Florida

Welcome to the community

UnitedHealthcare Community Plan

Medicaid Member Handbook

United Healthcare Community Plan

CSFL23MD0086155_000

Language help

If you do not speak English, call us at MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language.

Spanish:
Si usted no habla inglés, llámenos al MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French:
Si vous ne parlez pas anglais, appelez-nous au MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**. Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Creole:
Si ou pa pale lang Anglè, rele nou nan MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**. Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a."

Italian:
Se non parli inglese chiamaci al MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**. Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua.

Russian:
Если вы не разговариваете по-английски, позвоните нам по номеру MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**. У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке.

Vietnamese:
Nếu bạn không nói được tiếng Anh, hãy gọi cho chúng tôi theo số MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**. Chúng tôi có quyền truy cập vào các dịch vụ thông dịch viên và có thể giúp trả lời các câu hỏi của bạn bằng ngôn ngữ của bạn. Chúng tôi cũng có thể giúp bạn tìm một nhà cung cấp dịch vụ chăm sóc sức khỏe có thể nói chuyện với bạn bằng ngôn ngữ của bạn.

Important contact information

Member Services Help Line — Available 24 hours
MMA Member Services **1-888-716-8787**
LTC Member Services **1-800-791-9233**

Member Services Help Line TTY — Available 24 hours . . . . . TTY **711**

Website . . . . . **myuhc.com/CommunityPlan**

Address . . . . . **3100 SW 145th Avenue**
Miramar, FL 33027

Transportation services: non-emergency
Modivcare MMA **1-866-372-9891**
Modivcare LTC **1-877-931-4751**

iCare **1-877-393-2272**

Dental
Contact your case manager directly or at **1-888-716-8787**
for help with arranging these services.

To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults . . . . . **1-800-96-ABUSE (1-800-962-2873)**
TTY **711** or **1-800-955-8771**
http://www.myflfamilies.com/service-programs/abuse-hotline

For Medicaid eligibility **1-866-762-2237**
TTY **711** or **1-800-955-8771**
http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid

To report Medicaid fraud and/or abuse **1-888-419-3456**
https://apps.ahca.myflorida.com/mpi-complaintform/

To file a complaint about a health care facility **1-888-419-3450**
http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml

To request a Medicaid Fair Hearing **1-877-254-1055**
1-239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

To file a complaint about Medicaid services **1-877-254-1055**
TDD **1-866-467-4970**
http://ahca.myflorida.com/Medicaid/complaints/

To find information for elders . . . . . **1-800-96-ELDER (1-800-963-5337)**
http://www.elderaffairs.org/doea/arc.php

To find out information about domestic violence **1-800-799-7233**
TTY **1-800-787-3224**
http://www.thehotline.org/

To find information about health facilities in Florida . . . . . **http://www.floridahealthfinder.gov/index.html**

To find information about urgent care
MMA . . . . . **1-888-716-8787**, TTY **711**
LTC . . . . . **1-800-791-9233**, TTY **711**

For an emergency **9-1-1**
Or go to the nearest emergency room

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Welcome to UnitedHealthcare's Statewide Medicaid Managed Care Plan

UnitedHealthcare has a contract with the Florida Agency for Health Care Administration (Agency) to provide health care services to people with Medicaid. This is called the **Statewide Medicaid Managed Care (SMMC) Program**. You are enrolled in our SMMC plan. This means we will offer you Medicaid services. We work with a group of health care providers to help meet your needs.

There are many types of Medicaid services you can receive in the SMMC program. You can receive medical services, like doctor visits, labs, and emergency care, from a **Managed Medical Assistance (MMA)** plan. If you are an elder or adult with disabilities, you can receive nursing facility and home and community-based services in a **Long-Term Care (LTC)** plan. If you have a certain health condition, like AIDS, you can receive care that is designed to meet your needs in a **Specialty** plan.

If your child is enrolled in the Florida KidCare **MediKids** program, most of the information in this handbook applies to you. We will let you know if something does not apply.

This handbook will be your guide for all health care services available to you. You can ask us any questions, or get help making appointments. If you need to speak with us, just call us at MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**.

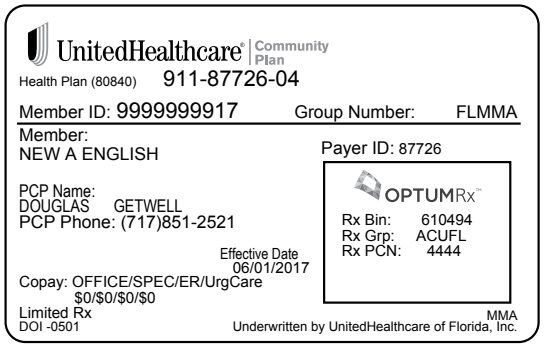
Section 1: Your plan identification card (ID card)

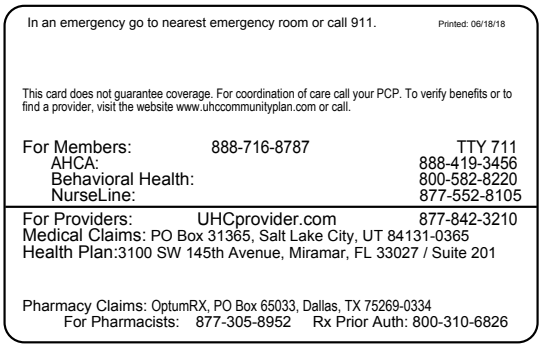
You should have received your ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own ID card.

Always carry your ID card and show it each time you go to a health care appointment or the hospital. Never give your ID card to anyone else to use. If your card is lost or stolen, call us so we can give you a new card.

Your ID card will look like this:

MMA Plan — Your ID card will look like this:





 Questions? Call MMA Member Services at **1-888-716-8787**, TTY **711**, or LTC Member Services at **1-800-791-9233**, TTY **711**.

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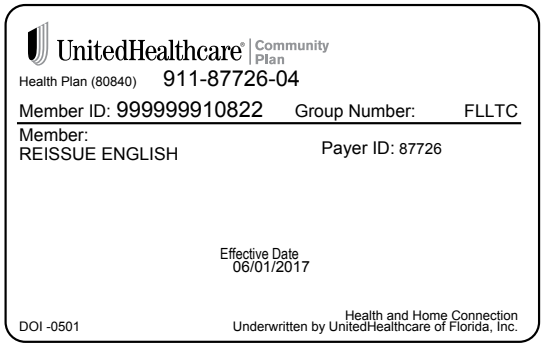
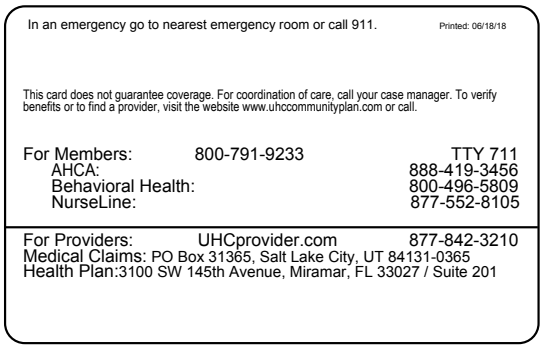
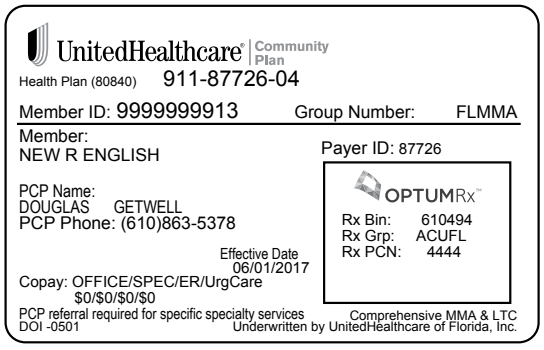
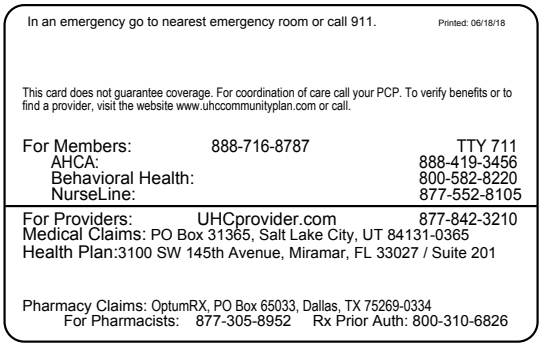
LTC Plan — Your ID card will look like this:


UnitedHealthcare® | Community Plan
Health Plan (80840) 911-87726-04
Member ID: 999999910822 Group Number: FLLTC
Member:
REISSUE ENGLISH
Payer ID: 87726
Effective Date
06/01/2017
DOI -0501
Health and Home Connection
Underwritten by UnitedHealthcare of Florida, Inc.


In an emergency go to nearest emergency room or call 911. Printed: 06/18/18
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
For Providers: UHCprovider.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

MMA and LTC Plan — Your ID card will look like this:


UnitedHealthcare® | Community Plan
Health Plan (80840) 911-87726-04
Member ID: 9999999913 Group Number: FLMMA
Member:
NEW R ENGLISH
Payer ID: 87726
PCP Name:
DOUGLAS GETWELL
PCP Phone: (610)863-5378
OPTUMRx
Rx Bin: 610494
Rx Grp: ACUFL
Rx PCN: 4444
Effective Date
06/01/2017
Copay: OFFICE/SPEC/ER/UrgCare
$0/$0/$0/$0
PCP referral required for specific specialty services
DOI -0501
Comprehensive MMA & LTC
Underwritten by UnitedHealthcare of Florida, Inc.


In an emergency go to nearest emergency room or call 911. Printed: 06/18/18
This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website www.uhccommunityplan.com or call.
For Members: 888-716-8787 TTY 711
AHCA: 888-419-3456
Behavioral Health: 800-582-8220
NurseLine: 877-552-8105
For Providers: UHCprovider.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
Pharmacy Claims: OptumRX, PO Box 65033, Dallas, TX 75269-0334
For Pharmacists: 877-305-8952 Rx Prior Auth: 800-310-6826

Section 2: Your privacy

Your privacy is important to us. You have rights when it comes to protecting your health information, such as your name, Plan identification number, race, ethnicity, and other things that identify you. We will not share any health information about you that is not allowed by law.

If you have any questions, call Member Services. Our privacy policies and protections are:

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, 2022

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 e-mail. 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 collect, use, and share your information

We collect, use and share your HI with:

- You or your legal representative.
- Government agencies.

We have the right to collect, 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 collect, use, and share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may collect, use, and 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 collect, use, and share your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may collect, use and share your HI to send you appointment reminders and information about your health benefits.
- **For Communications to You.** We may use the phone number or email you gave us to contact you about your benefits, healthcare or payments.

We may collect, use, and 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. We will follow stricter laws that apply.
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

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)**.
- **To ask that we correct or amend** your HI. Depending on where you live, you can also ask us to delete your HI. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

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/RTT **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.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; 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.; and UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Financial Information Privacy Notice

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

Effective January 1, 2022

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 health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-633-2446**, or TTY/RTT **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: AmeriChoice Corporation.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; gethealthinsurance.com Agency, Inc. Genoa Healthcare, LLC; Golden Outlook, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Life Print Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, Inc.; OptumHealth Holdings, LLC; Optum Labs, LLC; Optum Networks of New Jersey, Inc.; Optum Women's and Children's Health, LLC; OrthoNet, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Sanvello Health, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, 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. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Section 3: Getting help from our Member Services

Our Member Services Department can answer all of your questions. We can help you choose or change your Primary Care Provider (PCP for short), find out if a service is covered, get referrals, find a provider, replace a lost ID card, report the birth of a new baby, and explain any changes that might affect you or your family's benefits.

Contacting Member Services

You may call us at MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711**; 8:00 a.m.–7:00 p.m., but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. (If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our nurseline at 1-877-552-8105, TTY 711. Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4:
Do you need help communicating?

If you do not speak English

We can help. We have people who help us talk to you in your language. We provide this help for free.

Call MMA Member Services at **1-888-716-8787**, TTY **711**
or LTC Member Services at **1-800-791-9233**, TTY **711**

For people with disabilities

If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a provider's office is wheelchair accessible or has devices for communication. Also, we have services like:

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call **711** and give them our Member Services phone number. It is MMA Member Services at **1-888-716-8787**, TTY **711** or LTC Member Services at **1-800-791-9233**, TTY **711**. They will connect you to us.
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

All of these services are provided free to you.

Section 5: When your information changes

If any of your personal information changes, let us know as soon as possible. You can do so by calling Member Services. We need to be able to reach you about your health care needs.

The Department of Children and Families (DCF) needs to know when your name, address, county, or telephone number changes as well. Call DCF toll free at 1-866-762-2237 (TTY 1-800-955-8771) Monday through Friday from 8:00 a.m. to 5:30 p.m. You can also go online and make the changes in your Automated Community Connection to Economic Self Sufficiency (ACCESS) account at **https://dcf-access.dcf.state.fl.us/access/index.do**.

If you receive Supplemental Security Income (SSI), you must also contact the Social Security Administration (SSA) to report changes. Call SSA toll free at 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 7:00 a.m. to 7:00 p.m. You may also contact your local Social Security office or go online and make changes in your Social Security account at **https://secure.ssa.gov/RIL/SiView.do**.

Section 6: Your Medicaid eligibility

You must be covered by Medicaid and enrolled in our plan for UnitedHealthcare Community Plan to pay for your health care services and health care appointments. This is called having **Medicaid eligibility**. If you receive SSI, you qualify for Medicaid. If you do not receive SSI, you must apply for Medicaid with DCF.

Sometimes things in your life might change, and these changes can affect whether you can still have Medicaid. It is very important to make sure that you have Medicaid before you go to any appointments. Just because you have a Plan ID Card does not mean you still have Medicaid. Do not worry! If you think your Medicaid has changed or if you have any questions about your Medicaid, call Member Services. We can help you check on your coverage.

If you lose your Medicaid eligibility

If you lose your Medicaid and get it back within 180 days, you will be enrolled back into our plan.

If you have Medicare

If you have Medicare, continue to use your Medicare ID card when you need medical services (like going to the doctor or the hospital), but also give the provider your Medicaid Plan ID card too.

If you are having a baby

If you have a baby, he or she will be covered by us on the date of birth. Call Member Services to let us know that your baby has arrived, and we will help make sure your baby is covered and has Medicaid right away.

It is helpful if you let us know you are pregnant **before** your baby is born to make sure your baby has Medicaid. Call DCF toll free at 1-866-762-2237 while you are pregnant. If you need help talking to DCF, call us. DCF will make sure your baby has Medicaid from the day he or she is born. They will give you a Medicaid number for your baby. Let us know the baby's Medicaid number when you get it.

Section 7: Enrollment in our plan

Initial enrollment

When you first join our plan, you have 120 days to try our plan. If you do not like it for any reason, you can enroll in another SMMC plan in the same region. Once those 120 days are over, you are enrolled in our plan for the rest of the year. This is called being **locked-in** to a plan. Every year you have Medicaid and are in the SMMC program, you will have an open enrollment period.

Open enrollment period

Each year, you will have 60 days when you can change your plan if you want. This is called your **open enrollment period**. Your open enrollment period is based upon where you live in Florida. The State's Enrollment Broker will send you a letter to tell you when your open enrollment period is.

You do not have to change plans during your open enrollment period. If you do choose to leave our plan and enroll in a new one, you will start with your new plan at the end of your open enrollment period. Once you are enrolled in the new plan, you are locked-in until your next open enrollment period. You can call the Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

Enrollment in the SMMC Long-Term Care program

The SMMC Long-Term Care (LTC) program provides nursing facility services and home and community-based care to elders and adults (ages 18 years and older) with disabilities. Home and community-based services help people stay in their homes, with services like help with bathing, dressing, and eating; help with chores; help with shopping; or supervision.

We pay for services that are provided at the nursing facility. If you live in a Medicaid nursing facility full-time, you are probably already in the LTC program. If you don't know, or don't think you are enrolled in the LTC program, call Member Services. We can help you.

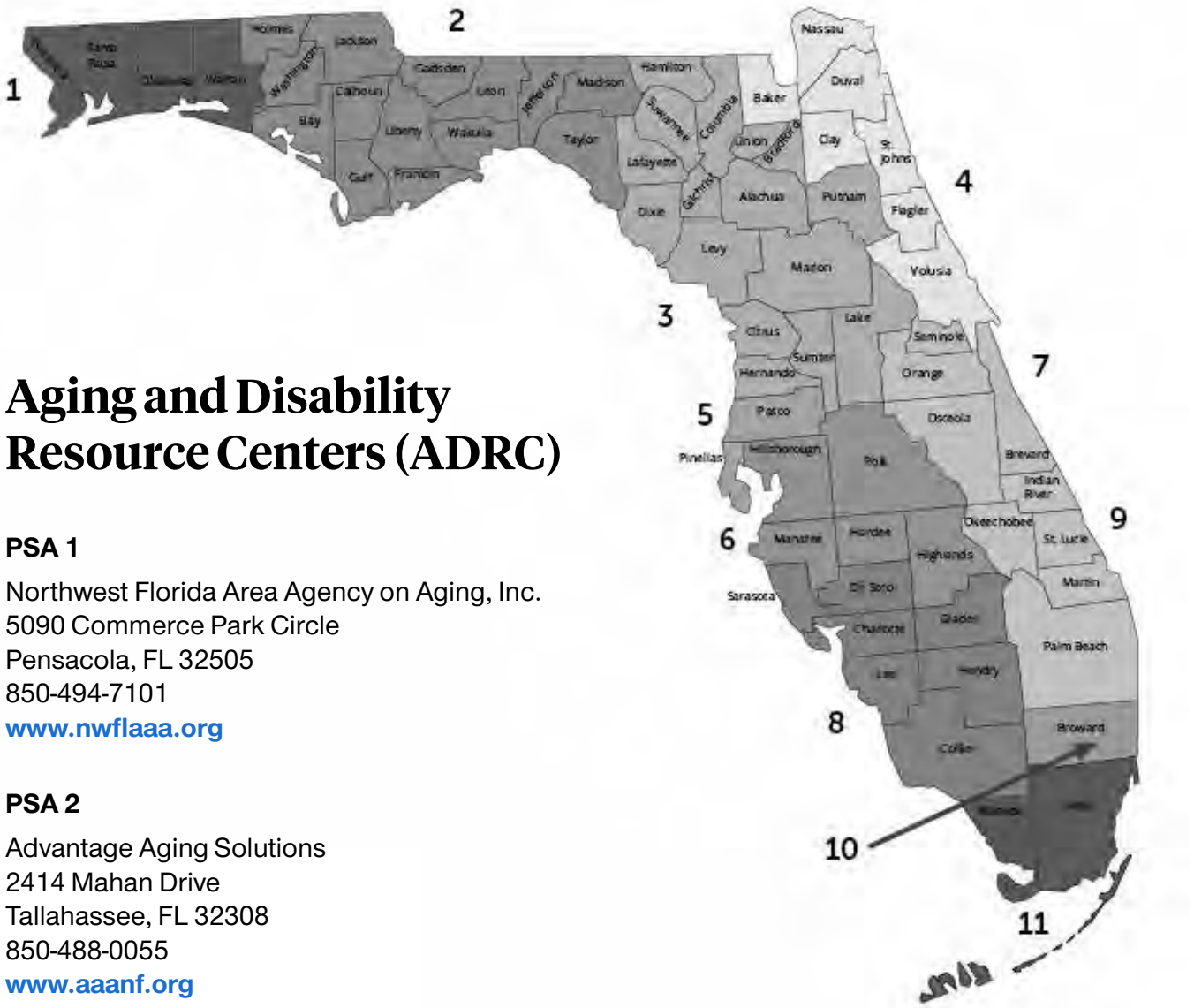
The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you have to speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs' Aging and Disability Resource Centers (ADRCs) complete these screenings. Once the screening is complete, the ADRC will notify you about your wait list placement or provide you with a list of resources if you are not placed on the wait list. If you are placed on the wait list and a space becomes available for you in the LTC program, the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet requirements for the program each year.

Some enrollees do not have to complete the screening or wait list process if they meet all other LTC program eligibility requirements. For more information on Screening Exceptions in the LTC Program, visit the Agency's web page at **https://ahca.myflorida.com/Medicaid/statewide_mc/ltc_scrn.shtml**. For example:

1. Are you 18, 19, or 20 years old?
2. Do you have a chronic debilitating disease or condition of one or more physiological or organ systems?
3. Do you need 24-hour-per-day medical, nursing, or health supervision or intervention?

If you said "yes" to all three questions, you may contact UnitedHealthcare Community Plan to request an assessment for the LTC program.

You can find the phone number for your local ADRC using the following map. They can also help answer any other questions that you have about the LTC program. Visit **https://ahca.myflorida.com/Medicaid/statewide_mc/smmc_ltc.shtml** for more information.



Aging and Disability Resource Centers (ADRC)

PSA 1

Northwest Florida Area Agency on Aging, Inc.
5090 Commerce Park Circle
Pensacola, FL 32505
850-494-7101
www.nwflaaa.org

PSA 2

Advantage Aging Solutions
2414 Mahan Drive
Tallahassee, FL 32308
850-488-0055
www.aaanf.org

PSA 3

Elder Options
100 SW 75th Street, Suite 301
Gainesville, FL 32607
352-378-6649
www.agingresources.org

PSA 4

Elder Source,
The Area Agency on Aging of Northeast Florida
10688 Old St. Augustine Road
Jacksonville, FL 32257
904-391-6600
www.myeldersource.org

PSA 5

Area Agency on Aging of Pasco-Pinellas, Inc.
9549 Koger Boulevard
Gadsden Building, Suite 100
St. Petersburg, FL 33702
727-570-9696
www.agingcarefl.org

PSA 6

Senior Connection Center, Inc
8928 Brittany Way
Tampa, FL 33619
813-740-3888
www.seniorconnectioncenter.org

PSA 7

Senior Resource Alliance
3319 Maguire Boulevard, Suite 100
Orlando, FL 32803
407-514-1832
www.seniorresourcealliance.org

PSA 8

Area Agency on Aging
for Southwest Florida, Inc.
2830 Winkler Avenue, Suite 112
Fort Myers, FL 33916
239-652-6900
www.aaaswfl.org

PSA 9

Area Agency on Aging
of Palm Beach/Treasure Coast, Inc.
4400 N Congress Avenue
West Palm Beach, FL 33407
561-684-5885
www.youragingresourcecenter.org

PSA 10

Aging and Disability Resource Center
of Broward County, Inc.
5300 Hiatus Road
Sunrise, FL 33351
954-745-9567
www.adrcbroward.org

PSA 11

Alliance for Aging, Inc.
760 NW 107th Avenue, Suite 214, 2nd Floor
Miami, FL 33172
305-670-6500
www.allianceforaging.org

Section 8: Leaving our plan (disenrollment)

Leaving a plan is called **disenrolling**. By law, people cannot leave or change plans while they are locked-in except for specific reasons. If you want to leave our plan while you are locked-in, call the State's Enrollment Broker to see if you would be allowed to change plans.

You can leave our plan at any time for the following reasons (also known as **For Cause Disenrollment** reasons[1]):

- We do not cover a service for moral or religious reasons
- You live in and get your Long-Term Care services from an assisted living facility, adult family care home, or nursing facility provider that was in our network but is no longer in our network

You can also leave our plan for the following reasons, if you have completed our grievance and appeal process[2]:

- You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records
- You cannot get the services you need through our plan, but you can get the services you need through another plan
- Your services were delayed without a good reason

If you have any questions about whether you can change plans, call:

MMA Member Services at **1-888-716-8787**, TTY **711**,
or LTC Member Services at **1-800-791-9233**, TTY **711**,
or the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

[1] For the full list of For Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600: **https://www.flrules.org/gateway/RuleNo.asp?title=MANAGEDCARE&ID=59G-8.600**

[2] To learn how to ask for an appeal, please turn to Section 15, Member Satisfaction, on page 77.

Removal from our plan (involuntary disenrollment)

The Agency can remove you from our plan (and sometimes the SMMC program entirely) for certain reasons. This is called **involuntary disenrollment**. These reasons include:

- You lose your Medicaid
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions
- You or your caregivers behave in a way that makes it hard for us to provide you with care
- You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like[3]

If the Agency removes you from our plan because you broke the law or for your behavior, you cannot come back to the SMMC program.

[3] This is for Long-Term Care program enrollees only. If you have questions about you facility's compliance with this federal requirement, please call Member Services or your case manager.

Section 9: Managing your care

If you have a medical condition or illness that requires extra support and coordination, we may assign a case manager to work with you. Your case manager will help you get the services you need. The case manager will work with your other providers to manage your health care. If we provide you with a case manager and you do not want one, call Member Services to let us know.

If you are in the LTC program, we will assign you a case manager. You must have a case manager if you are in the LTC program. Your case manager is your go-to person and is responsible for **coordinating your care**. This means they are the person who will help you figure out what LTC services you need and how to get them.

If you have a problem with your care, or something in your life changes, let your case manager know and they will help you decide if your services need to change to better support you.

Changing case managers

If you want to choose a different case manager, call Member Services. There may be times when we will have to change your case manager. If we need to do this, we will send a letter to let you know and we may give you a call.

Important things to tell your case manager

If something changes in your life or you don't like a service or provider, let your case manager know. You should tell your case manager if:

- You don't like a service
- You have concerns about a service provider
- Your services aren't right
- You get new health insurance
- You go to the hospital or emergency room
- Your caregiver can't help you anymore
- Your living situation changes
- Your name, telephone number, address, or county changes

Request to put your services on hold

If something changes in your life and you need to stop your service(s) for a while, let your case manager know. Your case manager will ask you to fill out and sign a Consent for Voluntary Suspension Form to put your service(s) on hold.

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 evidence from medical studies to help decide whether UnitedHealthcare Community Plan should approve new equipment, procedures, or drugs.

Utilization management services

UnitedHealthcare conducts utilization management services to make sure you get the right care at the right time in the right setting. To learn more about utilization management, call 1**-888-716-8787**, TTY **711**, 8:00 a.m.–5:00 p.m., Monday–Friday with questions. We will explain how UM works and what it means for your care. Voicemail is available 24 hours a day, 7 days a week. Additional language assistance is available, and we can get you the materials in a language or format that is easy for you to understand.

Utilization management programs

UnitedHealthcare Community Plan wants you to get care that's right for you, without getting care you don't need. We help make sure you get the right care by making decisions based on medical need, appropriateness, and whether it is a covered benefit. To make sure decisions are fair, we do not reward the staff who make these decisions for saying no. If you have questions about how these decisions are made, call **1-888-716-8787**, TTY **711**, 8:00 a.m.–5:00 p.m., Monday–Friday.

Utilization review policy and procedures

UnitedHealthcare Community Plan has policies and steps we follow in decision making about approving medical services. We want to make sure that the health care services provided are medically necessary, right for your condition and are provided in the best care facility. We make sure that quality care is delivered. The criteria used in our decision-making are available to you and your doctor if you ask for it.

Our employees or providers are not rewarded in any way for not giving you the care or services you need or for saying that you should not get them.

There are also some treatments and procedures we need to review before you can get them. Your providers know what they are, and they take care of letting us know to review them. The review we do is a called a Utilization Review. We do not reward anyone for saying no to needed care. If you have questions about Utilization Management, you can talk to our staff. Our staff is available 8:00 a.m.–5:00 p.m., Monday–Friday at **1-888-716-8787**, TTY **711**. Language assistance is available.

Section 10: Accessing services

Before you get a service or go to a health care appointment, we have to make sure you need the service and that it is medically right for you. This is called **prior authorization**. To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

Providers in our plan

For the most part, you must use doctors, hospitals, and other health care providers that are in our **provider network**. Our provider network is the group of doctors, therapists, hospitals, facilities, and other health care providers that we work with. You can choose from any provider in our provider network. This is called your **freedom of choice**. If you use a health care provider that is not in our network, you may have to pay for that appointment or service.

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call MMA Member Services at **1-888-716-8787**, TTY **711**; and LTC Member Services at **1-800-791-9233**, TTY **711** to get a copy or visit our website at **myuhc.com/CommunityPlan**.

You can learn information about network doctors, at **myuhc.com/CommunityPlan**, or by calling Member Services. We can tell you the following information:

1. Name, address, phone number
2. Professional qualifications
3. Specialty
4. Board certifications
5. Languages spoken by the provider
6. Information about medical school attended and residency program
7. Board certification status

If you are in the LTC program, your case manager is the person who will help you choose a service provider who is in our network for each of your services. Once you choose a service provider, they will contact them to begin your services. This is how services are **approved** in the LTC program. Your case manager will work with you, your family, your caregivers, your doctors and other providers to make sure that your LTC services work with your medical care and other parts of your life.

Providers not in our plan

There are some services that you may be able to get from providers who are not in our provider network. These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

When we pay for your dental services

Your dental plan will cover most of your dental services, but some services may be covered by UnitedHealthcare Community Plan. The table below will help you understand which plan pays for a service.

Type of dental service(s)	Dental plan covers	Medical plan covers
Dental Services	Covered when you see your dentist or dental hygienist.	Covered when you see your doctor or nurse.
Scheduled dental services in a hospital or surgery center	Covered for dental services by your dentist.	Covered for doctors, nurses, hospitals, and surgery centers.
Hospital visit for a dental problem	Not covered.	Covered.

Type of dental service(s)	Dental plan covers	Medical plan covers
Prescription drugs for a dental visit or problem	Not covered.	Covered.
Transportation to your dental service or appointment	Not covered.	Covered.

Call MMA Member Services at **1-888-716-8787**, TTY **711** or LTC Member Services at **1-800-791-9233**, TTY **711** for help with arranging these services.

What do I have to pay for?

You may have to pay for appointments or services that are not covered. A covered service is a service we must provide in the Medicaid program. All the services listed in this handbook are covered services. Medicaid members do not have copays. Remember, just because a service is covered, does not mean you will need it. You may have to pay for services if we did not approve it first.

If you get a bill from a provider, call Member Services. Do not pay the bill until you have spoken to us. We will help you.

Services for children[4]

We must provide all medically necessary services for our members who are ages 0–20 years old. This is the law. This is true even if we do not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

- No dollar limits, or
- No time limits, like hourly or daily limits.

Your provider may need to ask us for approval before giving your child the service. Call Member Services if you want to know how to ask for these services.

[4] Also known as "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" requirements.

Services covered by the Medicaid fee-for-service delivery system, not covered through UnitedHealthcare Community Plan

The Medicaid fee-for-service program is responsible for covering the following services, instead of UnitedHealthcare Community Plan covering these services:

- Behavior Analysis (BA)
- County Health Department (CHD) Certified Match Program
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver
- Familial Dysautonomia (FD) Home and Community-Based Services Waiver
- Hemophilia Factor-related Drugs
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID)
- Medicaid Certified School Match (MCSM) Program
- Model Home and Community-Based Services Waiver
- Newborn Hearing Services
- Prescribed Pediatric Extended Care
- Substance Abuse County Match Program

This Agency web page provides details about each of the services listed above and how to access these services: **http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/Covered_Services_HCBS_Waivers.shtml**.

Moral or religious objections

If we do not cover a service because of a religious or moral reason, we will tell you that the service is not covered. In these cases, you must call the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970). The Enrollment Broker will help you find a provider for these services.

Section 11: Helpful information about your benefits

Choosing a Primary Care Provider (PCP)

If you have Medicare, please contact the number on your Medicare ID card for information about your PCP.

One of the first things you will need to do when you enroll in our plan is choose a PCP. This can be a doctor, nurse practitioner, or a physician assistant. You will contact your PCP to make an appointment for services such as regular check-ups, shots (immunizations), or when you are sick. Your PCP will also help you get care from other providers or specialists. This is called a **referral**. You can choose your PCP by calling Member Services.

You can choose a different PCP for each family member or you can choose one PCP for the entire family. If you do not choose a PCP, we will assign a PCP for you and your family. You can change your PCP at any time. To change your PCP, call Member Services.

Choosing a PCP for your child

You can pick a PCP for your baby before your baby is born. We can help you with this by calling Member Services. If you do not pick a PCP by the time your baby is born, we will pick one for you. If you want to change your baby's PCP, call us.

It is important that you select a PCP for your child to make sure they get their well child visits each year. Well child visits are for children 0–20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy.[5] You can take your child to a pediatrician, family practice provider, or other health care provider.

You do not need a referral for well child visits. Also, there is no charge for well child visits.

Specialist care and referrals

Sometimes, you may need to see a provider other than your PCP for medical problems like special conditions, injuries, or illnesses. Talk to your PCP first. Your PCP will refer you to a **specialist**. A specialist is a provider who works in one health care area.

If you have a case manager, make sure you tell your case manager about your **referrals**. The case manager will work with the specialist to get you care.

Second opinions

You have the right to get a **second opinion** about your care. This means talking to a different provider to see what they have to say about your care. The second provider will give you their point of view. This may help you decide if certain services or treatments are best for you. There is no cost to you to get a second opinion.

Your PCP, case manager or Member Services can help find a provider to give you a second opinion. You can pick any of our providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before you see them.

[5] For more information about the screenings and assessments that are recommended for children, please refer to the "Recommendations for Preventative Pediatric Health Care — Periodicity Schedule" at **Periodicity Schedule** (aap.org).

Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. Your health or life are not usually in danger, but you cannot wait to see your PCP or it is after your PCP's office has closed.

If you need Urgent Care after office hours and you cannot reach your PCP, please go to the nearest emergency room.

You may also find the closest Urgent Care center to you by calling MMA Member Services at **1-888-716-8787**, TTY **711**; LTC Member Services at **1-800-791-9233**, TTY **711**; or going online to **myuhc.com/CommunityPlan**.

Hospital care

If you need to go to the hospital for an appointment, surgery or overnight stay, your PCP will set it up. We must approve services in the hospital before you go, except for emergencies. We will not pay for hospital services unless we approve them ahead of time or it is an emergency.

If you have a case manager, they will work with you and your provider to put services in place when you go home from the hospital.

Emergency care

You have a medical **emergency** when you are so sick or hurt that your life or health is in danger if you do not get medical help right away. Some examples are:

- Broken bones
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Trouble breathing
- Suddenly unable to see, move, or talk

Emergency services are those services that you get when you are very ill or injured. These services try to keep you alive or to keep you from getting worse. They are usually delivered in an emergency room.

If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do.

The hospital or facility does not need to be part of our provider network or in our service area. You also do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call Member Services when you are able and let us know.

Teledoc®

If you have a non-emergency problem, skip the wait of the ER and urgent care and chat with a doctor in minutes. Teledoc® connects you to a doctor wherever you are, like at home, at work or out and about. And there's no cost to you.

Getting started is easy

Visit **Teladoc.com**, download the Teladoc app or call 1-800-Teladoc (835-2362) to speak to a doctor anytime for free.

Filling prescriptions

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Preferred Drug List**. You can find this list on our website at **myuhc.com/CommunityPlan** or by calling Member Services.

We cover **brand name** and **generic** drugs. Generic drugs have the same ingredients as brand name drugs, but they are often cheaper than brand name drugs. They work the same. Sometimes, we may need to approve using a brand name drug before your prescription is filled.

We have pharmacies in our provider network. You can fill your prescription at any pharmacy that is in our provider network. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time, but we will let you know if anything changes.

Some medications on the Preferred Drug List need prior authorization. This means they must be approved before you can get them. When a drug needs prior authorization, your doctor must contact our Pharmacy Department. They will review the doctor's request. The decision may take up to 24 hours once all medically necessary information is provided. You and your doctor will be informed of the outcome. There are no copays for prescription medications for Medicaid members.

Specialty pharmacy information

In some cases you may be prescribed a medication not carried by most standard pharmacies, which can only be filled at a Specialty Pharmacy.

If this occurs, UnitedHealthcare may assign you to a network specialty pharmacy to assist with having the prescription filled in your area. If you are assigned to a specialty pharmacy, you will receive a letter providing the name and location.

If you prefer another specialty pharmacy, you do have 30 days to request a change by calling MMA Member Services at **1-888-716-8787**, TTY **711**; LTC Member Services at **1-800-791-9233**, TTY **711**; or going online to **myuhc.com/CommunityPlan**. After 30 days, your request will need to be in writing to:

UnitedHealthcare Community Plan
3100 SW 145th Avenue
Miramar, FL 33027

Behavioral health services

There are times when you may need to speak to a therapist or counselor, for example, if you are having any of the following feelings or problems:

- Always feeling sad
- Not wanting to do the things that you used to enjoy
- Feeling worthless
- Having trouble sleeping
- Not feeling like eating
- Alcohol or drug abuse
- Trouble in your marriage
- Parenting concerns

We cover many different types of behavioral health services that can help with issues you may be facing. You can call a behavioral health provider for an appointment. You can get help finding a behavioral health provider by:

- Calling MMA Member Services at **1-888-716-8787**, TTY **711**;
  LTC Member Services at **1-800-791-9233**, TTY **711**
- Going to our website **myuhc.com/CommunityPlan**

Someone is there to help you 24 hours a day, 7 days a week.

You do not need a referral from your PCP for behavioral health services.

If you are thinking about hurting yourself or someone else, call 911. You can also go to the nearest emergency room or crisis stabilization center, even if it is out of our service area. Once you are in a safe place, call your PCP if you can. Follow up with your provider within 24–48 hours. If you get emergency care outside of the service area, we will make plans to transfer you to a hospital or provider that is in our plan's network once you are stable.

Member reward programs

We offer programs to help keep you healthy and to help you live a healthier life (like losing weight or quitting smoking). We call these **healthy behavior programs**. You can earn rewards while participating in these programs. Our plan offers the following programs:

Substance abuse incentive program — You will work with your doctor to set and complete goals. You can join the program in different ways. You can call your doctor to join, talk to your case manager, or do an online health assessment. You can also choose to have a different behavioral health case manager. You can earn rewards each time you complete a goal stage. To get the reward, your doctor needs to sign a form when the goal is complete.

Stop smoking — Do you smoke? If so, do you want to try and quit? We have a smoking cessation program that is available at no cost.

Health coaching for weight loss — This program will help you set goals to live healthier. You will work with a coach over the phone. You will also get mailings with tips for living healthy. You can call your doctor to join or do an online health assessment.

Baby Blocks — This is a web-based program. You will get text messages and emails. You can sign up for reminders for your doctor visits while you are pregnant. Once your baby is born, you will get tips on when to bring your baby in for checkups. You can get rewards for making all your doctor visits. You can also get rewards for going to all your baby's checkups until he or she is 15 months old.

If you choose to disenroll from UnitedHealthcare Community Plan, you will lose any program rewards. If you lose Medicaid eligibility for more than 180 calendar days and you are not automatically reinstated, you will lose any earned program rewards. Please remember that rewards cannot be transferred. If you leave our Plan for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call MMA Member Services at **1-888-716-8787**, TTY **711**; LTC Member Services at **1-800-791-9233**, TTY **711**; or go online to **myuhc.com/CommunityPlan**.

Disease management programs

We have special programs available that will help you if you have one of these conditions.

- Cancer
- Diabetes
- Asthma
- High blood pressure (hypertension)
- Behavioral health

End of life issues including information on Advance Directives

The patient's right to decide

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

You have a right to 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, D.C. 20049
1-888-687-2277

If you are in the LTC program, we also offer programs for Dementia and Alzheimer's issues.

Quality enhancement programs

We want you to get quality health care. We offer additional programs that help make the care you receive better. The programs 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. You also have a right to tell us about changes you think we should make.

To get more information about our quality enhancement program or to give us your ideas, call **1-888-716-8787**, TTY **711**; LTC Member Services at **1-800-791-9233**, TTY **711**; or go online to **myuhc.com/CommunityPlan**.

Section 12: Your plan benefits – Managed medical assistance services

The table below lists the medical services that are covered by our Plan. Remember, you may need a referral from your PCP or approval from us before you go to an appointment or use a service. Services must be medically necessary for us to pay for them.[6]

There may be some services we do not cover but might still be covered by Medicaid. To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call 1-866-372-9892 (TTY 1-844-488-9724) to schedule a ride.

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the date the change takes place.

If you have questions about any of the covered medical services, please call Member Services.

Service	Description	Coverage/Limitations	Prior authorization
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction.	As medically necessary and recommended by us.	Yes

[6] You can find the definition for Medical Necessity at **http://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf**.

Service	Description	Coverage/Limitations	Prior authorization
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness.	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots.	No
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities.	Covered as medically necessary.	No
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol.	As medically necessary and recommended by us.	Yes
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient).	Covered as medically necessary.	Prior authorization may be required.
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures.	Covered as medically necessary.	No

Service	Description	Coverage/Limitations	Prior authorization
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication.	We cover 365/366 days of services per year, as medically necessary.	Prior authorization may be required.
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders.	We cover, as medically necessary: • One initial assessment per year • One reassessment per year • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day) See Expanded Benefits section below for additional information.	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0–18) enrolled in a DCF program.	We cover 365/366 days of medically necessary services per year, including therapy, support services and aftercare planning.	Yes
Behavioral Health Services – Child Welfare	A special mental health program for children enrolled in a DCF program.	As medically necessary and recommended by us.	No
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system.	We cover the following as prescribed by your doctor, when medically necessary: • Cardiac testing • Cardiac surgical procedures • Cardiac devices	Yes

Service	Description	Coverage/Limitations	Prior authorization
Child Health Services Targeted Case Management	Services provided to children (ages 0–3) to help them get health care and other services. Or Services provided to children (ages 0–20) who use medical foster care services.	Your child must be enrolled in the DOH Early Steps program. Or Your child must be receiving medical foster care services.	No
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs.	We cover, as medically necessary: • 24 patient visits per year, per member • X-rays	Yes
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic.	Visits to a federally qualified health center or rural health clinic visit, medically necessary.	No

Service	Description	Coverage/Limitations	Prior authorization
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital.	As medically necessary and recommended by us.	No
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys.	We cover the following as prescribed by your treating doctor, when medically necessary: • Hemodialysis treatments • Peritoneal dialysis treatments	No
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing.	As medically necessary and recommended by us.	No

Service	Description	Coverage/Limitations	Prior authorization
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away.	As medically necessary, some service and age limits apply. Call Member Services at **1-888-716-8787** for more information.	Prior authorization required only in outpatient settings, to include patient's home and must be more than $500.
Early Intervention Services	Services to children ages 0–3 who have developmental delays and other conditions.	We cover medically necessary: • One initial evaluation per lifetime, completed by a team • Up to 3 screenings per year • Up to 3 follow-up evaluations per year • Up to 2 training or support sessions per week	Prior authorization may be required.
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency.	Covered as medically necessary.	No

Service	Description	Coverage/Limitations	Prior authorization
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness.	We cover medically necessary: • One adult health screening (check-up) per year • Well child visits are provided based on age and developmental needs • One visit per month for people living in nursing facilities • Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional.	We cover medically necessary: • Up to 26 hours per year	No
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system.	We cover: • Covered as medically necessary	Yes
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system.	We cover: • Covered as medically necessary	Prior authorization may be required.

Service	Description	Coverage/Limitations	Prior authorization
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional.	We cover medically necessary: • Up to 39 hours per year See Expanded Benefits section below for additional information.	No
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs.	We cover hearing tests and the following as prescribed by your doctor, when medically necessary: • Cochlear implants • One new hearing aid per ear, once every 3 years • Repairs	Yes
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury.	We cover, when medically necessary: • Up to 4 visits per day for pregnant recipients and recipients ages 0–20 • Up to 3 visits per day for all other recipients	Prior authorization may be required.

Service	Description	Coverage/Limitations	Prior authorization
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	Covered as medically necessary. Copayment: See information on Patient Responsibility for copayment information; you may have Patient Responsibility for hospice services whether living at home, in a facility, or in a nursing facility.	No
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional.	We cover medically necessary: • Up to 26 hours per year See Expanded Benefits section below for additional information.	No
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	We cover the following inpatient hospital services based on age and situation, when medically necessary: • Up to 365/366 days for recipients ages 0–20 • Up to 45 days for all other recipients (extra days are covered for emergencies)	Admission requires prior authorization.
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases.	Covered as medically necessary.	Prior authorization may be required.

Service	Description	Coverage/Limitations	Prior authorization
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases.	Covered as medically necessary.	Prior authorization may be required.
Medical Foster Care Services	Services that help children with health problems who live in foster care homes.	Must be in the custody of the Department of Children and Families.	No
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction.	Covered as medically necessary.	No
Medication Management Services	Services to help people understand and make the best choices for taking medication.	Covered as medically necessary.	No
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses.	Covered as medically necessary.	No
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system.	Covered as medically necessary.	Prior authorization may be required.

Service	Description	Coverage/Limitations	Prior authorization
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	We cover the following services for recipients who have no transportation: • Out-of-state travel • Transfers between hospitals or facilities • Escorts when medically necessary	No
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term.	We cover 365/366 days of services in nursing facilities as medically necessary. Copayment: See information on Patient Responsibility for room and board copayment information.	Admission requires prior authorization.
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house.	We cover for children ages 0–20 and for adults under the $1,500 outpatient services cap, as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: • Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes

Service	Description	Coverage/Limitations	Prior authorization
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity.	Covered as medically necessary.	Prior authorization may be required.
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints.	Covered as medically necessary.	Prior authorization may be required.
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	Emergency services are covered as medically necessary. Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over.	Yes
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided.	Covered as medically necessary. Some service limits may apply.	Yes

Service	Description	Coverage/Limitations	Prior authorization
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition.	We cover for children ages 0–20 and for adults under the $1,500 outpatient services cap, as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: • Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes
Podiatry Services	Medical care and other treatments for the feet.	We cover, as medically necessary: • Up to 24 office visits per year • Foot and nail care • X-rays and other imaging for the foot, ankle and lower leg • Surgery on the foot, ankle or lower leg	No
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider.	We cover, as medically necessary: • Up to a 34-day supply of drugs, per prescription • Refills, as prescribed	Prior authorization may be required.

Service	Description	Coverage/Limitations	Prior authorization
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care.	We cover, as medically necessary: • Up to 24 hours per day	Yes
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital.	As medically necessary and recommended by us.	Yes
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas.	We cover, as medically necessary: • 10 hours of psychological testing per year See Expanded Benefits section below for additional information.	Prior authorization may be required.
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores.	We cover, as medically necessary: • Up to 480 hours per year	No
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays.	Covered as medically necessary.	Yes

Service	Description	Coverage/Limitations	Prior authorization
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions.	Covered as medically necessary.	Admission requires authorization.
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family.	We cover medically necessary family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	No
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system.	We cover medically necessary: • Respiratory testing • Respiratory surgical procedures • Respiratory device management	Prior authorization may be required.
Respiratory Therapy Services	Services for recipients ages 0–20 to help you breathe better while being treated for a respiratory condition, illness or disease.	We cover medically necessary: • One initial evaluation per year • One therapy re-evaluation per 6 months • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	Prior authorization may be required.

Service	Description	Coverage/Limitations	Prior authorization
Specialized Therapeutic Services	Services provided to children ages 0–20 with mental illnesses or substance use disorders.	We cover the following medically necessary: • Assessments • Foster care services • Group home services	Yes
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better.	We cover the following medically necessary services for children ages 0–20: • Communication devices and services • Up to 210 minutes of treatment per week • One initial evaluation per year We cover the following medically necessary services for adults: • One communication evaluation per 5 years	Yes
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital.	Covered as medically necessary for children ages 0–20.	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0–20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility.	We cover medically necessary services: • Up to 9 hours per month See Expanded Benefits section below for additional information.	No

Service	Description	Coverage/Limitations	Prior authorization
Transplant Services	Services that include all surgery and pre and post-surgical care.	Covered as medically necessary.	Yes
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes.	We cover the following medically necessary services when prescribed by your doctor: • Two pairs of eyeglasses for children ages 0–20 • One frame every two years and two lenses every 365 days for adults ages 21 and older • Contact lenses • Prosthetic eyes	No
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes.	Covered as medically necessary.	No

Your plan benefits – Expanded benefits

Expanded benefits are extra goods or services we provide to you, free of charge. Call Member Services to ask about getting expanded benefits.

Service	Description	Coverage/Limitations	Prior authorization
Acupuncture	A non-traditional pain management alternative.	Unlimited visits for members age 21 and older.	Yes
Behavioral Health Services	Mental health.	You may receive the below services to help you with different behavioral health needs: • Assessment services • Behavioral health day services/day treatment • Behavioral health screening services • Behavioral health medical services (verbal interaction) • Behavioral health medical services (medication management) • Behavioral health medical services (drug screening) • Medication assisted treatment • Psychosocial rehabilitation • Substance abuse treatment or detoxification services (outpatient) • Therapy (individual/family) • Therapy (group) • Therapeutic behavioral on-site services • Targeted case management	

Service	Description	Coverage/Limitations	Prior authorization
Cellular Phone Service	A cellular phone is provided to those who qualify to assist with day to day tasks.	1 cellphone, 350 minutes, unlimited text messages, 1 GB of data.	Yes
Chiropractic	A non-traditional pain management alternative involving spine manipulation.	Unlimited visits for members age 21 and older.	Yes
Cognitive Behavioral Analysis	A computer application that offers clinical solutions to help dial down the symptoms of stress, anxiety and depression	Health and behavior assessment, reassessment. Intervention — individual, group, family (with or without patient present). Unlimited.	No
Doula Services	Home visits for prenatal and postnatal monitoring, assessment, and follow-up care; and newborn care and assessment. Prenatal includes fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring.	Unlimited visits for members up to age 20 years.	Yes

Service	Description	Coverage/Limitations	Prior authorization
Durable Medical Equipment	Hospital grade breast pump.	One (1) hospital grade breast pump. One (1) per pregnancy for female members who have recently given birth and meet medical necessity criteria.	No
Hearing Services	Services to help you hear.	You are covered for medically necessary hearing screenings and diagnostic testing. For members age 21 and older, the plan covers: • 1 hearing aid assessment, fitting, checking, and evaluation every 2 years • 1 in ear monaural hearing aid per ear each year • 1 hearing aid, all other types, per ear every 2 years	No
Home Delivered Meals – Post-Facility Discharge (Hospital or Nursing Facility)	This service delivers healthy meals to your home.	Maximum of 3 meals per year, no more than one unit per day.	Yes
Home Delivered Meals – Disaster Preparedness/ Relief	This service delivers healthy meals to your home.	One (1) meal annually; cannot be combined with Medical Nutrition Therapy.	Yes

Service	Description	Coverage/Limitations	Prior authorization
Home Health Nursing/Aide Services	Care in the home provided by a home health aide, certified nurse assistant, registered nurse, or licensed practical nurse.	1 extra visit per day for members 21 years and older on top of visits provided under the Managed Medical Assistance Services listed above.	Yes
Housing Assistance	Support with obtaining housing.	Supported housing, per month; increase to one thousand dollars ($1,000.00) per eligible enrollee per lifetime. Prior authorization required. Available for MMA and Long-Term Care enrollees.	Yes
Massage Therapy	Massage therapy to enhance health and well-being.	Unlimited visits for members age 21 and older.	Yes
Meals – Non-Emergency Transportation Day-Trips	Meals for a member and their caregiver provided for medically-necessary doctor visits over 100 miles each way.	$30 per day.	Yes
Medically Related Home Care Services/ Homemaker	Homemaker services.	2 carpet cleanings per year for individuals diagnosed with asthma.	Yes
Newborn Circumcision	Newborn circumcision.	Your male baby is covered up to 28 days old.	No

Service	Description	Coverage/Limitations	Prior authorization
Nutritional Counseling	Visits with a dietician to help with a nutrition plan and healthy eating habits.	Up to 3 visits per year, no more than one visit per day.	Yes
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house.	You are covered for: • 1 evaluation/re-evaluation per year, and • Up to 7 therapy units per week, for occupational, physical, and speech services. • Max 4 units per day	Yes
Outpatient Hospital Services	Outpatient services or medical care you get at the hospital without staying overnight.	Waived $1,500 limit on outpatient hospital services. No limits on PET scan, pharmacy services, professional, physical therapy, occupational therapy, radiology services, routine dental services, sleep studies, speech therapy, sterilization services, supplies — medical/surgical, therapeutic radiology, therapeutic, transplant, treatment/OBS room services, and Urgent Care services.	Yes
Over-the-Counter	Allowance to purchase over the counter products.	Up to $25 per household per month.	No

Service	Description	Coverage/Limitations	Prior authorization
Prenatal Services	Care before and after pregnancy.	The plan covers: • 1 hospital grade breast pump per year, rental only • 1 regular breast pump per 2 years, rental only • Prenatal visits, 14 visits for low risk pregnancies, 18 visits for high-risk pregnancies • Postpartum care, 3 visits within 90 days following delivery	No
Primary Care Services	Primary care provider visits.	Unlimited primary care provider visits.	No
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition.	You are covered for: • 1 evaluation/re-evaluation per year, and • Up to 7 therapy units per week, for occupational, physical, and speech services. • Max 4 units per day	Yes
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better.	You are covered for: • 1 evaluation/re-evaluation per year, and • Up to 7 therapy units per week, for occupational, physical, and speech services. • Up to 1 unit per day for respiratory therapy services	No

Service	Description	Coverage/Limitations	Prior authorization
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow.	You are covered for: • 1 evaluation/re-evaluation per year, and • Up to 7 therapy units per week, for occupational, physical, and speech services. • Max 4 units per day	Yes
Swimming Lessons (Drowning Prevention)	Help with swimming for children.	Available to Children in MMA, ages 2-12 years of age; $200 per enrollee, Max. 1,000 enrollees per contract period.	Yes
Vaccine – TDaP	A vaccine to prevent tetanus, diphtheria, and pertussis.	For members age 21 and older, administered as medically advised.	No
Vaccine – Influenza	A vaccine to prevent the flu.	For members age 21 and older, administered as medically advised.	No
Vaccine – Shingles	A vaccine to prevent shingles.	For members age 21 and older, administered as medically advised.	No
Vaccine – Pneumonia	A vaccine to prevent pneumonia.	For members age 21 and older, administered as medically advised.	No

Service	Description	Coverage/Limitations	Prior authorization
Vision Services	Eye care services.	For members age 21 and over, the plan covers: • 1 eye exam a year • 1 set of glasses a year • 1 set of frames a year • A 6 month supply of contact lenses with a doctor's prescription	No
Waived Copayments	No copays for certain services.	For members age 21 and older, no copays for chiropractor services, community behavioral health services, home health services, hospital outpatient services, federally qualified health center visits, independent laboratory services, non-emergency transportation services, nurse practitioner services, optometrist services, physician and physician assistant services, podiatrist services, portable X-ray services, rural health clinic visits, and use of the hospital emergency department for non-emergency service.	No

Section 13: Long-Term Care (LTC) program helpful information

**(Read this section if you are in the LTC program.
If you are not in the LTC program, skip to Section 15)**

Starting services

It is important that we learn about you so we can make sure you get the care that you need. Your case manager will set up a time to come to your home or nursing facility to meet you.

At this first visit, your case manager will tell you about the LTC program and our Plan. She or he will also ask you questions about:

- Your health,
- How you take care of yourself,
- How you spend your time,
- Who helps takes care of you, and
- Other things.

These questions make up your **initial assessment**. The initial assessment helps us learn about what you need to live safely in your home. It also helps us decide what services will help you the most.

Developing a plan of care

Before you can begin to get services under the LTC program, you must have a **person-centered plan of care (plan of care)**. Your case manager makes your plan of care with you. Your plan of care is the document that tells you all about the services you get from our LTC program. Your case manager will talk to you and any family members or caregivers you want to include to decide what LTC services will help. They will use the initial assessment and other information to make a plan that is just for you. Your plan of care will tell you:

- What services you are getting
- Who is providing your service (your service providers)
- How often you get a service
- When a service starts and when it ends (if it has an end date)
- What your services are trying to help you do. For example, if you need help doing light housekeeping tasks around your house, your plan of care will tell you that an adult companion care provider comes 2 days a week to help with your light housekeeping tasks.
- How your LTC services work with other services you get from outside our Plan, such as from Medicare, your church or other federal programs
- Your **personal goals**

We don't just want to make sure that you are living safely. We also want to make sure that you are happy and feel connected to your community and other people. When your case manager is making your plan of care, they will ask you about any **personal goals** you might have. These can be anything, really, but we want to make sure that your LTC services help you accomplish your goals. Some examples of personal goals include:

- Walking for 10 minutes every day
- Calling a loved one once a week
- Going to the senior center once a week
- Moving from a nursing facility to an assisted living facility

You or your **authorized representative** (someone you trust who is allowed to talk to us about your care) must sign your plan of care. This is how you show you agree with the **services on your plan of care**.

Your case manager will send your PCP a copy of your plan of care. They will also share it with your other health care providers.

Updating your plan of care

Every month your case manager will call you to see how your services are going and how you are doing. If any changes are made, she or he will update your plan of care and get you a new copy.

Your case manager will come to see you in person to review your plan of care every 90 days (or about 3 months). This is a good time to talk to them about your services, what is working and isn't working for you, and how your goals are going. They will update your plan of care with any changes. Every time your plan of care changes, you or your authorized representative must sign it.

Remember, you can call your case manager any time to talk about problems you have, changes in your life, or other things. Your case manager or a health plan representative is available to you when you need them.

Your back-up plan

Your case manager will help you make a **back-up plan**. A back-up plan tells you what to do if a service provider does not show up to give a service. For example, your home health aide did not come to give you a bath.

Remember, if you have any problems getting your services, call your case manager.

Section 14: Your plan benefits – Long-Term Care services

The table below lists the Long-Term care services covered by our Plan. Remember, services must be medically necessary in order for us to pay for them.[7]

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the effective date of the change.

If you have any questions about any of the covered Long-Term care services, please call your case manager or Member Services.

Service	Description	Prior authorization
Adult Companion Care	This service helps you fix meals, do laundry and light housekeeping.	Yes
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during meal times, you can eat there.	Yes
Assistive Care Services	These are 24-hour services if you live in an adult family care home.	Yes

[7] You can find a copy of the Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy at **http://ahca.myflorida.com/medicaid/review/Specific/59G-4.192_LTC_Program_Policy.pdf**.

Service	Description	Prior authorization
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Yes
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury.	Yes
Behavioral Management	Services for mental health or substance abuse needs.	Yes
Caregiver Training	Training and counseling for the people who help take care of you.	Yes
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	Yes
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	Yes
Home Delivered Meals	This service delivers healthy meals to your home.	Yes
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores.	Yes

Service	Description	Prior authorization
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	Yes
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time.	Yes
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	Yes
Medication Administration	Help taking medications if you can't take medication by yourself.	Yes
Medication Management	A review of all the prescription and over-the-counter medications you are taking.	Yes
Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy.	Yes
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology.	Yes

Section 14: Your plan benefits – Long-Term Care services

Service	Description	Prior authorization
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Yes
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime.	Yes
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Facility.	Yes
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house.	Yes
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition.	Yes
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better.	Yes
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow.	Yes
Structured Family Caregiving	Services provided in your home to help you live at home instead of in a nursing facility.	We may offer the choice to use this service instead of nursing facility services.

Service	Description	Prior authorization
Transportation	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	Yes

Long-Term Care Participant Direction Option (PDO)

You may be offered the Participant Direction Option (PDO). You can use PDO if you use any of these services and live in your home:

- Attendant care services
- Homemaker services
- Personal Care services
- Adult companion care services
- Intermittent and skilled nursing care services

PDO lets you **self-direct** your services. This means you get to choose your service provider and how and when you get your service. You have to hire, train, and supervise the people who work for you (your direct service workers).

You can hire family members, neighbors, or friends. You will work with a case manager who can help you with PDO.

If you are interested in PDO, ask your case manager for more details. You can also ask for a copy of the PDO Guidelines to read and help you decide if this option is the right choice for you.

Your plan benefits – LTC expanded benefits

Expanded benefits are extra services we provide to you at no cost. Talk to your case manager about getting expanded benefits.

Expanded benefits	Benefit description	Coverage/Limitations	Prior authorization
Assisted Living Facility/Adult Family Care Home – Bed Hold Days	Up to a thirty day bed hold.	Your bed will be saved for up to 30 days each time you leave an assisted living facility (ALF) or adult family care home (AFCH) for a minimum of 30 days between episodes. Resident must intend to return to the facility and continue to make any room, board and patient responsibility payments.	Yes
Transition Assistance – Nursing Facility to Community Setting	Community transition waiver.	Up to a maximum of $5,000 per enrollee per lifetime. This money assists with deposits for housing or utilities, household items (e.g., furniture, microwave), health and safety items and moving expenses.	Yes
Individual Therapy Sessions for Caregivers	Therapeutic behavioral services.	Up to two sessions per year.	No
Non-Medical Transportation Services	Transportation to and from non-medical engagements.	Once per month.	No

Section 15: Member satisfaction

Complaints, grievances, and plan appeals

We want you to be happy with us and the care you receive from our providers. Let us know right away if at any time you are not happy with anything about us or our providers. This includes if you do not agree with a decision we have made.

Additionally, it includes concerns you may have about preservice review (review before the service), urgent review (fast review due to health issues), concurrent review (review during the service), and post-service review (review after the service) procedures.

How to submit a claim for covered services? N/A

	What you can do:	What we will do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time MMA: **1-888-716-8787**, TTY **711** LTC: **1-800-791-9233**, TTY **711**	We will: • Try to solve your issue within 1 business day
If you are not happy with us or our providers, you can file a **Grievance**	You can: • Write us or call us at any time • Call us to ask for more time to solve your grievance if you think more time will help UnitedHealthcare Community Plan Appeals and Grievance Unit P.O. Box 31364 Salt Lake City, UT 84131 MMA: **1-888-716-8787**, TTY **711** LTC: **1-800-791-9233**, TTY **711**	We will: • Review your grievance and send you a letter with our decision within 90 days If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree

	What you can do:	What we will do:
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write us, or call us and follow up in writing, within 60 days of our decision about your services • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. UnitedHealthcare Community Plan Appeals and Grievance Unit P.O. Box 31364 Salt Lake City, UT 84131 MMA: **1-888-716-8787**, TTY **711** LTC: **1-800-791-9233**, TTY **711**	We will: • Send you a letter within 5 business days to tell you we received your appeal • Help you complete any forms • Review your appeal and send you a letter within 30 days to answer you
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited** or **"Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services UnitedHealthcare Community Plan Appeals and Grievance Unit P.O. Box 31364 Salt Lake City, UT 84131 MMA: **1-888-716-8787**, TTY **711** LTC: **1-800-791-9233**, TTY **711**	We will: • Give you an answer within 48 hours after we receive your request • Call you the same day if we do not agree that you need a fast appeal, and send you a letter within 2 days

	What you can do:	What we will do:
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing**	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings • Ask us for a copy of your medical record • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. * You must finish the appeal process before you can have a Medicaid Fair Hearing.	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed • Restart your services if the State agrees with you If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Fast plan appeal

If we deny your request for a fast appeal, we will transfer your appeal into the regular appeal time frame of 30 days. If you disagree with our decision not to give you a fast appeal, you can call us to file a grievance.

Medicaid Fair Hearings (for Medicaid members)

You may ask for a fair hearing at any time up to 120 days after you get a Notice of Plan Appeal Resolution by calling or writing to:

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

1-877-254-1055 (toll-free)
1-239-338-2642 (fax)

MedicaidFairHearingUnit@ahca.myflorida.com

If you request a fair hearing in writing, please include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where you or your representative can be reached

You may also include the following information, if you have it:

- Why you think the decision should be changed
- The service(s) you think you need
- Any medical information to support the request
- Who you would like to help with your fair hearing

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request. A hearing officer who works for the State will review the decision we made.

If you are a Title XXI MediKids member, you are not allowed to have a Medicaid Fair Hearing.

Review by the State (for MediKids members)

When you ask for a review, a hearing officer who works for the State reviews the decision made during the Plan appeal. You may ask for a review by the State any time up to 30 days after you get the notice. **You must finish your appeal process first.**

You may ask for a review by the State by calling or writing to:

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

1-877 254-1055 (toll-free)
1-239-338-2642 (fax)

MedicaidHearingUnit@ahca.myflorida.com

After getting your request, the Agency will tell you in writing that they got your request.

Continuation of benefits for Medicaid members

If you are now getting a service that is going to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made for your **Plan appeal** or **Medicaid Fair Hearing**. If your services are continued, there will be no change in your services until a final decision is made.

If your services are continued, and our decision is not in your favor, we may ask you to 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 your appeal or fair hearing, you must file your appeal and ask to continue services within this timeframe, whichever is later:

- 10 days after you receive a Notice of Adverse Benefits Determination (NABD), or
- On or before the first day that your services will be reduced, suspended or terminated.

Section 16: Your member rights

As a recipient of Medicaid and a member in a Plan, you also have certain rights.

You have the right to:

- To receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities
- To participate with practitioners in making decisions about their health care
- A right to a candid discussion about appropriate or medically necessary treatment options for conditions, regardless of cost or benefit coverage
- To voice complaints or appeals about the organization or the care it provides
- A right to make recommendations regarding the organization's member rights and responsibilities
- Be treated with courtesy and respect
- Always have your dignity and privacy considered and respected
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment

- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can't make them yourself (Advanced Directive)
- To file a grievance about any matter other than a Plan's decision about your services
- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Speak freely about your health care and concerns without any bad results
- Freely exercise your rights without the Plan or its network providers treating you badly
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation
- Request and receive a copy of your medical records and ask that they be amended or corrected

LTC members have the right to:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive services in a home-like environment regardless where you live
- Receive information about being involved in your community, setting personal goals and how you can participate in that process
- Be told where, when and how to get the services you need
- To be able to take part in decisions about your health care
- To talk openly about the treatment options for your conditions, regardless of cost or benefit
- To choose the programs you participate in and the providers that give you care

Section 17: Your member responsibilities

As a recipient of Medicaid and a member in a plan, you also have certain responsibilities.

You have the responsibility to:

- Follow plans and instructions for care they have agreed to with providers
- To understand health problems and participate in developing mutually agreed upon treatment goals, to the degree
- Give accurate information about your health to your Plan and providers
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions for care, and ask questions
- Keep your appointments, and notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff and case manager with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for your safety
- Report fraud, abuse and overpayment

LTC members have the responsibility to:

- Tell your case manager if you want to disenroll from the Long-Term Care program
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager

Section 18: Other important information

Patient responsibility for Long-Term Care (LTC) or hospice services

If you receive LTC or hospice services, you may have to pay a "share in cost" for your services each month. This share in cost is called "patient responsibility." The Department of Children and Families (DCF) will mail you a letter when you become eligible (or to tell you about changes) for Medicaid LTC or hospice services. This letter is called a "Notice of Case Action" or "NOCA." The NOCA letter will tell you your dates of eligibility and how much you must pay the facility where you live, if you live in a facility, towards your share in the cost of your LTC or hospice services.

To learn more about patient responsibility, you can talk to your LTC case manager, contact the DCF by calling 1-866-762-2237 toll-free, or visit the DCF web page at **https://www.myflfamilies.com/service-programs/access/medicaid.shtml** (scroll down to the Medicaid for Aged or Disabled section and select the document entitled 'SSI-Related Fact Sheets').

Indian Health Care Provider (IHCP) protection

Indians are exempt from all cost sharing for services furnished or received by an IHCP or referral under contract health services.

Emergency disaster plan

Disasters can happen at any time. To protect yourself and your family, it is important to be prepared. There are three steps to preparing for a disaster: 1) Be informed; 2) Make a Plan; and 3) Get a Kit. For help with your emergency disaster plan, call Member Services or your case manager. The Florida Division of Emergency Management can also help you with your plan. You can call them at 1-850-413-9969 or visit their website at **www.floridadisaster.org**.

For LTC members, your case manager will assist you in creating a disaster plan.

Tips on how to prevent Medicaid fraud and abuse:

- **Do not** share personal information, including your Medicaid number, with anyone other than your trusted providers
- Be cautious of anyone offering you money, free or low-cost medical services, or gifts in exchange for your Medicaid information
- Be careful with door-to-door visits or calls you did not ask for
- Be careful with links included in texts or emails you did not ask for, or on social media platforms

Fraud/abuse/overpayment in the Medicaid program

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/mpi-complaintform/**.

You can also report fraud and abuse to us directly by contacting MMA at **1-888-716-8787**, TTY **711**; and LTC at **1-800-791-9233**, TTY **711**.

Abuse/neglect/exploitation of people

You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. You can talk to your PCP or case manager about your feelings.

If you feel that you are being mistreated or neglected, you can call the Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873) or for TTY/TDD at 1-800-955-8771.

You can also call the hotline if you know of someone else that is being mistreated.

Domestic violence is also abuse. Here are some safety tips:

- If you are hurt, call your PCP
- If you need emergency care, call **911** or go to the nearest hospital. For more information, see the section called **Emergency Care**.
- Have a plan to get to a safe place (a friend's or relative's home)
- Pack a small bag, give it to a friend to keep for you

If you have questions or need help, please call the National Domestic Violence Hotline toll free at 1-800-799-7233 (TTY 1-800-787-3224).

Advance Directives

An Advance Directive is a written or spoken statement about how you want medical decisions made if you can't make them yourself. Some people make Advance Directives when they get very sick or are at the end of their lives. Other people make Advance Directives when they are healthy. You can change your mind and these documents at any time. We can help you get and understand these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

1. A Living Will
2. Health Care Surrogate Designation
3. An Anatomical (organ or tissue) Donation

You can download an advanced directive form from this website: **http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx**.

Make sure that someone, like your PCP, lawyer, family member, or case manager knows that you have an Advance Directive and where it is located.

If there are any changes in the law about Advance Directives, we will let you know within 90 days. You don't have to have an Advance Directive if you do not want one.

If your provider is not following your Advance Directive, you can file a complaint with Member Services at MMA **1-888-716-8787**, TTY **711**; and LTC **1-800-791-9233**, TTY **711** or the Agency by calling 1-888-419-3456.

Getting more information

You have a right to ask for information. Call Member Services or talk to your case manager about what kinds of information you can receive for free. Some examples are:

- Your member record
- A description of how we operate
- Provider Directory

Section 19: Additional resources

Floridahealthfinder.gov

The Agency is committed to its mission of providing "Better Health Care for All Floridians". The Agency has created a website **www.FloridaHealthFinder.gov** where you can view information about Florida home health agencies, nursing facilities, assisted living facilities, ambulatory surgery centers and hospitals. You can find the following types of information on the website:

- Up-to-date licensure information
- Inspection reports
- Legal actions
- Health outcomes
- Pricing
- Performance measures
- Consumer education brochures
- Living wills
- Quality performance ratings, including member satisfaction survey results

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit **http://www.floridahealthfinder.gov/HealthPlans/search.aspx**. You may choose to view the information by each Plan or all Plans at once.

Elder Housing Unit

The Elder Housing Unit provides information and technical assistance to elders and community leaders about affordable housing and assisted living choices. The Florida Department of Elder Affairs maintains a website for information about assisted living facilities, adult family care homes, adult day care centers and nursing facilities at **https://elderaffairs.org/programs-services/housing-options/** as well as links to additional Federal and State resources.

MediKids information

For information on MediKids coverage please visit: **http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/MediKids.shtml**

Aging and Disability Resource Center

You can also find additional information and assistance on State and federal benefits, local programs and services, legal and crime prevention services, income planning or educational opportunities by contacting the Aging and Disability Resource Center.

Independent Consumer Support Program

The Florida Department of Elder Affairs also offers an Independent Consumer Support Program (ICSP). The ICSP works with the Statewide Long-Term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed. For more information, please call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) or visit **https://elderaffairs.org/programs-services/medicaid-long-term-care-services/statewide-medicaid-managed-care-long-term-care-program/**.

Section 20: Forms

Living Will

A Living Will may, but need not, be in the following form:

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

_____ (initial) I have a terminal condition.

Or _____ (initial) I have an end-stage condition.

Or _____ (initial) I am in a persistent vegetative state.

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

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

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

Name: _____

Address: _____

City, State: _____

ZIP Code: _____ Phone: _____

Living Will

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

Additional instructions (optional):

_____

_____

_____

_____

_____

_____

_____

_____

(Signed) _____

Witness _____

Address _____

Witness _____

Address _____

Authorized Representative form

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: _____

Authorized Representative form:

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

United Healthcare 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 Member Services at **1-888-716-8787**, TTY **711**, 8 a.m. – 7 p.m., Monday – Friday.

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 Member Services at **1-888-716-8787**, TTY **711**, 8 a.m. – 7 p.m., Monday – Friday.

ATTENTION: If you do not speak English, language assistance services, at no cost to you, are available. Call **1-888-716-8787, TTY 711**.

ATENCIÓN: Si no habla inglés, los servicios de asistencia de idiomas están disponibles sin costo para usted. Llame al **1-888-716-8787, TTY 711**.

ATANSYON: Si w pa pale Anglè, gen sèvis èd pou lang ki disponib san w pa peye anyen. Rele **1-888-716-8787, TTY 711**.

ВНИМАНИЕ: Если Вы не говорите по-русски, Вы можете воспользоваться бесплатной языковой помощью. Позвоните по телефону **1-888-716-8787, телетайп 711**.

注意：如果您不會說英文，您可獲得免費語言協助服務。請致電 **1-800-716-8787，聽障專線 (TTY) 711**。

We're here for you

Remember, we're always ready to answer any questions you may have. Just call:

MMA Member Services at **1-888-716-8787**, TTY **711**, or
LTC Member Services at **1-800-791-9233**.

You can also visit our website at **myuhc.com/CommunityPlan**.

UnitedHealthcare Community Plan
3100 SW 145th Avenue
Miramar, FL 33027

United Healthcare
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