UnitedHealthcare Community Plan
Member Handbook

Delaware Medicaid Long Term Care
Diamond State Health Plan Plus
Telephone Numbers

Member Services .................................................. 1-877-542-9248
TTY for the hearing impaired ..................................... 711
Monday – Friday: 8 a.m. – 5 p.m. ET

Long Term Care Case Management ......................... 1-855-821-9102

Member Advocates .................................................. 1-877-901-5523
TTY .......................................................... 711

24/7 NurseLine ....................................................... 1-866-915-0311

Healthy First Steps .................................................. 1-800-599-5985

Fraud and Abuse Hotline .......................................... 1-877-766-3844

State of Delaware, Division of Social Services
and Division of Medicaid and Medical Assistance
Customer Relations .............................................. 1-800-372-2022 or 1-302-571-4900

Health Benefits Manager - Enrollment ...................... 1-800-996-9969

Pharmacy Benefits Manager ...................................... 1-800-996-9969, option 2

Logisticare Transportation Services
Non-Emergency Transportation ................................. 1-866-412-3778
Where’s My Ride? Hotline ....................................... 1-866-896-7211

For an emergency, dial 911 or go to your nearest emergency room.

Website www.UHCCommunityPlan.com

UnitedHealthcare Community Plan
4051 Ogletown Road, Suite 200
Newark, DE 19713

Call Member Services if you need this handbook in Braille,
large print, audio, or another language.

Your Health Providers

Name: ____________________________ Phone: ____________________________
Name: ____________________________ Phone: ____________________________
Name: ____________________________ Phone: ____________________________
Pharmacy: ________________________ Phone: ________________________
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Welcome to UnitedHealthcare Community Plan

Coordination of Long Term Services
Thank you for choosing UnitedHealthcare Community Plan! We will help you stay healthy and get good care. We will help you get access to the care you need. With UnitedHealthcare Community Plan, you will receive all of your regular Medicaid benefits plus additional services.

Your guide to good health
Please read this Handbook. It will help you use your health plan. It explains your benefits. We can answer any questions you have. Look at your UnitedHealthcare Community Plan ID card. Make sure the information on the ID card is correct.

If you have questions, call us. Our toll-free number is 1-877-542-9248. There are people who can speak with you in English, Spanish, or other languages. If you need an interpreter, tell us. We will connect you to the AT&T Language Line. If you are speech or hearing impaired, call TTY 711. Call us if you need this book in Braille, large print, audio, or another language.

Member Services
UnitedHealthcare Community Plan Member Services has information on:

- Membership.
- Choosing a primary care provider.
- Specialists, hospitals, and other providers.
- Covered services.
- Changing doctors.
- Making a grievance.
- Name or address changes.
- Medicaid and Medicare coverage.
- Getting an interpreter.
- Getting a ride to the doctor.
- Prior authorization questions.
- Other questions.

Member Services can also connect you with your Care Coordinator if you need information about health care, such as:

- Living with a chronic illness.
- Disease Management programs.
- How to get behavioral health care.
- Eating healthy foods.
- Safe sex and birth control.
- HIV/AIDS.
- Keeping children well with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

We are happy to help with other topics. Just call 1-877-542-9248. If you are speech or hearing impaired, call TTY 711. You can call 24 hours a day. For medical questions, you can talk to someone at any time. For non-medical questions, leave a message. We will return your call by the next business day.
About Diamond State Health Plan Plus

Diamond State Health Plan Plus is a Medicaid managed care program from the Delaware Division of Medicaid & Medical Assistance. Managed care means that Delaware hires a company, also known as a Managed Care Organization (MCO), to help you manage your health care.

The UnitedHealthcare Community Plan is one option for Delaware residents who qualify for Diamond State Health Plan Plus. The state decides if you are eligible for long term care. Mandatory populations include:

1. Members residing in a Nursing Facility.
2. Members receiving Home and Community based services.
3. Members that have Medicare and Medicaid.

UnitedHealthcare Community Plan is available statewide in Delaware and:

- Offers medical coverage and services to help with daily life.
- Promotes independent living.
- Promotes checkups.
- Lets you take part in decisions.
- Provides a Care Coordinator.

UnitedHealthcare Community Plan has a network of providers. If you have Medicaid only, for most services, you must use doctors, hospitals, or other providers approved by UnitedHealthcare Community Plan. If you feel you need care from a provider not in the network, prior authorization is required. Authorizations are subject to medical necessity review. Member Services can help you find providers in our network. You may use any provider for emergencies.

If you have questions, call us. Our toll-free Member Services number is 1-877-542-9248 (TTY: 711).

Alternative Languages

If English is not your first language, you can ask for a translator when you visit your doctor. This is a free service. Call your doctor before your visit and say you want a translator. We will coordinate for one to be there for your appointment. You can also check our provider directory for doctors who speak your language.

Interpretive Services

If you have any problems reading or understanding any information we send you, please call Member Services at 1-877-542-9248 (TTY: 711). We can help explain it to you or read it to you orally, either in English or in another language. We may have the information printed in other languages or in other ways. If you are vision impaired or hearing impaired, we can give you special help.

24-Hour NurseLine℠

We have a free hotline for members to speak with a nurse. NurseLine is open 24 hours a day, 7 days a week. Just call 1-866-915-0311.

Quality Improvement

For a description of the Quality Improvement program, our practice guidelines or how we meet our goals, write to:

Quality Improvement
UnitedHealthcare Community Plan
4051 Ogletown Road, Suite 200
Newark, DE 19713
If You Have Both Medicare and Medicaid

If you have both Medicare and Medicaid, you have more than one insurance coverage. Medicare is considered your primary insurance and Medicaid is your secondary insurance. This means your doctor will bill Medicare first for services covered by both programs and Medicaid will be billed second for any cost-sharing. You do not have to pay for any services covered by Medicare or Medicaid. Your Medicaid benefits will not change your primary insurance benefits. Your Care Coordinator will work with your primary insurance to help set up your health care.

If you have both Medicare and Medicaid, Medicare Part D will cover most of your drugs (you will still have to pay Medicare Part D copays), unless you live in a nursing facility or receive home and community-based services. If you have Medicare, you can use your current doctor. You can get Medicare specialty services without approval from Medicaid.

We will work with your doctor for the services you get through your Medicaid Long Term Care Plan (Diamond State Health Plan Plus). We can help you pick a doctor if you do not have one. This doctor can set up your health care services. If you are in a Medicare Advantage Plan, your primary care provider (PCP) is your Medicare Advantage doctor.

You do not have to pick another primary care provider for Diamond State Health Plan Plus. Medicare or your Medicare Advantage Plan will pay for your services before Diamond State Health Plan Plus. Our plan may cover some services that are not covered by Medicare.

**Our office location:**
UnitedHealthcare Community Plan
4051 Ogletown Road
Suite 200
Newark, DE 19713

**Business hours:** 8 a.m. to 5 p.m.
Toll-free **1-877-542-9248**.
TTY **711**, for hearing impaired.

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**Bring your State of Delaware Medical Assistance Program Card and your UnitedHealthcare Community Plan ID card to all doctor and pharmacy visits. If you have Medicare, bring your Medicare card too.**
Your UnitedHealthcare Community Plan Member ID Card

You and your family members enrolled in UnitedHealthcare Community Plan will each get a separate member ID card. Bring your member ID card with you to all health appointments. If you lose your card, call Member Services to get a new card. You should also bring your State of Delaware Medical Assistance Program Card to all your health appointments. You can call Medicaid at 1-800-372-2022 if you have questions about your State of Delaware Medical Assistance Program Card.

**UnitedHealthcare Community Plan LTC**

- NH LOC-Community (Medicaid ONLY)
- NH LOC-NH Resident (Medicaid ONLY)

**UnitedHealthcare Community Plan LTC**

- NH LOC-Community (DUAL)
- NH LOC-NH Resident (DUAL)

Your UnitedHealthcare Community Plan member ID card will look like this:

### PCP Assigned

<table>
<thead>
<tr>
<th>Member ID: 9999999999</th>
<th>Group: 9999</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Community Plan - Long Term Care Administered by Unison Health Plan of Delaware, Inc.</td>
<td></td>
</tr>
</tbody>
</table>

**Health Plan (80840) 999-99999-99**

**Payer ID:** UnitedHealthcare Community Plan - Long Term Care 999999999

**PCP Assigned**

- Member: SUBSCRIBER BROWN
- MMC ID #: 9999999999
- Payer ID: 9999

**PCP Name:**

- DR. PROVIDER BROWN

**PCP Phone:** (999)999-9999

**CCHS Adult Medicine**

- In an emergency go to nearest emergency room or call 911.

**This card does not guarantee coverage.**

For Members: 877-542-9348  TTY 711

NurseLine: 866-915-0311  TTY 711

Mental Health: 866-261-7692  TTY 711

For Providers: www.uhccommunityplan.com  800-600-9007

Medical Claims: PO Box 8207, Kingston, NY, 12402

Eligibility: 888-566-4766  Utilization Management: 800-366-7304

### No PCP Assigned

<table>
<thead>
<tr>
<th>Member ID: 9999999999</th>
<th>Group: 9999</th>
</tr>
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<tbody>
<tr>
<td>UnitedHealthcare Community Plan - Long Term Care Administered by Unison Health Plan of Delaware, Inc.</td>
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**Health Plan (80840) 999-99999-99**

**Payer ID:** UnitedHealthcare Community Plan - Long Term Care 999999999

**Member ID:**

- SUBSCRIBER BROWN

**MMC ID #:** 9999999999

**Payer ID:** 9999

**In an emergency go to nearest emergency room or call 911.**

**This card does not guarantee coverage.**

For Members: 877-542-9348  TTY 711

NurseLine: 866-915-0311  TTY 711

Mental Health: 866-261-7692  TTY 711

For Providers: www.uhccommunityplan.com  800-600-9007

Medical Claims: PO Box 8207, Kingston, NY, 12402

Eligibility: 888-566-4766  Utilization Management: 800-366-7304
Your State of Delaware Medical Assistance Program Card

In addition to your UnitedHealthcare Community Plan member ID card, you should also bring your state-issued Medicaid ID card to all health appointments. You can call Medicaid at 1-800-372-2022 if you have questions about your State of Delaware Medical Assistance Program Card. Some of the services not covered by UnitedHealthcare Community Plan are covered by the state of Delaware. Use your Medicaid ID card to get the following services not covered by UnitedHealthcare Community Plan.

• Prescription drugs.
• Dental services for members age 20 and younger.
• Non-emergency transportation.
Care Management

UnitedHealthcare Community Plan’s Care Management Program is a holistic approach to helping our members live healthier lives.

Our focus is to work with you and your Primary Care Provider (PCP) to keep you healthy and independent in the community.

Our program encourages and promotes member involvement, active decision-making, and active participation in planning your health care needs.

Care Coordination and Role of the Care Coordinator

If you are a member of Diamond State Health Plan Plus and have Long Term Care on your card, UnitedHealthcare Community Plan is responsible for managing all the services you receive to meet your physical health, mental health and long term care needs. UnitedHealthcare Community Plan does this through Care Coordination.

UnitedHealthcare Community Plan will assign you a Care Coordinator if you are enrolled in Diamond State Health Plan Plus. If you are in the AIDS/HIV Waiver Program, you will receive care coordination through a special agency of your choice. You will receive a phone call that will let you know the name of your Care Coordinator and how to reach this person. Your Care Coordinator is your main contact person and is the first person you should go to if you have any questions about your services.

If there is any delay in assigning your Care Coordinator, UnitedHealthcare Community Plan will send a letter that tells you how to reach the Care Coordination Department for help.

Your Care Coordinator will provide support and education and will assist you with coordinating services. S/he will work with you and your PCP to ensure you receive timely access to care with the right provider, at the right time, at the right place of service.

Contacting Your Care Coordinator

You can contact your Care Coordinator anytime you have a question or concern about your health care – you do not need to wait until a home visit or a phone call from the Care Coordinator. You should contact your Care Coordinator when you have a change in your health condition or other things that may affect the kind or amount of care you need.

To reach the Care Management Department, call 1-855-821-9102.

For additional care, our NurseLine is open 24 hours a day, 7 days a week. Just call 1-866-915-0311.
Care Coordination and Your Doctor

• If you do not have a Primary Care Provider (PCP), your Care Coordinator will help you find one.
• Your Care Coordinator can help make sure your PCP and other providers are working with you.
• Your PCP is advised of any assessments and screenings you have had.
• A copy of your Individual Service Plan (ISP) will be sent to your PCP.
• Your Care Coordinator works with your PCP to make sure you are involved in programs that can improve your health.
• Your Care Coordinator makes sure that your specialists share their findings with your PCP. In some cases your permission may be needed.
• Your Care Coordinator works with your PCP to make sure you get the services you need when you come out of the hospital.
• Your PCP can refer you to other doctors or specialists you may need, including behavioral health services. You can also contact OptumHealth directly to get a referral for behavioral health needs.

Changing Care Coordinators

If you are unhappy with your Care Coordinator, please call UnitedHealthcare Community Plan at 1-877-542-9248 (TTY: 711).

If we cannot resolve your concern, we may assign a new Care Coordinator to you. This does not mean you can pick your own Care Coordinator. UnitedHealthcare Community Plan must be able to meet the needs of all Diamond State Health Plan Plus members and assign Care Coordinators that are best suited for each member.

There may be times when UnitedHealthcare Community Plan will have to change your Care Coordinator. If we need to change your Care Coordinator, we will let you know. If you have any questions, please call Member Services at 1-877-542-9248 (TTY: 711).

Care Options Available to You:

If you have Diamond State Health Plan Plus Long Term Care on your card, you may choose to get care:

• In your home,
• Or in another place in the community (such as an assisted living facility),
• Or in a nursing home.

If you are in a nursing home, you may be able to move from the nursing home to your own home and get health care. Talk with your Care Coordinator if you are interested in doing this.
To receive care in your home or in the community, UnitedHealthcare Community Plan will help. However, the cost of your care cannot be more than the cost of your care in a nursing home.

To get care in your home or in the community, contact your Care Coordinator. For more information contact the DMMA Central Intake Unit at 1-866-940-8963 to apply for Long Term Care Services.

You will not be forced to leave the nursing home if you do not want to do so, even if we think care in the community costs less, as long as you qualify for nursing home care.

Your Care Coordinator will work with you to discuss changes you want to consider and decide what setting is the best place to meet your needs and ensure your well-being.

You can also help choose the providers who will give your care. This could be an assisted living or nursing home, or the agency that will provide care at home. You may also be able to hire your own workers for some kinds of care (called Consumer Direction).

The provider you choose must be willing and able to give your care. Your Care Coordinator will help you arrange this. If you do not get the provider you want, you cannot appeal and get a fair hearing. You can file an appeal only if you do not get the services you think you need.

If you receive care in a nursing home, your Care Coordinator will:

- Be part of the care planning process at the nursing home where you live.
- Perform any additional needs assessment that may be helpful in managing your health and long term care needs.
- Supplement (or add to) the nursing home's plan of care if there are things UnitedHealthcare Community Plan can do to help manage health problems or coordinate other kinds of physical and mental health care you need.
- Conduct face-to-face visits at least every 6 months.
- Coordinate with the nursing home when you need services the nursing home isn’t responsible for providing.
- Determine if you are interested and able to move from the nursing home back to the community and if so, help make this happen.

If you receive care at home, your Care Coordinator will:

- Complete a comprehensive, individual assessment of your health and long term care needs. We will help to determine the best health care services for your needs.
- Help you develop your Individual Service Plan (ISP) of care.
- Make sure the right health care professionals are consulted during your plan of care process.
• Give you information to help you choose long term care providers contracted with UnitedHealthcare Community Plan.
• Conduct face-to-face visits at least once every 3 months.
• Help coordinate your plan of care so that it works like it should to meet your needs.
• Monitor your health care and make sure that you are getting the care you need. If you need additional care, the Care Coordinator will help you.
• Give you information about community resources that might be helpful to you.
• Make sure the services you receive at home are based on your needs and do not cost more than care in a nursing home.
• Help you coordinate your care and service needs.

Community Transition

What if I live in a nursing home and want to move out?

We want to help you live in the place that is right for you. Talk to your Care Coordinator about your options if you are thinking about moving. You can talk to your Care Coordinator by calling 1-877-542-9248 (TTY: 711).

Member Advocate

The Member Advocate is another person at UnitedHealthcare Community Plan to help you in addition to your Care Coordinator. The Member Advocate is available to:

• Help our staff and providers better understand the values and practices of all cultures we serve.
• Provide information about the Diamond State Health Plan Plus plan.
• Help you figure out how things work at UnitedHealthcare Community Plan, such as filing a grievance, changing Care Coordinators or getting the care you need.
• Make referrals to the right UnitedHealthcare Community Plan staff.
• Help solve problems with your care.

To reach the UnitedHealthcare Community Plan Member Advocate, call UnitedHealthcare Community Plan at 1-877-901-5523 TTY: 711. Ask to speak with the Member Advocate.
A prior authorization is when UnitedHealthcare Community Plan gives the doctor permission to perform certain services.

<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Liners</td>
<td>Covered for members age 4 and up; Prior Authorization for quantities greater than 200.</td>
</tr>
<tr>
<td>Behavioral Health – Outpatient</td>
<td>Covered. Outpatient Mental Health and Substance Abuse.</td>
</tr>
<tr>
<td></td>
<td>• 18 and above: 20 visits per fiscal year.</td>
</tr>
<tr>
<td></td>
<td>• Under age 18: 30 visits per fiscal year.</td>
</tr>
<tr>
<td>Behavioral Health – Inpatient</td>
<td>Covered. Inpatient Hospitalization (Use your Medicaid ID card).</td>
</tr>
<tr>
<td></td>
<td>• 18 and above: 30 days per fiscal year covered for Medicaid members.</td>
</tr>
<tr>
<td></td>
<td>• Under age 18: covered by the Delaware Department of Prevention and Behavioral Health Services (DDPBHS) for the Delaware Healthy Children Program (DHCP) members and Medicaid members.</td>
</tr>
<tr>
<td>Bone Mass Measurement (bone density)</td>
<td>Covered.</td>
</tr>
<tr>
<td>Case Management</td>
<td>Covered.</td>
</tr>
<tr>
<td>Chemistry</td>
<td>Covered. Prior Authorization on amounts over $250.</td>
</tr>
<tr>
<td>Colorectal/Prostate Screening Exams</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>CT Scans</td>
<td>Covered.</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Age 20 and younger: covered by the State of Delaware Medical Assistance Program Card. Please call 1-866-843-7212 for information. Age 21 and over: removal of bony impacted wisdom teeth is covered by UnitedHealthcare.</td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Services</td>
<td>Coverage</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diabetic Equipment</td>
<td>Covered. Insulin pump and supplies; Prior Authorization on amounts over $300 and all rentals.</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Covered. Glucose/Strips (covered by Delaware Medicaid: use your Medicaid ID card).</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Diapers (for members age 4 and up)</td>
<td>Covered. Prior Authorization on quantities over 200.</td>
</tr>
<tr>
<td>Drugs Prescribed by a Doctor</td>
<td>Covered. Prior Authorization on amounts over $250.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered. Prior Authorization on amounts over $300.</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services (for under age 21)</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Emergency Medical Transportation</td>
<td>Covered. Self-referred service. Air and ambulance.</td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Eye Exam, Medical (for conditions such as diabetes and eye infections)</td>
<td>Covered, all members.</td>
</tr>
<tr>
<td>Eye Exam, Routine</td>
<td>Covered if age 20 and younger.</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Covered.</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>Covered.</td>
</tr>
<tr>
<td>Glaucoma Screening</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Gynecology Visits</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Hearing Aids and Batteries</td>
<td>Covered if age 20 and younger. Self-referred service.</td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Services</td>
<td>Coverage</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Home Health Care and Infusion Therapy</td>
<td>Covered.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered.</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Covered.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Lab Tests and X-rays</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Mammograms</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered. Prior Authorization on amounts over $300 and all rentals.</td>
</tr>
<tr>
<td>MRI, MRA, PET Scan</td>
<td>Covered.</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>Covered for the first 30 days, when medically necessary. Additional days are considered long term care; an application must be submitted to and approved by the Delaware Medical Assistance Program.</td>
</tr>
<tr>
<td>Obstetrical/Maternity Care</td>
<td>Covered.</td>
</tr>
<tr>
<td>Orthopedic Shoes</td>
<td>Covered. Prior Authorization on amounts over $300.</td>
</tr>
<tr>
<td>Outpatient Surgery, Same Day Surgery, Ambulatory</td>
<td>Covered.</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td>Covered.</td>
</tr>
<tr>
<td>Parenting / Child Birth Education</td>
<td>Covered.</td>
</tr>
<tr>
<td>Personal Care (in home) / Aide Services</td>
<td>Covered.</td>
</tr>
<tr>
<td>Podiatry Care (routine diabetic care or peripheral vascular disease)</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered by Delaware Medicaid. Please call 1-800-996-9969.</td>
</tr>
</tbody>
</table>
### Basic Covered Benefits and Services (cont.)

<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider Visits</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Covered.</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>Covered. Prior Authorization on amounts over $300.</td>
</tr>
<tr>
<td>Radiation</td>
<td>Covered.</td>
</tr>
<tr>
<td>Rehabilitation (inpatient hospital)</td>
<td>Covered.</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>Covered. Up to 30 days per year.</td>
</tr>
<tr>
<td>Sleep Apnea Studies / Sleep Therapy</td>
<td>Covered.</td>
</tr>
<tr>
<td>Smoking Cessation Counseling</td>
<td>Covered.</td>
</tr>
<tr>
<td>Specialty Physician Services</td>
<td>Covered. Self-referred service.</td>
</tr>
<tr>
<td>Surgical Center</td>
<td>Covered.</td>
</tr>
<tr>
<td>Therapy - Outpatient Occupational, Physical, Speech</td>
<td>Covered.</td>
</tr>
<tr>
<td>Transportation</td>
<td>Covered. Routine Non-Emergency (Not covered for Delaware Healthy Children Program (DHCP) members. Covered for Medicaid members by Delaware Medicaid).</td>
</tr>
</tbody>
</table>
Enhanced Benefits

The long term care services you can receive depend on your needs and whether you are receiving care in a nursing home or receiving care at home. The following long term care services are available to Diamond State Health Plan Plus members when the services have been determined to be cost-effective and medically necessary.

Long term care includes help doing everyday activities that you may no longer be able to do for yourself as you grow older, or if you have a disability — like bathing, dressing, getting around your home, preparing meals, or doing household chores. Long term care services include care in a nursing home. Long term care also includes care in your own home or in the community. These are called Home and Community Based Services or HCBS.
## Enhanced Benefits (cont.)

A prior authorization is when UnitedHealthcare Community Plan gives the doctor permission to perform certain services.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Care</td>
<td>A place that provides supervised care and activities during the day.</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>Cognitive Services</td>
<td><strong>Services that:</strong>&lt;br&gt;• Assess your ability to care for yourself.&lt;br&gt;• Assess your ability to interact with others.&lt;br&gt;• Help you create a plan to help you do these things.&lt;br&gt;• Help improve the member’s behavior or thinking disorders.</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>Community-Based Residential Alternatives That Include Assisted Living Facilities</td>
<td>A place where you live that provides help with personal care needs and taking your medicine. You must pay for your room and board.</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>Day Habilitation</td>
<td><strong>A place, other than your private home, where you receive help to:</strong>&lt;br&gt;• Reinforce skills you learned in another setting.&lt;br&gt;• Gain additional skills that give you more independence and control of your life.&lt;br&gt;This service is often for people who have problems acting or thinking clearly because of an injury. A common example is a traumatic brain injury.</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>Up to 1 meal per day.</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>In-Home Respite Care</td>
<td>Someone to come and stay with you in your home for a short time, so your caregiver can get some rest.</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
<td>Requirements</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>In-Patient Respite Care</td>
<td>A short stay in a nursing home or assisted care living facility, so your caregiver can get some rest.</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td>Minor Home Modifications</td>
<td>Changes to your home to help you get around easier and safer when medically necessary. For example, a wheelchair ramp.</td>
<td>Prior Authorization Benefit Limits Max $ Limits</td>
</tr>
<tr>
<td>Nursing Facility Care</td>
<td>These residential facilities provide all personal and 24 hour nursing care for those with long term care needs.</td>
<td>Prior Authorization</td>
</tr>
</tbody>
</table>
| Personal Care Attendant/Care Services        | Help with Activities of Daily Living (ADL), such as:  
• Getting out of bed.  
• Bathing.  
• Getting dressed.  
• Using the bathroom.  
May also include help with Instrumental Activities of Daily Living (IADLs). This kind of help is available if it’s part of your plan of care.  
Examples:  
• Light housekeeping chores.  
• Shopping.  
• Fixing a meal. | Prior Authorization |
| Personal Emergency Response System (PERS)    | A call button so you can get help in an emergency. Use it when your caregiver is not around.  
This service is not available if you:  
• Live in an assisted care living facility.  
• Live in a nursing home.  
These facilities already have a way to help you when you need it. | Prior Authorization |
| Specialized Durable Medical Equipment and Supplies | Items or devices that help you do things easier or safer in your home. For example, grabbers to reach things. Not covered under the Medicaid State Plan. | Prior Authorization |
### Enhanced Benefits (cont.)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for Consumer Direction</td>
<td><strong>Information and assistance to:</strong></td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td></td>
<td>• Direct your Personal Care/Attendant services yourself.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Help managing the money to do this.</td>
<td></td>
</tr>
<tr>
<td>Transition Services</td>
<td>Help with the initial costs of a move from a nursing home back to a home in the community.</td>
<td></td>
</tr>
<tr>
<td>(Money Follows the Person Only)</td>
<td><strong>Examples:</strong></td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td></td>
<td>• Security deposit.</td>
<td>Max $ Limits</td>
</tr>
<tr>
<td></td>
<td>• Telephone connection fee.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Groceries to get you started.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Furniture.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bedding.</td>
<td></td>
</tr>
<tr>
<td>Transition Services Workshops</td>
<td>Workshops that help prepare you and your family and other caregivers for community living. Available under the Money Follows the Person only.</td>
<td></td>
</tr>
</tbody>
</table>

### Covered Benefit Changes

UnitedHealthcare Community Plan may change the benefits and services we cover. If we do change our benefits, we will tell you in writing, when we can, before the change occurs.
Your Primary Care Provider

Your primary care provider (PCP) is a doctor or a nurse practitioner. When you are a member of UnitedHealthcare Community Plan, you pick a PCP for you and your family. Be sure to go to your PCP for all of your non-emergency health care unless your PCP sends you to a specialist for care. Some PCP sites may have medical residents, nurse practitioners and physician assistants who will give you care under the supervision of your PCP. When you have picked a PCP, you need to call the PCP’s office. 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 approval from me to get my records from another office?
• Do I need to meet my PCP if I am a new patient?
• Am I due for a check-up?

It is important to know all the staff at your PCP’s office. They will help you. You need a PCP you can trust. Your PCP will want to:

• Know your health history.
• Know your lifestyle.
• Know your health.
• Try to stop illness and disease.
• Give you tips to live a healthy lifestyle.
• Address all your regular health needs.

A reminder: If you are eligible for both Medicare and Medicaid, you do not have to pick a Primary Care Provider. You can continue to see your Medicare doctor.

Take Your ID Cards With You When You Visit a Doctor

You must take your UnitedHealthcare Community Plan ID card and State of Delaware Medical Assistance Program Card with you when you get any health care services. If you have Medicare, also bring your State of Delaware Medical Assistance Program Card.

Participating Doctors

UnitedHealthcare Community Plan sends you a Welcome Packet within 30 days of joining. If you would like information about your primary care provider (PCP), a specialist or another participating doctor, such as his/her schooling, residency or whether s/he is accepting new patients, call Member Services at 1-877-542-9248 (TTY: 711). The provider directory is also online at www.UHCCommunityPlan.com.

Choosing A New PCP

If you want to get a new primary care provider (PCP), call Member Services. The change will take place right away. You will get a new ID card that lists your new PCP. You can see a list of our providers at www.UHCCommunityPlan.com. Members may change PCPs up to three times a year.
Preventive Health

Regular visits to your doctor are important to your health. Attached are preventive health guidelines for women, children, and men. Please talk to your doctor about any services that may be needed. You may need other services if you are at risk for any health problems.

Services covered under your preventive health benefit are:

• Immunizations;
• Preventive screenings;
• Promoting healthy lifestyle choices;
• Family planning; and
• Prenatal care.

Transportation

If you need a ride to a doctor visit and cannot get there by yourself, call Logisticare at 1-866-412-3778 Monday through Friday, 8 a.m. to 4:30 p.m. Customer Service is available 24 hours a day, 7 days a week. You may also call your 211 number (Human Services) to find out about other services. Remember:

• This service is only for a non-emergency ride. Call 911 in a true emergency.
• Please call 48 hours before your appointment. This will help Logisticare arrange transportation and give you the best service they can.
• You can call to request ambulatory, wheelchair and stretcher transportation.
• You can bring someone with you if you want to.

Behavioral Health Services

Our approach to providing behavioral health services accounts for all of a member's family and medical needs. We believe it’s important to coordinate care between the member, the member’s family, the behavioral health providers, the medical providers and our case managers. OptumHealth manages your Medicaid behavioral health benefit.

UnitedHealthcare Community Plan or your primary care provider (PCP) can work with them. You can talk with your Care Coordinator or your PCP about your behavioral health needs or you can contact OptumHealth at 1-866-261-7692 (TTY: 711). They will assist you in finding a behavioral health provider close to where you live.

If you are currently receiving behavioral health services, please let your UnitedHealthcare Community Plan Care Coordinator know. It is important for them to be aware of all the services you are receiving or need.

Also, please let your behavioral health provider know that you are enrolled in UnitedHealthcare Community Plan’s Diamond State Health Plan Plus plan. They may have questions about the services you are receiving through our plan and how we can work together to help you get the care you need.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

EPSDT Program
UnitedHealthcare Community Plan will pay for children under 21 to see the doctor regularly. These visits are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. These visits make sure your child is growing normally and check for problems and conditions. These exams include screenings and are recommended by the American Academy of Pediatrics (AAP) periodic schedule. These screenings will include many things:

- Health history.
- Complete physical exam.
- Lab tests (as appropriate).
- Immunizations.
- Vision, hearing and dental screenings.
- Developmental and behavioral screenings.
- Advice on how to keep your child healthy.

You also get other services, such as:

- Treatment, including rehabilitation for any physical, developmental or mental health conditions discovered during a screening.
- Regular visits to a dentist for check-ups and treatment (this benefit is offered through your Medicaid ID card).
- Immunizations (shots).
- Regular tests of and treatment for the child’s hearing and eyesight.
- Routine lab tests, as well as tests for lead in the blood and sickle cell anemia, if the child is at-risk.
- Lead investigations, if your child has a high level of lead in his or her blood.
- Transportation: if you cannot get your child to his or her visits, you may be able to get a ride through Logisticare.
- Other tests and services needed to correct or prevent defects, physical conditions and mental illnesses discovered by the screenings. Making and keeping your child’s EPSDT appointments can help your child stay healthy. The best time to prevent serious health problems is before they develop.

Lead Testing – The doctor will need to do a blood test to make sure your child does not have too much lead. Your child should be checked at 12 months and 24 months of age or if they have never been checked.

Dental Exam – Dental is covered for children through the Division of Health and Social Services (use your State of Delaware Medical Assistance Program Card).

Private Duty Nursing – When your child’s doctor wants a nurse to provide care at home or at school.

Personal Care Services – When your child’s doctor wants a caregiver to help your child with eating, bathing, dressing and toileting.

EPSDT also provides hearing services, vision services, school-based services and more. If you have questions, please contact your Care Coordinator.
Health problems should be identified and treated as early as possible. If your child needs special services like Private Duty Nursing or Personal Care Services, they will be provided under EPSDT through UnitedHealthcare Community Plan.

Please speak with your doctor about any shots your child may need.

**Children With Special Needs**

UnitedHealthcare will work closely with schools that provide education and family service programs to children with special health needs. UnitedHealthcare will work with these types of programs:

- Individualized Education Programs (IEPs).
- Individualized Family Service Plans (IFSPs) for children from birth to three years old.

**Prescription Drug Coverage**

This benefit is covered by the Division of Medicaid & Medical Assistance (DMMA) and you have to use your State of Delaware Medical Assistance Program Card for this benefit. If you need help, please call the Pharmacy Benefits Manager at 1-800-996-9969, option 2.

**Out-of-Area Services**

**Health Care When You Are Traveling**

If you get sick while traveling, you can get medical help, even if you are outside of the local area. To get help:

- Call Member Services at 1-877-542-9248 (TTY: 711). The number is on the back of your UnitedHealthcare Community Plan ID card.
- You can call NurseLine anytime. You can call the 24/7 toll-free number from any state within the United States. The number is 1-866-915-0311.

If you need to be treated right away, go to the nearest urgent care facility or emergency room.

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

If you are outside of the United States and need medical care, any health care services you receive will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services you receive outside of the United States.

**Out-of-Network Services**

If UnitedHealthcare Community Plan does not have a specialist able to help you in your area, you have the right to get help from an out-of-network doctor. The out-of-network doctor will need to call us to get an approval (prior authorization). We will pay if you have our prior authorization, as long as you are eligible at the time of service.

If you need help getting your medications, please call the Pharmacy Benefits Manager at 1-800-996-9969, option 2.
### Appointment Standards

You should receive an appointment based on these standards:

<table>
<thead>
<tr>
<th><strong>Primary Care Providers (PCPs)</strong></th>
<th><strong>You will receive an appointment...</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency appointments</td>
<td>The same day or referred to an emergency facility</td>
</tr>
<tr>
<td>Urgent care appointments</td>
<td>Within 2 calendar days</td>
</tr>
<tr>
<td>Routine appointments</td>
<td>Within 3 weeks of request</td>
</tr>
<tr>
<td>EPSDT/child preventive care appointments</td>
<td>Within 2 weeks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Specialty Physician Referrals</strong></th>
<th><strong>You will receive an appointment...</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency appointments</td>
<td>Immediately upon referral</td>
</tr>
<tr>
<td>Urgent care appointments</td>
<td>Within 48 hours of referral</td>
</tr>
<tr>
<td>Routine appointments</td>
<td>Within 3 weeks of referral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maternity Care:</strong></th>
<th><strong>You will receive an appointment...</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>First trimester</td>
<td>Within 3 weeks of request</td>
</tr>
<tr>
<td>Second trimester</td>
<td>Within 7 calendar days of request</td>
</tr>
<tr>
<td>Third trimester</td>
<td>Within 3 calendar days of request</td>
</tr>
<tr>
<td>High-risk pregnancies</td>
<td>Within 3 calendar days of identification as high-risk, or immediately if an emergency exists</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Behavioral Health</strong></th>
<th><strong>You will receive an appointment...</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Life-threatening emergency</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-life-threatening emergency</td>
<td>Services within 6 hours of request</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Routine care</td>
<td>Within 7 calendar days of request</td>
</tr>
</tbody>
</table>

### Vision

UnitedHealthcare Community Plan works with March Vision Care for your eye care benefits (see benefits chart for age and medical requirements for eye care benefit). The provider directory lists the March Vision Care doctors who participate with UnitedHealthcare Community Plan. Once you find a doctor you like, you can call the doctor and schedule a visit. If you have any vision benefit questions, call Member Services at 1-877-542-9248.
Non-Covered Services

Some services are not covered by UnitedHealthcare Community Plan or the Delaware Medicaid program.

- Services that are not medically necessary.
- Non-emergency services from an out-of-network doctor that are not prior-approved.
- Vaccines for travel outside the United States.
- Abortion, unless in cases of rape or incest or in life-threatening situations.
- Sterilization of a mentally incompetent or institutionalized person.
- Single antigen vaccines when a combined antigen is medically appropriate.
- Inpatient hospital tests not ordered by the attending doctor, except in an emergency.
- Experimental procedures.
- Cosmetic services or items.
- Autopsies.
- Dental services for members age 21 and over.
- Hearing aids for members age 21 and over.
- Certain medicines used to treat obesity or sexual dysfunction or for cosmetic purposes.
- Infertility treatments.
- Routine podiatry, unless medically necessary.
- Chiropractic services.
- Sex change services and hormone therapy.
- Medical care that is started or requested by a non-participating doctor.
- Christian Science nurses and sanitariums.
- Prescriptions written by non-participating doctors (except when a member needs an emergency supply or is outside the service area).
Medical Necessity

Medical necessity means essential need for medical care. (This refers to all state Medicaid plan services, subject to age, eligibility or EPSDT requirements.) This care must be ordered by the primary doctor. It must be given by an authorized provider. Also:

- It must be for the person’s medical condition or its effects. It must be given to the beneficiary only.
- It must be appropriate for the patient and his or her family. (This includes their needs, abilities and environment.)
- It must be to treat the condition or its effects for all daily living. But it must not be solely for purposes of convenience.
- It must be timely. It must be expected to achieve the intended outcomes in a reasonable time.
- It must be the least costly option that is appropriate. It must be an effective use of program funds.
- It must be the best care that is safe and effective. It must not duplicate other services.
- It must have the scope and duration to attain its goal.
- It must be the treatment of choice, the common practice or the same as other commonly given care.
- It must be for a condition that threatens life or an injury or an illness. Or it must be for a condition that could result in a physical or mental limitation. Also, it must be for one or more of the purposes below.
  - To diagnose, cure, or improve physical or mental illness.
  - To prevent issues from getting worse.
  - To reduce the need for medical care in an institution or other Medicaid program.
  - To restore or improve function.
  - To help get access to medical, social or other services to treat the condition.

Prior Authorizations

A prior authorization is when UnitedHealthcare Community Plan gives the doctor permission to perform certain services. The benefit section outlines which services need approval before you can get them.

There are nurses and doctors who work for UnitedHealthcare Community Plan who determine whether services are covered. These doctors and nurses are part of our Utilization Management (UM) Department. If you need a service that requires approval, your doctor will call UM. UM will review the medical information provided by your doctor. This process is called prior authorization. Some (but not all) of the services that need a prior authorization are:

- Hospital admission.
- Medical equipment for your home.
- Nurses to come to your home.
- The use of an out-of-network doctor.
- The use of an ambulance, if you do not have an emergency.

If you need to have tests or an operation, your primary care provider (PCP) will ask us to review the request. If the request is for a non-covered service, your PCP can request an exception. For a complete list of services requiring a prior authorization, please call Member Services at 1-877-542-9248.
Denied Authorizations

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 care you already receive.
- Deny payment for a non-covered service you received.

Previously Approved Services

If you change health plans, any services approved by your old plan but not yet used must be reviewed by your new health plan. If you are changing to our plan, we will work with you and your provider to try to ensure you continue to get the medically necessary services you require.

Utilization Management (UM) Decisions

UnitedHealthcare Community Plan follows policies and procedures when making decisions about medical services. The goals are to be sure you get quality care and that it is medically necessary and given in the right setting. We need to verify that some services are medically necessary before you can get them. The services you get are very important to us. We help you get the right care, at the right time, in the right setting. We don’t want you to get too little care or care you don’t need.

Only doctors and pharmacists decide what services are covered. These decisions are based on medical necessity. We do not reward our UM team for decisions they make about a member’s care.

How to Contact the UnitedHealthcare Community Plan Utilization Management Team

The UnitedHealthcare Community Plan team is available Monday – Friday, 8:00 a.m. – 5:00 p.m. to help you with utilization management and/or prior authorization (approval) questions. You can reach the team by calling toll-free at: 1-877-542-9248 (TTY: 711). Assistance is available after hours as well. An on-call doctor is available after hours to assist providers.

What if I want a second opinion?

You can get a second opinion for your health care from an in-network provider or, if one is not available, from an out-of-network provider at no cost to you. Prior authorization (approval) may be required for an out-of-network provider. Call your primary care provider or your Care Coordinator. You can also call Member Services.
Women’s Health

What if I need an obstetrician/gynecologist (OB/GYN)?
You have the right to pick an OB/GYN without going to your doctor first. This is called “direct access.” The access to an OB/GYN includes:
• One well-woman checkup per year.
• Family planning services.
• Care for pregnancy.
• Counseling services for HIV testing.
• Case Management for pregnant women through the Healthy First Steps program.

How do I choose an OB/GYN or midwife?
Call Member Services at 1-877-542-9248 (TTY: 711) or you can pick from the provider directory.

Can I stay with my OB/GYN even if they are not in the UnitedHealthcare Community Plan network?
You do not have to pick an OB/GYN or midwife in the UnitedHealthcare Community Plan network if you have Medicare. If you do not have Medicare, you must pick from the UnitedHealthcare Community Plan network. Prior authorization (approval) may be needed if you choose a doctor that is not in the UnitedHealthcare Community Plan network.

Will I need a referral for an OB/GYN or midwife?
No.

After Your Delivery
It is important for you to schedule your post partum visit to occur 3 to 8 weeks after your baby is born. Your doctor may want to see you sooner. You will get a well-woman check-up and your doctor will talk to you about family planning options.

Family Planning Services
We provide confidential family planning service to all members, including members under age 18. If you do not want to talk to your primary care provider (PCP) about family planning, call Member Services at 1-877-542-9248 (TTY: 711). We will help you choose a family planning doctor who is different from your PCP.

We encourage you to receive your family planning services from a UnitedHealthcare doctor. That way we can better coordinate all your health care. You can choose any doctor to give you reproductive care and supplies, even if that doctor isn’t in our network. But, choosing a UnitedHealthcare doctor will help us coordinate your care better.

Seeing a Family Planning Specialist:
When you need to see a Family Planning Specialist, such as an OB/GYN, you do not need permission from UnitedHealthcare Community Plan or your doctor. You can schedule an appointment with the Specialist directly.
Healthy First Steps®

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. Some can cause early labor. A baby born too early may be sick or have to stay in the hospital. It is important to see a doctor as soon as you think you are pregnant.

Healthy First Steps is our special program for pregnant women. Our staff of nurses, social workers and health educators will work with you and your doctor to make your pregnancy healthier and easier. We can:

- Help you and your baby find a doctor.
- Help you make prenatal appointments.
- Arrange for home health care if your doctor requests it.
- Help you set up doctor and home visits after delivery.
- Arrange rides to your appointments.
- Order any special supplies that your doctor requests for you and your baby.
- Stay in touch with you and your doctor in case you have any health care problems.
- Help finding a primary care provider (PCP) or specialist.

With Healthy First Steps, you will learn what to expect when you see your doctor and how to take care of your changing body. We can help you with:

- **Local Resources** – Food stamps, baby items, prenatal classes, child care and support groups.
- **You, Your Doctor and the Health Care System** – Choosing a doctor, being a patient and selecting hospitals.
- **Nutrition, Weight, and Well-Being** – Healthy foods, your weight, the Women, Infant and Children’s (WIC) Program and breastfeeding.
- **Sexual Health** – Sexually transmitted diseases (STDs), HIV counseling and testing and family planning.
- **Substance Abuse** – Alcohol, tobacco and prescription and over-the-counter drugs.

**Text4baby**

Text4baby is a free mobile service to help you during your pregnancy and baby’s first year of life. Get text messages on your cell phone each week.

The text4baby will give you tips about:

- Keeping healthy
- Labor and delivery
- Nursing
- The importance of immunizations (shots)
- Exercise and healthy eating

Text BABY to 511411 to sign up, or visit the website at [www.text4baby.org](http://www.text4baby.org)

If you are pregnant, call to enroll in Healthy First Steps at 1-800-599-5985.
Smart Start Services
The Smart Start program helps women deliver a healthy, full-term baby. Smart Start can help you get home visits from a nurse, nutritionist or social worker. You can also get education information through the program. You can get these services during your pregnancy and after you deliver your baby. If you are pregnant, call us toll-free at: 1-800-599-5985.

Early Intervention
Did you know there is a program that helps families develop their children’s potential? Children grow and learn at different rates. Children who develop more slowly are eligible for early intervention support.

Infants, toddlers and preschoolers with special needs due to development delays or disabilities can get this service. UnitedHealthcare Community Plan’s high-risk pregnancy case managers work with doctors to identify children who:

• Weighed less than 3 pounds at birth.
• Needed neonatal intensive care.
• Have a chemically addicted mother.

Our Early and Periodic Screening, Diagnosis and Treatment (EPSDT) coordinator works with your primary care provider (PCP) when an elevated lead screen is noted for possible referral to the program. If you have questions about your child’s development or disability, talk with your PCP or EPSDT coordinator. We work as a team so your child receives the best care for his/her quality of life. For more information on the early intervention program called Child Development Watch, call 1-302-424-7300 or 1-800-752-9393.

Women, Infants and Children (WIC)
WIC is the special nutrition program for women, infants and children. The WIC program provides healthy food at no cost, breastfeeding support, nutrition education and health care referrals. If you are pregnant, ask your doctor to fill out a WIC application during your next visit. If you have an infant or child, ask their doctor to fill out a WIC application or call WIC at 1-800-222-2189. You may also contact your local WIC office.

School-Based Health Center Services
Some schools have health centers that give certain services to their students. These health centers can provide family planning services and help with certain illnesses, including giving medicine. Please contact your school’s health center for the services they provide.
Emergency Care

An emergency is when you have symptoms so severe that if not treated they could result in grave risk to your health. This may include risk to a body function, organ or part. It may include risk to an unborn child. These symptoms may include severe pain.

In an emergency, you do not need a prior authorization. Call 911 or go to the nearest emergency room. You can get emergency care 24 hours a day, 7 days a week. Some emergencies are:

- Sudden loss of feeling or not being able to move.
- Woman in labor or having a miscarriage.
- Severe pain in your stomach or chest or throwing up blood.
- Poisoning.
- Fainting or a severe dizziness.
- Serious accident.
- Severe burns, wounds or heavy bleeding.
- Damage to your eyes.
- Severe spasms or convulsions.
- Broken bones.
- Choking, severe shortness of breath or being unable to breathe.
- Strong feeling that you might kill yourself or another person.

Colds and sore throats are not usually emergencies. If you are not sure if you have an emergency, call your PCP. Or call our 24/7 NurseLine at 1-866-915-0311.

In an emergency, the hospital will stabilize your condition. They will not transfer you to another hospital without your consent and until you are stabilized. Sometimes, the hospital you go to cannot give you the best care. They may ask you to let them transfer you to another hospital. If you agree, they will give you treatment to minimize any risk to your health before you go to the new hospital. When you go to the hospital, call your PCP as soon as possible for a follow-up visit.

All emergency care is covered at any hospital in the United States. Members do not have to pay for any emergency services.

What is post-stabilization care?
Post-stabilization care is Medicaid covered care you get after an emergency to keep your condition stable. UnitedHealthcare Community Plan will pay for these services.

Urgent Care and After-Hours Care
Sometimes, you may need your primary care provider (PCP) when the office is closed. If you need urgent care, call your PCP's office. They will give you directions on how to reach your PCP. Someone is there to help you 24 hours a day, 7 days a week. You should feel free to contact your PCP at any time regarding all of your medical needs. You may also contact our 24/7 NurseLine at 1-866-915-0311. In emergency cases, you may also go directly to the nearest emergency room.
Enrollment

If Your Membership Stops
Medicaid may stop your membership with UnitedHealthcare Community Plan. This is called disenrollment. Your membership may end because you:

• Move out of the state.
• Give your Medicaid ID card to someone else to use.
• Go to prison.
• Lose eligibility for Medicaid.
• Have a change in your Medicaid benefits that keeps you from being covered by UnitedHealthcare Community Plan.

Call the Division of Medicaid & Medical Assistance (DMMA) if you have any of these third-party liability coverages. If you have questions, please call the Third Party Liability Unit at 1-800-372-2022.

Changing Your Health Plan
You may change your health plan at any time during the first 90 days after your initial enrollment in a health plan. You can also change your health plan during the open enrollment period each May. If you want to change your health plan, please call the Health Benefits Manager at 1-800-996-9969.

Coordination of Benefits (COB)
If you have coverage with both UnitedHealthcare Community Plan and another health plan, both plans will share the cost of any services you get. This other health plan is called third-party coverage. This cost-sharing is called a coordination of benefits.

If you have any of these third-party liability coverages. If you have any of these third-party liability coverages. If you have questions, please call the Third Party Liability Unit at 1-800-372-2022.

Changing Your Health Plan
You may change your health plan at any time during the first 90 days after your initial enrollment in a health plan. You can also change your health plan during the open enrollment period each May. If you want to change your health plan, please call the Health Benefits Manager at 1-800-996-9969.

Continuity of Care
If you are getting medically necessary medical care covered by Medicaid before you join UnitedHealthcare Community Plan, you can keep getting that care until we can find an in-network provider to help you. If the doctor giving you these services is not in our provider network, we need to give our approval for you to keep seeing this doctor.

Reporting Accidents and Injuries
If you get hurt on the job or are involved in an accident and need medical help, you need to call Member Services and Medicaid as soon as possible. We will talk or write to your employer, auto insurance company or other health plan to pay the bill.
Enrollment (cont.)

Reporting Changes

If you change your name, address or phone number, please call:

• Member Services at 1-877-542-9248 (TTY: 711)
• DSS/DMMA Change Report Center at 1-866-843-7212.

Call both Member Services and your Medicaid eligibility worker at the Division of Social Services or DMMA to report any changes in your family size (birth, adoption, marriage, divorce, death). When you have a baby, you should make these calls as soon as possible to add your baby to your records. This will take care of any bills and let your new baby get medical care.

If you do not know your Medicaid eligibility worker’s contact information, call 1-800-372-2022.

Disenrollment From Diamond State Health Plan Plus

Your enrollment in Diamond State Health Plan Plus and receipt of long term care services can end for the following reasons:

• You no longer qualify for Medicaid.
• You no longer need the level of care provided in a nursing home.
• You no longer need and are not receiving any long term care services.

If you are receiving care in a Nursing Home, you can have a disruption in service if:

1. You do not pay your patient pay amount.

   If you do not pay your patient pay amount, the nursing home where you live may decide it cannot serve you. As a result, other nursing homes may not be willing to serve you either.

   If we cannot find a nursing home that will admit you, UnitedHealthcare Community Plan will discuss with the Division of Medicaid and Medical Assistance on appropriate next steps.

   Should a member refuse to pay his/her patient pay amount to a nursing facility, the facility may notify the Contractor that it is terminating services to the member. Should this occur, the Contractor shall work to find an alternative nursing facility willing to serve the member. If the Contractor is unable to find an alternative facility, the Contractor shall consult with DMMA on appropriate next steps.
If you receive care at Home or in the Community, you can be disenrolled if:

1. We decide we can no longer safely meet your needs in the home or community.
   
   This could include things like:
   
   • You refuse to let a Care Coordinator visit you in your home. We cannot be sure that you are safe and healthy if our Care Coordinator can’t visit you in your home.
   
   • You refuse to receive services that are identified as needed services in your plan of care.
   
   • If, by receiving care at home or in the community, the risk to your health and safety is too great.
   
   • We determine your needs cannot be safely met in the home or community at a cost that is not more than the cost of nursing home care, and you choose not to move to a nursing home.

2. If you are no longer on Diamond State Health Plan Plus, you may not be eligible to receive long term care services paid by Diamond State Health Plan Plus. You might qualify for traditional Medicaid. You will get a letter that says why your Diamond State Health Plan Plus is ending and how to appeal if you think it is a mistake.
Payment for Services

Getting Billed for Services

Before getting any health care services, talk to your doctor about whether the services are covered by UnitedHealthcare Community Plan. Your doctor may not bill you for any covered services. If you ask for a service not covered by UnitedHealthcare Community Plan, ask your doctor about the cost and how you can pay the bill. If you receive a non-covered service and sign a form agreeing to pay the bill, you will have to pay the bill.

What if I get a bill from my doctor?

If you receive a bill for a covered service, call your doctor right away and give him or her your insurance information and our address. Do not pay the bill yourself. If you still get bills, please call Member Services at 1-877-542-9248 (TTY: 711) for help.

New Services or Procedures

We will review all new technologies your doctor thinks would help you. Our medical directors, who consider new medical and scientific information, as well as governmental requirements, review these requests together. They will review any medically necessary treatment that is not experimental. We will notify you and your doctor of the decision. We will notify you as new procedures, services and devices are evaluated and approved as newly covered benefits. We will let you know in our quarterly member newsletter or a special mailing.

Release for Ethical Reasons

UnitedHealthcare Community Plan does not require that a doctor perform a service that is against his or her conscience, religious beliefs, ethical principles or policies. We will allow the doctor to refer a member to another in-network doctor. If a doctor has an ethical reason for not completing a covered service, we will help you get this service through another doctor.

No participating doctor or employee will suggest, authorize or prescribe an unlawful procedure or service.

How We Pay Our Providers

UnitedHealthcare Community Plan pays its providers for each service they provide to members. This is called fee-for-service. Providers are only paid for giving you care for covered benefits that are medically necessary. UnitedHealthcare Community Plan will also pay its providers for services that require a prior authorization (approval) if you or your doctor gets an approval before you get those services. Utilization Management (UM) decisions are based on medical necessity and the appropriateness of care and service. We do not offer any rewards for denying coverage or incentives to encourage our employees, doctors or anyone related to our health plan to use benefits inappropriately. If you have a question on the UM process or a denial, please call Member Services.
Advance Directives

You have the right to make medical decisions even when you can’t speak for yourself. You need to complete an advance directive. Then your physician will know what you want done or not done if you can’t talk. A living will and a durable power of attorney are two types of advance directives.

Living Wills

A living will lets you state your wishes about medical care if you become terminally ill, permanently unconscious or enter a persistent vegetative state and can no longer make your own medical decisions.

How do I get an advance directive?

Contact Member Services or your Care Coordinator at 1-877-542-9248 (TTY: 711).

Who has the right to make care decisions?

You do, if you are an adult and able to let providers know your wishes. You say what health care you do not want. This means you give consent before you have treatment or services. You can refuse to give consent if there is health care you do not want.

What if I am unable to let providers know what I want?

You still have some control if you signed an advance directive. You may name someone to make decisions for you. Your doctor must put in your record whether you have an advance directive. If you have not named anyone, your doctor must find a person allowed by law to make decisions. You should complete the second type of Advance Directive called a Durable Power of Attorney for Medical Decisions, in which you name the person you want to make decisions for you if you are unable to do so.

Who can make health decisions for me if I can't and I have no advance directive?

A court may appoint a guardian for you. Otherwise, your doctor must find a person to make care decisions for you. Your doctor would pick from this list:

1) Your spouse, unless you are legally separated.
2) Another adult in a long-term relationship with you who has shown the care of a spouse (a domestic partner).
3) Your adult child or the majority of your adult children.
4) Your mother or father.
5) Your adult brother or sister.
6) Another adult who has shown special concern for you and knows your values.

If these persons cannot agree, they must go to court to get a guardian. Your doctors can ask the person to swear in writing that he or she has authority.

If your doctor cannot find a person to make care decisions for you, he or she can decide. Your doctor can do this with the approval of an ethics committee or another doctor.
You can keep anyone from making decisions for you by saying so in writing or by telling your provider. If you are able to make your own decisions again (even if someone else did so for a while), your decisions will be followed.

**What are my options for making an advance directive?**

In Delaware, you can make these directives:

**Durable Power of Attorney**

A durable power of attorney for health care lets you name someone to make medical decisions if you can no longer speak for yourself. This can also include decisions about life support. The person you appoint has the ability to speak for you at any time you are unable to make your own medical decisions, not just at the end of your life.

**For more information:**

- Call the Delaware Division of Services for Aging and Adults with Physical Disabilities at 1-800-223-9074. You may also visit [www.dhss.delaware.gov/dhss/dsaapd/index.html](http://www.dhss.delaware.gov/dhss/dsaapd/index.html) or [www.dhss.delaware.gov/dhss/dsaapd/advance.html](http://www.dhss.delaware.gov/dhss/dsaapd/advance.html).
- Visit [www.UHCCommunityPlan.com](http://www.UHCCommunityPlan.com) for more information or to download the advance directive health care forms.

**Individual Instructions for Health Care**

A written statement about health care you want or do not want if you cannot make these decisions. For example, your instructions can say if you would want to be fed through a tube if you were not conscious and not likely to recover. You may tell doctors to stop or not give treatment to sustain life if you are in a “terminal condition,” such as mechanical ventilation. You can tell doctors if you want other care to sustain life.

**Must my advance directive be followed?**

Yes. Your doctor, other providers, and your surrogate must follow your advance directive if they know about it. You should tell them.

**Must a lawyer do my advance directive?**

No. There are local and national groups that may help you. Be sure any form you use is valid under Delaware law. You may also tell your doctor in words so he or she can write it down.

**Who should have a copy of my advance directive?**

Give a copy to your doctor and any health center you enter. If you have a Durable Power of Attorney for Health Care, give a copy to the person you name. You may give a copy to your doctor. You should keep a copy for yourself.

**Do I have to make an advance directive?**

No. It is up to you. A provider cannot refuse care based on whether you have one.

**Can I change or cancel my advance directive?**

Yes. If you do, let anyone who has a copy know.

**What if I already have an advance directive?**

You may want to review it. If it was done in another state, be sure it is valid in Delaware. A new advance directive replaces any old ones.
Grievances and Appeals

Introduction to Grievances and Appeals

If you are unhappy with UnitedHealthcare Community Plan or its doctors, contact us right away. Your feedback is important to us so that we can ensure you are getting the appropriate care. This includes if you do not agree with a decision we made. You can contact us within 90 calendar days of the incident. If you want someone to speak for you, let us know.

There are two kinds of issues: Grievances and Appeals. Below we describe each kind, how we review them, and your rights.

Member Grievances

A grievance (like a complaint) is when you are unhappy with something about UnitedHealthcare Community Plan or one of our doctors not related to coverage.

Call us at 1-877-542-9248 or write within 90 calendar days of an incident. UnitedHealthcare Community Plan will send you a letter telling you we got your grievance. We will answer in writing within 90 calendar days from the date you contacted us.

During the grievance process, you can have someone represent you. If you want to do this, tell UnitedHealthcare Community Plan, in writing, the name of the person and how we can reach him or her. You or your representative may ask UnitedHealthcare Community Plan for information on your grievance. You may also send information to:

- Grievance and Appeals
  UnitedHealthcare Community Plan
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

If you need help with your grievance, call Member Services. We will assign someone who has not been involved to help you at no charge.

Member Appeals

If you do not agree with a decision to reduce, suspend, stop or deny care, deny payment, or fail to deliver a service on time, you can ask us to change the decision. This is an appeal.

You, your provider or someone you pick to represent you can make an appeal by calling us at 1-877-542-9248. Or write us within 90 calendar days of the date on the written notice of our decision. Written appeals must be mailed to:

- Grievance and Appeals
  UnitedHealthcare Community Plan
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

If you call, someone from UnitedHealthcare Community Plan will put your appeal in writing. We will contact you to check the information. If you want your doctor to file the appeal, you must give your written approval.

We will send you a letter saying we got your appeal within 5 business days of your request. We will answer your appeal in writing within 30 calendar days from the date you contacted us. If you need more time to gather information, you can ask to extend this time up to 14 days. We can also ask for an extension.

During the appeal, you can have someone represent you. If you want this, tell UnitedHealthcare Community Plan in writing the name of that person and how we can reach him or her. You or your representative may ask UnitedHealthcare Community Plan for information on your appeal. You may also send information to:

- Grievance and Appeals
  UnitedHealthcare Community Plan
  P.O. Box 31364
  Salt Lake City, UT 84131-0364
Community Plan for any information on your appeal. You may also send information to:

   Grievance and Appeals  
   UnitedHealthcare Community Plan  
   P.O. Box 31364  
   Salt Lake City, UT 84131-0364

You may ask for help with your appeal. Call Member Services at 1-877-542-9248. UnitedHealthcare Community Plan will assign someone who has not been involved to help you at no charge.

A committee that includes a physician, a representative of the State of Delaware, and others who were not involved in the denial will decide your appeal. You, your representative or your provider may request to participate at the appeal review by videoconference, telephone or in person at the local Delaware office located at: 4051 Ogletown Stanton Rd, Ste 200, Newark, DE 19713. You may bring a family member, friend, lawyer or other person. If you want to appear, call Member Services at 1-877-542-9248 (TTY: 711) when you get the letter telling you we got your appeal.

We will send you the decision in writing. The letter will have the reasons for our decision. It will say what to do if you don’t like our decision.

Continuing Services – If you have been getting an ongoing service that is being reduced, changed or stopped, you can ask for it to continue during the appeal. To do so, you must ask for your appeal or state fair hearing within 10 days of the date on the notice of action or appeal decision.

If the State of Delaware decides UnitedHealthcare Community Plan’s decision was correct, you may have to pay for the services you got while your appeal was being reviewed.

Expedited Appeals – If your doctor thinks the time for an appeal will harm your health, he/she can call UnitedHealthcare Community Plan and ask for it to be decided faster. This is an expedited appeal. Your doctor must call Member Services at 877-542-9248 to explain why a fast appeal is needed. UnitedHealthcare Community Plan will call you with our decision within 3 working days of getting your request. You can ask to extend this up to 14 days if you need more time to gather information. We will also send a letter with the reasons for our decision. It will say what to do if you don’t like the decision.
UnitedHealthcare Community Plan wants to help you. To contact us you can:

- Call Member Services at 1-877-542-9248 (TTY: 711).
- Fill out the Grievance and Appeal form in the back of this handbook. (You can also call Member Services to get the form.)
- Write a letter telling us what has made you unhappy. Include your name, ID number, address and phone. (Your ID number is on the front of your UnitedHealthcare Community Plan ID card.) Also send any information about your problem.

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

State Fair Hearings

A state fair hearing is a meeting with you, someone from UnitedHealthcare Community Plan, and a hearing officer from the Delaware Department of Health and Social Services. UnitedHealthcare Community Plan will explain why we made our decision. You can then say why you think we made a mistake. The state officer listens and decides who is right and whether we followed the rules.

If you do not agree with a decision we made to reduce, suspend, stop or deny care, deny payment, or fail to deliver a service on time, you may request a state fair hearing. You do not need to exhaust UnitedHealthcare Community Plan’s appeal process before asking for a state fair hearing. You must ask for the hearing within 90 calendar days of the date on the notice of our decision. If you appeal, you can also ask for a hearing within 90 days of our appeal decision.

To ask for a state fair hearing, call 1-302-255-9500 or 1-800-372-2022 (toll-free). Or mail your request to:
DSS Fair Hearing Officer
Herman M. Holloway Campus
Lewis Bldg.
P.O. Box 906
New Castle, DE 19720

If the State of Delaware decides our decision was wrong, your services will be authorized. We will arrange for you to get them immediately.
Fraud and Abuse

Fraud and abuse takes many forms. It is a criminal act if anyone deliberately gets Medicaid coverage based on false information. It is also against the law:

- For another person to help someone get Medicaid coverage based on false information.
- To misrepresent, impersonate or conceal any fact that would cause Medicaid to provide coverage when a person is not eligible.
- To get or help someone get more benefits or benefits at a higher level than they should get.
- For any person or business to make a false statement about a person's health status or eligibility for health insurance.

If found guilty, penalties range from paying back Medicaid and UnitedHealthcare Community Plan for payments made for a person’s health care to jail time.

Health care providers found to commit fraud and abuse can be banned from taking part in the Medicaid program, as well as other penalties.

Some additional examples of fraud and abuse are:

- Billing or charging you for services your health plan covers.
- Offering you gifts or money to get treatment or services.
- Offering you free services, equipment or supplies in exchange for your Medicaid number.
- Giving you treatment or services you don’t need.
- Physical, mental or sexual abuse by medical staff.
- Someone using another person’s Medicaid or UnitedHealthcare Community Plan identification card.

If you suspect anyone is committing fraud and abuse, including providers, call UnitedHealthcare Community Plan’s anonymous reporting hotline at 1-877-766-3844. You can remain anonymous. If you do give your name, the provider will not be told you called.

You can also anonymously report provider fraud to Delaware Crime Stoppers at 1-800-TIP-3333 or by calling the Division of Medicaid & Medical Assistance Surveillance Utilization Review Unit at 1-302-255-9646 or toll free at 1-800-372-2022.
All Members Have Certain Rights and Responsibilities. They Are Listed Below.

You have the right to:

- Be treated with respect and dignity.
- Get covered benefits or services regardless of gender, race, ethnicity, age, religion, national origin, sexual orientation, physical or mental disability, type of illness or condition, ability to pay or ability to speak English.
- Pick a doctor who works with our provider network.
- Not have your medical records shown to others without your approval, unless allowed by law.
- Privacy when you are at an office visit, getting treatment or talking to the health plan.
- Get information about UnitedHealthcare Community Plan, the services we cover, the doctors who provide care, and the member’s Rights and Responsibilities.
- Have your doctor tell how he or she plans to treat you. The doctor should tell you if other treatments can be used and the risks for each one no matter how much they cost or if UnitedHealthcare Community Plan will pay for it.
- Know the cost to you if you choose to get a service that UnitedHealthcare Community Plan does not cover.
- Be involved in deciding the type of care you want or do not want.
- Get a second opinion from an appropriately qualified participating health care professional at no cost to you. If a UnitedHealthcare Community Plan provider is not available, we will help you get a second opinion from a non-participating provider at no cost to you.
- Find out what is in your medical records, as allowed by law, and request a copy of your records.
- You can ask that corrections be made to your medical records if they are incorrect.
- You can ask for a list of people who have been given a copy of your medical records.
- To be free from any form of restraint and/or seclusion used as a means of coercion, discipline, or staff convenience or retaliation.
- Get interpretation services if you do not speak English or have a hearing impairment to help you get the medical services you need.
- You may ask for materials to be presented in a manner or language that you understand, at no cost to you.
- Voice your grievances about UnitedHealthcare Community Plan and the care you get from your doctor.
- Use the methods listed in this handbook to share questions and concerns about your health care or about UnitedHealthcare Community Plan.
- Tell us ways to improve our policies and procedures, including the Member Rights and Responsibilities.
- Develop Advance Directives or a Living Will, which tell how to have medical decisions made for you if you are not able to make them for yourself.
- Know how UnitedHealthcare Community Plan pays providers, controls costs and uses services.
Rights and Responsibilities (cont.)

• Get emergency health care services without the approval of your primary care provider (PCP) or UnitedHealthcare Community Plan when you have a true medical emergency.
• Say no to treatment, services, or PCPs, and be told what may happen if you refuse the treatment. You can continue to get Medicaid and medical care even if you refuse treatment.
• Refuse care from a doctor you were referred to and ask for a referral to a different doctor.
• Be told in writing by UnitedHealthcare Community Plan when any of your health care services requested by your PCP are reduced, suspended, terminated, or denied. You must follow the instructions in your notification letter.

There Are Additional Rights That Long Term Care Members Have. They Are Listed Below.

You have the right to:
• Receive considerate, respectful, and appropriate care, treatment and services.
• Receive reasonable continuity of care.
• Choose a personal attending physician.
• Not be transferred or discharged out of a facility except for medical reasons, your own welfare or the welfare of other residents; or for non-payment of justified charges. You will be given 30 days advance notice, except where the situation is deemed an emergency.

• Respect and privacy.
• Be free from restraints.
• Privacy in your room.
• Privacy in visits with your spouse.
• Retain and use your own clothing and personal possessions.
• Not have to perform a service for the facility.
• Make choices regarding activities, schedules, health care and other aspects of your life.
• Participate in an ongoing program of activities.
• Participate in social, religious and community activities.
• Receive from the administrator and staff a timely, courteous and reasonable response.
• Requests or grievances – in writing, if requested.
• Associate or communicate with others without restriction.
• Manage your own financial affairs.
• Recommend changes or present grievances to the facility staff, the Long Term Care Ombudsman, or others.
• Be fully informed of all rights and responsibilities.
• Be free from verbal, physical, or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep.
• Receive notice before your room or roommate is changed, except in emergencies, and to have the facility honor requests for a room or roommate whenever possible.
• Exercise your rights as a citizen of the State and the United States of America.
• Receive, prior to or at the time of admission, a written statement of the services provided.
• Receive a written itemized statement of charges and services.
• Receive from the attending physician complete and current information concerning your diagnosis, treatment, and prognosis.
• Inspect all records pertaining to you.
• Have placed at your bedside, the facility name, address, and phone number of the physician responsible for your care.
• Receive, in writing, information regarding any relationship the facility has with other health care or related institutions or service providers.
• Examine the most recent survey of the facility.
• Receive information from agencies acting as client advocates and be afforded the opportunity to contact those agencies.
• Request information regarding minimum acceptable staffing levels as it relates to your care.
• Request the names and positions of staff members providing care to you.
• Request an organizational chart outlining the facility’s chain of command for contact purposes.

Right to Nondiscrimination

In accordance with Federal law and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, age, disability, political beliefs, or retaliation.

If you require this information in alternative format (Braille, large print, audiotape, etc.), contact the USDA’s TARGET Center at 1-202-720-2600 (Voice or TDD).

If you require information about this program, activity or facility in a language other than English, contact the USDA agency responsible for the program or activity, or any USDA office.

To file a complaint alleging discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call, toll-free, 1-866-632-9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at 1-800-877-8339 (TDD) or 1-866-377-8642 (relay voice users). USDA is an equal opportunity provider and employer.
HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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, 2013

We1 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 health plan website www.UHCCommunityPlan.com. We have the right to make changes apply to HI that we have and to future information.

We collect and keep your HI so we can run our business. We limit access to your HI 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 HI.

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 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.

• **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.
Protected Information Release

Member's Name ___________________________ ID # ___________________________

Address ________________________________________________________________

I hereby authorize _______________________________________________________

Address ________________________________________________________________

to provide the following information to _______________________________________

Address ________________________________________________________________

for health care coordination, care management, coordination of benefits and other health insurance purposes.

- Social History
- Psychiatric Evaluation
- Psychological Evaluation
- Service Coordination Plans
- Other

- Authorized Services/Treatment Received
- Diagnosis
- Summary of CM Services
- Other Referrals/Consultations
- HIV-related Information/Status

I have been informed and understand that I can revoke this authorization at any time by informing UnitedHealthcare Community Plan in writing. Revocation is not effective for disclosures of protected health information that have already occurred. I understand that UnitedHealthcare Community Plan may not condition the provision of treatment, payment, enrollment in the health plan or eligibility for benefits on the provision of an authorization. This authorization is effective beginning on __________. It does not expire until I notify UnitedHealthcare Community Plan in writing.

____________________________________________________________________________
Member or Personal Representative / Relationship to Member    Date

____________________________________________________________________________
Witness                                    Date

Member Services
UnitedHealthcare Community Plan
4051 Ogletown Road, Suite 200
Newark, DE 19713
Grievances and Appeals Form

Member's Name ___________________________ ID # ___________________________

Address __________________________________________

Telephone Number: (Home) ___________________ (Work) ___________________________

Please choose one of the following:

☐ Are you unhappy about a decision we made?

☐ Are you unhappy about something other than a decision we made; for example, are you unhappy about how you were treated?

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) _____________________________

Member Services
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364