UnitedHealthcare Community Plan
M★Plus Medicaid Member Handbook
For Non-Reform Counties
Important Telephone Numbers

Sponsored by: The State of Florida Agency for Health Care Administration

Be sure to fill in the blanks so you will have these numbers ready.

UnitedHealthcare Community Plan Customer Service:
Available 24 hours a day, 7 days a week.
Toll Free: 1-888-716-8787
TTY (for the hearing impaired): 711
UnitedHealthcare Community Plan online: www.UHCCommunityPlan.com
Statewide Consumer Call Hotline: 1-888-419-3456
Statewide TDD (for the hearing impaired): 1-800-653-9803

Medicaid Area Offices:
Area 3A (Putnam County): 1-800-803-3245
Area 3B (Citrus, Lake, Hernando and Marion Counties): 1-877-724-2358
Area 4 (Baker, Clay, Duval, Flagler, Nassau and Volusia Counties): 1-800-273-5880
Area 5 (Pasco and Pinellas Counties): 1-800-299-4844
Area 6 (Highlands, Hillsborough, Manatee and Polk Counties): 1-800-226-2316
Area 7 (Brevard, Osceola and Seminole Counties): 1-877-254-1055
Area 9 (Palm Beach County): 1-800-226-5082
Area 10 (Broward County): 1-866-875-9131
Area 11 (Dade County): 1-800-953-0555

Your Health Providers

Your PCP: ______________________________________
Nearest Emergency Room: ______________________________________
Local Pharmacy: ______________________________________
Other Health Care Providers: ______________________________________
______________________________________________________________
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Welcome to UnitedHealthcare Community Plan

We take great pride in our company and the quality of service we provide our members. There are many good reasons for being a member of UnitedHealthcare Community Plan. We will help with all your medical needs and provide high quality service.

We hope this handbook will help answer any questions you may have about your health Plan. Our goal is to serve your health care needs and help you stay healthy.

If you need anything please call our Customer Service number on the back of your ID card. Customer service is available 24 hours a day, 7 days a week. You can visit us online at www.UHCCommunityPlan.com. We will be here to help you at any time. Another way we keep in contact with you is by notifying you on an annual basis of your right to request information regarding the services provided to you by UnitedHealthcare Community Plan. And upon request, our Customer Service Department can give you Plan information regarding our quality performance ratings, member satisfaction survey results, structure and operation of the health plan (including pay incentives, if applicable).

Company History

CAC Ramsay Health Plans, Inc. was the first HMO licensed in the State of Florida in 1973. It was bought by UnitedHealthcare Corporation in 1994. UnitedHealthcare Corporation has been a national leader in health care management since 1974. UnitedHealthcare has a contract with the State of Florida to take care of the health care needs of the members in M★Plus (Medicaid). UnitedHealthcare Community Plan has many providers and hospitals contracted in their network to help meet your health care needs.

This statewide network has many providers, this includes primary care providers (meaning family practice providers, pediatricians and internal medicine providers) and specialty providers (specialists like cardiologists) and contracted hospitals. You’ll find a list of participating providers and other health care providers in our provider directory. If you don’t currently have a primary care provider or health care provider please call UnitedHealthcare’s Customer Service number on the back of your ID card.

For the rest of the handbook, the name the “Plan” or “UnitedHealthcare” will stand for UnitedHealthcare Community Plan.

Assigned M★Plus (Medicaid) Members

You must have Medicaid in order to be part of this health Plan. Most Medicaid recipients have to choose to be in a Medicaid HMO or MediPass. If you do not choose an HMO or MediPass, the State of Florida will choose one for you. If you did not request to enroll with UnitedHealthcare Community Plan, then the State of Florida has placed you in this health Plan. We have picked a primary care provider for you, and your provider’s name is on your ID card. You may choose to change your primary care provider and can call Customer Service to help you do this. Also, you may choose to have all family members, who are on UnitedHealthcare Community Plan’s M★Plus (Medicaid) Plan, served by the same primary care provider, or you may choose different primary care providers based on each person’s needs. If you do not wish to stay with this health Plan, see the “How Do I Disenroll” section of this handbook.
### Enrollment

If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in UnitedHealthcare Community Plan or the state enrolls you in a health plan, you will have 90 days from the date of your first enrollment to try the plan. During the first 90 days you can change health plans for any reason. After the 90 days, if you are still eligible for Medicaid, you will be enrolled in the plan for the next nine months. This is called “lock-in.”

### Open Enrollment

If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called “open enrollment.” You do not have to change plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next 12 months. Every year you can change health plans during your 60-day open enrollment period.

If you have questions about Open Enrollment and to Enroll, call Medicaid Options toll free at 1-866-454-3959, between the hours of 8:00 a.m. and 7:00 p.m., Monday through Friday.

### Disenrollment

If you are a mandatory enrollee and you want to change plans after the initial 90-day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state approved cause reasons to change health plans:

A mandatory Enrollee may request Disenrollment from the Health Plan for Cause at any time. Such request shall be submitted to the Agency or its Agent. The following reasons constitute Cause for Disenrollment from the Health Plan:

1. The Enrollee moves out of the county, or the Enrollee’s address is incorrect and the county, or the Enrollee’s address is incorrect and the Enrollee does not live in a county where the Plan is authorized to provide services.
2. The Provider is no longer with the Health Plan.
3. The Enrollee is excluded from enrollment.
4. A substantiated marketing or community outreach violation has occurred.
5. The Enrollee is prevented from participating in the development of his/her treatment plan.
6. The Enrollee has an active relationship with a provider who is not on the Health Plan’s panel, but is on the panel of another Health Plan.
7. The Enrollee is in the wrong Health Plan as determined by the Agency.
8. The Health Plan no longer participates in the county.
9. The State has imposed intermediate sanctions upon the Health Plan, as specified in 42 CFR 438.702(a)(3).

10. The Enrollee needs related services to be performed concurrently, but not all related services are available within the Health Plan Network; or, the Enrollee’s PCP has determined that receiving the services separately would subject the Enrollee to unnecessary risk.

11. The Health Plan does not, because of moral or religious objections, cover the service the Enrollee seeks.

12. The Enrollee missed Open Enrollment due to temporary loss of eligibility, defined as 180 days or less.

13. Other reasons per 42 CFR 438.56(d)(2), including, but not limited to, poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; services access impairments due to significant changes in the geographic location of services; lack of access to Providers experienced in dealing with the Enrollee’s health care needs; or fraudulent Enrollment.

Voluntary Enrollees may disenroll from the Health Plan at any time.

If you think you have a “cause” for Disenrollment, you will need to call Medicaid Options toll free at 1-888-367-6554, between the hours of 8:00 a.m. and 7:00 p.m., Monday through Friday.

Some Medicaid recipients can change health plans whenever they choose, for any reason. For example, people who are eligible for both Medicaid and Medicare benefits and children who receive SSI benefits can change plans at any time for any reason. To find out if you can change plans, call Medicaid Options toll free at 1-888-367-6554.

**Loss of Eligibility – Reinstatement Process**

If you regain eligibility within 180 days of when you first enrolled with UnitedHealthcare Community Plan, you will be reinstated as a UnitedHealthcare Community Plan member. You will be assigned to the same primary care provider you had previously.
Your Identification Card

Member – The name of the person covered by the Plan.

Member Number – Your personal Plan identification (ID) number. Your Member number is also your State Assigned Medicaid ID Number. Please have this number ready when you call to make provider appointments or when you call or write to the Plan.

Effective Date – The day your health benefits begin with the Plan or the last date of change under your Plan.

Primary Care Provider (PCP) Name and Phone Number – The name of the primary provider and the direct telephone number.

Delivery Model (If Applicable) – The group of providers that you must get health care from. (For example, if you signed up with a clinic, you need to go to the providers in that clinic.)

Carry Your Identification Card at All Times

Each time you go to the provider or hospital, you must show your Medicaid card AND your UnitedHealthcare identification card. If you lose your Plan identification card, call the Customer Service Department. DO NOT let anyone use your card or you may lose membership with the Plan. If you lose your Medicaid card, contact your Case Worker. Be sure to tell the Case Worker you are a member of UnitedHealthcare Community Plan.

Lost or Stolen Cards, Changes or Corrections

If your identification card becomes lost or stolen, you will not lose your covered services, but you must call the Customer Service Department right away to get a new card. You must also call the Customer Service Department anytime you need to make changes (when you move) or corrections to the identification card (name change). You must also report these changes or corrections to your Case Worker.
Primary Doctor

When you sign up for the Plan you must pick a Primary Provider (sometimes called a “PCP” or a Primary Care Provider) or one will be chosen for you. You may choose to change your primary care provider and can call Customer Service to help you do this. Also, you may choose to have all family members, who are on UnitedHealthcare Community Plan’s M★Plus (Medicaid) Plan, served by the same primary care provider, or you may choose different primary care providers based on each person’s needs. We would like you to see your primary provider within the first 3 months of becoming our member even if you do not have medical needs. You must call your Primary Provider every time you have health care needs. He or she will make sure that you receive the care that you need. Medicaid and the health Plan will not pay for any care or supplies if you go to a provider that does not belong to the Plan or if you don’t call your Primary Provider first except in an emergency.

There are some services that you do not have to call your Primary Provider for prior notification. Please refer to the covered services section in this handbook to find out what those services are.

If you are pregnant, you may pick a participating OB/GYN provider as your Primary Provider. This provider will arrange your health care needs while you are pregnant. Please go to the provider right away if you are pregnant or think that you are pregnant. Early care will help you to protect the health of you and your baby.

Medical Release Form

When you visit your provider for the first time, please make sure that you sign a Medical Release Form so that he/she can get your medical records from your previous provider.

Your First Appointment

1. Call your Primary Provider’s office at the telephone number listed on your identification card. Have your ID number handy.
2. Say that you are a new member of Florida (Medicaid).
3. When you ask for an appointment with a Primary Provider, tell them what is wrong or what you want. When they give you a time and a date, be sure to write this down so that you don’t forget the appointment.
4. If you need assistance to have your medical records transferred to your new provider, you can call Customer Service for help.

Appointment Cancellations

If you have to cancel an appointment, please call your Primary Provider as soon as possible, hopefully at least a day before your appointment. The office will make a new appointment for you. When you call ahead to cancel your appointment you give someone else a chance to see the provider in your place.
Changing Your Primary Provider

If you wish to change your Primary Provider, just call our Customer Service Department. Customer Service will tell you the date the change becomes effective. A new identification card will be mailed to you. Please use this new card when you see the provider.

Notification of Changes

Should there be changes in covered services or other changes that will affect you, the Plan will notify you by mail. We will also provide information on your choices as a result of these changes. In addition to telling us and your case worker at the Department of Children and Families of any local address changes, please call Customer Service if you are moving to a new county. We can tell you if you can stay on our Plan or if you need to disenroll. If you can stay in the Plan after your move, we will help you pick a new primary provider.

About Your Participating Providers and Healthcare Providers

As a member, you can get information about the providers in our network. If you wish to find out about your provider(s), please call the Customer Service Department.

UnitedHealthcare’s (Medicaid) network has providers and other licensed medical professionals. You may sometimes receive care from any of these people (such as nurse practitioners, provider’s assistants and midwives).

In some areas when you join the Plan, you may pick a Primary Provider who is in a special network (such as a clinic). The provider you pick will help to provide all of your health care services. He or she will make sure that you receive the care you need. He or she will also recommend you to other specialists in our network, if needed.

UnitedHealthcare Community Plan will not make any payments for any services you get from providers who do not belong to the network, except for emergency and urgently needed services. If a provider you wish to see is not in the network, you will need to call the Customer Service Department to change your primary Provider.

Access/Availability

UnitedHealthcare (Medicaid) providers are required to meet the following access to care standards:

- Emergency Medical Care — available 24 hours a day/7 days a week
- Urgent Care — within one day
- Routine Sick Care — within one week
- Well Care — within one month
Keeping Healthy Through Routine Check-Ups

Regular check-ups, tests and immunizations are important to your health. Regular check-ups can help find health problems before they get too bad. You should learn what you can do to stay healthy. Always ask your health care provider about any health questions you have. Please see the preventive guidelines section of this handbook, which will show you what tests you should have and when you should have them.

The Child Health Check-Up Program
(This is Medicaid’s program that used to be called EPSDT – Early and Periodic Screening, Diagnosis and Treatment).

Have routine check-ups according to the preventive guidelines section of this handbook. As their caregiver, it is up to you to make certain that your child(ren) are seen regularly by their primary provider.

UnitedHealthcare Community Plan will cover services associated with the Child Health Check-Up program of preventive health services for children. These include:

- Health and development history
- Nutritional Assessment
- Laboratory test (including lead screening)
- Hearing Screening
- Health Education
- Unclothed Physical assessment or examination
- Routine immunization update
- Vision Screening
- Dental Screening
- Development Assessment

Prenatal Care
It is important to see a provider on a regular basis during your pregnancy. UnitedHealthcare offers prenatal care for all eligible pregnant members. If you are pregnant or think you are pregnant, see your provider right away. As soon as you know you are pregnant and immediately after your baby is born, please call your Department of Children and Families (DCF) Case Worker and UnitedHealthcare’s Customer Service Department.

Unborn ID Activation Process
If you are pregnant, you need to contact your Department of Children and Family (DCF) Case Worker and notify the Plan. Your Case Worker will generate an Unborn ID # which will be activated once you notify them of delivery. We encourage you to provide this information to the Plan by contacting the Customer Service telephone number located on the back of your ID card.

Healthy First Steps™
This is a program that is in place that UnitedHealthcare has started to help you through your pregnancy. When you first know that you are pregnant please contact us through Customer Service. A case manager will then contact you and help you get the care you need. We care about the health of you and your unborn baby.
Preventive Guidelines

UnitedHealthcare Community Plan has adopted the following preventive care guidelines based on recommendations by the U.S. Preventive Services Task Force. Coverage and reimbursement may differ from these guidelines depending on provider judgment, state or federal law and other circumstances. Please contact Customer Service for questions about specific coverage information. Persons with symptoms or at high risk for disease may need additional services or more frequent interventions.

Children Younger Than 10 Years

Screenings

**Height/Weight** – Regularly throughout infancy and childhood

**Blood Pressure** – Periodically* throughout childhood

**Vision Screening** – Once between ages 3 – 4

**T4 and/or TSH** – Optimally between day 2 and 6, but in all cases before discharge from the hospital

**PKU level** – At birth

**Lead Testing Screening** – Done at 12 and 24 months old; and between 24 and 72 months if not previously screened.

Immunizations

**DTaP or DTP** – Five immunizations at 2, 4, and 6 months, between 15 – 18 months and once between ages 4 – 6

**Polio** – Four immunizations at 2 and 4 months, between 6 – 18 months and between ages 4 – 6

**MMR** – Two immunizations between 12 – 15 months and between ages 4 – 6. If missed, give by ages 11 – 12

**H. influenzae type B (Hib)** – Three or four immunizations, depending on the vaccine, at 2, 4, and 6 months and between 12 – 15 months

**Hepatitis B** – Three immunizations: beginning at age 2 months or at age 6 months (depending on whether or not the vaccine used contains thimerosal). All three immunizations should be completed by age 18 months. If not immunized by age 11, three immunizations given according to your provider’s recommendations.

**Pneumococcal Conjugate Vaccine** – Four immunizations done at 2, 4, 6 and between 12 – 15 months old

**Varicella** – One immunization between 12 – 18 months or older children, if missed, and no history of chicken pox

* Frequency should be discussed with your provider.

Provider Discussion Topics

**Diet and Exercise**

- Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
- Regular physical activity

**Substance Use**

- Effects of passive smoking
- Anti-tobacco message

**Dental Health**

- Baby bottle tooth decay
- Regular dental visits
- Floss, brush and fluoride
Preventive Guidelines (cont.)

Injury Prevention
- Child safety car seats
- Bicycle helmet; avoid bicycling near traffic
- Lap and shoulder seat belts
- Smoke detector, flame retardant sleepwear
- Set hot water heater temperature lower than 120° – 130°F
- Window and stair guards, swimming pool fence
- Safe storage of drugs, toxins, firearms and matches
- Syrup of ipecac, poison control phone number
- CPR training for parents/caregivers

Young Adults 11 – 24 Years

Screenings
Height/Weight – Periodically*
Blood Pressure – Periodically*
Papanicolaou (Pap) test – Every one to three years sexually active females or beginning at age 18
Chlamydia screening – Routine* screenings recommended for all sexually active females
Rubella serology or vaccination history – Recommended for all females of child-bearing age

Immunizations
Tetanus-diphtheria (Td) – Boosters between ages 11 – 16 and then every 10 years*
Hepatitis B – If not previously immunized, one immunization at current (next) visit, one month later and six months later

MMR – Between ages 11 – 12 if second dose was not received
Varicella – Between ages 11 – 12 if susceptible to chicken pox
Rubella – Administered after age 12 — females who are not pregnant

Other Preventions
Multivitamins with folic acid – Females (Planning/capable of pregnancy)

Diet and Exercise
- Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
- Regular physical activity
- Adequate calcium intake

Substance Abuse
- Avoid underage drinking/illicit drug use
- Avoid tobacco use

Sexual Behavior
- Sexually transmitted disease (STD) prevention/abstinence
- Avoid high-risk behavior
- Unintended pregnancy

Injury Prevention
- Bicycle/motorcycle/ATV helmets — safety
- Lap and shoulder seat belts
- Smoke detectors
- Safe firearm handling
- Set hot water heater temperature lower than 120° – 130°
- CPR training for parents/caregivers
Dental Health
- Regular dental visits
- Floss, brush and fluoride

Adults 25 – 64 Years

Screenings
Height/Weight – Periodically*
Blood Pressure – Periodically*
Total Blood Cholesterol – Periodically* males between ages 35 – 64, females between ages 45 – 64
Fecal Occult blood test – Annually* beginning at age 50
Sigmoidoscopy – Every 3 to 5 years beginning at age 50
Clinical breast exam – Annually, females between ages 50 – 69
Mammogram – Every one to two years females between ages 50 – 69**
Papanicolaou (Pap) test – Every one to three years sexually active females who have not had a hysterectomy

Immunizations
Rubella serology or vaccination history – Recommended once for all females of child-bearing age
Tetanus-diphtheria (Td) – Boosters every 10 years, or as recommended*

Other Preventions
Discuss hormone replacement therapy – Periodically*, peri- and post menopausal females

Multivitamins with folic acid – Females (Planning/capable of pregnancy)

Provider Discussion Topics
Diet and Exercise
- Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
- Regular physical activity
- Adequate calcium intake

Substance Abuse
- Avoid alcohol/drug use
- Avoid tobacco use

Sexual Behavior
- Unintended pregnancy
- Sexually transmitted disease (STD) prevention
- Avoid high-risk behavior

Injury Prevention
- Bicycle/motorcycle/ATV helmets — safety
- Lap and shoulder seat belts
- Smoke detectors
- Safe firearm handling
- CPR training for parents/caregivers

Dental Health
- Regular dental visits
- Floss, brush and fluoride

* Frequency should be discussed with your provider.

** Effective January 1, 1998, Medicare requires coverage for annual Mammograms for all women ages 40 and older.
Preventive Guidelines (cont.)

Adults 65 Years and Older

Screenings
Height/Weight – Periodically*
Blood Pressure – Periodically*
Papanicolaou (Pap) test – Every one to three years — sexually active females who have not had a hysterectomy; consider discontinuing if previous regular screenings were normal*
Fecal Occult blood test – Annually
Sigmoidoscopy – Every 3 to 5 years
Clinical breast exam – Annually, females between ages 65 – 69
Mammogram – Every one to two years — females between ages 65 – 69**
Vision Screening – Annually
Hearing Screening – Periodically*

Immunizations
Tetanus-diphtheria (Td) – Boosters every 10 years, or as recommended*
Influenza – Annually
Pneumococcal – Administered one time to all people whose immune systems have not been compromised

Other Preventions
Discuss hormone replacement therapy – Periodically*, peri- and post menopausal females

Provider Discussion Topics

Diet and Exercise
• Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
• Regular physical activity

Substance Abuse
• Avoid alcohol/drug use
• Avoid tobacco use

Sexual Behavior
• Sexually transmitted disease (STD) prevention
• Avoid high-risk behavior

Dental Health
• Regular dental visits
• Floss, brush, and fluoride

Injury Prevention
• Lap and shoulder seat belts
• Bicycle and motorcycle helmets — safety
• Safe firearm handling
• Smoke detectors
• Set hot water heater temperature lower than 120° – 130°
• CPR training for household members/ Caregivers

* Frequency should be discussed with your provider.
** Effective January 1, 1998, Medicare requires coverage for annual Mammograms for all women ages 40 and older.
Specialty Care – Specialty Providers/Out of Network

If you think you need to see a specialty provider you must call your Primary Provider first. Many times your Primary Provider will be able to help you. If your Primary Provider thinks you should see a specialist, he or she will recommend a specialist. Before making an appointment to see the specialist, please call the Customer Service Department to make certain the specialist is still part of the Plan.

By joining UnitedHealthcare Community Plan, you have agreed to receive all of your health care from UnitedHealthcare’s network of providers, hospitals and other providers. If you go outside the network without your Primary Provider directing you to do so, you may have to pay that medical bill.

If you are in need of a specialty provider that is not in network and UnitedHealthcare Community Plan doesn’t have an in-network provider of that specialty, you can receive services if the provider you wish to see can get prior approval. Please contact Customer Service number on the back of your card for more information.

Second Medical Opinion

As a member of UnitedHealthcare Community Plan you have the right to a second medical opinion if you need surgery or if you have a serious injury or illness. You have the right to go to either a provider in the Plan or you can go to a provider that is not part of the health Plan network. You must first contact your Primary care Provider to arrange for a second medical opinion whether you choose a network provider or a provider who is not part of the plan. You may have to pay up to 40% of the medical bill.

Your primary care provider must be notified about all tests that the second medical opinion provider orders before you have them done. The Plan’s participating providers will offer their medical judgment. Please call UnitedHealthcare Community Plan to find out if the recommended treatment is a covered service.

Behavioral Health or Substance Abuse

Behavioral health services you can get include inpatient and outpatient hospital services and psychiatric doctor services. You and your children can also get a wide range of behavioral health and case management services. You can get these services in the community, in your home and in schools. Some of the services include:

- Individual, family, and group therapy
- Social rehabilitation
- Day treatment for adults and children
- Individual and family assessments
- Evaluations
- Treatment planning

Call the Behavioral Health Services number on the back of your ID card, 24 hours a day, seven (7) days a week if you want to know more. The United Behavioral Health staff will be happy to help you. United Behavioral Health provides free of charge, interpreters for potential and existing members whose primary language is not English.
Specialty and Hospital Care (cont.)

What to do if you are having a problem
If you are having any of the following feelings or problems you should contact a Behavioral Health Provider:

- Constantly feeling sad
- Feeling hopeless and/or helpless
- Feelings of guilt
- Worthlessness
- Difficulty sleeping
- Constant pain such as headaches, stomach and back aches
- Poor appetite
- Weight loss
- Loss of interest
- Difficulty concentrating
- Irritability

Prior authorization or referral from your PCP is not required to see a Behavioral Health Provider

What to do in an Emergency, or if you are out of the UnitedHealthcare Community Plan service area
First, decide if you are having a true behavioral health emergency. Do you think that you are a danger to yourself or others? Call “911” or go to the nearest emergency room for attention if you think you are. Follow these steps even if the emergency facility is not in the Plan’s service area.

If you need emergency Behavioral Health help outside the plan’s service area, please tell the plan by calling the Behavioral Health Services number on your ID card. You should also call your PCP if you can and follow up with your doctor within 24 to 48 hours. For out-of-area emergency care, when you are stable, plans will be made for transfer to an in-network facility.

Obtaining Behavioral Health Services
If you need help finding a Behavioral Health Provider in your area you can call United Behavioral Health toll free at 1-800-582-8220, 24 hours a day, seven (7) days a week. You will be given the names of several providers in your local community from which you can choose to call for an appointment. You can also choose a different behavioral health care coordinator or direct service behavioral health care provider within the Plan if one is available.

Behavioral Health providers are required to meet the following access to care standards:

- Urgent Care — within one day
- Routine Patient Care — within one week
- Well Care Visit — within one month
Behavioral Health Limitations and Exclusions

Adults can get up to 45 inpatient days a year and unlimited outpatient behavioral health services with Medicaid. Medicaid does not include a benefit for substance abuse treatment. If you or a family member has a substance abuse problem, you should call your local Medicaid Office. You can also ask our Behavioral Health staff to help you with a referral. If you have any questions about this process please call the Customer Service phone number on the back of your ID card.

A consent form will need to be signed by parents/legal guardians of children under the age of 13 who are on Medicaid and take certain Psychotropic medicines. This form will need to be signed with every new prescription. Your child’s doctor will send the signed consent form to the drug store. This consent form can be sent to the drug store by fax, mail, or online. Call Customer Service at the number on the back of your ID card if you have questions.

Hospital Care

As an M★Plus (Medicaid) member, you should receive health care from participating hospitals. If you need to go to the hospital, it is important to be aware of and to follow these steps:

1. If hospital care is required within the service area, your Primary Provider will arrange for admission to one of the Plan hospitals. Make sure your provider admits you to a Plan hospital. A list of UnitedHealthcare M★Plus (Medicaid) hospitals can be found in your provider directory or you can call Customer Service.

2. Hospital services, including inpatient (overnight stay) or outpatient (one day only) services, require your provider to notify UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will pay claims for covered services at participating hospitals when your provider has notified UnitedHealthcare Community Plan. Please call Customer Service if you have any questions about prior notification. UnitedHealthcare Community Plan will pay claims for emergency medical conditions (please read Emergency Care for more information).

3. Show your Plan identification card when you are admitted to the hospital.
Emergency Care

A medical emergency is a serious medical problem that occurs from an injury or illness. It comes on fast and needs quick care to avoid long lasting harm to your health. Here are some examples of emergencies:

- Poisoning
- Serious burn
- Severe shortness of breath
- Severe chest pain
- Severe body pain
- Vomiting blood
- Convulsions
- Unconsciousness

If you require emergency services:
1. Go to the nearest emergency room or call 911.
2. Present your Plan identification card.
3. Ask the facility to call your Primary Provider after you have received care.
4. You must call your Primary Provider for a follow-up.

If the emergency room provider decides that you do not have a medical emergency but you decide that you still want to be treated in the hospital, you can do so, but you will have to pay the hospital and all related bills. If you are hospitalized as a result of an emergency, please tell the hospital to call UnitedHealthcare Community Plan within 24 hours of admission. The Plan may transfer you to another facility, such as a participating hospital if you were admitted to a nonparticipating hospital, when your medical condition is stable.

Urgent Care Outside the Service Area

Urgent care services are those resulting from an unexpected illness or injury. Examples of these are sprained ankles, less serious wounds, etc. If you need urgent care services while outside the service area, you must contact your Primary Provider before receiving health care services.

Your identification card instructs providers and hospitals outside the service area to send all bills directly to UnitedHealthcare Community Plan. Some providers or hospitals may ask you to pay the bill directly. When that happens, keep all receipts and bills and send them to UnitedHealthcare Community Plan. Give us the name of the provider or hospital, the date you received care, procedures performed, amount charged, as well as the amount paid. Call Customer Service for more information.

Coverage is not provided for routine care received outside the service area.

No Medical Coverage Outside of the United States

Any health care services you or your enrolled family member get while out of the country will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services you get outside of the United States.
**After Hours**

If you need care after regular office hours, except for emergency situations, you must contact your Primary Provider. Primary Providers are required to have coverage for their patients 24 hours a day, seven (7) days a week. If you are sick or injured after regular office hours, please take the following steps:

1. Always call your Primary Provider.
2. Identify yourself as a member of UnitedHealthcare Community Plan.

Your Primary Provider or another Plan provider can give you treatment advice by telephone, prescribe medication, ask you to come to his/her office, refer you to an emergency facility or to another provider for treatment or ask you to make an appointment during office hours. You may also seek health care at a participating urgent care facility.
Customer Service

Our Customer Service Staff can:

• Be available to you 24 hours a day/7 days a week.
• Explain your covered services
• Assist you with claims and billing issues
• Replace identification cards
• Make changes in your address or telephone number
• Change your Primary care Provider or send you a new listing of providers
• Assist you when you become pregnant and when your baby is born
• Listen and help you with a problem
• Provide our quality performance ratings, member satisfaction survey results, structure and operation of the Health Plan
• Describe our quality benefit enhancements
• Provide interpreter services

Should you have any questions, concerns, comments, or suggestions, our Customer Service Department is here to help you. Please call the number on the back of your ID card.
Disenrollment Options

How Do I Disenroll?
If you are unhappy in any way with this Health Plan, we hope you will call the Customer Service Department. Please allow us the chance to fix any problems. However, if you still wish to disenroll, you may do so by calling Medicaid Options toll free at 1-888-367-6554, between the hours of 8:00 a.m. and 7:00 p.m., Monday through Friday.

The Medicaid Options will process your request to disenroll. There are “cause” reasons that may allow you to change Plans before your next open enrollment period. If you think you have a “cause” reason, you will need to call Medicaid Options toll free at 1-888-367-6554, between the hours of 8:00 a.m. and 7:00 p.m., Monday through Friday.

When Can UnitedHealthcare M★Plus (Medicaid) Disenroll Me?
With proper written documentation, the following are acceptable reasons for which the Health Plan shall submit involuntary Disenrollment request to the Agency:

1. Letting someone else use your identification card.
2. Knowingly giving false or incomplete information.
3. Behaving in a disruptive or abusive manner after one verbal and one written warning.
4. Not following the provider’s recommendations, after one verbal and one written warning.
5. Missing three straight provider appointments within a six-month period, after one verbal and one written warning.
6. Moving outside of the service area.
7. For assigned members, not using Plan services within the first four months of enrollment, and the Plan not being able to contact (through mail, phone, or personal visit) you within the first four months of enrollment.

If we know you cannot be a member of this Plan, we will notify Medicaid to disenroll you.
Member Rights and Responsibilities

Uphold Customer “Bill of Rights”

As a UnitedHealthcare Community Plan’s M★Plus Medicaid member, you have certain rights and responsibilities when you enroll. It is important that you fully understand both your rights and your responsibilities. The following statement of rights and responsibilities is presented here for your information. The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

Customers Have the Right to:

- Receive information about UnitedHealthcare, our services and network physicians and health care professionals in accordance with federal and state regulations.
- Be treated with respect and with due consideration for his or her dignity and privacy by UnitedHealthcare personnel, network physicians, and health care professionals as well as privacy and confidentiality for treatments, tests or procedures received.
- Voice concerns about the service and care they receive as well as register complaints and appeals concerning their health plan or the care provided to them and receive timely responses to their concerns.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand, regardless of cost or benefit coverage.
- Participate with their doctor and other caregivers in decisions about their healthcare including the right to refuse treatment.
- Be informed of, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards.
- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of his or her medical records, and request that they be amended or corrected.
- Make recommendations regarding the Plan’s Member Rights and Responsibilities.
Customers Have the Responsibility to:

• Know and confirm your benefits before receiving treatment.
• Contact an appropriate health care professional when you have a medical need or concern.
• Show your identification card before receiving health care services.
• Verify that the physician or health care professional you receive services from is in the UnitedHealthcare network.
• Pay any necessary copayment at the time you receive treatment.
• Use emergency room services only for injury or illness that, if not treated immediately, could post serious threat to your life or health.
• Keep scheduled appointments.
• Provide information needed for your care.
• Follow the agreed-upon instructions and guidelines of physicians and health care professionals.
• Notify UnitedHealthcare Customer Service of a change in address, family status other coverage information.
• Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Fraud and Abuse:

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or

Complete a Medicaid Fraud and Abuse Complaint Form, which is available online at [https://ahcaxnet.fdhc.state.fl.us/InspectorGeneral/fraud_complaintform.aspx](https://ahcaxnet.fdhc.state.fl.us/InspectorGeneral/fraud_complaintform.aspx)

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General’s Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General’s Office about keeping your identity confidential and protected.
Appeals and Grievances

Your Appeals and Grievances Rights

We hope that UnitedHealthcare Community Plan has served you well. If you have a concern or question regarding care or coverage under the Plan, you should contact the Customer Service Department at the number listed on the back of your ID card or using the contact information below. A Customer Service Representative will answer any questions or concerns. They can also assist you to file your grievance or appeal. Your provider can also file a grievance or appeal on your behalf with your written permission. We will not take any negative action against your provider for assisting you or filing your grievance or appeal for you.

How to File a Grievance

If you are not happy with service UnitedHealthcare Community Plan has provided you can file a grievance. Grievances are for anything other than an “action.” An action is when we say no to a service you or your doctor requested. It can be when we limit, reduce, or end your service. It can also be when we do not allow payment. You can file a grievance by calling the Customer Service Department on the back of your ID card. You could also send us a letter to the address below.

UnitedHealthcare Community Plan
Appeals and Grievance Unit
P.O. Box 31364
Salt Lake City, UT 84131

Your letter must have the following information: your name, your member ID number, your contact information (telephone number and address), and the reason for your grievance.

You have 1 year to file your grievance from the date of the event that caused you to be unhappy. We will tell you that we have your grievance. We will finish reviewing your case within 90 days. We will let you know if we need an extra 14 (calendar) days to look at your case. We will let you know by letter within 5 days of deciding. We will only take more time if it could help you or if you ask us.

While we look at your case you can request a Medicaid Fair Hearing (does not apply to Medikids members). You could also ask for a Medicaid fair hearing if you are not happy with our decision. You must ask for a Medicaid fair hearing by 90 days after you receive our decision letter. You can ask someone to represent you at the hearing. You can file a Medicaid fair hearing by writing to:

Office of Public Assistance
Appeals Hearings
1317 Winewood Boulevard
Building 5, Room 203
Tallahassee, Florida 32399-0700
How to File an Appeal

If you are not happy with a decision we made, called an “action,” you can file an appeal. You have 30 calendar days of getting our letter to file your appeal. This applies to the following actions:

- We issued a denial or limitation of a requested service, type of service, or level of service
- We reduced, suspended, or terminated a previously authorized service
- We denied a whole or partial payment of a service (claims are denied)
- We failed to provide a service in a timely manner as defined by regulations
- We denied the right to access services outside of the network if the member resides in a rural area with only one managed care entity
- We denied services that were ordered by an authorized provider
- The authorization period has not expired

You or your provider can file an appeal on your behalf. You can ask for an appeal by letter or by phone. Call the Customer Service number on the back of your ID card to appeal by phone. If you appeal by phone you must also send us a letter within 10 days of calling us. We will start working on your case the same day you call. Your letter must have the following information: your name, your member ID number, your contact information (telephone number and address), and the reason for your appeal. Please send your letter to:

UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131

You can ask to continue services. You must ask within 10 days of getting our letter saying no to the services or within 10 days after the start date of the action, whichever is later. Your appeal must be related to ending, suspending or reducing something for which we had already said yes. The services must have been asked for by a provider that was allowed. The time approved for the services must not have ended. If services continue and we say no to your appeal, you may have to pay for services.

We will resolve your appeal in 45 days. We will let you know if we need more time to resolve your appeal. We will only take more time if it will help your case.

If you are unhappy with our decision, you have a right to request a review with the Beneficiary Assistance Program. You must request this review with the Beneficiary Assistance Program within 365 days from the receipt of our decision letter.

To file an appeal with the Beneficiary Assistance Program, write or call:

Agency for Health Care Administration
Beneficiary Assistance Program
2727 Mahan Drive, Building 1, MS# 26
Tallahassee, FL 32308
1-850-412-4502
Toll Free 1-888-419-3456

Please make sure your letter to the Beneficiary Assistance Program includes the following information: our Plan name (UnitedHealthcare Community Plan), your name, your member ID #, contact information, and the reason for your appeal.
How to File an Expedited Appeal

If we make a decision that you are not happy with and you want to file an appeal, but feel that the time for this appeal could be a danger to your life or health or cause you to be injured, you or your provider may ask for a fast review. You can ask by phone or mail. Fast reviews are also called expedited appeals. You and your provider will get the answer to the fast review within 72 hours. For fast reviews, please call the Customer Service number on the back of your ID card.

When we get your request for an expedited appeal we will make the decision if your appeal requires a fast review. If we decide that your appeal does not need a fast review, we will let you know and then process your appeal as a regular appeal according to the procedures and timeframes mentioned in the section “How to file an Appeal.” You can always call the Customer Service Department if you need more information on expedited appeals.
Advance Directives

The Patient’s Right to Decide

All Enrollees age 18 and older in health care facilities such as hospitals, nursing homes, hospices, home health agencies, and health maintenance organizations have certain rights under Florida law.

You have a right to file an “Advance Directive.” This document says, in advance, what kind of treatment you want or do not want when you may be under special, serious medical conditions, conditions that would stop you from telling your provider how you want to be treated. For example, if you were taken to a health care facility in a coma, would you want the facility’s staff to know your specific wishes about decisions affecting your treatment? An Advance Directive will let the providers know how you want your health care to be handled.

What Is an Advance Directive?

An Advance Directive is a written or oral statement, which is made and witnessed in advance of serious illness or injury. It tells others how you want health care decisions made when you are not able to make them yourself. There are two forms of an Advance Directive:

1. A “Living Will”
2. Health Care Surrogate Designation

An Advance Directive allows you to state your choices about health care, or to name someone to make those choices for you, if and when you become unable to make decisions about your health care treatment for yourself. An Advance Directive can enable you to make decisions about your future health care treatment.

What Is a Living Will?

A Living Will generally states the kind of health care you want or do not want if you become unable to make your own decisions. In Florida, the definition of “Life Prolonging Procedures” was changed by the government to include giving food and water to a person with a terminal illness. It is called a “Living Will” because it takes effect while you are still living. Florida’s law provides a suggested form to use for a Living Will. You may use it or some other form. You may wish to speak to an attorney or provider to be certain you have completed the Living Will so that your wishes will be understood.

What Is a Health Care Surrogate Designation?

A Health Care Surrogate Designation is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son or close friend as your agent. This person will then be the one who will make health care decisions for you if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Florida law provides a suggested form to use for a Designation of a Health Care Surrogate. You may use it or some other form. You may wish to name a second person as a backup who will stand in, if your first choice is not available.
You may wish to have both a living will and a Health Care Surrogate Designation, or you may want to combine them into a single document that describes treatment choices in a variety of situations and names someone to make health care decisions for you should you be unable to make these decisions for yourself.

Do I Have to Write an Advance Directive Under Florida Law?

No, there is no legal requirement to complete an Advance Directive. However, if you have not made an Advance Directive or designated a Health Care Surrogate, health care decisions may be made for you by a court appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend in that order. This person would be called a “proxy.”

Can I Change My Mind After I Write a Living Will or Designate a Health Care Surrogate?

Yes, you may change or cancel these documents at any time. Any change should be written, signed and dated. You can also change an Advance Directive by oral statement.

What if I Have Filled out an Advance Directive in Another State and Need Treatment in a Health Care Facility in Florida?

An Advance Directive completed in another state, in compliance with the other state’s law, can be honored in Florida.

What Should I Do With My Advance Directive if I Choose to Have One?

Make sure that someone such as your provider, lawyer, or family member knows that you have an Advance Directive and where it is located. Consider the following:

• If you have designated a health care surrogate, give a copy of the written designation form or the original to that person.
• Give a copy of your Advance Directive to your provider for your health care file.
• Keep a copy of your Advance Directive in a place where it can easily be found.
• Keep a card or note in your purse or wallet which states that you have an Advance Directive and where it is located.
• If you change your Advance Directive, make sure your provider, lawyer and/or family member has the latest copy.
Please note: You have a right to choose a new health care provider in situations when a health care provider cannot honor the Advance Directive wishes of his/her patients due to objections of conscience. For further information, ask those in charge of your care or contact the Customer Service Department.

Florida State law requires that any changes to Advanced Directive Laws be provided to you as soon as possible, but no later than ninety (90) days after the effective date of the change.

If you believe your provider is not following Advance Directive laws and regulations, you may file a complaint by calling the Consumer Complaint Hotline toll-free at 1-888-419-3456.

Confidentiality of Member Information

Privacy of member information and records is important to UnitedHealthcare Community Plan. There are several ways we protect your records.

- Members sign a release of medical records. This means you give us permission to get your health care records when researching a quality matter or health care inquiry.
- The Plan has written and implemented policies and procedures that protect the privacy of your data. This type of data can be released to a person or organization that has provided your written consent.
- Contracts between the Plan and its health care providers include terms concerning the privacy of your records.

UnitedHealthcare Community Plan is committed to maintaining the privacy of your records and data. If you have any questions regarding this information, please contact our Customer Service Department at the telephone number on the back of your identification card.

How Can I Make an Advance Directive?

You can speak with your primary care physician, an attorney or go to http://flsenate.gov/Statutes.

A living will may, BUT NEED NOT, be in the following form:
Living Will

Declaration made this _____ day of _______, (year), I, _________________________, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

_______ (initial) I have a terminal condition
or _______ (initial) I have an end-stage condition
or _______ (initial) I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: ___________________________________________________________________________________

Address: ______________________________________________________________________________

Zip Code: ___________________________ Phone: ________________________________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

(Signed)

Witness
Address
Phone

Witness
Address
Phone
You may receive covered services which are performed, prescribed, or directed by a participating provider. Remember you must receive your health care services by a participating network provider. It is your responsibility to check if a provider is participating. You can look in your M★Plus Provider and Health Care Provider Directory. Since the network changes, you may also call Customer Service to make sure the provider you choose is a UnitedHealthcare Community Plan participating provider.

Services are limited to Medicaid-covered services as specified in the contract with the State of Florida Agency for Health Care Administration. The following is a summary of the Plan’s health services and limitations on covered services. Please call Customer Service to verify covered services. Services that are considered experimental and cosmetic are not covered. For a counseling or referral service that the health plan does not cover because of moral or religious objections, the health plan need not furnish information on how and where to obtain the service.

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Adult Basic Dental Services (such as cleaning, simple fillings, and/or extractions)</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Child Check-Up Services</td>
<td>Routine check-ups according to the preventive guidelines section of this handbook. These services include: health and development history, unclothed physical assessment or examination, nutritional assessment, routine immunization update, laboratory tests (including lead screening), vision screening, hearing screening, dental screening, health education, and development assessment. You do not need a referral for these services</td>
</tr>
<tr>
<td>Diabetes Supplies and Education</td>
<td>Coverage for medically appropriate and necessary equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services, if your treating provider says these services are necessary.</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Includes emergency medical care 24 hours a day, 7 days a week. You do not need approval from UnitedHealthcare or your PCP to go to the emergency room if you are having a medical situation. See page 18 for more information.</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>To help you plan a family size or help you space the time between having children. Family Planning Services includes information, referral education, counseling, diagnostic procedures and contraceptive drugs and supplies. Services are voluntary and you are permitted full freedom of choice of methods for Family Planning. You can go to any provider that participates with Medicaid for these services without a referral from your Primary Provider.</td>
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</table>
### Covered Services (cont.)

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>Freestanding Dialysis Facility Services</td>
<td>Includes routine laboratory tests, dialysis-related supplies, ancillary and other items. Services include all services and procedures rendered by a participating provider when needed for preventive, diagnostic, therapeutic, or to treat a particular injury, illness or disease.</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Hearing Services include examinations and evaluations necessary for the furnishing of one standard hearing aid every three years.</td>
</tr>
<tr>
<td>Home Health Care Services and Durable Medical Equipment</td>
<td>Includes intermittent or part-time nursing services (R.N. or L.P.N.), personal care services by a home health aide, and medical items (limited to approved types of supplies and equipment, suitable for use in the home). All services and equipment must be ordered by a participating provider. Your Primary Provider must notify UnitedHealthcare for services or equipment which require home health care. Home health care does not include homemaker services, Meals on Wheels, companion, sitter or social services.</td>
</tr>
<tr>
<td>Hospital Ancillary Services</td>
<td>When you provider authorizes these to be provided by the hospital: radiology, pathology, neurology, neonatology, and anesthesiology.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>According to childhood immunization schedule as approved by the appropriate Recommended Childhood Immunization Schedule for the United States.</td>
</tr>
<tr>
<td>Independent Laboratory and Portable X-Ray Services</td>
<td>Includes laboratory and x-ray services when ordered by a participating provider.</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Includes all items and services needed to give appropriate care during a stay at a participating hospital, including room and board, nursing care, medical supplies, and all diagnostic and therapeutic services. UnitedHealthcare covers a maximum of 45 inpatient days for the period from July 1st through June 30th. (Includes only non-emergency care at hospitals where prior notification was obtained by your Primary Provider from UnitedHealthcare).</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>If you are in need of interpreter services or are vision and/or hearing impaired, please call the Member Service phone number on the back of your ID card. These services are free of charge for all foreign languages as well as the visually and/or hearing impaired.</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
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</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>Maternity services include the following: nursing assessment and counseling, Florida's Health Start Prenatal Risk Screening, nutrition assessment, delivery and follow-up care, Florida's Health Start Infant (Postnatal) Screening, and follow-up care.</td>
</tr>
<tr>
<td></td>
<td>As soon as you know you are pregnant and again after your baby is born, remember to call:</td>
</tr>
<tr>
<td></td>
<td>1. Your Department of Children and Family Care Worker; AND 2. The Plan's Member Services Department.</td>
</tr>
<tr>
<td></td>
<td>If you wish to enroll your baby into the Plan, you can contact Medicaid Options toll free at 1-888-367-6554, between the hours of 8:00 am and 7:00 pm, Monday through Friday.</td>
</tr>
<tr>
<td></td>
<td>Once your baby is enrolled in our Plan, please call the Member Service phone number on the back of your ID card to select a pediatrician for your baby.</td>
</tr>
<tr>
<td></td>
<td>It is your responsibility to call your Case Worker to get Medicaid benefits for your baby. If you do not do so, the Plan will not pay your baby's health care bills.</td>
</tr>
<tr>
<td></td>
<td>The Women, Infant, and Children (WIC) Program includes referrals for all pregnant breast-feeding and post-partum women, infants and children up to the age of five. Contact your Case Worker for information.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> See Unborn ID Activation Process on page 10 of this handbook for further information regarding the Newborn Enrollment process.</td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td>If you are in need of Behavioral Health, counseling and referral services, you will be evaluated by a participating psychiatrist. If you are in need of further services, the provider will then refer you to the Community Health Center. To call your Behavioral Health Provider, please refer to the back of your ID card. If you are enrolled in the Child Welfare Prepaid Mental Health Plan through the Florida Safe Families Network, UnitedHealthcare Community Plan does not provide coverage for behavioral health services. Please contact the Community Based Care Partnership at 1-800-327-5542 or your local Medicaid office for further information.</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>Outpatient services provided in an outpatient hospital setting. Your Primary Provider can obtain prior notification for health care services which may require notification.</td>
</tr>
</tbody>
</table>
## Covered Services (cont.)

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the Counter (OTC)</td>
<td>UnitedHealthcare Community Plan gives each household benefits for over-the-counter drugs and first aid items each month. Call Customer Service if you have any questions about how to receive these services.</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Includes all services and procedures rendered by a participating provider when needed for preventive, diagnostic, therapeutic, or to treat a particular injury, illness or disease. Excludes experimental procedures and cosmetic surgery.  These physician services include:  Advanced registered nurse practitioner, physician assistant, podiatry, ambulatory surgical centers, community health departments, rural health clinic services, federally qualified health centers, birthing centers, certified nurse midwives, chiropractic, and psychiatrists.</td>
</tr>
<tr>
<td>Post Stabilization Services</td>
<td>Post Stabilization services are covered without prior authorization. These are services related to an emergency medical condition that are provided after you are stabilized in order to maintain, improve or resolve your condition.</td>
</tr>
<tr>
<td>Prescribed Drugs</td>
<td>Includes prescribed drugs currently covered by the Medicaid Program, when ordered by a participating provider and supplied by a licensed participating pharmacy.</td>
</tr>
<tr>
<td>Therapy Services – physical, respiratory, occupational and speech therapies</td>
<td>Are covered for recipients under 21 years of age as medically necessary. Adults (21 years and older) are covered for outpatient physical and respiratory therapy.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Vision services include eye exams and up to two pairs of standard eyeglasses per year. Contact lenses for cosmetic purposes are not covered.</td>
</tr>
</tbody>
</table>

### Consent Form Required Services

A consent form will need to be signed by parents/legal guardians of children under the age of 13 who are on Medicaid and take certain Psychotropic medicines. This form will need to be signed with every new prescription. Your child’s doctor will send the signed consent form to the drug store. This consent form can be sent to the drug store by fax, mail, or online. Call Customer Service at the number on the back of your ID card if you have questions.
Regular Medicaid Services
The following are some Medicaid services that are NOT covered by UnitedHealthcare Community Plan, but you can receive these services by calling your local Area Medicaid Office for information (see Important Phone Numbers page for a list of Area Medicaid Office phone numbers):

- Dental services
- Transportation services
- Inpatient days for children beyond the initial 45 days

New Technology
Requests to cover new medical procedures, devices, or drugs are reviewed by the UnitedHealthcare Community Plan Technology Assessment Committee. This group includes doctors and other health care experts. The team uses national guidelines and scientific proof from medical studies to help decide whether UnitedHealthcare Community Plan should approve such equipment, procedures, or drugs.

Other Benefits
Ready to quit smoking? Do you want to take classes to learn more about quitting smoking? Call the Member Service number on the back of your ID card or call Florida Quit for Life 1-877-822-6669, for classes near you.

Is someone hurting you? Domestic violence hurts. You are not alone. You have choices. Call the Florida Domestic Violence Hotline at 1-800-500-1119 anytime, 24 hours a day, seven (7) days a week. If you have a problem with alcohol or drugs, talk to your provider. You can also get substance abuse help from these 12 step programs:
### Other Benefits (cont.)

<table>
<thead>
<tr>
<th>Alcoholic Anonymous</th>
<th>Narcotics Anonymous</th>
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<tbody>
<tr>
<td>Brevard County 1-321-724-2247</td>
<td>Broward County 1-954-476-9297 or 1-954-584-6578</td>
</tr>
<tr>
<td>Broward County 1-954-462-0265</td>
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<tr>
<td>Citrus County 1-352-621-0599</td>
<td>Citrus County 1-352-382-0851</td>
</tr>
<tr>
<td>Dade County 1-305-461-2425</td>
<td>Dade County 1-305-620-3875</td>
</tr>
<tr>
<td>Duval County 1-904-339-8535</td>
<td>Duval County 1-904-723-5683</td>
</tr>
<tr>
<td>Flagler County 1-386-445-4357</td>
<td>Flagler County 1-800-477-0731</td>
</tr>
<tr>
<td>Hernando County 1-352-683-4597</td>
<td>Hernando County 1-352-754-7200</td>
</tr>
<tr>
<td>Highlands County 1-863-382-2694</td>
<td>Highlands County 1-863-683-0630</td>
</tr>
<tr>
<td>Hillsborough County 1-813-933-9123</td>
<td>Hillsborough County 1-813-879-4357</td>
</tr>
<tr>
<td>Lake County 1-352-360-0960</td>
<td>Lake County 1-352-219-5617</td>
</tr>
<tr>
<td>Manatee County 1-941-951-6810</td>
<td>Manatee County 1-941-957-7910</td>
</tr>
<tr>
<td>Marion County 1-352-867-0660</td>
<td>Marion County 1-352-368-6061</td>
</tr>
<tr>
<td>Okeechobee County 1-863-763-1006</td>
<td>Okeechobee County 1-772-343-8373</td>
</tr>
<tr>
<td>Orange County 1-407-260-5408</td>
<td>Orange County 1-407-425-5157</td>
</tr>
<tr>
<td>Osceola County 1-407-260-5408</td>
<td>Osceola County 1-407-425-5157</td>
</tr>
<tr>
<td>Palm Beach County 1-561-655-5700</td>
<td>Palm Beach County 1-561-848-6262</td>
</tr>
<tr>
<td>Pasco County 1-727-847-0777</td>
<td>Pasco County 1-727-842-2433</td>
</tr>
<tr>
<td>Pinellas County 1-727-360-0415</td>
<td>Pinellas County 1-727-547-0444</td>
</tr>
<tr>
<td>Polk County 1-863-688-0211</td>
<td>Polk County 1-863-683-0630</td>
</tr>
<tr>
<td>Putnam County 1-877-572-4187</td>
<td>Putman County 1-904-723-5683</td>
</tr>
<tr>
<td>Seminole County 1-800-859-1767</td>
<td>Seminole County 1-407-425-5157</td>
</tr>
<tr>
<td>Volusia County 1-386-756-2930</td>
<td>Volusia County 1-800-477-0731</td>
</tr>
</tbody>
</table>

**For Reference: Toll Free Nationwide Phone Numbers**

- **Alcoholic Anonymous:** 1-800-859-1767
- **Narcotics Anonymous:** 1-866-288-6262
HEALTH PLAN NOTICES OF PRIVACY PRACTICES

Medical Information Privacy Notice

This notice says how medical information about you may be used and shared. It says how you can get access to this information. Read it carefully.

Effective January 1, 2012

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

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

We must by law follow the terms of this notice.

“Health information” (or HI) in this notice means information that can be used to identify you. And it must relate to your health or health care services. We have the right to change our privacy practices. If we change them, we will mail you a notice or we may provide you with a notice by e-mail, if permitted by law. We will post the new notice on your healthplan website www.UHCCommunityPlan.com.

We have the right to make changes apply to HI that we have and to future information.

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 get confidential communications** in a different way or place. (For example, at a P.O. Box instead of your home.) We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.

• **To see or get a copy** of HI that we use to make decisions about you. You must ask in writing. Mail it to the address below. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed. If we keep an electronic record, if and when we are required by law, you will have the right to ask for an electronic copy to be sent to you or a third party. We may charge a fee for this.

• **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.

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, 2012

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. We do regular audits to ensure secure handling.

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.; Pacific Dental 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, 2012

The first part of this Notice (pages 1 – 4) 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**

<table>
<thead>
<tr>
<th>Alcohol and Drug Abuse Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>We may use and share alcohol and drug information protected by federal law only (1) in limited cases, and/or (2) with certain recipients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Genetic Information</th>
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</thead>
<tbody>
<tr>
<td>We may not use genetic information for underwriting.</td>
</tr>
</tbody>
</table>
### Summary of State Laws

#### General Health Information

<table>
<thead>
<tr>
<th>Information Type</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to share general health information only (1) in some limited cases, and /or (2) with certain persons or entities.</td>
<td>CA, NE, PR, RI, VT, WA, WI</td>
</tr>
<tr>
<td>HMOs must let enrollees approve or refuse sharing, with some exceptions.</td>
<td>KY</td>
</tr>
<tr>
<td>You may be able to limit certain electronic disclosures of health information.</td>
<td>NV</td>
</tr>
<tr>
<td>We may not use health information for certain purposes.</td>
<td>CA</td>
</tr>
<tr>
<td>We will not use and/or share information about certain public assistance programs except for certain purposes</td>
<td>MO, NJ, SD</td>
</tr>
</tbody>
</table>

#### Prescriptions

<table>
<thead>
<tr>
<th>Information Type</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We may share prescription-related information only (1) in some limited cases, and /or (2) with certain persons or entities.</td>
<td>ID, NH, NV</td>
</tr>
</tbody>
</table>

#### Communicable Diseases

<table>
<thead>
<tr>
<th>Information Type</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We may share communicable disease information only (1) in some limited cases, and /or (2) with certain persons or entities.</td>
<td>AZ, IN, KS, MI, NV, OK</td>
</tr>
</tbody>
</table>

#### Sexually Transmitted Diseases and Reproductive Health

<table>
<thead>
<tr>
<th>Information Type</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to share sexually transmitted disease and/or reproductive health information only (1) in some limited cases and/or (2) with certain persons or entities.</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>Information Type</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We may use and share alcohol and drug abuse information (1) in some limited cases, and/or (2) with certain persons or entities.</td>
<td>CT, GA, HI, KY, IL, IN, IA, LA, NC, NH, WA, WI</td>
</tr>
<tr>
<td>Sharing of alcohol and drug abuse information may be limited by the person who is the subject of the information.</td>
<td>WA</td>
</tr>
</tbody>
</table>
### Summary of State Laws (continued)

<table>
<thead>
<tr>
<th>Genetic Information</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We may not share genetic information without your written consent.</td>
<td>CA, CO, HI, IL, KS, KY, LA, NY, RI, TN, WY</td>
</tr>
<tr>
<td>We may share genetic information only (1) in some limited cases and/or (2) with certain persons or entities.</td>
<td>AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT</td>
</tr>
<tr>
<td>Limits apply to (1) the use, and/or (2) the keeping of genetic information.</td>
<td>FL, GA, IA, LA, MD, NM, OH, UT, VA, VT</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>HIV / AIDS</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We may share HIV/AIDS-related information only (1) in some limited cases and/or (2) with certain persons or entities.</td>
<td>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</td>
</tr>
<tr>
<td>Certain limits apply to oral disclosures of HIV/AIDS-related information.</td>
<td>CT, FL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We may share mental health information only (1) in some limited cases and/or (2) with certain persons or entities.</td>
<td>CA, CT, DC, HI, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI</td>
</tr>
<tr>
<td>Sharing may be limited by the person who is the subject of the information.</td>
<td>WA</td>
</tr>
<tr>
<td>Certain limits apply to oral disclosures of mental health information.</td>
<td>CT</td>
</tr>
<tr>
<td>Certain limits apply to the use of mental health information.</td>
<td>ME</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child or Adult Abuse</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>We may use and share child and/or adult abuse information only (1) in some limited cases, and/or (2) with certain persons or entities.</td>
<td>AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI</td>
</tr>
</tbody>
</table>