Welcome to the community.

Florida

Health and Home Connection™
Enrollee Handbook

UnitedHealthcare®
Community Plan

AHCA-03/18-10/18-717 CSFL18MC4261150_000

Telephone Numbers

Customer Service **1-800-791-9233**
TDD/TTY for the hearing impaired **711**
Monday – Friday: 8:00 a.m. to 8:00 p.m. local time

To Reach the Agency For Health Care Administration Consumer Hotline, call: . . **1-888-419-3456**

To Report Health Care Fraud, call: **1-888-419-3456**

To Report Abuse, Neglect, or Exploitation, call the Statewide Abuse Hotline: . . **1-800-96-ABUSE**

To Enroll or Check Eligibility:
Medicaid Options at **1-888-367-6554**
or **TTY** **1-866-467-4970**

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

To file a complaint about Medicaid services, please call 1-877-254-1055 or visit us online at **https://apps.ahca.myflorida.com/smmc_cirts/**.

To file a complaint about a health care facility, please call 1-888-419-3456.

Website **myuhc.com/CommunityPlan**

UnitedHealthcare Community Plan
Health and Home Connection
3100 SW 145th Avenue, Suite 200
Miramar, FL 33027

Your Health Providers

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Emergency Room: _____ Phone: _____

Pharmacy: _____ Phone: _____

Welcome to
UnitedHealthcare Community Plan

Dear Member:

We take great pride in our organization and the quality of services we provide our members. There are many advantages to being a member of UnitedHealthcare Community Plan Health and Home Connection. We will coordinate your medical care, reduce paperwork, and provide quality service.

Your ID card will be mailed soon. Your health plan ID card shows the effective date of coverage. This handbook will help answer any questions you may have regarding your health plan. Please read this handbook to help you use your health benefits. Keep it in a safe place for future use.

If you have questions, please call our Customer Service Department toll-free at **1-800-791-9233** (**TTY 711** for the hearing impaired). Or visit us online **myuhc.com/CommunityPlan**. If you or your caregiver have questions about your care, you can speak to a nurse 24 hours a day, 7 days a week. Call the number on the back of your ID card and ask to speak to a nurse.

The purpose of the LTC program is to provide you with an array of services that meet your needs and allow you to live in the setting of your choice. This includes allowing you to live in the community for as long as you choose. Thank you for choosing UnitedHealthcare Community Plan as your health care partner.

New Enrollee Checklist

Getting Started

Welcome to UnitedHealthcare Community Plan.

We are happy to have you as an enrollee. As a new enrollee, it's important that you complete this checklist. It will help you get the most from your health plan right away.

1

Review enrollee ID card.

A few days ago, you should have received an enrollee ID card in the mail. The card has the UnitedHealthcare Community Plan logo on it. You should have a separate ID card for each enrollee of your family who is in our plan. If you did not get an ID card, or if the information on it is not correct, call Customer Service.

2

Schedule a first appointment with your doctor.

For good health, it's important to have regular checkups with your doctor. Make an appointment to see your doctor within the next 30 days. Do not wait until you are sick.

3

Read your enrollee handbook.

Read this Enrollee Handbook and keep it handy. It tells about your health plan and programs to keep you healthy.

If you have an emergency, call 911 for help, or go to the nearest emergency room so that you can be seen.

Welcome to
UnitedHealthcare Community Plan

Welcome to the community. UnitedHealthcare Community Plan is a program for people who need help to stay at home. We help you get the right care. We work with you and your family to keep you well.

We set up the home, community, and health services you need. We work to coordinate our services with services you already have.

Our Customer Service hours are from 8:00 a.m. – 8:00 p.m. (EST) Monday to Friday, except for state holidays. If you call after-hours, your call will be answered by voicemail. A representative will call you back in one business day.

If you or your caregiver have questions about your care, you can speak to a nurse 24 hours a day, 7 days a week. Call the number on the back of your ID card and ask to speak to a nurse.

Our Customer Service Staff Can:

- Explain your covered services.
- Assist you with claims and billing issues.
- Replace identification cards.
- Make changes in your address or telephone number.
- Listen and help you with a problem.
- Provide our quality performance ratings (including pay incentives, if applicable), member satisfaction survey results, structure and operation of the Health Plan.
- Describe our quality benefit enhancements.
- Provide interpreter services.

The Long-Term Care (LTC) population are enrollees who:

1. Live in a Nursing Facility.
2. Get Home and Community-Based Services in a private home or other community setting such as an Assisted Living Facility.

The UnitedHealthcare Community Plan:

- Offers coverage and services to help with daily life.
- Promotes independent living.
- Promotes checkups.
- Lets you take part in decisions.
- Gives you a Case Manager.

Enrollment

If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in UnitedHealthcare Community Plan or the state enrolls you in a plan, you will have 120 days from the date of your first enrollment to try the Managed Care Plan. During the first 120 days, you can change Managed Care Plans for any reason. After the 120 days, if you are still eligible for Medicaid, you may be enrolled in the plan for the next eight months. This is called "lock-in."

Open Enrollment

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

Eligibility Determination

The Florida Department of Children and Families (formerly the Department of Health and Rehabilitative Services) and the Federal Social Security Administration determine a person's financial and categorical Medicaid eligibility. Financial eligibility for the program will be up to the Medicaid ICP income and asset level.

The Department's Comprehensive Assessment Review Evaluation Services (CARES) program determines a person's clinical eligibility for the program.

If you lose your Medicaid eligibility and your eligibility is regained within 60 days, you may be reinstated into the program.

Language Help

We can get you materials in a language or format that is easier for you. We have interpreters who speak your language. This is free when you speak to us. If you do not speak English, call Customer Service at **1-800-791-9233, TTY 711**. They will connect you with an interpreter.

If you have trouble hearing, the Telecommunications Relay Service (TRS) can help. This lets people with hearing or speech issues make phone calls. The service is free. Call **711** and give them the Customer Service phone number: **1-800-791-9233**. They will connect you to us.

If you need information in another language, call Customer Service. You can also get information in large print, Braille or audio tapes.

For help to translate or understand this, call **1-800-791-9233, TTY 711**.

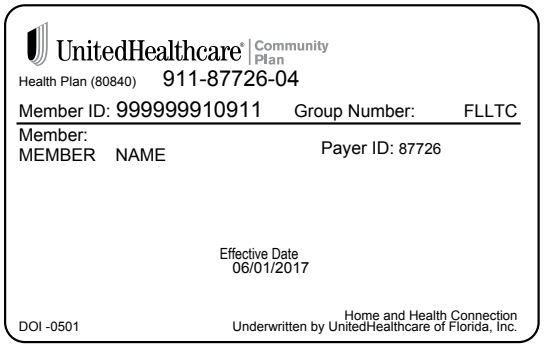
Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-791-9233, TTY 711**.

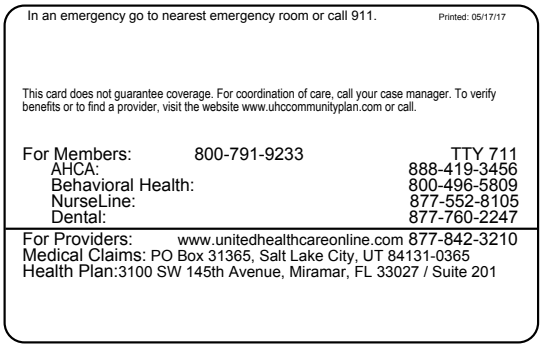
Your Enrollee ID Card

You should have gotten your ID card in the mail. Make sure it is all correct. If you have questions, call Customer Service at **1-800-791-9233, TTY 711**. Each enrollee of your family who is in UnitedHealthcare Community Plan should have their own ID card. Keep your card with you at all times.

Take your ID card when you go to the doctor or to the pharmacy. Never give your ID card to anyone else to use.

Your UnitedHealthcare Community Plan Enrollee ID Card will look like this:


UnitedHealthcare | Community Plan
Health Plan (80840) 911-87726-04
Member ID: 999999910911 Group Number: FLLTC
Member:
MEMBER NAME
Payer ID: 87726
Effective Date
06/01/2017
DOI -0501
Home and Health Connection
Underwritten by UnitedHealthcare of Florida, Inc.


In an emergency go to nearest emergency room or call 911.
Printed: 05/17/17
This card does not guarantee coverage. For coordination of care, call your case manager. To verify benefits or to find a provider, visit the website www.uhccommunityplan.com or call.
For Members: 800-791-9233 TTY 711
AHCA: 888-419-3456
Behavioral Health: 800-496-5809
NurseLine: 877-552-8105
Dental: 877-760-2247
For Providers: www.unitedhealthcareonline.com 877-842-3210
Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
Health Plan:3100 SW 145th Avenue, Miramar, FL 33027 / Suite 201

Important Things to Remember About Your Enrollee ID Card

Check your eligibility — it is very important you know if you are covered before you get a service. Your card does not guarantee coverage. Eligibility can change often. Even though you have a card, your coverage may have stopped.

- Show the card to your provider when you get medical services and medications. The provider will use the information on the card to check on your coverage and see if you are eligible.
- The provider may be able to tell you if your card will cover a service. It is recommended that you contact Customer Service to find out if your plan will cover certain services.

If You Have Medicare

Continue to use your Medicare ID card for the Medicare-covered services you are already familiar with such as physician office visits and hospitalization.

For any questions related to copayments or deductibles for Medicare-covered services that are also Medicaid-covered, please contact Customer Service at **1-800-791-9233**.

Care Management

UnitedHealthcare Health and Home Connection gives you a **Case Manager**. The Case Manager is helped by a Case Manager Associate. The **Case Manager** is your main contact for UnitedHealthcare Health and Home Connection.

Your Case Manager meets with you and your family in your home when you join UnitedHealthcare Health and Home Connection. In this meeting, the Case Manager tells you about UnitedHealthcare Health and Home Connection. He or she helps you learn how the program works and answers your questions.

Your Case Manager assesses your health care needs. When you first join UnitedHealthcare Health and Home Connection and at least every three months, your Case Manager will review your needs, home situation, and the help you can get from family and friends. The Case Manager will identify the services you need and arrange for you to get them.

He or she will assess your needs again if your health changes. You may contact your Case Manager at any time that you feel your health care needs have changed to request a reassessment of your plan of care.

Care Management and Role of the Case Manager

If you are an enrollee of Florida Medicaid and have Long-Term Care, UnitedHealthcare Community Plan manages your health, mental health, substance use and long-term care services. We do this through Care Coordination.

UnitedHealthcare Community Plan will assign you a Case Manager. You will get a phone call to tell you his or her name. We will tell you how to reach him or her. This is your main contact person. He or she is the first person you go to if you have any questions.

1. Does an assessment to know what services you need.
2. Sets up the amount and frequency of the services you need.
3. Talks with you and your family about your care.
4. Educates you and your family about your plan of care and treatment goals.
5. Works with you to put together a Service Gap-Contingency Plan.
   a. Definition of a service gap.
   b. What is not considered a service gap.
   c. Contact information for the providers of services.
   d. Backups for specific providers (Personal Care/Attendant Care, Homemaker Services, Respite Care, Nursing Services) and their contact information.

Call about changes in your health like:

- A hospital admission.
- Emergency visit.
- Admission to a Skilled Nursing Facility, Rehabilitation Center or Assisted Living Center.
- New doctor.
- Medication change.
- Lower appetite.
- Your ability to do daily tasks like bathing or dressing.
- New or increased confusion.
- Anytime you change your address, even for a short period, like vacation.

If you have questions, call Customer Service at 1-800-791-9233, TTY 711.

Contacting your Case Manager.
You should call your Case Manager/Case Manager Associate:

- If you or your caregiver think you need more care or less care. Call if you have a concern about services given by a worker in your home.
- If your caregiver (usually a family member) cannot give care as agreed to in your plan.

Changing Case Managers.
If you are unhappy with your Case Manager, call UnitedHealthcare Community Plan at **1-800-791-9233, TTY 711**. If we cannot resolve your concern, we may assign a new Case Manager to you.

There may be times when UnitedHealthcare Community Plan will have to change your Case Manager. If we need to do this, we will send you a letter. If you have any questions, call Customer Service at **1-800-791-9233, TTY 711**.

Requesting your Medical Records.
You have the right to request a copy of your medical records at any time. Your case manager can assist you with requesting a copy, or you can contact Customer Service at **1-800-791-9233, TTY 711**.

Care Management

Wherever you receive services, you have a right to receive them in a home-like environment.

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

A home-like environment could include:

- Private or semi-private room;
- Roommate for semi-private room;
- Locking door to living unit;
- Access to telephone and length of use;
- Flexible eating schedule;
- Participation in facility and community activities;
- Unlimited visitation;
- Maintain a personal sleeping schedule;
- Ability to prepare and have snacks as desired.

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 Case Manager if you want to do this.

To get care in your home or in the community, UnitedHealthcare Community Plan will help. You have the right to participate in your community regardless of your living arrangment; whether it is your own home, a nursing home, or in another place in the community (such as an assisted living facility).

Your Case Manager will discuss changes you want and help decide what setting is best to meet your needs, help you with personal goal planning and how you can work together through the process.

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

The provider you pick must be willing and able to give your care. Your Case Manager will help you arrange this.

Care Management

If you get care in a nursing home, your Case Manager will:

- Be part of your care planning at the nursing home.
- Perform any needs assessment that may help manage your care.
- Add to the nursing home's plan of care things UnitedHealthcare Community Plan can do to manage problems or help with the physical, mental health or substance use services you need.
- Make face-to-face visits at least every 6 months.
- Coordinate with the nursing home when you need services that the nursing home does not provide.
- See if you are interested and able to move from the nursing home back to the community and help make this happen.

If you get care at home, your Case Manager will:

- Evaluate your health and long-term care needs. We will work with you to decide the best services for your needs.
- Help you develop your plan of care.
- Make sure the right providers are consulted.
- Help you pick long-term care providers who are contracted with UnitedHealthcare Community Plan.
- Call you at least every 3 months and visit you at least once every 6 months, or more frequently as needed.
- Make sure your plan of care is carried out and works the way it needs to.
- Monitor your health care and make sure that you are getting the care you need. If you need more care, the Case Manager will help you.
- Tell you about community resources that might be helpful to you.
- Make sure the services you get at home are based on your needs.
- Help you manage 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 Case Manager about your options.

Self-Direction

Self-direction means that you choose your personal care attendant. Or you may pick someone to do this for you. You also say how your care is given. Your attendant works for you instead of a provider. The attendant may do things like help with dressing or cleaning. They may fix meals or help you take your drugs, etc.

Self-direction is offered with these waivers:

- Personal Care Services.
- Attendant Care Services (skilled and unskilled).
- Homemaker Services.
- Adult Companion Services.
- Respite Services.
- Intermittent and Skilled Nursing Services.

If you want to self-direct your personal care, you will hire, fire, train, and supervise your caregivers. You will work with a finance manager. They will help you with the paperwork. They will pay the worker and do the payroll tax forms, etc.

Ask your Case Manager for more details.

The Role of Your Primary Care Doctor

Your primary doctor will continue to take care of most of your medical problems, as well as coordinate other necessary medical services. He or she will treat you if you become ill, order medical services such as X-rays and lab tests, make referrals for consultations, or arrange for hospitalization. From time to time, your primary doctor and **Case Manager** may discuss your need for various services to ensure that you receive the assistance you need.

If you need medical care after regular office hours, please call your primary doctor.

Notification of Changes

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

Cancel an Appointment

Cancel appointments as soon as you can, at least 24 hours before. This helps you get a new appointment fast. It helps others who want to see your doctor.

Interpreter Services

Interpretation and other communication systems are free for all languages. If you need an interpreter to talk with your Case Manager, please call Customer Service toll-free at **1-800-791-9233** or **TTY 711**.

Medicare Coverage

If you have Medicare A and B, your Medicare benefits are still separate from UnitedHealthcare Health and Home Connection. You may see a Medicare doctor, who bills Medicare. UnitedHealthcare Health and Home Connection may cover some of your deductibles and copays.

UnitedHealthcare Community Plan does not pay for care from providers that are not contracted with us, except for emergency and urgently needed care.

Transportation Services

If needed, our Transportation Services (MedTrans) can arrange a safe and comfortable ride for the following covered services:

- Adult Day Care.
- Nursing Home to Nursing Home.
- Speech/Physical/Occupational Therapy.
- Dental Exams and Services.
- Counseling.
- Two one-way trips per month for non-medical needs (grocery store, pharmacy, etc.).

To schedule a ride:

- Call National MedTrans at 1-866-372-9891 Monday – Friday between 7:00 a.m. and 7:00 p.m.
- Scheduling your ride at least 2 business days in advance will help you to have the best experience.
- Urgent care and other urgent types of trips such as dialysis or chemotherapy can be scheduled same day.
- Rides can be scheduled up to 30 days in advance.
- Your privacy is important to us. You or the person calling on your behalf will need to verify some of the following details found in your record before they can assist you:
  - First and last Name.
  - Member ID.
  - Date of Birth.
  - Home address.
- To ensure that we provide you with the best mode of transportation, you will be asked if you are able to walk on your own, if you'll be using a cane or walker, if you have a wheelchair, or even if you have a cell phone.
- You will also be asked if an escort will be traveling with you.
  - Escorts must be 18 years or older to travel with you.
- You'll need to have these details about your appointment ready when you call:
  - Appointment address.
  - Doctor's name & phone number.
  - Purpose of the appointment.
  - Appointment time.

When it's time for your ride:

- It is important to be ready and waiting for your ride at the scheduled pick up time.
- You may receive a call from your driver or a call center representative. It is important that you answer calls from any unfamiliar numbers at this time.
- If your ride does not arrive on time, contact National MedTrans at 1-866-372-9892.
- If you are unsure of how long the appointment will take, the return ride was scheduled for "will-call." That means you will need to give National MedTrans a call when you're ready to go home at 1-866-372-9892.
- If you have a set time frame and you're certain you will be done at a specific time, you can set a time for your ride to be waiting when you're done. If they are not there at that set time call 1-866-372-9892 for assistance.

Cancellations, Changes and Other Support

Cancellations.
Whenever possible, rides should be cancelled at least 24 hours prior to the schedule transport.

If you need to cancel your ride contact National MedTrans so they can coordinate with the assigned transportation provider.

Changes.
There are times when you may need to update your ride details such as where you are going or what time you need to be picked up. If you need to make changes, contact National MedTrans.

Remember, if you do not make updates to your ride with National MedTrans, your driver will not be notified and will not be able to accommodate your request.

Other support.
National MedTrans is there to support you! It's important that you contact them regarding your transportation. Here are some things they can help you with:

- Scheduling a new ride or a standing order.
- Reporting issues with your transportation.
- Sharing a positive experience with your transportation.
- Your ride is not on time.
- You're ready to go home and you need your return ride.
- General questions regarding the transportation benefit and how you can use it.

If you have a complaint about the transportation service, call Customer Service at **1-800-791-9233, TTY 711**.

Limitations on Provider Access

UnitedHealthcare Community Plan has a network of contracted home care agencies, assisted living facilities, skilled nursing homes, medical supply companies and others to provide service to enrollees in our service area. The providers in our network can change at any time. UnitedHealthcare Community Plan will write you about changes. You can also check the provider directory or call Customer Service at **1-800-791-9233** or **TTY 711**.

Claims

You do not have to pay bills that we should pay. If you get a bill from your health care provider, ask why they are billing you. If you still get a bill, call:

Toll-free: **1-800-791-9233, TTY 711**

You should have your bill in front of you when you call. You will need to tell Customer Service who sent you the bill, the date of service, the amount and the doctor, hospital or provider's address, and phone number.

Quality Enhancements

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

For information on our Quality Enhancements or Quality Improvement program, how we are meeting our goals, or practice guidelines, call Customer Service toll-free at **1-800-791-9233, TTY 711**.

Examples of Quality Enhancements are:

- Home Safety and Fall Prevention.
- Information on Advance Directives.
- Domestic Violence Prevention Assistance.

Please call Customer Service to verify covered services. Services that are considered experimental and cosmetic are not covered. For a counseling or referral service that the health plan does not cover because of moral or religious objections, the health plan need not furnish information on how and where to obtain the service.

Emergency Care

A medical emergency is when you get so badly sick or injured that your life or health is at risk if you do not get care right away. Comprehensive members have emergency care covered under your Medicaid plan; this is not covered under the Home and Health Connection benefit.

This includes things that prevent you from making decisions. Some examples are problems with breathing, convulsions, bleeding, and/or unconsciousness. If you have an emergency, you should call your doctor for help if you can.

If you cannot contact your doctor and you need emergency care:

1. Get care at the closest medical facility or hospital emergency room. They do not have to be contracted with UnitedHealthcare Community Plan and you do not need prior authorization to receive emergency care.
2. Tell them you are an enrollee of UnitedHealthcare Community Plan.
3. Give them your ID card.
4. Ask them to contact UnitedHealthcare Community Plan or to call the numbers listed on the back of your ID card.

If you get care in an emergency room, you must tell your Case Manager no later than 48 hours after the care. Your Case Manager will make sure the care you got is authorized. All follow-up care must be set up by your doctor.

If you have any questions about emergency care, call our Customer Service Department at 1-800-791-9233 or TTY 711.

Post-Stabilization Services

Post-stabilization services are covered and provided without prior authorization. These are services that are medically necessary after an emergency medical condition has been stabilized.

Emergency Care Outside the Service Area

If you have an emergency outside the service area, get the care you need. However, you must tell your Case Manager right away. This will ensure that you get follow-up care. It will help ensure prompt payment for your care.

Non-Emergency Care Outside the Service Area

For medical care that is not an emergency outside the service area, you must contact your Case Manager before you receive the care. Non-emergency care outside the service area will not be covered by UnitedHealthcare Community Plan unless you have notified your Case Manager ahead of time. You will have to pay for care you get without prior notification.

After-Hours

If you need care after office hours, except for emergencies, you must contact your doctor. Your doctor or another UnitedHealthcare Community Plan contracted doctor can give you advice by phone, prescribe drugs, ask you to come to his or her office, send you to an emergency facility or to another doctor for treatment, or ask you to make an appointment during office hours.

For mental health emergencies, call 1-800-582-8220 for Crisis Support/Emergency Services available 24 hours a day, 7 days a week. An example of when you should call is if you are thinking about death or suicide.

Prior Authorization

Doctors need to get our approval before giving you care. This is called prior authorization. If your doctor does not get prior authorization, UnitedHealthcare Community Plan may not pay for these services. Your doctor should call Provider Services at **1-800-791-9233, TTY 711** to get prior authorizations.

Here are some types of care that need a prior authorization:

- Non-emergency or non-urgent hospital admissions, unless for a normal newborn delivery.
- Non-emergency services from an out-of-network provider.
- Some dental treatments.

You do not need a prior authorization for:

- Emergency and urgent care.
- Hospital admissions for normal newborn deliveries.

You do not need prior approval to get emergency care.

Specialty Care and Referrals

If you have Medicaid only and you need a specialist or other services that you cannot get from your doctor, your doctor will order a referral. The referral should be given to your Case Manager, who will tell the provider. Make sure your Case Manager is notified of referrals. If services are not noted by UnitedHealthcare Community Plan, you may have to pay for them. Exceptions are emergencies, family planning, or services from public providers for sexually transmitted and communicable diseases and immunizations.

Second Medical Opinion

If you have a question about treatment, you can ask for a second opinion. This is when another in-network provider examines you again. If you cannot find a second network provider, you can get a second opinion from an out-of-network provider with prior authorization. Call your Case Manager for help. There is no charge to you for a second opinion.

Hospital Care

If you need hospital care in the service area, your doctor will set this up.

UnitedHealthcare Community Plan will not pay claims unless we refer you or in an emergency. Notification is needed so that care will be paid by your plan. All hospital care, inpatient or outpatient, must be set up by your doctor and Case Manager.

When you go home from the hospital, your Case Manager will help you set up your services. If you have questions, your Case Manager will help you. A Care Plan is set up by your doctor and your Case Manager. They consider your health needs, home situation and support from family and friends. Your Case Manager will talk about this with you and your family. A UnitedHealthcare Community Plan representative will also visit with you to be sure you get good care.

Your Case Manager Can Set Up Services Like:

- Doctor's appointments and medical tests.
- Personal care aides and home nurses.
- Home delivery of drugs.
- Medical supplies and equipment.
- Placement in residential care settings.

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

- Urgent Care — within one day.
- Routine Patient Care — within one week.
- Well-Care Visit — within one month.

In-Home and Community Long-Term Care Services

The following services are included in your UnitedHealthcare Health and Home Connection benefit plan. Your **Case Manager** will work with you to determine which of these services best meet your care plan needs.

The level of services you will receive is based on your personal needs which are predetermined by UnitedHealthcare Health and Home Connection established guidelines.

The providers in the network can change at any time. You can ask for an updated Provider Directory at any time by calling our toll-free number, **1-800-791-9233**, or **TTY 711**, for hearing impaired.

For additional coverage details, please view the Florida Medicaid Statewide Medicaid Managed Care Long-Term Care Coverage Policy at **http://ahca.myflorida.com**.

In-Home and Community Long-Term Care Services

Benefit	Description
Adult Companion Services	Non-medical care, supervision and socialization. This service does not include hands-on nursing care.
Adult Day Health and Adult Day Care Services	Social and therapeutic activities in an organized program located in a community setting.
Assisted Living Services	UnitedHealthcare Health and Home Connection works to provide services to support your choice to remain safely in your own home. UnitedHealthcare Health and Home Connection will reimburse the facility for services provided to you. You are responsible for the cost of the room and board.
Assistive Care Services	An integrated set of twenty-four (24) hour services only for Medicaid-eligible residents in adult family care homes.

Benefit	Description
Attendant Care	Attendant Care services are a combination of several long-term care services provided during a specified period of time. These services include Companion, Homemaker and Personal Care. The enrollee has the ability to choose which services are to be performed during the time that the worker is in the enrollee's home. *Attendant Care workers do not assume any responsibility for the enrollee's banking, bill paying or ATM card usage and must have the ability to reconcile change when doing any shopping on behalf of the enrollee.
Behavior Management	UnitedHealthcare provides services to address mental health or substance abuse needs.
Care Coordination/ Case Management	Services that assist enrollees in gaining access to needed waiver and other State plan services, as well as other needed medical, social, and educational services, regardless of the funding source for the services to which access is gained.
Caregiver Training Services	Training and counseling services for individuals who provide unpaid support, training, companionship or supervision. Individuals are defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care or support to an enrollee.
Home Accessibility Adaptation Services	Physical adaptations to your home to assure your safety or enable you to function with greater independence. This service does not include those adaptations or improvements to your home that are of general utility and are not of direct medical or remedial benefit to you, such as carpeting, roof repairs, modifications to electrical or plumbing systems or central air conditioning. Adaptations that add to the total square footage of your home are not included in this benefit.
Home-Delivered Meals	Nutritionally sound meals delivered to your place of residence.

Covered Benefits

Benefit	Description
Homemaker Services	General household activities such as meal preparation and routine household tasks provided by a trained homemaker. * Homemakers are not to assume any responsibility for the enrollee's banking, bill paying or ATM card usage and must have the ability to reconcile change when doing any shopping on behalf of the enrollee.
Hospice	Services that are forms of palliative medical care designed to meet the physical, social, psychological, emotional, and spiritual needs of terminally ill recipients and their families.
Intermittent and Skilled Nursing	Skilled nursing services are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or whose need is predictable.
Medical Equipment and Supplies	Disposable supplies essential to adequately care for the needs of the enrollee. These supplies enable the enrollee to perform activities of daily living or stabilize or monitor a health condition. Consumable medical supplies include adult disposable diapers, tubes of ointment, cotton balls and alcohol for use with injections, medicated bandages, gauze and tape, colostomy and catheter supplies, and other consumable supplies. Not included are items covered under the Medicaid home health service, personal toiletries, and household items such as detergents, bleach, and paper towels, or prescription drugs.
Medication Administration	Assistance with self-administered medicines, in the home or in a facility. Help includes opening containers, lifting the container to the enrollee's mouth, applying topical medications and keeping a record when assistance is provided.
Medication Management	Review by a licensed nurse of all prescriptions and over-the-counter medications taken by the enrollee.

Benefit	Description
Nursing Facility Services	UnitedHealthcare Health and Home Connection works to provide services to support your choice to remain safely in your own home. Should permanent nursing home placement become necessary and you move to a nursing home, your UnitedHealthcare Health and Home Connection coverage continues.
Nutritional Assessment and Nutritional Risk Reduction Services	Assessment, education, and guidance to you and your family about your nutritional needs.
Occupational Therapy Services	Treatment to restore, improve or maintain impaired functions aimed at increasing or maintaining the enrollee's ability to perform tasks required for independent functioning when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
Personal Care Services	Assistance with eating, bathing, dressing, and personal hygiene.
Personal Emergency Response Systems (PERS)	An electronic device that enables you to secure emergency help while in your home.
Physical Therapy Services	Treatment to restore, improve, or maintain impaired functions by using activities and chemicals with heat light electricity or sound and by massage and active, resistive, or passive exercise when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
Respiratory Therapy Services	Treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems and bronchopulmonary drainage, breathing exercises and chest physiotherapy.
Respite Care Services	Assistance to you, on a short-term basis, when family or caregivers normally providing care to you will be absent.

Covered Benefits

Benefit	Description
Speech Therapy Services	The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism, or neurological conditions that affect oral motor functions. Therapy services include the evaluation and treatment of problems related to an oral motor dysfunction when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
Transportation	Non-emergency transportation is offered to and from services as described in the enrollee's plan of care.

Expanded Benefits

Benefit	Description
Adult Dental Services	Two (2) cleanings per year; unlimited amalgam fillings for one (1) to three (3) surfaces; unlimited resin-based composite fillings for one (1) to three (3) surfaces, posterior; twenty-five percent (25%) discount on dental services not covered by Medicaid.
Diagnostic and Preventive Dental Services	UnitedHealthcare provides diagnostic and preventive dental services not available with regular Medicaid. To get these services, you must contact our contracted provider, Solstice, at **1-877-760-2247**.
Household Set-up Kit	One (1) household set-up kit with a total retail value of one hundred dollars ($100) per enrollee per lifetime for enrollees transitioning to a community residence apartment; benefit not available for enrollees moving into an Assisted Living Facility (ALF) or family care home; kit consists of a gift card or a package containing common items needed to establish a new household; subject to prior authorization.
Non-Medical Transportation	One (1) round-trip transport per month to personal or community activities; may not be used for medical visits; enrollee must reside in a home and community-based setting; limited to trips within fifty (50) miles; must use a network provider.
Nurse Helpline Services	NurseLine gives you twenty-four (24) hour-per-day toll-free telephonic access to registered nurses through a Nurse Helpline for enrollees and their caregivers, for assistance with accessing appropriate resources for health care services based on severity of symptoms.
Welcome Home Basket	One (1) welcome home basket with a total retail value of one hundred and fifty dollars ($150) per enrollee per lifetime for enrollees transitioning to a community residence including an ALF; basket will contain a variety of health and safety items to ease the transition between settings; subject to prior authorization.

Benefit	Description
Over-The-Counter (OTC) Medication/Supplies	Maximum fifteen dollars ($15) per enrollee per month; enrollee purchases limited to an approved list of products; unused benefit does not carry over from month to month.
Support to Move Out of a Nursing Home	Benefit available for enrollees moving from a nursing facility into their own home; maximum three thousand dollars ($3,000) per enrollee per lifetime; up to one thousand dollars ($1,000) per lifetime for deposits for housing or utilities; up to one thousand dollars ($1,000) per lifetime for household items; up to five hundred dollars ($500) per lifetime for moving expenses; up to five hundred dollars ($500) per lifetime for health and safety items; funds must be paid directly to providers of goods or services; subject to prior authorization.
Nursing Facility Transition to Apartments	In addition to the available community resources, UnitedHealthcare will support the transition of enrollees from nursing facilities to community residence (excluding ALFs) by providing assistance with security deposits or apartment setup. **Security Deposits:** UnitedHealthcare will provide financial support to enrollees who are ready to move into an apartment setting but unable to make the required security deposit. Enrollees who face a financial barrier to moving into an apartment will be provided security deposits for either the apartment and/or utilities up to $350. The deposits will be paid to the apartment management or utility company. This offer will be available one time for enrollees when moving from a nursing facility to a community residence apartment only. It will not apply to enrollees moving into an ALF or family home. These apartment-related benefits will be available one time for enrollees moving from a nursing facility to a community residence apartment only. It will not apply to enrollees moving into an ALF or family home.

Regular Medicaid Services

There are some Medicaid services that are NOT covered by UnitedHealthcare Community Plan, but you can receive these services by calling your local Area Medicaid Office for information on these services and any cost sharing there could be (see Important Phone Numbers page for a list of Area Medicaid Office phone numbers). This could include counseling or referral of a service not covered because of moral or religious objections.

Patient Responsibility

You may live in a place that is paid for by the health plan. If you do, you may owe some money to the place that gives you care. This is called Patient Responsibility. The amount of Patient Responsibility is set by the Department of Children and Families (DCF). If you live in a place that gives you care, DCF will tell you about any money you may owe. The amount of money you owe may change from time to time. DCF will tell you about any changes. You must pay this amount each month for your care.

New Technology

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

Use of Out-of-Network Services

UnitedHealthcare Health and Home Connection has formed a network of providers that include home care agencies, assisted living facilities, skilled nursing homes, consumable medical supply companies and others that provide service to enrollees in the authorized service area.

At the time of your enrollee orientation, you will be given a list of contracted providers. You may select any provider from this list. **UnitedHealthcare Health and Home Connection will need to provide prior authorization for all services.**

The providers in our network can change at any time. You can ask for an updated Provider Directory at any time by calling our toll-free number, **1-800-791-9233** or **TTY 711**, for hearing impaired.

If you choose to use an out-of-network provider, you will be responsible to pay the entire claim.

Home and Community Services

For more information regarding how to develop a disaster/emergency plan, including information on shelters, emergency preparedness and special needs registry, please visit **www.floridadisaster.org**.

For instructions on how to access other state or local consumer resources, please visit the Health Finder website at **www.FloridaHealthFinder.gov** or the Florida Affordable Assisted Living consumer website, **http://elderaffairs.state.fl.us/faal/**.

You can find additional senior resources by contacting the Area Agency on Aging or Aging and Disability Resource center (ADRC) in your county, listed below. These organizations can provide information and assistance on state and federal benefits, as well as available local programs and services, such as utility assistance, legal and crime prevention services, income planning, or education opportunities.

PSA 1: Northwest Florida Area Agency on Aging
Serving Escambia, Okaloosa, Santa Rosa, and Walton Counties
5090 Commerce Park Circle
Pensacola, FL 32505
850-494-7100
http://www.nwflaaa.org

PSA 2: Area Agency on Aging for North Florida, Inc.
Serving Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington Counties
2414 Mahan Drive
Tallahassee, FL 32308
1-866-467-4624 or 850-488-0055
http://www.aaanf.org

PSA 3: Elder Options, the Mid-Florida Area Agency on Aging
Serving Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union Counties
5700 S.W. 34th St., Suite 222
Gainesville, FL 32608
352-378-6649 or 1-800-262-2243
http://www.agingresources.org/

PSA 4: ElderSource, Area Agency on Aging for Northeast Florida
Serving Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties
4160 Woodcock Drive, 2nd Floor
Jacksonville, FL 32207
904-391-6600 or 1-888-242-4464
http://www.myeldersource.org/

PSA 5: Area Agency on Aging of Pasco-Pinellas
Serving Pasco and Pinellas Counties
9887 4th Street North, Suite 100
St. Petersburg, FL 33702
727-570-9696, Fax 727-570-5098
http://www.agingcarefl.org/

PSA 6: West Central Florida Area Agency on Aging, Inc.
Serving Hardee, Hillsborough, Highland, Manatee, and Polk Counties
5905 Breckenridge Pkwy., Suite F
Tampa, FL 33610-4239
813-740-3888
http://www.agingflorida.com/

PSA 7: Senior Resource Alliance
Serving Brevard, Orange, Osceola, and Seminole Counties
988 Woodcock Rd., Suite 200
Orlando, FL 32803
407-514-1800
http://www.seniorresourcealliance.org/

PSA 8: Area Agency on Aging of Southwest Florida
Serving Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties
15201 N. Cleveland Avenue, Suite 1100
North Fort Myers, FL 33903
239-652-6900
http://www.aaaswfl.org//

PSA 9: Area Agency on Aging of Palm Beach/ Treasure Coast, Inc.
Serving Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties
4400 N. Congress Avenue
West Palm Beach, FL 33407-3226
561-684-5885
http://www.youragingresourcecenter.org/

PSA 10: Aging and Disability Resource Center of Broward County
Serving Broward County
5300 Hiatus Road
Sunrise, FL 33351
954-745-9567
http://www.adrcbroward.org/

PSA 11: Alliance for Aging
Serving Miami-Dade and Monroe Counties
760 NW 107th Avenue, Suite 214
Miami, FL 33172-3155
305-670-6500
http://www.allianceforaging.org/

We use preventive care guidelines from the U.S. Preventive Services Task Force. Your health plan may have a modified version of these guidelines. Coverage and reimbursement may vary depending on state or federal law. It may vary depending on your coverage plan. Call Customer Service at the number shown on your ID card if you have any questions.

Adults 25 – 64 Years

Screenings.

- Height/weight — Periodically.*
- Blood pressure — Periodically.*
- Total blood cholesterol — Periodically* — males between ages 35 – 64, females between ages 45 – 64.
- Fecal occult blood test — Annually* beginning at 50.
- Sigmoidoscopy — Every three to five years beginning at age 50.
- Clinical breast exam — Annually — females between ages 50 – 69.
- Mammogram — Every one to two years — females between ages 50 – 69.* *
- Papanicolaou (Pap) test — Every one to three years.

Immunizations.

- Rubella serology — Recommended once for all females of childbearing age or vaccination history.
- Tetanus-diphtheria (Td) Boosters — Every 10 years, or as recommended.*
- Influenza — Annually or as recommended by your doctor.
- Pneumococcal — Recommended at least once for all who have a compromised immune system and those with chronic illness; repeat as recommended by your doctor.

Other preventions.

- Discuss hormone replacement therapy — Periodically,* peri- and postmenopausal females.
- Discuss multivitamins, folic acid — Periodically.*

**Talk about the frequency with your doctor.*

We strongly encourage you to take advantage of the preventive health services offered by your plan.

Doctor Discussion Topics

Diet and exercise.

- Limited fat and cholesterol intake, maintain caloric balance, emphasize grains, fruits and vegetables.
- Regular physical activity.
- Adequate calcium intake.

Substance use.

- Avoid alcohol and drug use.
- Avoid tobacco use.

Sexual behavior.

- Unintended pregnancy.
- Sexually transmitted disease (STD) prevention.
- Avoiding high-risk behavior.

Injury prevention.

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

Dental health.

- Regular dental visits.
- Floss, brush, and fluoride.

Adults 65 Years and Older

Screenings.

- Height/weight — Periodically.*
- Blood pressure — Periodically.*
- Papanicolaou (Pap) test — Every one to three years.
- Fecal occult blood test — Annually.
- Sigmoidoscopy — Every three to five years.
- Clinical breast exam — Annually — females between ages 65 – 69.
- Mammogram — Every one to two years — females between ages 65 – 69.
- Vision screening — Annually.
- Hearing assessment — Periodically.*

Immunizations.

- Tetanus-diphtheria (Td) Boosters — Every 10 years or as recommended.*
- Influenza — Annually.
- Pneumococcal — At least once at or after age 65 — Repeat if the previous vaccination was five years or longer before age 65.

Other preventions.

- Discuss hormone replacement therapy — Periodically,* peri- and postmenopausal females.

** Talk about the frequency with your doctor.*

Doctor Discussion Topics

Diet and exercise.

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

Substance use.

- Avoid alcohol and drug use.
- Avoid tobacco use.

Sexual behavior.

- Sexually transmitted disease (STD) prevention.
- Avoiding high-risk behavior.

Injury prevention.

- Lap and shoulder seat belts.
- Bicycle and motorcycle helmets safety.
- Safe firearm handling.
- Smoke detectors.
- Set hot water heater temperature lower than 120° – 130° F.
- CPR training for household members/caregivers.

Dental health.

- Regular dental.
- Floss, brush, and fluoride.

Benefits Not Covered by UnitedHealthcare

You may be eligible for Medicaid benefits not covered by UnitedHealthcare Community Plan. These benefits may include out-of-pocket costs. To find out about these benefits, contact the Area Medicaid office listed in the front of this handbook.

The Following Services Are Not Covered by UnitedHealthcare Community Plan:

- Therapeutic Group Care Services.
- Behavioral Health Overlay.
- Certain Community Substance Abuse Services.
- Residential Care in an Inpatient Behavioral Health Setting.
- Sub-acute Inpatient Psychiatric Program Services.
- Clubhouse Services.
- Comprehensive Behavioral Assessment.
- Florida Assertive Community Treatment Services (FACT).

If you need these services, your Case Manager can help you find an appropriate Mental Health provider. UnitedHealthcare Community Plan does not pay for care from providers that are not contracted with us, except for emergency and urgently needed care.

If you are experiencing any of these symptoms for two weeks or longer — or if the illness or injury lasts long past what the doctor said it would, let your doctor know or call your Case Manager as you may be suffering from depression.

- A lack of interest in activities previously enjoyed.
- Appetite and weight changes.
- Sleep problems (insomnia, oversleeping or early-morning waking).
- Irritability.
- Withdrawing from friends and family.
- A lack of energy or sense of fatigue.
- Recurring aches and pains that seem to have no physical cause.
- Feelings of worthlessness and helplessness.
- Difficulty concentrating, remembering and making decisions.
- Talking about death or suicide.

Appeals Process

If UnitedHealthcare Community Plan makes a decision to deny, reduce, put on hold or stop a health care service you are getting, you will get a written **"Notice of Adverse Determination"** at least ten (10) days before the action takes place. If you do not agree with this action, you may file an appeal to request a review of the decision.

Standard Appeal

A **Standard Appeal** is a request to UnitedHealthcare Community Plan to review a decision about your health care services. You must file an appeal within sixty (60) days of the date you received the Notice of Adverse Determination. If you do not get a written notice from UnitedHealthcare Community Plan, then you have one (1) year to file an appeal. You can ask your doctor, a family member or friend to file the appeal for you. If someone helps you file an appeal, they must be your "authorized representative." To ask for an appeal, fax your letter to: **1-888-517-7113 (office hours 8:00 a.m. – 5:00 p.m., Monday – Friday Eastern Time)**.

Or you may mail it to:

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

Or you may call **1-800-791-9233** or **TTY 711**, for hearing impaired.

Upon your request, UnitedHealthcare Community Plan will make every effort to assist you in filling out the paperwork of your appeal, or if you need help in another language or with toll-free calling.

Your request will be reviewed. UnitedHealthcare Community Plan has thirty (30) days to look at your case. Before the end of that time, you will get a letter stating our decision about your appeal. The letter will tell you how we made our decision. It will tell you what laws or health plan policies we reviewed to decide your case.

Before we make a decision, you and/or the person helping you with your appeal can give information to UnitedHealthcare Community Plan. The new information can be in writing or in person.

You and your representative may look at your case file. The file might have medical records or other papers and records related to your appeal. You can look at your file any time while we are reviewing your appeal. If you need more time to get information for your appeal, you can have it. UnitedHealthcare Community Plan may also ask for more time. You or the plan can ask for up to fourteen (14) calendar days. If UnitedHealthcare Community Plan asks for extra time, we will send you a letter to let you know. We will also tell you why we need the extra time.

Continuation of benefits.
If you are now getting the service that is scheduled to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made in a plan appeal and, if requested, fair hearing. If your services are continued, there will be no change in your services until a final decision is made in your plan appeal and, if requested, fair hearing. If your services are continued and our decision is upheld in a plan appeal or fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services. To have your services continue during the plan appeal, you MUST file your plan appeal AND ask to continue your services within this time frame: File a request for your services to continue with UnitedHealthcare Community Plan no later than 10 days after our action letter was mailed OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, whichever is later.

If you are not satisfied with the outcome of your appeal after completion of the process, you can ask for a Medicaid Fair Hearing. Members may file for a Fair Hearing within one hundred twenty (120) calendar days of receiving your appeal's resolution. To ask for a Medicaid Fair Hearing, send a letter to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

877-254-1055 (toll-free)
239-338-2642 (fax)

MedicaidHearingUnit@ahca.myflorida.com

If your appeal is asking for care to continue, you may be able to keep getting care while waiting for a decision. If the decision is against you, you may have to pay for the services.

If, at your request, the Managed Care Plan continues or reinstates the benefits while the plan appeal is pending, the benefits must continue until one (1) of the following occurs:

- You withdraw the plan appeal.
- You did not request a fair hearing and continuation of benefits within ten (10) calendar days after UnitedHealthcare sent your notice of plan appeal resolution.

You may be asked to pay for services received during the review if the final decision from the Medicaid Fair Hearing is not in your favor.

If the Medicaid Fair Hearing agrees with you, UnitedHealthcare Community Plan will pay for the services you received while waiting for the decision. If the Medicaid Fair Hearing decision agrees with you and you did not continue to get the services while you were waiting for the decision, UnitedHealthcare Community Plan will issue an authorization for the services you are requesting to restart as soon as possible and we will pay for those services.

If you do not agree with UnitedHealthcare Community Plan's decision , you have up to one year after receipt of your appeals final decision letter to ask for review by the Subscriber Assistance Program (SAP). The SAP will not consider an enrollee appeal that has already been to a Medicaid Fair Hearing.

To ask for a review, send a letter to:

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive, Tallahassee, FL 32308

850-412-4502

888-419-3456 (toll-free)

If the decision from UnitedHealthcare Community Plan, the Medicaid Fair Hearing or the Subscriber Panel is in your favor and your services were not continued during the reviews, UnitedHealthcare Community Plan will start your services as soon as we can. We will pay for those services.

Expedited Appeal

An **Expedited Appeal** is a request to UnitedHealthcare Community Plan to review your request faster than a standard appeal because you feel that taking the time for a standard appeal could be a danger to your life or health or cause you to be permanently injured. You can only ask for fast appeals for health care services, not denied claims. To ask for a fast review, you or your doctor may call **1-800-791-9233** or **TTY 711**, for hearing impaired.

UnitedHealthcare Community Plan appeals coordinator will review your request. Before we make a decision, you and the person helping you with your appeal can give information to UnitedHealthcare Community Plan. The new information can be in writing or in person. If we say "yes" to your request for a fast review, you will receive a decision within 72 hours.

If we think that waiting to have your appeal would not harm you permanently, your appeal will be treated like a Standard Appeal.

Grievance Process

If you have a complaint about UnitedHealthcare Community Plan, you may file a **grievance** in writing or by phone. Grievances can be filed at any time. It may be filed by a provider with your written consent. You may file a grievance about such things as the quality of the care you receive from the Plan or a provider, rudeness from a Plan employee or a provider's employee, a lack of respect for your rights by the Plan or a provider or anything else you may be dissatisfied with — **except our decision not to provide or pay for a service**.

To file a grievance, call Customer Service at **1-800-791-9233** or **TTY 711**.

Or write to:

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

Or fax to: **1-888-517-7113** (Office hours 8:00 a.m. – 5:00 p.m., Monday – Friday Eastern Time)

If we do not resolve your grievance to your satisfaction by the end of business the day after we receive it, we will send you a letter that we received your grievance. You will usually get a decision letter from us within ninety (90) days from when we received your grievance.

If you need assistance in filing your grievance or need the help of an interpreter, call Customer Service at **1-800-791-9233** or **TTY 711**. The interpreter services are free.

If you need more time to get information, you may get up to fourteen (14) days more. If UnitedHealthcare Community Plan needs more time, we will tell you why in writing.

You may also ask for a Medicaid Fair Hearing. You or your provider, with your written consent, may ask for a hearing.

If you do not agree with UnitedHealthcare Community Plan's decision , you have up to one year after receipt of your appeals final decision letter to ask for review by the Subscriber Assistance Program (SAP). The SAP will not consider an enrollee appeal that has already been to a Medicaid Fair Hearing.

To ask for a review, call or write:

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive
Tallahassee, FL 32308

1-850-412-4502

1-888-419-3456 (toll-free)

Medicaid Fair Hearing

If you are not satisfied with the outcome of your appeal after completion of the process, you can ask for a Medicaid Fair Hearing. Member's may file for a Fair Hearing within one hundred twenty (120) calendar days of receiving your appeal's resolution. To ask for a **Medicaid Fair Hearing**, send a letter to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

877-254-1055 (toll-free)
239-338-2642 (fax)

MedicaidHearingUnit@ahca.myflorida.com

Non-Discrimination Compliance Coordinator.
UnitedHealthcare strives to treat all our members with the care and respect they deserve. If you feel that you have been subjected to discrimination of any nature, please contact UnitedHealthcare's Non-Discrimination Compliance Coordinator:

Juan Rodas
3100 SW 145th Avenue
Miramar, FL 33027
954-364-0715

We believe you will be pleased with services provided by the UnitedHealthcare Health and Home Connection program. Our goal is to support your choice to live at home by making sure you get the services you need. However, you may voluntarily disenroll at any time.

Disenrollment

If you are a mandatory enrollee and you want to change plans after the initial 120-day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state-approved cause reasons to change Managed Care Plans:

1. The enrollee does not live in a region where the Managed Care Plan is authorized to provide services, as indicated in FMMIS.
2. The provider is no longer with the Managed Care Plan.
3. The enrollee is excluded from enrollment.
4. A substantiated marketing violation has occurred.
5. The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
6. The enrollee has an active relationship with a provider who is not on the Managed Care Plan's panel, but is on the panel of another Managed Care Plan. "Active relationship" is defined as having received services from the provider within the six months preceding the disenrollment request.
7. The enrollee is in the wrong Managed Care Plan as determined by the Agency.
8. The Managed Care Plan no longer participates in the region.
9. The state has imposed intermediate sanctions upon the Managed Care Plan, as specified in 42 CFR 438.702(a)(4).
10. The enrollee needs related services to be performed concurrently, but not all related services are available within the Managed Care Plan network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
11. The Managed Care Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
12. The enrollee missed open enrollment due to a temporary loss of eligibility.
13. Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers experienced in dealing with the enrollee's health care needs; or fraudulent enrollment.

Voluntary Disenrollment

If you wish to leave UnitedHealthcare Community Plan, you must call Choice Counseling at their toll-free helpline **1-877-711-3662**. You will be disenrolled the last day of the month the Agency for Health Care Administration records the disenrollment.

Also, your enrollment will be ended if you:

- Move out of our service area.
- Become ineligible for Medicaid.

Some Medicaid recipients may change health Managed Care Plans whenever they choose, for any reason. To find out if you may change plans, call the Enrollment Broker at **1-877-711-3662**.

Involuntary Disenrollment

Enrollees may be involuntarily disenrolled from the UnitedHealthcare Health and Home Connection if one of the following events occurs:

- An enrollee becomes ineligible for Medicaid;
- An enrollee moves outside the service area;
- An enrollee's fraudulent use of their Medicaid ID card; or
- An enrollee or caregiver fails to cooperate, does not follow a recommended plan of care, or displays behavior that is disruptive, unruly, abusive, or uncooperative which seriously impairs UnitedHealthcare Health and Home Connection's ability to furnish services. If you are involuntarily disenrolled for non-compliance, you will not be eligible to re-enroll in the program.
- An enrollee refuses to relocate from an ALF or AFCH that does not, and will not, conform to HCB Settings Requirements.

Should this occur, UnitedHealthcare Health and Home Connection will provide at least one verbal and at least one written warning to the enrollee/caregiver discussing the full implications of the event or action up to and including disenrollment from the program.

Reinstatement Process

If you are disenrolled from the program for any reason other than non-compliance and desire to re-enroll in the program, you will need to contact the Department of Elder Affairs CARES office to inquire about reinstatement.

Health care fraud, whether against Medicare, Medicaid, or private insurers, increases everyone's health care costs. We must work together to help keep health care safe and reduce costs. First, do not deal with providers or accept supplies that your doctor or Case Manager has not spoken with you about. Never accept free equipment from any supplier. If you think something is wrong, call your Case Manager or call **1-800-791-9233**. Your confidentiality will be maintained.

Fraud and Abuse

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

Or

Complete a Medicaid Fraud and Abuse Complaint Form, which is available online at **https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx**.

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

To report suspected abuse, neglect, and exploitation, call the abuse hotline at 1-800-96-ABUSE.

The Patient's Right to Decide

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

You have a right to fill out a paper known as an "Advance Directive." The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions — conditions that would make you unable to make your own decisions. As an example, if you were in a coma, an Advance Directive would let the health care facility staff know your specific wishes about decisions affecting your care.

What Is an Advance Directive?

An Advance Directive is a written statement, which is made and witnessed in advance of serious illness or injury, about how you want medical decisions made. Two forms of an Advance Directive are:

- A Living Will.
- Health Care Surrogate Designation.

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

What is a Living Will?
A Living Will generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living. Florida law provides a suggested form for a Living Will. You may use it or some other form. You may wish to speak to an attorney or your doctor to be certain you have completed the Living Will in a way so that your wishes will be understood.

What is a Health Care Surrogate Designation?
A Health Care Surrogate Designation is a signed, dated and witnessed paper naming another person, such as a husband, wife, daughter, son or close friend as your agent to make medical decisions for you, if you should become unable to make them for yourself.

You can include instructions about any treatment you want or do not want. Florida law provides a suggested form for completing a Health Care Surrogate Designation. You may use it or some other form. You may wish to name a second person to stand in for you, if your first choice is unavailable.

Which is better?
You may wish to have both a Living Will and a Health Care Surrogate Designation, or combine them into a single document that describes treatment choices in a variety of situations and names someone to make decisions for you should you be unable to make decisions for yourself.

Do I have to write an Advance Directive under Florida law?
No, there is no legal requirement to complete an Advance Directive. However, if you have not made an Advance Directive by completing a Health Care Surrogate Designation or Living Will, health care decisions may be made for you. These decisions may be made by a court-appointed guardian, your spouse, your adult child, your parents, your adult sibling, an adult relative, or a close friend, in that order. This person would be called a proxy.

Can I change my mind after I write a Living Will or designate a Health Care Surrogate?
Yes, you may change or cancel these documents at any time. Any change should be written, signed and dated.

What should I do with my Advance Directive if I choose to have one?
Make sure that someone, such as your primary doctor, lawyer, or family member knows that you have an Advance Directive and where it is located. Consider the possibilities listed below:

- If you have designated a Health Care Surrogate, give a copy of the original to that person.
- Give a copy of your Advance Directive to your doctor for your medical file.
- Keep a copy of your Advance Directive in a place where it can be easily found.
- Keep a card or note in your purse or wallet, which states that you have an Advance Directive and where it is located.
- Give a copy of your Advance Directive to UnitedHealthcare Health and Home Connection.
- You have the right to file a complaint with the Department of Elder Affairs (DOEA) for non-compliance with Advance Directives.

If you change your Advance Directive, make sure your doctor, lawyer and/or family member and UnitedHealthcare Health and Home Connection have the latest copy.

Please note: You have a right to choose a new health care provider in situations when a health care provider cannot honor the Advance Directive wishes of his or her patients due to objections of conscience. For further information, ask those in charge of your care or contact the Customer Service Department.

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

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

How can I make an Advance Directive?
You can speak with your primary care physician, an attorney or go to **http://flsenate.gov/Statutes**.

For More Information

If you would like more information on creating an Advance Directive, contact one of these agencies:

Choice in Dying
200 Varick Street
New York, NY 10014
1-800-989-9455

State Ombudsman Office
6600 SW 57th Avenue
Miami, FL 33143
1-888-831-0404

American Association of Retired Persons (AARP) — To order public #D155294 and #D15529, write to:

AARP Fulfillment
606 E Street NW
Washington, DC 20049
1-888-687-2277

Confidentiality of Medical Records

We will not disclose any information concerning you for any purpose not in conformance with State and Federal Regulations.

You have certain rights and assume certain responsibilities when you become an enrollee of UnitedHealthcare Health and Home Connection.

It is important that you fully understand both your rights and your responsibilities. The following statement of rights and responsibilities is presented for your information. If you have any questions regarding these rights and responsibilities, please call UnitedHealthcare Health and Home Connection at **1-800-791-9233, TTY 711**.

Information Available Annually Upon Request

1. A detailed description of the UnitedHealthcare Health and Home Connection authorization and referral process for services.
2. A detailed description of the UnitedHealthcare Health and Home Connection process used to determine if services are medically necessary.
3. A detailed description of the UnitedHealthcare Health and Home Connection quality performance ratings, member satisfaction survey results, structure and operation of the Health Plan.
4. A detailed description of the UnitedHealthcare Health and Home Connection credentialing process.
5. The detailed description relating to the UnitedHealthcare Health and Home Connection prescription drug benefits program.
6. The detailed description relating to the confidentiality and disclosure of enrollee's medical records.
7. Information regarding the health plan's Physician Incentive Plans that affect the use of referral services.
8. The types of compensation arrangements the plan uses and whether stop-loss insurance is required.
9. A description of our quality enhancement or physician incentive programs.

You have a right to:

- Get information about UnitedHealthcare Community Plan, its services, the doctors giving care, and member rights and responsibilities.
- Be told by your doctor what is wrong, what can be done and what the result may be in language you understand.
- Learn about options for treatment and alternatives, regardless of cost or coverage, in a way that you can understand.
- Voice complaints or appeals about us and your care.
- Suggest changes to our member rights and responsibilities.
- Be cared for with respect and dignity and with regard to your privacy, without regard for health status, physical or mental handicap, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need.
- Get a second opinion.
- Give your OK to any treatment or care plan after it has been explained to you.
- Participate in decisions regarding your health care, including the right to refuse care and be told what you may risk if you do.
- Be free from any restraint or seclusion as a means of coercion, discipline, convenience or retaliation.
- Get a copy of your medical record. Talk about it with your doctor and ask, if needed, that it be amended or corrected.
- Have your medical record kept private, shared only when required by law or contract or with your approval.
- Get respectful care in a clean and safe environment free of unnecessary restraints.
- Get information about doctor incentives.
- Exercise your rights and not have this affect the way you are treated.
- Make an advance directive.
- Make a decision on organ donation.
- Receive services in a home-like environment regardless of your living arrangement.
- Receive information about community integration, the personal goal setting process and how you can participate in that process.

You have a responsibility to:

- Give information that UnitedHealthcare Community Plan and your doctor need to care for you.
- Listen to the doctor's advice, follow instructions and ask questions.
- Understand your health problems and work with your Case Manager to set treatment goals.
- Work with your doctor and Case Manager to guard and improve your health.
- Find out how your health care system works.
- Go back to your doctor or ask for a second opinion if you do not get better.
- Treat health care staff with respect.
- Tell us if you have problems with any health care staff.
- Keep your appointments. If you must cancel, call as soon as you can.
- Call your doctor when you need medical care, even after office hours.
- Use the emergency room only for real emergencies.
- If you live in a residential facility:
  - Attend all appointments or have a legal guardian attend for you.
  - Follow the amount and frequency of services in your care plan.

Glossary

Action

1. The denial or limited authorization of a requested service, including the type or level of service.
2. The reduction, suspension or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. To provide services in a timely manner, as defined by the state.
5. The failure of the contractor to act within the time frames provided.
6. For a resident of a rural area with only one managed care entity, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services outside the network.

Appeal

A request for review of action.

Grievance

A means of expressing dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the contractor level and access to the Medicaid fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a contractor or employee, or failure to respect the enrollee's rights.)

Grievance Process

The grievance process is the procedure for addressing enrollee grievances, which are expressions of dissatisfaction about any matter other than an action.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2018.

By law, we[1] must protect the privacy of your health information ("HI"). We must send you this notice. It tells you:

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

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

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

How We Use or Share Your Information
We must use and share your HI with:

- You or your legal representative.
- Government agencies.

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

- **For Payment.** We may use or share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.

- **For Underwriting Purposes.** We may use your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may use your HI to send you appointment reminders and information about your health benefits.

We may use or share your HI as follows.

- **As Required by Law.**
- **To Persons Involved With Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates if needed to give you services.** Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.

- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below.
  1. HIV/AIDS
  2. Mental health
  3. Genetic tests
  4. Alcohol and drug abuse
  5. Sexually transmitted diseases and reproductive health
  6. Child or adult abuse or neglect or sexual assault

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

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

Your Rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. You can have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete, you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons: (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website **(www.uhccommunityplan.com)**.

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or **TTY 711**.
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare Privacy Office
  MN017-E300
  P.O. Box 1459
  Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

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

Financial Information Privacy Notice

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

Effective January 1, 2018.

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

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

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connextions HCI, LLC; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions.

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

Revised: January 1, 2018.

The first part of this Notice (pages 55 – 58) says how we may use and share your health information ("HI") under federal privacy rules. Other laws may limit these rights. The charts below:

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

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

SUMMARY OF FEDERAL LAWS

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

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

SUMMARY OF STATE LAWS

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

Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, IL, MD, MA, ME, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT

HIV/AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

UnitedHealthcare®
Community Plan

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

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

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

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

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 8:00 p.m.

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

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

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

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

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

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Authorized Representative Form

UnitedHealthcare Community Plan

Health and Home Connection uses this form to obtain your permission to discuss or give out your personal health information to a person who is your Authorized Representative. Your approval on this form limits the use of your information for that purpose only.

Section A: Enrollee Information

By signing this form below, I understand and agree that Health and Home Connection, may release my personal health information to my Authorized Representative(s) named in Section B below.

Enrollee Name: _____

Address: _____

Telephone Number: _____ Enrollee ID Number: _____

Please Note: This authorization does not allow your "Authorized Representative" to make any of your treatment decisions or direct care decisions. If you want help with your health care and treatment decisions, you must get additional legal documentation. If you have questions, contact your attorney.

Section B: Authorized Use and/or Disclosure

Intended Use or Disclosure:
I understand that you can give my personal health information to those parties who are directly involved in my care. I also understand that it is Health and Home Connection's general policy not to give out my personal health information to other parties, without my written authorization unless it is permitted or required by law. For this reason, I authorize (permit) Health and Home Connection to discuss and give out my personal health information to the person(s) named below. I understand that it is for the purpose of helping me receive my health plan benefits or for payment of my health plan benefits. I understand that there are certain parties that must protect the privacy of my personal health information. These are health care providers and other parties who are required to do so under federal or related state laws. If my Authorized Representative is **not** a health care provider or another party required to protect my personal health information, it could be discussed or given out by my Authorized Representative without my permission. I understand and agree that my authorization is voluntary.

Authorized Representative #1:

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

Authorized Representative #2:

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

I understand that I have the right to limit the information that you give out under this authorization. For example, I can keep my Authorized Representative from knowing about one or more certain health care providers or certain medical conditions or diseases. If I want to limit information that you give to my Authorized Representative, I must list that below in writing. I understand that by leaving this section blank, I am allowing all of my personal medical information to be known by my Authorized Representative.

Limitations on Disclosure:

_____

_____

_____

_____

_____

_____

Section C: Expiration and Revocation

I understand that I have the right to end this authorization at any time. I understand that, if I do not wish the person(s) named in Section B to remain my Authorized Representative, I must cancel this authorization. I understand that I must put this **in writing** and send this written notice of my decision to the health plan contact listed below. I understand that if you have already released any of my personal health information before you receive my written request to end this authorization, my notice cannot cancel out any action you have already taken.

Section D: Signature / Authorization

I have read and thought about the content of this Authorized Representative Form. This authorization correctly describes my request of United Healthcare Services, Inc. I understand that, by signing this form, I am giving my permission for the health plan to use and/or give out my personal health information to the person(s) named in Section B.

Signature: _____ Date: _____

Witness: _____ Date: _____

(A witness signature is only needed if you must sign with an "X" due to physical limitations, illiteracy, or other reasons)

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO:

UnitedHealthcare Health And Home Connection
495 N. Keller Road, Suite 200
Maitland, FL 32751


UnitedHealthcare®
Community Plan