed Consent**

Consent means that you say “yes” to medical treatment. Informed consent means the treatment was explained to you and you understand.
- You say yes before getting any treatment.
- Sometimes you may need to say yes in writing.
- If you do not want the medical treatment, your PCP will talk to you and tell you other choices.
- You have the right to say yes or no.

**No Medical Coverage Outside of the United States**

Any health care services you receive while out of the country will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services you receive outside of the United States.
Available Services

UnitedHealthcare Community Plan also offers the following extra services and/or benefits to their members:

**Dental Services**
All members receive routine dental exams and cleanings every six months. Some non-routine dental services may require a prior authorization. Please refer to your Provider Directory for a list of dental providers that are in the UnitedHealthcare Community Plan network to set up your dental appointment.

**Vision Services**
All members receive an eye exam every 12 months. They also have a choice of glasses or retail allowance of $125 toward any type of contacts (must use at one time) every 12 months. UnitedHealthcare Community Plan also offers an additional frame selection beyond what Medicaid covers at no cost to you. Please refer to your Provider Directory for a list of optometrists that are in the UnitedHealthcare Community Plan network to set up your eye appointment.

**Transportation Services**
If you need a ride to your PCP or other medical provider, we may be able to help. UnitedHealthcare Community Plan will provide you with 30 one-way or 15 round trips per year to and from your PCP, WIC, pharmacy, or other participating health care providers, such as vision or dental. You may also request help to get to your Medicaid redetermination visits.

If you must travel 30 miles or more from your home to receive covered health care services, UnitedHealthcare Community Plan will provide transportation to and from the provider’s office. These services must be medically necessary and not available in your service area. You must also have a scheduled appointment (except in the case of urgent/emergent care). Please contact Member Services at 1-800-895-2017 (hard-of-hearing: 711) at least 48 hours in advance of your appointment for assistance.

In addition to the transportation assistance that UnitedHealthcare Community Plan provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.

**Members Matter**
UnitedHealthcare Community Plan provides our members with a Members Matter representative. Members can contact their personal Members Matter representative or speak with any of our dedicated Member Services team by calling 1-800-895-2017 (hard-of-hearing: 711). Your Members Matter representative can also explain things such as:

- Ordering new ID cards
- Changing PCPs
- Information on participating providers
- How to access specialty care
- How to file a grievance or appeal
Your Members Matter representative may also contact you periodically to see if you may be able to benefit from any of our care management services.

**Mental Health and Substance Abuse Services**

If you need mental health and/or substance abuse services, please call Member Services at 1-800-895-2017 (hard-of-hearing: 711). You can also find additional UnitedHealthcare Community Plan providers on our website at [www.myuhc.com/communityplan](http://www.myuhc.com/communityplan) and in our Provider Directory. Or you may self-refer directly to an Ohio Department of Mental Health (ODMH) certified community mental health center or Ohio Department of Alcohol and Drug Addictions Services (ODADAS) certified treatment centers. Please see your Provider Directory or call Member Services for the names and telephone numbers of the facilities near you.

If you decide to use a Ohio Department of Mental Health certified Community Mental Health Center or Ohio Department of Alcohol and Drug Addiction Services (ODADAS) certified treatment center, you do not need a prior authorization for outpatient therapy. The mental health or substance abuse provider must get a prior authorization from UnitedHealthcare Community Plan before you get other services from these providers. This can include non-emergency inpatient, intensive outpatient, outpatient ECT (Electroconvulsive Therapy), psychological testing and home health services.

**Durable Medical Equipment, Home Health Services**

To obtain durable medical equipment (i.e. crutches, wheelchair) or home health services, contact your Primary Care Provider (doctor). Your doctor will contact UnitedHealthcare Community Plan for authorization.

**Medically Necessary Services**

Those medical services which:

(a) Are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a UnitedHealthcare Community Plan member;

(b) Are provided at an appropriate facility and at the appropriate level of care for the treatment of UnitedHealthcare Community Plan member's medical condition; and,

(c) Are provided in accordance with generally accepted standards of medical practice.

Some medically necessary services must get prior authorization before you can get them. Please see page 14 of this handbook for more information on prior authorization.
**Self-Referred Services**

You can receive some services without your PCP referring or recommending you to another doctor. These are called self-referred services. Examples of services that you can receive without your PCP referring you to another doctor include:

- Dental care
- Vision care
- Women’s routine and preventive health care services provided by a women’s health specialist (obstetrics, gynecology, certified nurse midwife)
- Specialty care (except for chemotherapy and pain management specialist services)
- Emergency care
- Services provided by Qualified Family Planning Providers (QFPP)
- Mental health and substance abuse services
- Services provided at Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC)
- Dialysis
- Radiation therapy
- Mammograms

You must go to a participating provider for all self-referred services except for emergency care or for services provided at Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC), Qualified Family Planning Providers (QFPP), Ohio Department of Mental Health certified community mental health centers, and Ohio Department of Alcohol and Drug Addiction Services certified treatment centers which are Medicaid providers. Participating providers would be those providers listed in your UnitedHealthcare Community Plan Provider Directory. Your Provider Directory will include specialists such as oncologists, gynecologists, optometrists, dentists, and psychologists. If you do not see your provider listed, call Member Services or visit [www.myuhc.com/communityplan](http://www.myuhc.com/communityplan) to find out if your provider is now accepting UnitedHealth Community Plan. To make sure you receive the best care, tell your PCP about any self-referred visits to specialists and other providers. By doing this, your PCP can help coordinate your health care. If you visit a provider that is not a participating provider with UnitedHealthcare Community Plan, these services may require a prior authorization.

**Women, Infants and Children Program (WIC)**

WIC is the Special Supplemental Nutrition Program for Women, Infants and Children. The WIC program provides nutritious food at no cost, breast-feeding support, nutrition education and health care referrals. If you are pregnant, ask your doctor to complete a WIC application at your doctor’s appointment. If you have an infant or child, ask your doctor to complete a WIC application or call Member Services at 1-800-895-2017 (hard-of-hearing: 711) for more information about the WIC program. Our Member Services staff can also give you information about the Help Me Grow program.
Kickoff to Good Health Program

As a new plan member, you can earn benefit credits for getting important check-ups. These credits can be used for a wide range of products such as personal hygiene/care, child care items, safety, and general wellness items from our Health Benefit Catalog at no cost to you. See the PCP on your member ID card within your first 90 days as a member to earn benefits credits to spend in our Health Benefit Catalog. Once you see your PCP, if you visit a participating dentist and participating vision provider within the first 6 months you can earn benefit credits for each of those visits as well. You must visit the PCP on your ID card within 90 days to qualify for any credits. If you need to change the PCP on your ID card, please call Member Services before your visit.

This program is available to new members who have not been with the plan in the past 12 months. New members will get information on the program in the mail, including information on how to earn credits and order items once their credits are awarded. Benefit credits are awarded in January and July each year. All credits awarded must be used at one time. Benefit credits expire 12 months after being awarded. You must be a current member to use benefit credits.
Your Health Plan Benefits

Services Covered by UnitedHealthcare Community Plan
As a UnitedHealthcare Community Plan member, you will continue to receive all medically-necessary Medicaid-covered services at no cost to you. These services may or may not require prior authorization before you receive the service. Please see the following charts to determine if your benefits require prior authorization.

Services That DO NOT Require a Prior Authorization (PA)
UnitedHealthcare Community Plan encourages you to work with your PCP to help coordinate access to these services. However, it is not required that you see your PCP prior to receiving these services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Nurse Midwife services</td>
<td>Covered</td>
</tr>
<tr>
<td>Certified Nurse Practitioner services</td>
<td>Covered</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered</td>
</tr>
<tr>
<td>Dental services</td>
<td>Routine exams and cleanings every six months. Some non-routine dental services may require a prior authorization.</td>
</tr>
<tr>
<td>Emergency services</td>
<td>Covered</td>
</tr>
<tr>
<td>Eye exams, routine vision (optical) services, including eyeglasses*</td>
<td>1 exam and 1 pair glasses or retail allowance of $125 toward any type of contacts (must use the entire benefit at one time) per 12 months. Must be for vision correction and not for cosmetic reasons only. Additional replacements may require prior authorization.</td>
</tr>
<tr>
<td>Family planning services and supplies</td>
<td>Covered</td>
</tr>
<tr>
<td>Federally Qualified Health Center or Rural Health Clinic services</td>
<td>Covered</td>
</tr>
<tr>
<td>Free-standing birth center services at a free-standing birth center</td>
<td>Call Member Services to find a qualified clinic</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Immunizations (shots)</td>
<td>Covered</td>
</tr>
<tr>
<td>Mental health and substance abuse services</td>
<td>*Prior authorization is required for mental health services not provided at Ohio Department of Mental Health certified community mental health centers and for substance abuse services not provided at Ohio Department of Alcohol and Drug Addiction Services certified treatment centers.</td>
</tr>
<tr>
<td>Obstetrical (maternity care — prenatal and postpartum including at risk pregnancy services) and gynecological services</td>
<td>Covered</td>
</tr>
<tr>
<td>Physical exam required for employment or for participation in job training programs</td>
<td>Covered if the exam is not provided free of charge by another source</td>
</tr>
<tr>
<td>Podiatry (foot) services</td>
<td>Covered</td>
</tr>
<tr>
<td>Preventative Mammogram (breast) and cervical cancer (pap smear) exams</td>
<td>Covered</td>
</tr>
<tr>
<td>Primary Care Provider services</td>
<td>Covered</td>
</tr>
<tr>
<td>Renal dialysis (kidney disease)</td>
<td>Covered</td>
</tr>
<tr>
<td>Respite Services</td>
<td>Covered. This service is for SSI members under 21 years of age</td>
</tr>
<tr>
<td>Screening and counseling for obesity</td>
<td>Covered</td>
</tr>
<tr>
<td>Specialist services</td>
<td>Covered in network in most cases</td>
</tr>
<tr>
<td>Yearly Well Adult Exams</td>
<td>Covered</td>
</tr>
<tr>
<td>Well-child (Healthchek) exams for children under the age of 21</td>
<td>Covered</td>
</tr>
</tbody>
</table>
### Services That DO Require a Prior Authorization (PA)

Your doctor must call UnitedHealthcare Community Plan’s Utilization Management Department at 1-800-366-7304 to get approval before you can receive the following services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic (back) services</td>
<td>Members age 21 and over are covered for 15 visits per calendar year.</td>
</tr>
<tr>
<td>Developmental therapy services for children aged birth to six years</td>
<td>Covered</td>
</tr>
<tr>
<td>Home health services</td>
<td>Covered</td>
</tr>
<tr>
<td>Hospice care (care for terminally ill, e.g., cancer patients)</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient hospital services</td>
<td>Covered</td>
</tr>
<tr>
<td>Medically necessary plastic or cosmetic surgery</td>
<td>Covered (Initial plastic surgery office visit to determine treatment does not require prior authorization.)</td>
</tr>
<tr>
<td>Nursing facility services for a short term rehabilitative stay</td>
<td>Covered for up to 60 days (end of month after admission). For example: If admitted March 3rd, coverage lasts from admission date through April 30th:</td>
</tr>
<tr>
<td>Pain management specialist services</td>
<td>Covered</td>
</tr>
<tr>
<td>Physical and occupational therapy</td>
<td>Covered</td>
</tr>
<tr>
<td>Speech and hearing services, including hearing aids</td>
<td>Covered</td>
</tr>
</tbody>
</table>
### Services That MAY Require a Prior Authorization (PA)

Depending on the level of care needed, these services may require approval before you can receive them. Please see your Primary Care Provider (PCP).

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance and ambulette transportation</td>
<td>Covered</td>
</tr>
<tr>
<td>Diagnostic services (X-ray, lab)</td>
<td>Covered</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Covered</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient surgeries</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescription Drugs, including certain prescribed over-the-counter drugs</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>Please refer to Preferred Drug List for details.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.myuhc.com/communityplan">www.myuhc.com/communityplan</a></td>
</tr>
<tr>
<td>Services for children with medical handicaps (Title V)</td>
<td>Covered</td>
</tr>
</tbody>
</table>
Services NOT Covered by UnitedHealthcare Community Plan or Ohio Medicaid

UnitedHealthcare Community Plan will not pay for services or supplies received without following the directions in this handbook. UnitedHealthcare Community Plan will not pay for the following services that are not covered by Medicaid:

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Acupuncture and biofeedback services
- All services or supplies that are not medically necessary
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered)
- Paternity testing
- Plastic or cosmetic surgery that is not medically necessary
- Services for the treatment of obesity unless determined medically necessary
- Services to find cause of death (autopsy) or services related to forensic studies
- Services determined by Medicare or another third-party payer as not medically necessary
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure

This is not a complete list of the services that are not covered by Medicaid or UnitedHealthcare Community Plan. If you have a question about whether a service is covered, please call the Member Services Department.
Getting Prescriptions

Prescription Drugs
While UnitedHealthcare Community Plan covers all medically necessary Medicaid-covered medications, we use a preferred drug list (PDL). These are the drugs that we prefer that your provider prescribe. We may also require that your provider submit information to us (a prior authorization request) to explain why a specific medication and/or certain amount of a medication is needed. We must approve the request before you can get the medication. Reasons why we may prior authorize a drug include:

• There is a generic or pharmacy alternative drug available,
• The drug can be misused/abused,
• There are other drugs that must be tried first.
• There are other drugs that may be better for your condition.

Some drugs may also have quantity (amount) limits, and some drugs are never covered, such as drugs for weight loss.

We also apply limits to certain classes of drugs. You may fill any FOUR medications from the following classes in a 30-day period:

• Opiate analgesics
• Benzodiazepines
• Sedative hypnotic agents
• Barbiturates
• Select muscle relaxants

Additional fills will require prior authorization. Medications in these classes may also be subject to individual quantity limits.

If we do not approve a prior authorization request for medication, we will send you information on how you can appeal our decision and your right to a state hearing.

You can call member services to request information on our PDL and medications that require prior authorization. You can also look on our website at www.myuhc.com/communityplan. Select your plan. Then select “Find a Drug.” Please note that our PDL and list of medications that require prior authorization can change so it is important for you and/or your provider to check this information when you need to fill/refill a medication.

Coordinated Services Program
UnitedHealthcare Community Plan provides care management to members who use services in an amount or frequency that exceeds medical necessity. This is done to make sure you get high quality, coordinated health care. If you are chosen to be part of this program you will be given a Care Manager. The Care Manager will get in touch with you prior to your start date in the program.
If you are part of the program, you will get a letter asking you to pick a pharmacy and confirm your PCP. If you do not choose a pharmacy within 30 days from the date the letter was mailed, UnitedHealthcare Community Plan will pick a network pharmacy based on the following:

- Where you have gone before
- Open 24 hours, if possible
- Close to your home

Before your start date with this program, you will get a new ID card that will list your pharmacy and PCP. If you need to change the pharmacy on your ID card, call Member Services at 1-800-895-2017 (Relay: 711). Requests for pharmacy changes will be reviewed on an individual basis.

Those chosen for the program will get more details in the mail and will be notified of their right to a state hearing.
UnitedHealthcare Community Plan
Programs and Services

Quality Improvement

UnitedHealthcare Community Plan wants you to get quality health care and services. We study the care you get from your doctors and other health care providers. We look for ways to make our services to you better and find and fix any problems.

For a description of the Quality Improvement program for UnitedHealthcare Community Plan, information on how we are meeting our goals or information on our practice guidelines, please write to:

UnitedHealthcare Community Plan
Quality Improvement
9200 Worthington Road, 3rd Floor
Westerville, Ohio 43082

Disease and Care Management Programs

UnitedHealthcare Community Plan offers care management services that are available to children and adults with special health care needs. Our Personal Care Model™ cares for members who have serious health problems and/or on-going conditions. We want our members to enjoy the highest quality of life.

What can the UnitedHealthcare Community Plan Care Manager provide for you?

• A health assessment to identify your special needs
• Contact by phone and home visits as needed
• Help finding community resources and home health care
• Help with medical transportation
• Arranging for Durable Medical Equipment (DME) and other services as needed or ordered by the physician
• Help with keeping doctor’s appointments
• Neo-natal Intensive Care Unit/Case Management
• High Risk Pregnancy Care Management
• Health education and educational materials
• Disease management programs for conditions such as
  – Asthma
  – Diabetes
  – COPD (Lung diseases)
  – Heart Failure
  – Kidney Disease
  – Behavioral Health

UnitedHealthcare Community Plan may ask you questions to learn more information about your condition(s). We may contact you if you or your doctor request a phone call or if we think we have care management services that would be helpful to you. UnitedHealthcare Community Plan staff will talk to your PCP and other service providers to coordinate care. Disease and Care Management staff may include nurses, care managers, health coaches, social workers and behavioral health team members.

My Advocate™

My Advocate™ helps members learn about and get enroll into money-saving social programs like, food, housing, utility discounts, free wireless cell phone programs and child care in their community.
To reach a live Advocate call 1-855-759-5342, or log on to myadvocatehelps.com. My Advocate™ representatives can help bring much needed relief from some of the financial challenges facing a growing number of low-income, seniors, and disabled individuals throughout the country by accessing the more than 7,500 public and privately sponsored social programs.

**Do You Need Help?**

Call us if you have any questions about or feel you would benefit from Care Management services. To learn more about our programs, call Member Service at 1-800-895-2017 (hard-of-hearing: 711).

**If You Are Going to Have a Baby**

**Healthy First Steps™ (A Program for Our Pregnant Members)**

Healthy moms are more likely to have a healthy baby. Pregnancy is an important time for women to take good care of themselves and their unborn baby. Some women may have risk factors that can cause problems during pregnancy. These problems could cause early labor. A baby born too early may be sick or have to stay in the hospital. We want the best possible health for the mom and baby.

We have a special program for pregnant members. Our Healthy First Steps™ program gives pregnant women the information, education and support they need during pregnancy. If you are pregnant, call to enroll in Healthy First Steps™ at 1-800-599-5985.

We want to help you have a healthy pregnancy. Our staff will assist you in getting the care you need. We can also help you get ready for the birth and care of your baby.

It is important to see a doctor as soon as you think you are pregnant. If you have problems finding a doctor or getting an appointment we can help you. We will also work with you in locating community services such as WIC, behavioral health care and social services.

Let Healthy First Steps™ help you make your pregnancy the healthiest it can be.

**Healthchek**

Healthchek is Ohio’s Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone eligible for Medicaid and under the age of 21 years. These exams are important to make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at birth, 3 – 5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year.

Healthchek also covers complete medical, vision, dental, hearing, nutritional, developmental and mental health exams, in addition to other care to treat physical, mental or other problems or conditions found by an exam. Healthchek covers tests and treatment services that may not be covered for people over age 20; some of the tests and treatment services may require prior authorization.
Healthchek services are available at no cost to members and include:

- Preventative check-ups for newborns, infants, children, teens, and young adults under the age of 21.
- Healthchek screenings:
  - Complete medical exams (with a review of physical and mental health development)
  - Vision exams
  - Dental exams
  - Hearing exams
  - Nutrition checks
  - Developmental exams
  - Lead testing
- Laboratory tests for certain ages.
- Immunizations
- Medically necessary follow up care to treat physical, mental, or other health problems or issues found during a screening. This could include, but is not limited to, services such as:
  - Visits with a primary care provider, specialist, dentist, optometrist and other UnitedHealthcare Community Plan providers to diagnose and treat problems or issues
  - In-patient or outpatient hospital care
  - Clinic visits
  - Prescription drugs
  - Laboratory tests
- Health Education

It is very important to get preventive check ups and screenings so your providers can find any health problems early and treat them, or make a referral to a specialist for treatment, before the problem gets more serious. Some services may require a referral from your PCP or prior authorization by UnitedHealthcare Community Plan. Also, for some EPSDT items or services, your provider may request prior authorization for UnitedHealthcare Community Plan to cover things that have limits or are not covered for members over age 20. Please see pages 22 – 23 to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members under the age of 21 years who have special health care needs. Please see pages 27 – 31 to learn more about the care management services offered by UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan will give you the help you need to get a Healthchek screening and any follow-up services. Call UnitedHealthcare Community Plan Member Services at 1-800-895-2017 (hard-of-hearing: 711) to see if you are eligible for Healthchek and to receive information on how to obtain Healthchek services. You can also call your PCP to make an appointment for a Healthchek exam. Please make sure to ask for a Healthchek exam when you call. It is very important to make appointments with a PCP and dentist for regular check-ups. If your child is under age 2, you may also be eligible to earn gift rewards by taking your child for regular Healthchek visits. Call Member Services at 1-800-895-2017 (hard-of-hearing: 711) for more information.

We can help you find a doctor, dentist or healthcare specialist. We will call you with reminders when your child is due for a Healthchek screen. If you need help making appointments, we will help you. If you do not
have a way of getting to your appointments, ask us for help with transportation. If you suspect a problem with your child, schedule a Healthchek visit even if it is not yet time for one. This will help you detect and treat any problems early.

If you would like more information on Healthchek or how you can earn rewards for Healthchek visits for children under age 2, please contact Member Services at 1-800-895-2017 (hard-of-hearing: 711).

**Baby Blocks™ Program**

**Gives Your Baby a Healthy Start**

If you are a UnitedHealthcare Community Plan member who is pregnant, you can earn rewards with Baby Blocks™. When you join, you get a gift card or other cool gear for your baby. Then earn up to seven more rewards with doctor visits during pregnancy and your baby’s first 15 months. You earn great rewards while both you and your baby get the care you need to stay healthy. To enroll, go to [www.uhcbabyblocks.com](http://www.uhcbabyblocks.com). Click on “Sign up.”

**Dr. Health E. Hound® Program**

We are proud of our mascot — Dr. Health E. Hound®. Dr. Health E. Hound’s goal is to help teach your kids about fun ways to stay fit and healthy. Dr. Health E. Hound loves to travel around the state and meet kids of all ages. He likes to hand out flyers, posters, stickers and coloring books to remind kids to eat healthy foods and exercise. He also helps kids understand that going to the doctor for check-ups and shots is an important way to stay healthy.

You and your family can meet Dr. Health E. Hound in person at some of our health plan events. We encourage you to come to an event and learn about the importance of healthy eating and exercise. Bring a camera to these events and get your picture taken with Dr. Health E. Hound.

**Community Rewards™**

Help your child get a healthy start in life. And earn points for toys, games, electronics and more. Here’s how it works:

- Children earn points for things like brushing their teeth, eating healthy and getting a good night’s sleep.
- Mom and dad earn points for things like reading the welcome kit, calling our NurseLine™, and taking their children to the doctor for well-child visits.
- Use your computer or smartphone to record each healthy thing your family does.
- Do something every day, and your family’s points can really add up.
- Use your points to reward your child or yourself. Choose from toys, electronics, kitchen tools, exercise equipment and more.

It’s that easy. The rewards are great. But your child’s health is the best reason of all to start today.

Enroll at [UHCCommunityRewards.com](http://UHCCommunityRewards.com). Register all your children who are 21 years of age and younger, and are UnitedHealthcare Community Plan members. You’ll need each child’s member ID number.
Member Advisory Board

The Member Advisory Board is an advisory council to ensure that UHC actively engages consumers, families, advocacy groups, and other key stakeholders as partners in the complex care program design and delivery system.

Who can join?

- UnitedHealthcare Community Plan members
- Family members and caregivers of UnitedHealthcare Community Plan members.
- Representatives from community and consumer advocacy groups

Participants can:

- Share feedback and ideas with the UnitedHealthcare team.
- Join a monthly call with UnitedHealthcare leaders about health and wellness.
- Attend an annual regional meeting.
- Sign up for free advocacy trainings.

For information about the advisory council, contact:

Members Matters at 1-800-895-2017 extensions 6, 7 or 8.
Membership Information

Changes to Your Membership

Please call or write UnitedHealthcare Community Plan if you have changed:
• Your address
• Your phone number.

Automatic Renewal of MCP Membership

If you lose your Medicaid eligibility but it is started again within 60 days, you will automatically become a UnitedHealthcare Community Plan member again.

Changes in Your Family Size

If any changes occur in your family size (marriage, divorce, birth, adoption and death), call your local County Department of Job and Family Services (CDJFS) to let them know. You should also call Member Services at 1-800-895-2017 (hard-of-hearing: 711) and let us know.

Ending Your MCP Membership

As a member of a managed care plan, you have the right to choose to end your membership at certain times during the year. You can choose to end your membership during the first three months of your membership or during the annual open enrollment month for your area. The Ohio Department of Medicaid will send you something in the mail to let you know when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care.

If you want to end your membership during the first three months of your membership or open enrollment month for your area, you can call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). You can also submit a request online to the Medicaid Hotline website at www.ohiomh.com. Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you choose another managed care plan, your new plan will send you information in the mail before your membership start date.

Choosing a New Plan

If you are thinking about ending your membership to change to another health plan, you should learn about your choices. Especially if you want to keep your current doctor(s). Remember, each health plan has its own list of doctors and hospitals that they will allow you to use. Each health plan also has written information which explains the benefits it offers and the rules that it has. If you would like written information about a health plan you are thinking of joining or if you simply would like to ask questions about the health plan, you may either call the plan or call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). You can also find information about the health plans in your area by visiting the Medicaid Hotline website at www.ohiomh.com.
**Just Cause Membership Terminations**

Sometimes there may be a special reason that you need to end your health plan membership. This is called a “Just Cause” membership termination. Before you can ask for a just cause membership termination you must first call your managed care plan and give them a chance to resolve the issue. If they cannot resolve the issue, you can ask for a just cause termination at any time if you have one of the following reasons:

1. You move and your current MCP is not available where you now live and you must receive non-emergency medical care in your new area before your MCP membership ends.

2. The MCP does not, for moral or religious objections, cover a medical service that you need.

3. Your doctor has said that some of the medical services you need must be received at the same time and all of the services aren’t available on your MCP’s panel.

4. You have concerns that you are not receiving quality care and the services you need are not available from another provider on your MCP’s panel.

5. Lack of access to medically necessary Medicaid-covered services or lack of access to providers that are experienced in dealing with your special health care needs.

6. The PCP that you chose is no longer on your MCP’s panel and he/she was the only PCP on your MCP’s panel that spoke your language that is located within a reasonable distance from you. Another health plan has a PCP on their panel that speaks your language that is located within a reasonable distance from you and will accept you as a patient.

7. Other — If you think staying as a member in your current health plan is harmful to you and not in your best interest.

You may ask to end your membership for Just Cause by calling the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). The Ohio Department of Medicaid will review your request to end your membership for just cause and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your membership and the date it ends. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care unless the Ohio Department of Medicaid tells you differently. If your just cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.
Things to Keep in Mind if You End Your Membership

If you have followed any of the above steps to end your membership, remember:

• Continue to use UnitedHealthcare Community Plan doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.

• If you chose a new health plan and have not received a member ID card before the first day of the month when you are a member of the new plan, call the plan’s Member Services Department. If they are unable to help you, call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572).

• If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker.

• If you have chosen a new health plan and have any medical visits scheduled, please call your new plan to be sure that these providers are on the new plan’s list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new doctor, a surgery, blood test or X-ray scheduled and especially if you are pregnant.

• If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

Optional Membership Terminations

Children under nineteen (19) years of age have the option to choose not to be a member of a managed care plan if they are:

• Receiving foster care or adoption assistance under Title IV-E;

• In foster care or an out of home placement; or

• Receiving services through the Ohio Department of Health’s Bureau for Children with Medical Handicaps (BCMH).

Additionally, if anyone is a member of a federally recognized Indian tribe, regardless of age, they have the option to not be a member of a managed care plan. If you believe that you/your child meet any of the above criteria and do not want to be a member of a managed care plan, you can call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). If someone meets the above criteria and does not want to be an MCP member, their membership will be ended.

Exclusions – Individuals That Are Not Permitted to Join a MCP

• Dually eligible under both the Medicaid and Medicare programs;

• Institutionalized (in a nursing home, long-term care facility, ICF-MR, or some other kind of institution);
• Eligible for Medicaid by spending down their income or resources to a level that meets the Medicaid program’s financial eligibility requirements; or
• Receiving Medicaid Waiver services.
• Receiving services through the Ohio Department of Health’s Bureau for Children with Medical Handicaps (BCMH) for a diagnosis of cancer, cystic fibrosis or hemophilia.

If you believe that you meet any of the above criteria and should not be a member of a managed care plan, you must call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). If you meet the above criteria your MCP membership will be ended.

Can UnitedHealthcare Community Plan End My Membership?

UnitedHealthcare Community Plan may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio Department of Medicaid must okay the request before your membership can be ended. The reasons that UnitedHealthcare Community Plan can ask to end your membership are:

• For fraud or for misuse of your UnitedHealthcare Community Plan Member ID Card
• For disruptive or uncooperative behavior to the extent that it affects the MCP’s ability to provide services to you or other members.

UnitedHealthcare Community Plan provides services to our members because of a contract that UnitedHealthcare Community Plan has with the Ohio Department of Medicaid. If you want to contact the Ohio Department of Medicaid you can write to:

Ohio Department of Medicaid
Bureau of Managed Care
P.O. Box 182709
Columbus, Ohio 43218-2709

or call:
1-800-324-8680
TTY: 1-800-292-3572

You can also visit the Ohio Department of Medicaid on the web at www.medicaid.ohio.gov.

You can contact UnitedHealthcare Community Plan to get any other information you want including the structure and operation of UnitedHealthcare Community Plan and how we pay our providers. If you want to tell us about things you think we should change, please call Member Services at 1-800-895-2017 (hard-of-hearing: 711).

Other Health Insurance (Coordination of Benefits – COB)

If you or anyone in your family has health insurance with another company, it is very important that you call the member services department and your county caseworker about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent then you need to call the Member Services Department to give us the information.
It is also important to call member services and your county caseworker if you have lost health insurance that you had previously reported. Not giving us this information can cause problems with getting care and with bills.

UnitedHealthcare Community Plan follows Ohio insurance guidelines for members with commercial insurance. Your commercial insurance is considered your primary or first coverage. UnitedHealthcare Community Plan is second. You should follow the guidelines of your primary insurance when you get medical care. Be sure to show both insurance cards to your health care providers.

Providers will bill your primary insurance first. After your primary insurance pays the allowed amount, the provider will bill UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will pay the provider the amount agreed upon in our contract with the provider.

**Accidental Injury or Illness**

*(Subrogation)*

If a UnitedHealthcare Community Plan member has to see a doctor for an injury or illness that was caused by another person or business, you must call the Member Services Department to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store then another insurance company might have to pay the doctor's and/or hospital’s bill.

When you call we will need the name of the person at fault, their insurance company and the name(s) of any attorneys involved. UnitedHealthcare Community Plan will then work with your employer or auto insurance company and other health plans to help make sure that the bills are paid.

**Loss of Medicaid Eligibility**

It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don’t give them the information they ask for, you can lose your Medicaid eligibility. If this happened, UnitedHealthcare Community Plan would be told to stop your membership as a Medicaid member and you would no longer be covered by UnitedHealthcare Community Plan. If you need assistance with transportation to keep your redetermination visit with the County Department of Job and Family Services, please call Member Services at 1-800-895-2017 (hard-of-hearing: 711).

**Loss of Insurance Notice**

*(Certificate of Creditable Coverage)*

Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company that says you no longer have insurance. It is important that you keep a copy of this notice for your records because you might be asked to provide a copy.
New Member Information

If you were on Medicaid fee-for-service the month before you became a UnitedHealthcare Community Plan member and have health care services already approved and/or scheduled, it is very important that you call member services immediately (today or as soon as possible).

In certain situations, and for a specified time period after you enroll, we may allow you to receive the care from a provider that is not a UnitedHealthcare Community Plan panel provider. Additionally, we may allow you to continue to receive services that were authorized by Medicaid fee-for-service. **However, you must call UnitedHealthcare Community Plan before you receive the care.**

If you do not call us, you may not be able to receive the care and/or the claim may not be paid. For example, you need to call Member Services if you have the following services already approved and/or scheduled:

- Organ, bone marrow, or hematopoietic stem cell transplant
- Third trimester prenatal (pregnancy) care, including delivery
- Inpatient/outpatient surgery
- Appointment with a specialty provider
- Chemotherapy or radiation treatments
- Treatment following discharge from the hospital in the last 30 days
- Non-routine dental or vision services (for example braces or surgery)
- Medical equipment
- Services you receive at home, including home health, therapies, and nursing

After you enroll, your MCP will tell you if any of your current medications require authorization that did not require prior authorization when they were paid by Medicaid fee-for-service. It is very important that you look at the information the MCP provides and contact your MCP’s member services if you have any questions. You can also look on your MCP’s website to find out if your medication(s) require prior authorization. You may need to follow up with your prescriber’s office to submit a prior authorization request to your MCP if it is needed. If your medication(s) requires prior authorization, you cannot get the medication(s) until your provider submits a request to your MCP and it is approved.
Fraud and Abuse

Fraud and Abuse Hotline

The Ohio Department of Insurance has a toll free number to call if you want to report a medical provider (for example a doctor, dentist, therapist, hospital) or business (medical supplier) for suspected fraud or abuse for services provided to anyone with a UnitedHealthcare Community Plan Member ID Card or Medicaid card. The number is 1-800-686-1527 or, 614-644-2671.

You may also write to ODI at:
Ohio Department of Insurance:
Fraud Unit
2100 Stella Court
Columbus, Ohio 43215

Additionally you can send a paper or electronic form to UnitedHealthcare Community Plan that can be accessed via link noted below:

http://www.UHCCommunityPlan.com/assets/SpecialInvestigationReferralForm.pdf

Some common examples of fraud and abuse are:

• Billing or charging you for services that your health plan covers
• Offering you free services, equipment, or supplies in exchange for your Medicaid number
• Giving you treatment or services that you don’t need
• Physical, mental, or sexual abuse by medical staff
• Someone using another person’s Medicaid or UnitedHealthcare Community Plan Member ID card. You do not have to give your name and if you do, the provider will not be told you called.

Fraud and Abuse Hotline

You can also report suspected fraud and abuse to UnitedHealthcare Community Plan by calling toll-free at 1-877-766-3844 and leaving a detailed message. This also has been set up so you do not have to give your name.

Remember: never give your member ID card to anyone else to use.
As a Member of UnitedHealthcare Community Plan, You Have the Following Rights:

- To receive all services that UnitedHealthcare Community Plan must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure that others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless UnitedHealthcare Community Plan has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or MCP must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See the section called “How to Let UnitedHealthcare Community Plan Know if You Are Unhappy or Do Not Agree With a Decision We Made” in this Member Handbook for information.
- To be able to get all UnitedHealthcare Community Plan written member information from the plan:
  - At no cost to you;
  - In the prevalent non-English languages of members in the MCP’s service area;
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To get information about UnitedHealthcare Community Plan services, our practitioners and providers, and member rights and responsibilities.
- To be able to get help free of charge from UnitedHealthcare Community Plan and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See pages 45 – 49, which explains about
advance directives. You can also contact member services for information.

• To file any complaint about not following your advance directive with the Ohio Department of Health.

• To change your Primary Care Provider (PCP) to another PCP on UnitedHealthcare Community Plan’s panel at least monthly. UnitedHealthcare Community Plan must send you something in writing that says who the new PCP is and the date the change began.

• To be free to carry out your rights and know that the MCP, the MCP’s providers, or the Ohio Department of Medicaid will not hold this against you.

• To know that the MCP must follow all federal and state laws, and other laws about privacy that apply.

• To choose the provider that gives you care whenever possible and appropriate.

• If you are a female, to be able to go to a woman’s health provider on UnitedHealthcare Community Plan’s panel for covered woman’s health services.

• To be able to get a second opinion from a qualified provider on UnitedHealthcare Community Plan’s panel. If a qualified provider is not able to see you, UnitedHealthcare Community Plan must set up a visit with a provider not on our panel.

• To get information about UnitedHealthcare Community Plan from us.

• To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Medicaid Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran’s status, ancestry, health status or need for health services.

Office for Civil Rights:
United States Department of Health and Human Services
233 N. Michigan Ave. – Suite 240
Chicago, Illinois 60601
1-312-886-2359 (TTY: 1-312-353-5693)

Bureau of Civil Rights Ohio:
Ohio Department of Medicaid
30 E. Broad St., 30th Floor
Columbus, Ohio 43215
1-614-644-2703; 1-866-227-6353
(TTY: 1-866-221-6700)
Fax: 1-614-752-6381

• To share ideas to make UnitedHealthcare Community Plan better; including recommendations regarding your rights and responsibilities.

• To talk openly about all appropriate and needed medical treatment options no matter what the cost or benefit coverage.
As a Member of UnitedHealthcare Community Plan, You Have the Responsibility:

- To understand how UnitedHealthcare Community Plan works by reading this book
- To choose your Primary Care Provider
- To carry your UnitedHealthcare Community Plan card; (You must show your card when receiving services and to report a stolen or lost card as soon as possible. You also must inform UnitedHealthcare Community Plan of any other insurance you may have, and to present current insurance information to your Primary Care Provider.).
- To seek medical attention as needed.
- To be on time for all appointments.
- To tell your PCP’s office or any medical office if you need to change an appointment.
- To respect the rights and property of your PCP, other healthcare workers, and other patients.
- To know when to take your medicine, how to take your medicine and to follow your doctor’s instructions.
- To give the right medical information about yourself.
- To take full responsibility, think about the consequences of your decision if you refuse care (say no) to treatment, and ask questions if you don’t understand.
- To understand as best you can your health problems and take part in developing mutually agreed upon treatments
- To be sure that your Primary Care Provider has all your medical records; (This includes all medical records from other doctors.)
- To let UnitedHealthcare Community Plan know if you are in the hospital: (Do this in 24 hours or as soon as possible.)
- To consent to the proper use of your health information
- To keep your Medicaid eligibility current so you do not lose your UnitedHealthcare Community Plan membership.
When You Are Unhappy With a Decision We Have Made

How to Let UnitedHealthcare Community Plan Know if You Are Unhappy or Do Not Agree With a Decision We Made

If you are unhappy with anything about UnitedHealthcare Community Plan or its providers you should contact us as soon as possible. This includes if you do not agree with a decision we have made. You, or someone you want to speak for you can contact us. If you want someone to speak for you, you will need to let us know this. UnitedHealthcare Community Plan wants you to contact us so that we can help you. To contact us you can:

• Call Member Services at 1-800-895-2017 (hard-of-hearing: 711), or
• Fill out the form in your member handbook, or
• Call Member Services to request they mail you a form, or
• Visit our website at www.UHCCommunityPlan.com, or
• Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your UnitedHealthcare Community Plan Member ID Card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

Mail the form or your letter to:
UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

UnitedHealthcare Community Plan will send you something in writing if we make a decision to:
• Deny a request to cover a service for you;
• Reduce, suspend or stop services before you receive all of the services that were approved; or
• Deny payment for a service you received that is not covered by UnitedHealthcare Community Plan.

We will also send you something in writing if, by the date we should have, we did not:
• Make a decision on whether to okay a request to cover a service for you, or
• Give you an answer to something you told us you were unhappy about.

If you do not agree with the decision/action listed in the letter, and you contact us within 90 calendar days to ask that we change our decision/action, this is called an appeal. The 90 calendar day period begins on the day after the mailing date on the letter. Unless we tell you a different date, we will give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we have made a decision to reduce, suspend or stop services before you receive all of the services that were approved, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services.
If you contact us because you are unhappy with something about UnitedHealthcare Community Plan or one of our providers, this is called a grievance. UnitedHealthcare Community Plan will give you an answer to your grievance by phone (or by mail if we can’t reach you by phone) within the following time frames:

- 2 working days for grievances about not being able to get medical care
- 30 calendar days for all other grievances except grievances that are about getting a bill for care you have received
- 60 calendar days for grievances about getting a bill for care you have received.

You also have the right at anytime to file a complaint by contacting the:

Ohio Department of Medicaid
Bureau of Managed Care
P.O. Box 182709
Columbus, OH 43218-2709
1-800-605-3040; 1-800-324-8680
TTY: 1-800-292-3572

Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, OH 43215
1-800-686-1526

State Hearings

UnitedHealthcare Community Plan will notify you of your right to request a state hearing when:

- A decision is made to deny services
- A decision is made to reduce, suspend, or stop services before all of the approved services are received
- A provider is billing you because UnitedHealthcare Community Plan has denied payment of the service
- A decision is made to propose enrollment or continue enrollment in the UnitedHealthcare Community Plan Coordinated Services Program.
- A decision is made to deny your request to change your UnitedHealthcare Community Plan Coordinated Services Program provider.

At the time UnitedHealthcare Community Plan makes the decision, or is aware that the provider is billing you for payment, we will mail you a state hearing form. If you want a state hearing, you must request a hearing within 90 calendar days. The 90 calendar day period begins on the day after the mailing date on the hearing form. If we have made a decision to reduce, suspend, or stop services before all of the approved services are received and you request the hearing within 15 calendar days from the mailing date on the form, we will not take the action until all approved services are received or until the hearing is decided, whichever date comes first.
You may have to pay for services you receive after the proposed date to reduce, suspend, or stop services if the hearing officer agrees with our decision. If we propose to enroll you in the UnitedHealthcare’s Coordinated Service Program (CSP) and you request the hearing within 15 calendar days from the mailing date on the form, we will not enroll you in the program until the hearing decision.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if the MCP or Bureau of State Hearings decides that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than 3 working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function. To request a hearing you can sign and return the state hearing form to the address of fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit your request via email at bsh@jfs.ohio.gov. A state hearing is a meeting with you, someone from the County Department of Job and Family Services, someone from UnitedHealthcare Community Plan and a hearing officer from the Ohio Department of Medicaid. UnitedHealthcare Community Plan will explain why we made our decision and you will tell why you think we made the wrong decision. The hearing officer will listen and then decide who is right based upon the information given and whether we followed the rules. If you want information on free legal services but don’t know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 1-800-589-5888, for the local number.
**Advance Directives**

**You Have the Right**

**Using Advance Directives to State Your Wishes About Your Medical Care**

Many people today worry about the medical care they would get if they became too sick to make their wishes known. Some people may not want to spend months or years on life support. Others may want every step taken to lengthen life.

**You Have a Choice**

A growing number of people are acting to make their wishes known. You can state your medical care wishes in writing while you are healthy and able to choose. Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes in writing. This brochure explains your rights under Ohio law to accept or refuse medical care. It will help you choose your own medical care. This brochure also explains how you can state your wishes about the care you would want if you could not choose for yourself. This brochure does not contain legal advice, but will help you understand your rights under the law. For legal advice, you may want to talk to a lawyer. For information about free legal services, 1-800-589-5888, Monday through Friday, 8:30 a.m. to 5 p.m.

**What kinds of forms are there?**

Under Ohio law, there are four different forms, or advance directives, you can use. You can use either a Living Will, a Declaration for Mental Health Treatment, or a Durable Power of Attorney for medical care or a Do Not Resuscitate (DNR) Order. You fill out an advance directive while you're able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

**Do I have to fill out an advance directive before I get medical care?**

No. No one can make you fill out an advance directive. You decide if you want to fill one out.

**Who can fill out an advance directive?**

Anyone 18 years old or older who is of sound mind and can make his or her own decisions can fill one out.

**Do I need a lawyer?**

No, you don't need a lawyer to fill out an advance directive. Still, you may decide you want to talk with a lawyer.

**What if I'm too sick to decide? What if I can't make my wishes known?**

Most people can make their wishes about their medical care known to their doctors. But, some people become too sick to tell their doctors about the type of care they want. Under Ohio law, you have the right to fill out a form while you're able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.
Do the people giving me medical care have to follow my wishes?
Yes, if your wishes follow state law. However, Ohio law includes a conscience clause. A person giving you medical care may not be able to follow your wishes because they go against his or her conscience. If so, they will help you find someone else who will follow your wishes.

Living Will
This form allows you to put your wishes about your medical care in writing. You can choose what you would want if you were too sick to make your wishes known. You can state when you would or would not want food and water supplied artificially (see page 48).

How does a Living Will work?
A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are:

- In a coma that is not expected to end, or
- Beyond medical help with no hope of getting better and can’t make your wishes known, or
- Expected to die and can’t make your wishes known.

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes. Only you can change or cancel your Living Will. You can do so at any time.

Do Not Resuscitate Order
State regulations offer a Do Not Resuscitate (DNR) Comfort Care and Comfort Care Arrest Protocol as developed by the Ohio Department of Health. A DNR Order means a directive issued by a physician or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, which identifies a person and specifies that CPR should not be administered to the person so identified. CPR means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person’s airway for a purpose other than as a component of CPR.

The DNR Comfort Care and Comfort Care Arrest Protocol lists the specific actions that paramedics, emergency medical technicians, physicians or nurses will take when attending to a DNR Comfort Care or Comfort Care Arrest order. The protocol also lists what specific actions will not be taken.

You should talk to your doctor about the DNR Comfort Care and Comfort Care Arrest order and protocol options.
Durable Power of Attorney

A Durable Power of Attorney for medical care is different from other types of powers of attorney. This brochure talks only about a Durable Power of Attorney for medical care, not about other types of powers of attorney. A Durable Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person who acts for you if you can’t act for yourself. This could be for a short or a long while.

Who should I choose?
You can choose any adult relative or friend whom you trust to act for you when you can’t act for yourself. Be sure to talk with the person about what you want. Then write down what you do or don’t want on your form. You should also talk talk to your doctor about what you want. The person you choose must follow your wishes.

When does my Durable Power of Attorney for medical care take effect?
This form takes effect only when you can’t choose your care for yourself, whether for a short or long while. The form only allows your relative or friend to stop life support only in the following circumstances:

- If you are in a coma that is not expected to end, or
- If you are expected to die.

Declaration for Mental Health Treatment

A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows a person, while capable, to appoint a proxy to make decisions on his or her behalf when he or she lacks the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. The person can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

The Declaration for Mental Health Treatment supercedes a Durable Power of Attorney for mental health care, but does not supercede a Living Will.

Advance Directives

What is the difference between a Durable Power of Attorney for medical care and a Living Will?
Your Living Will explains, in writing, the type of medical care you would want if you couldn’t make your wishes known.

Your Durable Power of Attorney lets you choose someone to carry out your wishes for medical care when you can’t act for yourself.
Advance Directives (cont.)

If I have a Durable Power of Attorney for medical care, do I need a Living Will, too?
You may want both. Each addresses different parts of your medical care. A Living Will makes your wishes known directly to your doctors, but only states your wishes about the use of life-support methods. A Durable Power of Attorney for medical care allows a person you choose to carry out your wishes for all of your medical care when you can't act for yourself. A Durable Power of Attorney for medical care does not supersede a Living Will.

Can I change my advance directive?
Yes, you can change your advance directive whenever you want. If you already have an advance directive, make sure it follows Ohio’s law (effective October 10, 1991). You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. Make sure they still say what you want and that they cover all areas.

If I don’t have an advance directive, who chooses my medical care when I can’t?
Ohio law allows your next-of-kin to choose your medical care if you are expected to die and can’t act for yourself. If you are in a coma that is not expected to end, your next-of-kin could decide to stop or not use life support after 12 months. Your next-of-kin may be able to decide to stop or not use artificially supplied food and water also.

Other Matters to Think About

What about stopping or not using artificially supplied food and water?
Artificially supplied food and water means nutrition supplied by way of tubes placed inside you. Whether you can decide to stop or not use these depends on your state of health.

- If you are expected to die and can’t make your wishes known, and your Living Will simply states you don’t want life-support methods used to lengthen your life, then artificially supplied food and water can be stopped or not used.
- If you are expected to die and can’t make your wishes known, and you don’t have a Living Will, then Ohio law allows your next-of-kin to stop or not use artificially supplied food and water.
- If you are in a coma that is not expected to end, and your Living Will states you don’t want artificially supplied food and water, then artificially supplied food and water may be stopped or not used.
- If you are in a coma that is not expected to end, and you don’t have a Living Will, then Ohio law allows your next-of-kin to stop or not use artificially supplied food and water. However, he or she must wait 12 months and get approval from a probate court.

By filling out an advance directive, am I taking part in euthanasia or assisted suicide?
No, Ohio law doesn’t allow euthanasia or assisted suicide.
Where do I get the advance directive forms?
Many of the people and places that give you medical care have advance directive forms. Ask Member Services for an advance directive form — either a Living Will, a Durable Power of Attorney for medical care, a DNR Order, or a Declaration for Mental Health Treatment. A lawyer could also help you.

What do I do with my forms after filling them out?
You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Durable Power of Attorney for medical care, give that person a copy. Put a copy with your personal papers. You may want to give one to your lawyer or clergy person.

Be sure to tell your family and friends about what you have done. Don’t just put these forms away and forget about them.

Advance Directives are serious decisions that will affect the healthcare you receive. Whether you should use an Advance Directive and, if so, which type is right for you, can be complicated; so we suggest you discuss it with a trusted family member, friend or other advisor. While UnitedHealthcare Community Plan does not endorse any particular Advance Directive form, you can find links to some sample forms at:

Nlm.nih.gov/medlineplus/advancedirectives,
or at: Familydoctor.org,
or at: Uslivingwillregistry.com/forms.

You may also ask your doctor or other medical provider for advice regarding the different kinds of Advance Directives and how they work for people who choose to have one. UnitedHealthcare Community Plan does not limit the implementation of Advance Directives as a matter of conscience or for any other reason. We provide training to our employees about your right to have an Advance Directive. If the laws about Advance Directives change, we will change our policy to match the change no later than 90 days after the effective date of the change.

Advance Directives are usually implemented by the doctors who are involved in and working with you to handle your healthcare needs. If you have an Advance Directive, you should try to make sure that your doctors and anyone else who is involved in your healthcare knows that you have an Advance Directive, which should be made part of your medical records. The providers who work with UnitedHealthcare Community Plan are not allowed to discriminate against you if you choose to have an Advance Directive. UnitedHealthcare Community Plan will attempt to assist you, to the extent possible, to have an Advance Directive implemented and you can file a complaint if a provider does not comply with an Advance Directive by calling Member Services at 1-800-895-2017 (hard-of-hearing: 711), or on our website at www.UHCCommunityPlan.com. You may also file a complaint with the Ohio Department of Health by contacting them at 1-800-342-0553.
## Important Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>Harming someone on purpose. (Includes yelling, ignoring a person's need and inappropriate touching.)</td>
</tr>
<tr>
<td>Advance Directive</td>
<td>A decision about your health care that you make ahead of time in case you are ever unable to speak for yourself. This will let your family and your doctors know what decisions you would make if you were able to.</td>
</tr>
<tr>
<td>Appeal</td>
<td>An appeal is a dispute made by a member, his or her representative or a provider with the member’s permission, challenging an action by the health plan to deny or limit authorization of a service, including the type or level of service or reduce, suspend, or terminate payment for a previously authorized service; or any failure to authorize services in a timely manner or decide a grievance or appeal within the required time frames.</td>
</tr>
<tr>
<td>Authorization</td>
<td>An O.K. or approval for a service.</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services, procedures and medications that UnitedHealthcare Community Plan will cover for you.</td>
</tr>
<tr>
<td>Clinical Care Management</td>
<td>One-on-one help by a nurse providing education and coordination of UnitedHealthcare Community Plan benefits, tailored to your needs.</td>
</tr>
<tr>
<td>Disenrollment</td>
<td>To stop your membership in UnitedHealthcare Community Plan.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Durable Medical Equipment includes things such as wheelchairs, walkers, diabetic glucose meter, IV poles that have to be used for a length of time. It can also be equipment that must be thrown away such as bandages, catheters and needles. DME must be requested by your doctor.</td>
</tr>
<tr>
<td>Emergency</td>
<td>A sudden and, at the time, unexpected change in a person’s physical or mental condition which, if a procedure or treatment is not performed right away, could be expected to result in 1) the loss of life or limb, 2) significant impairment to a bodily function, 3) permanent damage to a body part or health of unborn child.</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fraud</td>
<td>An untruthful act (example: if someone other than you uses your member ID card and pretends to be you).</td>
</tr>
<tr>
<td>Grievance</td>
<td>A grievance is an expression of dissatisfaction about the health plan, or a practitioner or any matter other than an action taken by the plan. Grievances can include issues with the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect a member's rights.</td>
</tr>
<tr>
<td>Health Information</td>
<td>Facts about your health and care. This information may come from UnitedHealthcare Community Plan or a provider. It includes information about your physical and mental health, as well as payments for care.</td>
</tr>
<tr>
<td>ID card</td>
<td>An identification card that says you are a UnitedHealthcare Community Plan member. You should have this card with you at all times.</td>
</tr>
<tr>
<td>Immunization</td>
<td>A shot that protects from a disease. Children should get a variety at specific ages. Shots are often given during regular doctor visits.</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>That all medical treatments have been explained to you; you understand and agree to them.</td>
</tr>
<tr>
<td>In-Network</td>
<td>Doctors, specialists, hospitals, pharmacies and other providers who have an arrangement with UnitedHealthcare Community Plan to provide health care services to members.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>When you are admitted into a hospital for a length of time.</td>
</tr>
<tr>
<td>Member</td>
<td>An eligible person enrolled with UnitedHealthcare Community Plan in the Medicaid or DHCP programs.</td>
</tr>
<tr>
<td>ODM</td>
<td>Ohio Department of Medicaid</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Doctors, specialists, hospitals, pharmacies and other providers who do not have an arrangement with UnitedHealthcare to provide health care services to members.</td>
</tr>
</tbody>
</table>
## Important Terms (cont.)

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td>When you have a procedure done that does not require a hospital stay over night.</td>
</tr>
<tr>
<td><strong>Prescription</strong></td>
<td>A doctor’s written instructions for drugs or treatment.</td>
</tr>
<tr>
<td><strong>Primary Care Provider (PCP)</strong></td>
<td>A doctor you choose to be your primary care provider who has his/her own private practice. Your PCP will coordinate all of your health care.</td>
</tr>
<tr>
<td><strong>Prior Authorization</strong></td>
<td>Process that your doctor uses to get approval for services that need to be approved before they can be done.</td>
</tr>
<tr>
<td><strong>Provider Directory</strong></td>
<td>A list of providers who participate with UnitedHealthcare Community Plan to help take care of your healthcare needs.</td>
</tr>
<tr>
<td><strong>Provider or Practitioner</strong></td>
<td>A person or facility that offers health care (doctor, pharmacy, dentist, clinic, hospital, etc.).</td>
</tr>
<tr>
<td><strong>Referral</strong></td>
<td>When you and your PCP agree you need to see another doctor and your PCP sends you to a network specialist.</td>
</tr>
<tr>
<td><strong>Self-Referred Services</strong></td>
<td>Services for which you do not need to see your PCP for a referral.</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>Any doctor who has special training for a specific condition or illness.</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>When you are sick but it is not an emergency, and you need treatment or medical advice within a 48-hour time period.</td>
</tr>
<tr>
<td><strong>WIC</strong></td>
<td>Supplemental Food Program for Women, Infants and Children which provides nutrition counseling, nutrition education, and nutritious foods to pregnant and postpartum women, infants and children up to the age of 2. Children deemed nutritionally deficient are covered up to age 5 if they are low income and are determined to be at nutritional risk.</td>
</tr>
</tbody>
</table>
How We Use or Share Information

We must use and share your HI if asked for by:

- You or your legal representative.
- The Secretary of the Department of Health and Human Services to make sure your privacy is protected.

We have the right to use and share HI. This must be for your treatment, to pay for care and to run our business. For example, we may use and share it:

- For Payments. This also may include coordinating benefits.
- For Treatment or managing care. For example, we may share your HI with providers to help them give you care.
- For Health Care Operations related to your care. For example, we may suggest a disease management or wellness program. We may study data to see how we can improve our services.
- To tell you about Health Programs or Products. This may be other treatments or products and services. These activities may be limited by law.
- For Plan Sponsors. We may give enrollment and summary HI to an employer plan sponsor. We may give them other HI if they agree to limit its use per federal law.
- For Reminders on benefits or care. Such as appointment reminders.
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. This may happen if you are unable to agree or object. Examples are an emergency or when you agree or fail to object when asked. If you are not able to object, we will use our best judgment.
• **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, as allowed by law.
• **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; (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.
• **To Notify of a Data Breach.** To give notice of unauthorized access or disclosure of your HI. We may send notice to you or to your plan sponsor.
• **Other Restrictions.** Federal and state laws may limit the use and sharing of highly confidential HI. This may include state laws on:
  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

If stricter laws apply, we aim to meet those laws. Attached is a Summary of Federal and State Laws.
Except as stated in this notice, we use your HI only with your written consent. If you allow us to share your HI, we do not promise that the person who gets it will not share it. You may take back your consent, unless we have acted on it. To find out how, call the phone number on the back of your ID card.

Your Rights
You have a right:

- **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 involved in your care or payment for it. 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 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: (i) Prior to April 14, 2003; (ii) For treatment, payment, and health care operations; (iii) With you or with your consent; (iv) With correctional institutions or law enforcement. This will not list the disclosures that federal law does require us to track.

- **To get a paper copy of this notice.** You may ask for a copy at any time. Even if you agreed to get this notice electronically, you have a right to a paper copy. 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 the back of your ID card. Or you may contact the UnitedHealth Group Call Center at 1-866-633-2446.

- **To Submit a Written Request.** Mail to:
  
  **UnitedHealthcare Government Programs Privacy Office**  
  MN006-W800  
  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.

Financial Information Privacy Notice

THIS NOTICE SAYS HOW YOUR FINANCIAL INFORMATION MAY BE USED AND SHARED. IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

Effective January 1, 2013

We protect your “personal financial information” (“FI”). This means non-health information about someone with health care coverage or someone applying for coverage. It is information that identifies the person and is generally not public.

Information We Collect

We get FI about you from:

• Applications or forms. This may be name, address, age and social security number.
• Your transactions with us or others. This may be premium payment data.

Sharing of FI

We do not share FI about our members or former members, except as required or permitted by law.

To run our business, we may share FI without your consent to our affiliates. This is to tell them about your transactions, such as premium payment.

• To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
• To other companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
• To other companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We limit access to your FI to our employees and service providers who manage your coverage and provide services. We have physical, electronic and procedural safeguards per federal standards to guard your FI.

Questions About This Notice

If you have any questions about this notice, please call the toll-free member phone number on the back of your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446.

For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; PacificDental Benefits, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, 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 HIPAA covered entities or health insurance products.
UnitedHealth Group Health Plan Notice of Privacy Practices: Federal and State Amendments

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

Revised: January 1, 2013

The first part of this Notice (pages 53 – 56) 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 & 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

<table>
<thead>
<tr>
<th>Statement</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.</td>
<td>CA, NE, PR, RI, VT, WA, WI</td>
</tr>
<tr>
<td>HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.</td>
<td>KY</td>
</tr>
<tr>
<td>You may be able to restrict certain electronic disclosures of health information.</td>
<td>NV</td>
</tr>
<tr>
<td>We are not allowed to use health information for certain purposes.</td>
<td>CA</td>
</tr>
<tr>
<td>We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.</td>
<td>MO, NJ, SD</td>
</tr>
</tbody>
</table>

### Prescriptions

<table>
<thead>
<tr>
<th>Statement</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.</td>
<td>ID, NH, NV</td>
</tr>
</tbody>
</table>

### Communicable Diseases

<table>
<thead>
<tr>
<th>Statement</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.</td>
<td>AZ, IN, KS, MI, NV, OK</td>
</tr>
</tbody>
</table>

### Sexually Transmitted Diseases and Reproductive Health

<table>
<thead>
<tr>
<th>Statement</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>CA, FL, HI, IN, KS, MI, MT, NJ, NV, PR, WA, WY</td>
</tr>
</tbody>
</table>

### Alcohol and Drug Abuse

<table>
<thead>
<tr>
<th>Statement</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or (2) to specific recipients.</td>
<td>CT, GA, HI, KY, IL, IN, IA, LA, NC, NH, WA, WI</td>
</tr>
<tr>
<td>Disclosures of alcohol and drug abuse information may be by the individual who is the subject of the information.</td>
<td>WA</td>
</tr>
</tbody>
</table>
### Genetic Information

We are not allowed to disclose genetic information without your written consent. | CA, CO, HI, IL, 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, MD, MA, 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, HI, 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

### 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, HI, 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 (2) to specific recipients. | AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI
Grievance and Appeal Form

Member's Name ___________________________  ID # ___________________________

Address _______________________________________________________________________

Telephone Number: (Home) _______________ (Work) ______________________________

Please describe your concern in detail using names, dates, places of services, time of day and issues that occurred. If applicable, also state why UnitedHealthcare Community Plan should consider payment for requested services that are not normally covered. Please mail this completed form to the address listed at the bottom.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
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____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

(Signature) ___________________________ (Date) ___________________________

UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364
Primary Care Provider (PCP) Change Request

Your PCP is the main person who gives you health care. Do you need to change your PCP? Page 11 of this handbook tells you about changing your PCP.

Fill this out and mail to:

UnitedHealthcare Community Plan
9200 Worthington Rd.
Westerville, OH 43082

When you choose a PCP, we will send you a new ID card. If we are unable to process your request, we will call you.

Member Information:

Member Name ____________________________________________________________

Last                                    First                                    MI

Address _________________________________________________________________

City________________ State_________ Zip Code_____________________

Member ID #________________________ Birth Date ______/______/_______

Telephone Number: (_______) ____________________________

Area code Number

Signature:_________________________________________ Date:__________

PCP Choice 1:

Name of PCP you want ______________________________________________________

Last                            First

Address _________________________________________________________________

City________________ State_________ Zip Code_____________________

Telephone Number: (_______) ____________________________

Area code Number

Provider ID number (listed in the Provider Directory) ____________________________

PCP Choice 2:

Name of PCP you want ______________________________________________________

Last                            First

Address _________________________________________________________________

City________________ State_________ Zip Code_____________________

Telephone Number: (_______) ____________________________

Area code Number

Provider ID number (listed in the Provider Directory) ____________________________
Ohio Department of Job and Family Services

Designation of Authorized Representative

<table>
<thead>
<tr>
<th>First Name of Applicant/Recipient</th>
<th>MI</th>
<th>Last Name</th>
<th>Medicaid billing # or SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address, including Apt. #</td>
<td></td>
<td>City</td>
<td>Zip</td>
</tr>
</tbody>
</table>

I hereby authorize the following person or company to act as my representative:

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
<td>Company</td>
<td>Work Phone</td>
</tr>
</tbody>
</table>

Mailing Address | City | State | Zip

I authorize this person or company to represent me regarding:
- [ ] Food Assistance
- [ ] Cash Assistance
- [ ] Medicaid
- [ ] Child Care

This authority lasts until:
- [ ] My application has been approved
- [ ] I rescind this authority, or appoint a new representative
- [ ] Other (please specify a date or action) ________________________________

I authorize this person or company to do the following on my behalf:
- [ ] Take any action that may be needed to ensure that I receive or continue to receive the benefits indicated above
- [ ] OR only the specific actions selected below:
  - [ ] Present my application for benefits
  - [ ] Represent me at a state hearing
  - [ ] Provide verifications to the CDJFS on my behalf
  - [ ] Collect my medical records
  - [ ] Receive and respond to copies of all correspondence regarding my application
  - [ ] Other (please specify) ________________________________________________

While this authorization is in effect, all notices sent by the County Department of Job & Family Services or the Ohio Department of Job & Family Services will also be sent to your authorized representative.

Signatures. This form has no effect unless signed by the person granting authority and by the authorized representative or an employee of the company appointed to be the authorized representative.

<table>
<thead>
<tr>
<th>Signature of Person Granting Authority</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Authorized Representative</td>
<td>Date</td>
</tr>
<tr>
<td>Title (if employee of authorized company)</td>
<td></td>
</tr>
</tbody>
</table>