

NEW YORK

UnitedHealthcare Personal Assist

Member Handbook





Important Phone Numbers

- Member Services** 1-877-512-9354
- TDD/TTY (for the hearing impaired) 711
- Care Coordination:** 1-877-512-9354
- Dental Services:** 1-877-512-9354
- Transportation:** 1-877-512-9354

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



Website www.uhcommunityplan.com

UnitedHealthcare Personal Assist

77 Water Street, 14th Floor
New York, NY 10005

New York State Department of Health:

NYS Managed Long-Term Care Complaint Hotline

Phone Number: 1-866-712-7197

New York State Department of Health

Phone Number: 1-800-541-2831

New York State Department of Health

Corning Tower
Empire State Plaza
Albany, NY 11237

New York Medicaid Choice

Phone Number: 1-800-505-5678



Your Health Providers

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Emergency Room: _____ Phone: _____

Pharmacy: _____ Phone: _____

UnitedHealthcare Personal Assist is the trademark of UnitedHealthcare of New York, Inc.'s Managed Long-Term Care Program.

Table of Contents

Getting Started

Welcome	4
About Managed Long-Term Care	4
Using Your Member Handbook	5
Your UnitedHealthcare Personal Assist ID Card	5
Our Service Area	5

Joining UnitedHealthcare Personal Assist

Who Can Join? (Enrollment Criteria)	6
How Can I Join? (Eligibility Assessment)	7
Enrollment for Mandatory Members	7
The Enrollment Eligibility Assessment	8
Denial of Enrollment	8

Advance Directives

Advance Directives	10
--------------------	----

Getting Help

Member Services Department	11
After-Hours Assistance	11
Interpreter Services	11
Services for the Visually Impaired, Hearing Impaired or Developmentally Disabled	12
Keeping Us Informed	12

Your Benefits and Plan Procedures

Covered Services	13
Coordinated Services	21
If You Have Both Medicaid and Medicare	22

Selecting Your Providers

Developing Your Patient-Centered Service Plan	23
Care Coordination and Your Team	23
How Your Care Coordinator Can Assist You	24
Contacting Your Care Coordinator	24
Changing Your Care Coordinator	24
Working with Your Doctor	24
Choosing Your PCP	25
Choosing Providers for Covered Services	25
How You Can Change Your Provider	25

How to Obtain Services

Requesting New or Additional Services	26
Prior Authorization (New Services)	26
Retrospective Review (More of the Same)	26
Expedited Reviews	26
Extensions of Request Timeframes	27
Denial of Requests	27

Transitional, Out-of-Network, Out-of-Area Care

Transitional Care	28
Out-of-Network	28
When You Are Away from Home	28

Emergency Care

What is an Emergency?	29
What to Do After an Emergency	29
If You Are Hospitalized	29

Grievances, Plan Actions and Appeals

What is a Grievance?	30
Grievances Appeals	30
What is a Plan Action?	31
Appeals of Plan Actions	32
Expedited Appeals	33
State Fair Hearings and External Appeals	34

Leaving the Plan

Voluntary Disenrollment	36
Involuntary Disenrollment	37

Payment for Services

UnitedHealthcare Personal Assist Funding	38
How Our Providers Get Paid	38
If You Have a Medicaid Spend-Down	38
Coordination of Benefits	38

Member Rights and Responsibilities

Fraud and Abuse

Health Plan Notice of Privacy Practices

Information Available to You

Upon Request

Forms/Notes

Getting Started

Welcome

Welcome to UnitedHealthcare Personal Assist™. We are happy that you have selected us as your managed long-term care plan and look forward to working with you, your family and your personal Primary Care Physician (PCP), if applicable, to coordinate your care. Our staff will work with you to address your needs and answer any questions you may have about how the plan works and your benefits. If you have questions or concerns, please call our **Member Services department at 877-512-9354 (TTY/TDD 711)**.

About UnitedHealthcare Personal Assist Managed Long-Term Care

A managed long-term care plan receives Medicaid funding to arrange, coordinate and pay for health and long-term care services for people who are chronically ill and/or have disabilities.

UnitedHealthcare Personal Assist has been approved by the New York State Department of Health to offer you managed long-term care. Through UnitedHealthcare Personal Assist, you will receive coordination of medical, specialty and home and community-based services to help maintain or improve your quality of life and overall health, despite chronic illness or disability. Through our coordination and oversight, we will help you to live safely in your home and/or community for as long as possible.

As a member of UnitedHealthcare Personal Assist, you will also receive:

- A Registered Nurse (RN) who will visit you in your home to assess your needs
- An RN Care Coordinator who will come to your home and assess your needs and work with you to ensure that you receive appropriate, timely care to meet your specific needs
- A personalized plan of care, developed to address your specific needs
- Extensive choices in providers that offer your managed long-term care benefits
- Access to UnitedHealthcare Personal Assist 24 hours a day, 7 days a week

As a member, you will receive a personalized plan of care through a wide range of long-term care and health-related services in your home, the community and, if necessary, in a nursing home. We will also assist you in obtaining other services that are not covered by UnitedHealthcare Personal Assist.

Using Your Member Handbook

Your member handbook is an important resource to obtain information about UnitedHealthcare Personal Assist. By enrolling, you have agreed to terms and conditions of membership as described in this member handbook. Your handbook describes your member rights and responsibilities in relation to receiving covered benefits and the steps you can take to make UnitedHealthcare Personal Assist work best for you.


Keep this handbook in a convenient place for future reference. If you cannot find the information you are looking for, or need additional information or help, our Member Services department is available to assist you. The Member Services department can also put you in touch with your Care Coordinator.


To contact **Member Services**, please call toll-free: **877-512-9354**, 24 hours a day, 7 days a week.

Your Member ID Card

Each member of UnitedHealthcare Personal Assist will receive a member ID card. It is important that you carry this ID card with you at all times to receive services and benefits covered by UnitedHealthcare Personal Assist. You should also bring your Medicaid and Medicare cards with you to all health appointments since you will continue to use these cards for some of your medical needs. If you lose your card, call Member Services to get a new card.

You **do not need** to show your UnitedHealthcare Personal Assist ID card before you receive emergency care. Call 911 or go to the nearest emergency room. Below is a sample indicating what your UnitedHealthcare Personal Assist identification card will look like.

 UnitedHealthcare Community Plan	
Health Plan (80840)	911-87726-04
Member ID: 999999999	Group Number: NYLTC
Member: SUBSCRIBER BROWN	Payer ID: 87726
CIN#: XX99999X	
0501	UnitedHealthcare Personal Assist Administered by UnitedHealthcare of New York, Inc.

In an emergency go to nearest emergency room or call 911. <small>Printed: 08/23/11</small>	
	
<small>This individual is enrolled in a NYS Managed Long Term Care plan that provides coverage for long term care. This card does not guarantee coverage. Use of this card by anyone other than the member is fraud. To verify benefits or to find a provider, visit the website www.myuhc.com/communityplan or call.</small>	
For Members:	877-512-9354 TDD 711
Dental:	877-512-9354
For Providers:	www.uhccommunityplan.com 866-362-3368
MLTC Claims:	PO Box 5240, Kingston, NY, 12402-5240

Our Service Area

You are eligible to join UnitedHealthcare Personal Assist if you live in any of the five boroughs of New York City, including: Albany, Bronx, Brooklyn, Broome, Erie, Monroe, New York (Manhattan), Onondaga, Oneida, Orange, Queens, Rockland and Staten Island.

Joining UnitedHealthcare Personal Assist

Joining UnitedHealthcare Personal Assist?

Enrollment in UnitedHealthcare Personal Assist is voluntary.* You may also transfer to UnitedHealthcare Personal Assist from another MLTC plan at any time, if you wish. You can call our **Member Services department at 877-512-9354** and we will be happy to assist you with the enrollment or transfer process. If you have applied for enrollment but are not yet a member, you can withdraw your application at any time before enrollment.

*In 2012, the New York State Department of Health made Managed Long-Term Care (MLTC) a mandatory plan for certain populations. People in the mandatory group have, or will, receive a letter from the New York State Department of Health letting them know that they must join an MLTC plan in order to continue to receive their Home and Community-Based services. If you do not choose an MLTC plan, New York State will choose one for you. While mandatory members must join an MLTC plan to receive these services, they may enroll in the MLTC plan of their choice.

Enrollment Criteria

Any applicant who completes the enrollment agreement and the appropriate releases of information and meets all of the following enrollment criteria is eligible for UnitedHealthcare Personal Assist:

- Be 18 years of age or older
- Be eligible for New York State Medicaid
- Live in the plan's service area
- For people with Medicaid but not Medicare, at the time of enrollment you

must have health problems and/or limitations that would qualify you for nursing home level of care**

- For members with Medicaid and Medicare benefits, also known as dual members, you must require at least one of the following services and care coordination from UnitedHealthcare Personal Assist**:
 - Assistance for more than 120 days from the effective date of enrollment
 - Nursing services in the home
 - Therapies in the home
 - Home Health Aide services
 - Personal care services in the home
 - Adult day healthcare
 - Private Duty Nursing
 - Consumer Directed Personal Assistance Services
- Upon enrollment, be able to return to or remain safely at home without jeopardy to his or her health**

**Determination is made based upon individual circumstances in accordance with New York State assessment guidelines.

An applicant who is enrolled in another managed care plan capitated by Medicaid, a home and community-based waiver program or an Office for People with Developmental Disabilities (OPWDD) Day Treatment Center, or is currently receiving services from a hospice***, may be enrolled with UnitedHealthcare Personal Assist upon termination from these other programs or plans.

***Currently enrolled MLTC members who require and meet requirements for hospice

may elect the Hospice benefit without disenrolling from their MLTC plan.

An applicant who is an inpatient or resident of a hospital or residential facility operated under the auspices of the Office for People with Developmental Disabilities may enroll upon discharge to the applicant's home in the community.

Applicants cannot be discriminated against based on their health status and/or the need for or cost of covered services.

Eligibility for enrollment in UnitedHealthcare Personal Assist must be determined through a New York State Department of Health approved clinical assessment, which is completed in the applicant's home by a UnitedHealthcare Personal Assist RN.

UnitedHealthcare Personal Assist assessment nurses have experience and expertise in home care and home and community-based long-term care services. Our assessment nurses will determine your clinical eligibility for the program by visiting you in your home and completing a comprehensive assessment to determine the level of care you need and your ability to remain safely in your home. The home assessment will be scheduled as soon as possible, generally within ten (10) days of your expressing interest in enrolling in UnitedHealthcare Personal Assist.

How Can I Join UnitedHealthcare Personal Assist?

Potential enrollees and/or other referrers, like your provider or caregiver, can contact UnitedHealthcare Personal Assist by

telephone, or may fax or mail a pre-enrollment referral form to the plan. The referral form can also be collected in person by a designee of the plan, if required.

A UnitedHealthcare Personal Assist Intake Coordinator will contact you within five (5) days of becoming aware of your interest in UnitedHealthcare Personal Assist. Our staff is available to answer any questions you may have about the plan. We will also review the eligibility criteria with you, help you determine if you meet the minimum requirements, and explain what you can expect as a UnitedHealthcare Personal Assist member.

If you meet the minimum eligibility criteria, and would like to continue with the enrollment process, we will schedule a home visit with one of our Personal Assist nurses who will complete the enrollment eligibility assessment.

Enrollment for Mandatory Members

Mandatory members enrolling in an MLTC are entitled to a ninety (90) day continuity of care period. This means that for ninety (90) days after enrollment, the MLTC plan must continue to provide the long-term care services that the member was receiving prior to their enrollment. After enrollment, a UnitedHealthcare Personal Assist RN will schedule a home visit to complete an assessment to evaluate your ongoing needs and answer any questions you may have.

Joining UnitedHealthcare Personal Assist (cont.)

The Enrollment Eligibility Assessment

During the enrollment visit, you will be given a guide to New York's Medicaid Managed Long-Term Care and a list of available plans. A copy of the member handbook and the provider directory, will also be provided and reviewed with you. The RN will also talk to you about how the plan works and answer any questions you may have. After completing the home assessment, the RN will work with you, and if you wish, your family or informal supports, to develop a proposed person-centered service plan to meet your individual needs.

If you remain interested in joining UnitedHealthcare Personal Assist, you will be given an enrollment agreement, attestation form and release of information forms to sign. It is required that you sign a Medical Release of Information form so that UnitedHealthcare Personal Assist can speak with your personal Primary Care Physician (PCP) and your other health providers to establish and coordinate the services included in the person-centered service plan. Following the enrollment visit, UnitedHealthcare Personal Assist will contact your PCP to discuss the proposed person-centered service plan. Your application will be submitted for processing to the Human Resource Administration/Local Department of Social Services (HRA/LDSS).

Although it is not required for your PCP to agree to work with UnitedHealthcare Personal Assist, we strive to work collaboratively with your health care providers to ensure your safety. If your PCP does not want to work with

UnitedHealthcare Personal Assist, we will speak with you and you can decide if you want to change your PCP. If you are enrolled in our Medicare plan, then we will work with your UnitedHealthcare PCP.

Remember that enrollment in UnitedHealthcare Personal Assist is voluntary and you can choose to withdraw your application at any time prior to enrollment. However, if you feel that you would like more time to think about enrolling in UnitedHealthcare, additional home visits can be scheduled.

Denial of Enrollment

You can be denied enrollment in UnitedHealthcare Personal Assist by HRA/LDSS for one or more of the following reasons:

- You are not at least 18 years of age
- You are not Medicaid eligible
- You are not eligible for nursing home level of care, if applicable
- You are not capable of returning to or remaining in the home without jeopardy to your health or safety at the time of enrollment
- You do not require community-based long-term care services from UnitedHealthcare Personal Assist for more than 120 days
- You have been previously involuntarily disenrolled from UnitedHealthcare Personal Assist, as determined on a case-by-case basis

- You are currently enrolled in another Medicaid managed care plan, a home and community-based services waiver plan, an OPWDD Day Treatment Program, or are receiving services from a hospice and do not wish to end your enrollment in one of these programs
- You are an inpatient or resident of a hospital or residential facility operated by the State Office of Mental Health, Office of Alcohol and Substance Abuse Services or the State OPWDD; applications for enrollment may be taken but enrollment may only begin upon discharge to your home in the community

If it is determined that you are not clinically eligible for UnitedHealthcare Personal Assist, you will be advised and you can withdraw the application. If you do not wish to withdraw, the application will be processed with a recommend to deny enrollment. HRA/LDSS will then make the final decision whether you are eligible to enroll.

You can withdraw your application at any time prior to the effective date of enrollment by indicating your desire to withdraw verbally or in writing, and we will send you a written acknowledgement of your withdrawal.

If UnitedHealthcare Personal Assist determines that you do not meet enrollment criteria, we will recommend to HRA/LDSS or NY Medicaid Choice, as applicable, that your enrollment application be denied. We will send you a letter informing you of this. HRA/LDSS or NY Medicaid Choice, as applicable, will make the final determination regarding denial of enrollment and will send you a letter with their decision and will notify you of your rights.

If UnitedHealthcare Personal Assist determines that you are ineligible due to age, residence or Medicaid eligibility, we will advise you of this. If you disagree with this decision, we will submit any additional information you give us to HRA/LDSS or NY Medicaid Choice, as applicable. HRA/LDSS or NY Medicaid Choice, as applicable, will then decide if we were correct in our decision. If HRA/LDSS agrees that you are ineligible, then you will not be enrolled.

Advance Directives

Advance Directives

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get 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.

Health Care Proxy

With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and DNR

You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor Card

This wallet-sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

Getting Help

Member Services Department

UnitedHealthcare Personal Assist's Member Services department is available to answer your questions and help you with a wide range of requests. The Member Services department operates a call center 24 hours a day, 7 days a week, 365 days a year. You can contact **Member Services at 877-512-9354 (TTY/TDD 711)**.

UnitedHealthcare Personal Assist Member Services can help you with:

- Membership questions
- Connecting with your Care Coordinator
- Benefit questions
- Changing providers
- Making a complaint
- Getting an interpreter
- Medicaid and Medicare questions
- Prior authorization questions
- Covered services
- Replacing a lost ID card
- Updating your contact information

After-Hours Assistance

If you have a medical question and cannot reach your PCP and it is after normal business hours, you can call UnitedHealthcare Personal Assist and speak to a nurse. You do not need to call your PCP first after-hours; you can call Personal Assist for help. You can contact **Member Services at 877-512-9354 (TTY/TDD 711)**.

Interpreter Services

UnitedHealthcare Personal Assist understands that our members are part of a population with unique needs, varying cultures and educational challenges. Our Member Services Representatives speak a wide variety of languages, but if you speak a language that our staff does not know, you can ask for a translator and we will access a translation service line to assist with the call. We also can provide written information in the most prevalent languages of our members. Oral interpretation of UnitedHealthcare Personal Assist materials is also available to members in different languages.

Getting Help (cont.)

Services for the Visually Impaired, Hearing Impaired and Developmentally Disabled

The plan provides a TTY/TTD number **711** for hearing and speech impaired individuals, which communicates with the Member Services team to provide assistance to members. Member handbooks in Braille, large print and audio-cassette will be made available for members with visual impairments, and information can be read to members, as requested. Member Services will address other needs as they arise, including those related to physical or developmental disabilities. Member Services staff will provide additional support for members as needed, including assisting with making calls and connecting you to your Care Coordination team.

Keeping Us Informed

Call Member Services if any of the following changes occur:

- You change your name, address or telephone number; you should also report the change to Medicaid and Medicare
- You have a change in circumstances that may affect your eligibility for Managed Long-Term Care, such as a change in your living conditions
- You become covered under another insurance plan

Your Benefits and Plan Procedures

Services Covered by UnitedHealthcare Personal Assist

Covered Services are those services available through membership in UnitedHealthcare Personal Assist and are paid for by UnitedHealthcare Personal Assist. All benefits and services are provided when **medically necessary**. Specific services and their frequency and duration are based upon your condition and health and social needs.

Following is a list of UnitedHealthcare Personal Assist covered services:

Benefit	Description
Care Management	A process to assist enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered by the plan.
Home Health Care ⁺	Includes the following services which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/ language pathology.
Medical Social Services	Assessing the need for, arranging for and providing aid for social problems related to the maintenance of a member in the home where such services are performed by a qualified social worker and provided within a plan of care.

Your Benefits and Plan Procedures (cont.)

Benefit	Description
Adult Day Health Services	Care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental pharmaceutical, and other ancillary services.
Personal Care	Some or total assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care must be medically necessary, ordered by a physician and provided by a qualified person in accordance with a plan of care.
Medical/Surgical Supplies	Items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.
Durable Medical Equipment +	Includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula and hearing aid batteries. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition.
Prosthetics and Orthotics +	Prosthetic appliances and devices are appliances and devices which replace any missing part of the body. Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Benefit

Enteral and Parenteral Supplements

Enteral supplements are nutrients delivered directly into the stomach, or small intestines. Parenteral supplements are nutrients delivered intravenously, bypassing the usual process of eating and digestion. Coverage is limited to nutritional supplements to those who can only ingest food by tube feeding, those with rare metabolic disorder, those with low Body Mass or children up to 21 years of age, who require liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized.

Personal Emergency Response System (PERS)

An electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.

Non-Emergency Transportation

Transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the Enrollee's condition for the Enrollee to obtain necessary medical care and services. Please call Member Services at 1-877-512-9354 to request transportation for any medical appointment or for Adult Day Healthcare services; UnitedHealthcare Personal Assist will provide transportation for you. Please request transportation at least three days in advance.

Podiatry ⁺

Services by a podiatrist which must include routine foot care when the Enrollee's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as a necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.

Your Benefits and Plan Procedures (cont.)

Benefit	Description
Dentistry	Includes but shall not be limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.
Optometry/Eyeglasses	Services of an optometrist and an ophthalmic dispenser, and includes eyeglasses; medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the Enrollee's condition.
Audiology/Hearing Aids, Hearing Aid Batteries	Include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, and hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.
Home-Delivered or Congregate Meals	Home-delivered and congregate meals provided in accordance with each individual Enrollee's plan of care.
Social Day Care	A structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.

Benefit	Description
Physical, Occupational, Speech or Other Therapies in a Setting Other than the Home ⁺	Provision of professional Physical, Occupational, Speech or other therapies in a setting other than the member's home. Physical therapy, occupational therapy, and speech therapy will be limited to 20 Medicaid visits each , per therapy, per 12-month benefit year, except for 18- to 20-year-old members and the developmentally disabled (MLTC plan may authorize additional visits). This benefit limit applies to rehabilitation visits in private practitioners' offices, certified hospital outpatient departments, and diagnostic and treatment centers (free-standing clinics). The 12-month benefit year is a calendar year, beginning January 1 of each year and running through December 31 of the same year.
Respiratory Therapy ⁺	The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.
Nutritional Counseling	Assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment of nutritional status and food preferences; planning for provision of appropriate dietary intake within the patient's home environment and cultural considerations; nutritional education regarding therapeutic diets as part of the treatment milieu; development of a nutritional treatment plan; regular evaluation and revision of nutritional plans; provision of in-service education to health agency staff as well as consultation on specific dietary problems of patients; and nutrition teaching to patients and families.

Your Benefits and Plan Procedures (cont.)

Benefit	Description
Social Supports and Modifications to the Home	Services and items that support the medical needs of the Enrollees and are included in an Enrollee's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services and housing improvement.
Private Duty Nursing	Continuous and skilled nursing care provided in an Enrollee's home by properly licensed registered professional or licensed practical nurses.
Nursing Home Care +	Care provided to Enrollees by a licensed NYS Nursing Home facility.
Consumer Directed Personal Assistance Services (CDPAS)	Consumer directed personal assistance means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

+ Medicare coverage may apply.

Services Covered under Fee-for-Service Medicaid

When you joined our plan, you were informed that some services will not be covered by UnitedHealthcare Personal Assist. Those services are covered under Fee-for-Service or regular Medicaid and you can get these services by using your New York State Medicaid Benefits card. You can choose any provider that accepts regular Medicaid. Below is a list of services that you can get using your Medicaid Benefits card.

- Inpatient hospital services, room and board
- Outpatient hospital services
- Hospice services
- Physician services in office, clinic, hospital, facility or in the home
- Laboratory services
- Radiology and Radioisotope services
- Emergency Transportation
- Rural Health Clinic Services
- Chronic Renal Dialysis
- Mental Health services
- Alcohol and Substance Abuse services
- OPWDD services
- Family Planning services
- Prescription and non-prescription drugs including compounded prescriptions
- Assisted Living Program

Service Authorizations and Actions

Prior Authorization:

Some covered services require Prior Authorization (approval in advance) from your physician, UnitedHealthcare Personal Assist or both, before you can receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. Below is a list of the UnitedHealthcare Personal Assist benefits. The check mark (✓) will tell you if the treatment or service requires prior authorization from UnitedHealthcare Personal Assist or an order from your personal PCP, or both, before you can access the benefit.

UnitedHealthcare Personal Assist Benefits	Prior Authorization Required	Physician Order Required
Home Care Services	✓	✓
Adult Day Health Care	✓	✓
Personal Care	✓	✓
Durable Medical Equipment (for items over \$500)	✓	✓
Personal Emergency Response System (PERS)	✓	
Non-Emergency Transportation		
Podiatry		
Dentistry		
Optometry/Eyeglasses		
Physical Therapy/Occupational Therapy/Speech Therapy Provided in a Setting Other Than Home	✓	✓
Audiology/Hearing Aids	✓	
Respiratory Therapy	✓	✓
Nutrition	✓	✓
Private Duty Nursing	✓	✓
Consumer Directed Personal Assistance Services (CDPAS)	✓	✓
Home-Delivered Meals	✓	

Your Benefits and Plan Procedures (cont.)

UnitedHealthcare Personal Assist Benefits	Prior Authorization Required	Physician Order Required
Medical Social Services	✓	
Social Day Care	✓	
Social and Environmental Supports	✓	

When you ask for approval of a treatment or service, it is called a **Service Authorization**. To get a Service Authorization request, you or your doctor must call **Member Services** toll-free at **877-512-9354**. The Member Services Representative will assist you with your needs or transfer your request to the appropriate party.

For those UnitedHealthcare Personal Assist Benefits with no checkmark (✓), you may access the service or treatment directly. You can call **Member Services** toll-free at **877-512-9354 (TTY/TDD 711)** for assistance in accessing these benefits as well. You will be given the option of selecting transportation and dental services directly from the choices given to you when you call **Member Services**.

Services Coordinated by UnitedHealthcare Personal Assist

Coordinated services are services that are not paid for by UnitedHealthcare Personal Assist. You may choose any provider for these non-covered services provided the provider accepts Medicaid and/or Medicare, as applicable by service. Your UnitedHealthcare Personal Assist Care Coordinator is available to assist in arranging and coordinating these services for you. The Care Coordinator's primary job is to serve as a liaison between you and all of your health care providers to ensure that you receive services in a smooth and seamless manner.

Following is a list of UnitedHealthcare Personal Assist coordinated services that you can get by using your New York State Medicaid card.

Coordinated Services

- Emergency Room Services +
- Physician Services (including services provided in an office setting, a clinic, a facility or in the home) +
- Inpatient Hospital Services +
- Outpatient Hospital Services +
- Laboratory Services +
- Radiology and Radioisotope Services +
- Prescription and Non-Prescription Drugs+
- Emergency Transportation +
- Rural Health Clinic Services +
- Chronic Renal Dialysis +
- Mental Health Services +
- Alcohol/Substance Abuse Services +
- OPWDD Services
- Assisted Living Program

+ **Medicare coverage may apply.**

Your Benefits and Plan Procedures (cont.)

If You Have Both Medicaid and Medicare

If you have both Medicaid and Medicare, you have more than one insurance coverage. Medicare is considered your primary insurance and Medicaid is your secondary insurance. If Medicare does not cover the entire cost of the service, then UnitedHealthcare Personal Assist will be billed for any deductibles or coinsurance. Your Medicaid benefits will not change your primary insurance benefits. You will continue to be covered by Medicare for your physician visits, hospitalizations, lab tests, ambulance and other Medicare benefits. If you have Medicare, you will need to follow their authorization rules. If your Medicare benefits are exhausted and UnitedHealthcare Personal Assist becomes the primary payer for a covered service under the Personal Assist plan, you will need to switch to one of our network providers. You may want to consider enrolling in a UnitedHealthcare Dual Medicare product. Just ask your Care Coordinator for information.

Your Care Coordinator will work with your primary insurance to help set up your health care. For Medicare covered services, UnitedHealthcare Personal Assist Care Coordinators can:

- Assist with referral to physicians if needed
- Schedule health appointments and arrange non-emergency transportation
- Assist with discharge planning if you are admitted to a hospital
- Arrange Medicare-covered home care services

If you are currently receiving a Medicare covered service, you can continue using that provider, however, UnitedHealthcare Personal Assist recommends that you use a provider in our network, so that you do not have to change providers if Medicare coverage limits are met and UnitedHealthcare Personal Assist becomes responsible for primary payment for the care. You may also want to consider having your Medicare coverage with UnitedHealthcare.

Selecting Your Providers

Developing Your Patient-Centered Service Plan

When you enroll in UnitedHealthcare Personal Assist, your Care Coordinator and PCP will work together with you to help develop a patient-centered service plan that meets your needs. Your patient-centered service plan is a written description of all the types of services you will receive to help maintain and improve your health status and be as independent as possible. Your patient-centered service plan will include both UnitedHealthcare Personal Assist covered services and non-covered services and will change based on initial and follow-up assessments as your health care needs change.

Your initial patient-centered service plan will be based upon the results of the in-home RN assessment visit in collaboration with your personal PCP. It is not required for your personal PCP to work with UnitedHealthcare Personal Assist to develop your patient-centered service plan. Your UnitedHealthcare Personal Assist Care Coordinator will conduct reassessments as warranted by your condition, but no longer than 180 days from the last assessment. You will receive a confirmation letter indicating the covered services listed in your patient-centered service plan and will include the service type, the duration (length of time) and frequency (how often) of each covered service, as well as the date that the authorization expires.

Your patient-centered service plan will be periodically reviewed to ensure that your authorized services continue to meet your specific needs. As your health care needs change, you may require changes to the types and/or frequency of services you receive. This

will require a change to your patient-centered service plan. Your Care Coordinator will review the plan of care with you and your personal PCP and discuss the changes.

Because you are an important part of your health care team, it is very important for you to let UnitedHealthcare Personal Assist know what you need. You should talk to your personal PCP or your Care Coordinator if you have a need for services that you are not currently receiving, or if you would like to make a change to your patient-centered service plan.

Care Coordination and Your Care Team

Your UnitedHealthcare Personal Assist care team will consist of your Care Coordinator, your personal PCP and other UnitedHealthcare Personal Assist support staff. Support staff may consist of Member Services associates, social workers, pharmacists and our medical director.

An important benefit of joining UnitedHealthcare Personal Assist is that you will be assigned a Care Coordinator who will be responsible for managing all of your services. He or she will have expertise in community-based home care and will also make periodic visits to your home to reassess your condition. Your Care Coordinator will work with you to help you manage your chronic condition and live in your home as independently as possible, for as long as possible, with the goal to enhance your functionality and quality of life. Your Care Coordinator will be matched, based upon availability, to best meet your individual language and cultural needs.

Selecting Your Providers (cont.)

How Your Care Coordinator Can Assist You

- Complete a comprehensive, individual assessment of your health and long-term care needs and help you determine the services most appropriate to meet your needs
- Help you develop your patient-centered service plan
- Make sure the right health care professionals are consulted during your patient-centered service plan progress
- Give you information to help you choose long-term care providers contracted with UnitedHealthcare Personal Assist
- Contact you by telephone at least every three months and visit you every six months
- If your condition changes or you are hospitalized, your Care Coordinator will visit you to assess your needs and revise your patient-centered service plan to meet your needs
- Make sure your patient-centered service plan is carried out and works the way it needs to so that your needs are met
- Monitor to make sure you are getting what you need and that gaps in care are addressed right away
- Give you information about community resources that might be helpful to you
- Make sure that services you receive at home are based on your needs
- Help you coordinate your care and service needs

Contacting Your Care Coordinator

You can contact your Care Coordinator anytime you have a question or concern about your health care — by calling Member Services, who will access your Care Coordinator. You do not need to wait until a scheduled home visit or a phone call from the Care Coordinator. You should contact your Care Coordinator when you have a change in your status that may affect the kind or amount of care you need. If you need help after regular business hours and cannot wait until the next day, you can call UnitedHealthcare Personal Assist at **877-512-9354 (TTY/TDD 711)** for assistance.

Changing Your Care Coordinator

If you are unhappy with your Care Coordinator, it is important that you let us know by calling **877-512-9354 (TTY/TDD 711)**. If we cannot resolve your concern, you may have a new Care Coordinator assigned to you.

How Your Care Coordinator Will Work with Your Doctor

- If you do not have a personal PCP or if your PCP doesn't want to work with us, your Care Coordinator can assist you. It is not a requirement for your PCP to work with Personal Assist.
- Your Care Coordinator can help make sure that your personal PCP and other providers are working with you

- A copy of your patient-centered service plan will be shared with your personal PCP
- Your Care Coordinator will work with your personal PCP to make sure that you have the services you need when you come out of the hospital
- Your Care Coordinator will advise your personal PCP of any assessments and/or screenings that you have had

Choosing Your PCP

Primary and acute care services are **not covered** under UnitedHealthcare Personal Assist.

These services are covered by Medicaid and/or Medicare Fee-for-Service or regular Medicaid and/or Medicare. What you gain is an additional support person, your Care Coordinator, who will work with your personal PCP, if applicable, to help guide your care. If you need assistance in changing your PCP, your Care Coordinator can assist you in locating a qualified personal PCP near your home.

Selecting Providers for Covered Services

For services covered under Personal Assist, you may choose any provider in the UnitedHealthcare Personal Assist network that offers the service that you need. These providers have a contract with us so we are able to monitor their services and hold them to professional standards. If you are also enrolled with UnitedHealthcare's Dual Medicare plan, you should choose a PCP that accepts our Medicare plan.

Your **provider directory** is your resource for finding the care you need. UnitedHealthcare

Personal Assist will provide you with a provider directory. It lists providers who provide services to UnitedHealthcare Personal Assist members. The list includes Certified Home Care Agencies, Licensed Home Care Agencies, Durable Medical Equipment providers and others. For services covered through the Fee-for-Service portion of your Medicaid, you can choose any provider that accepts both Medicare and Medicaid.

The directory is also available online at www.uhccommunityplan.com, under the section for NY.

If you need a new copy or have questions about the directory or your benefits, please call Member Services at **877-512-9354 (TTY/TDD 711)**.

Changing Your Provider

UnitedHealthcare Personal Assist encourages your participation in managing your care and wants you to be happy with your providers of both covered and non-covered services. If you are not satisfied, we want to know about it and we will assist you in changing providers if it becomes necessary. If you are also enrolled in our Dual Medicare plan, you should make sure your provider accepts UnitedHealthcare.

To change your provider for covered services, contact our Member Services department. If you do not have a specific provider in mind, or your preferred provider is unable to meet your needs, we will work with you to find a provider who best matches your location, primary language and specific health care needs. We can also assist you in changing providers for non-covered services if that is required.

How to Obtain Services

Requesting New or Additional Services

Requests for new or additional benefits or services can be made by calling **Member Services** at **877-512-9354 (TTY/TDD 711)**. For some requests, your Care Coordinator or your physician will conduct a medical necessity determination to help ensure that your request for a particular service or quantity of services is most appropriate for your condition. If an assessment is required, it will be conducted as fast as your condition requires or within three business days of receipt of your request.

Prior Authorization (New Services)

When a new service is requested that you have never had before, it is considered to be a prior authorization request. A request to change a service in the patient-centered service plan for a future authorization period is also considered a prior authorization.

For these requests, a decision will be made as fast as your condition requires or within three business days of receipt of all necessary information, but no more than fourteen (14) days from the receipt of the request. You will be notified via phone and in writing about the decision. For an expedited prior authorization, you will be notified of the decision no more than three business days from the request for service.

Concurrent Review (More of Same Service)

When you request additional services that are currently authorized in the patient-centered service plan, the request is considered a concurrent review.

For these requests, a decision will be made as fast as your condition requires or within one (1) business day of receipt of all necessary information, but not more than fourteen (14) days from the receipt of your request. For an expedited concurrent review, you will be notified of the decision no more than one (1) business day from the receipt of necessary information but no more than three business days from receipt of the request for service.

Expedited Reviews

If UnitedHealthcare Personal Assist determines, or your provider indicates, that a delay in approving any service request would seriously jeopardize your life, health or ability to attain, maintain or regain maximum function, the request will be expedited. You may also request an expedited review. If we deny the request for an expedited review, we will complete the review using the standard timeframes. We will send a written notice to you to indicate that the request will not be handled as an expedited request, but will be handled as a standard request. You or your provider may file a grievance regarding the determination by UnitedHealthcare Personal Assist to complete the review using standard timeframes. Your Care Coordinator will notify you of any decision by phone and in writing as fast as your condition requires.

Extensions of Request Timeframes

UnitedHealthcare Personal Assist may extend the review period by up to fourteen (14) days if there is a need for additional information and the extension is in your best interest. You, or your provider, can also request an extension, verbally or in writing. We will send you a written notice of any extension that is initiated.

Denials of Requests (Plan Action)

If UnitedHealthcare Personal Assist denies coverage of your prior authorization or concurrent review request, you will receive a notice of plan action letter in the mail which will explain the decision. You or your provider may appeal the UnitedHealthcare Personal Assist decision.

Transitional, Out-of-Network, Out-of-Area Care

Transitional Care

Upon enrollment in UnitedHealthcare Personal Assist, you can continue an ongoing course of treatment for a transitional period of up to ninety (90) days from enrollment with a non-network health care provider for services that we provide coverage for. If your provider chooses to leave the UnitedHealthcare Personal Assist network, your ongoing treatment may be continued for a transitional period of up to 90 days. Ask your provider to call our Prior Authorization department at 866-604-3267 to request transitional care.

*Mandatory members enrolling in an MLTC are entitled to a ninety (90) day continuity of care period. This means that for ninety (90) days after enrollment, the MLTC plan must continue to provide the long-term care services that the member was receiving prior to their enrollment.

If you feel that you have a condition that meets the criteria for transitional care services, please discuss this with your Care Coordinator.

Out-of-Network Care

If UnitedHealthcare Personal Assist does not have a provider in our network with appropriate training or experience to meet your needs, you may obtain a referral to an out-of-network health care provider. If you feel that you need an out-of-network provider, please contact your Care Coordinator so he or she can assist you in obtaining a service authorization.

Before you see any out-of-network provider for covered services, you must get a service authorization from UnitedHealthcare Personal Assist. If you see the provider without a service

authorization, the provider will not be paid. If you have any questions regarding out-of-network care and/or authorizations, please call Member Services at **877-512-9354** (TTY/TDD 711).

Out-of-Area Care

Leaving the Plan's Service Area

We do not cover services provided outside its defined service area. However, if you are planning to be out of the service area for an extended period of time, please contact your Case Manager as soon as possible, so that any necessary supplies can be ordered for you to take with you. If you have an emergency (see the Emergency Care section of this handbook), go to the nearest emergency room or call **911**. Emergency coverage is covered as a part of your primary medical coverage, e.g., Medicaid or Medicare.

As a member of UnitedHealthcare Personal Assist, you can spend time out of the plan's service area for thirty (30) days or less. If you are planning to spend time away from home, please let your Care Coordinator know as early as possible, so he or she can make every effort to assist you in arranging necessary supplies for you while you are away. If you will be out of the service area for more than thirty (30) days, it will be difficult for UnitedHealthcare Personal Assist to continue to monitor your health care needs and services, and you will be disenrolled from the program. If you know that you will be out of the service area for more than thirty (30) days, you should call your Care Coordinator to discuss your options.

Emergency Care

What is an Emergency?

An emergency condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

You are NOT required to get preauthorization or prior authorization from UnitedHealthcare Personal Assist to get emergency care.

If you have an emergency and need immediate medical attention, **call 911 or rush to the nearest hospital emergency room.** You can get emergency care 24 hours a day, 7 days a week. If you are not sure if you have an emergency, you can call your PCP at **877-512-9354 (TTY/TDD 711).**

What to Do After an Emergency

You should notify your personal PCP and your Care Coordinator at UnitedHealthcare Personal Assist within 24 hours of the emergency. If indicated, your Care Coordinator will temporarily suspend your home care services until you return to your home, and will work with you to assure the appropriate level and type of services to meet your needs upon your return home.

If You Are Hospitalized

If you are hospitalized, you or your designee should contact UnitedHealthcare Personal Assist within 24 hours of admission. Your Care Coordinator will cancel your home care services and other appointments. You should also ask your PCP and the hospital's discharge planner to contact UnitedHealthcare Personal Assist. We will work with them to plan the right kind of care for you upon your discharge from the hospital.

Grievances, Plan Actions and Appeals

UnitedHealthcare Personal Assist will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by UnitedHealthcare Personal Assist staff or a health care provider because you file a grievance or an appeal. We will maintain your privacy. We will give you any help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a grievance or to appeal a plan action, please call: **877-512-9354 (TTY/TDD 711)** or write to:

**UnitedHealthcare Community Plan
Attn: UM Appeals and Grievance
Coordinator
P.O. Box 31364
Salt Lake City, UT 84131-0364**

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Grievance?

A grievance is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a grievance with us.

The Grievance Process

You may file a grievance orally or in writing with us. The person who receives your grievance will record it, and appropriate plan staff will oversee the review of the grievance. We will send you a letter telling you that we received your grievance and a description of our review process. We will review your grievance and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but no more than seven (7) calendar days from the receipt of the grievance.
2. For all other types of grievances, we will notify you of our decision within forty-five (45) days of receipt of necessary information, but the process must be completed within sixty (60) days of the receipt of the grievance. The review period can be increased up to fourteen (14) days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your grievance and our decision about your grievance.

How Do I Appeal a Grievance Decision?

If you are not satisfied with the decision we make concerning your grievance, you may request a second review of your issue by filing a grievance appeal. You must file a grievance appeal in writing. It must be filed within sixty (60) business days of receipt of our initial

decision about your grievance. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All grievance appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, who were not involved in the initial decision.

For standard grievance appeals, we will make the appeal decision within thirty (30) business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process.

For expedited grievance appeals, we will make our appeal decision within two (2) business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When UnitedHealthcare Personal Assist denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; reduces, suspends or terminates services that we already authorized; denies payment for services; does not provide timely services; or does not make grievance or appeal determinations within the required timeframes, those are considered plan “actions.” An action is subject to appeal.

(See How Do I File an Appeal of an Action? on the next page.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to reduce, suspend or terminate a service that is authorized, our letter will be sent at least ten (10) days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State’s external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

Grievances, Plan Actions and Appeals

(cont.)

If we are reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How Do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within forty-five (45) calendar days of the date on our letter notifying you of the action. If you call us to file your request for an appeal, you must send a written request unless you ask for an expedited review.

How Do I Contact My Plan to File an Appeal?

We can be reached by calling **877-512-9354** (TTY/TDD 711) or writing to:

**UnitedHealthcare Community Plan
Attn: UM Appeals and Grievance
Coordinator
P.O. Box 31364
Salt Lake City, UT 84131-0364**

If you need assistance in filing your appeal due to language barriers, hearing, speech or other issues, our Member Services department can

assist you. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while we are deciding your appeal. We must continue your service if you make your request to us no later than ten (10) days from our mailing of the notice to you about our intent to reduce, suspend or terminate your services, or by the intended effective date of our action, and the original period covered by the service authorization has not expired. Your services will continue until you withdraw the appeal, the original authorization period for your services has been met or until ten (10) days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section on the following page.)

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to

continue to receive them while your appeal was being reviewed.

How Long Will It Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than thirty (30) days from the day we receive an appeal. (The review period can be increased up to fourteen (14) days if you request an extension or we need more information and the delay is in your interest.) During our review, you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases, you may request an “expedited” appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a

serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within two (2) business days after we receive all necessary information. In no event will the time for issuing our decision be more than three (3) business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within two (2) days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request. If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

Grievances, Plan Actions and Appeals

(cont.)

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within sixty (60) days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within ten (10) days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for

paying for the services that were the subject of the Fair Hearing.

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal. When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Insurance within four (4) months from the date we denied your appeal.

Your external appeal will be decided within thirty (30) days. More time (up to five business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two (2) business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in three (3) days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

External Appeals

You may request an application for an external appeal by calling:

United Healthcare Personal Assist Member Services at **877-512-9354 (TTY/TDD 711)**, or

New York State Department of Financial Services at **1-800-400-8882**, or

Via e-mail at:

externalappealquestions@dfs.ny.gov

Send External Appeals applications to the Department of Financial Services by certified or registered mail to:

New York State External Appeal

P.O. Box 7209

Albany, NY 12224-0209, or

Fax to **1-800-332-2729**. If your appeal is expedited, you must also call **1-888-990-3991** (toll-free) to tell us.

Right to a Fair Hearing

If you believe that the action we have taken is wrong, you can ask for a State fair hearing by phone or by writing.

1. **Telephone:** Statewide Toll-Free **1-800-342-3334**. (Have your denial notice available when you call.)
2. **Fax:** Fax a copy of all the pages of your denial notice to **(518) 473-6735**.
3. **Walk-in:** Bring a copy of all the pages of your denial notice to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 330 West 34th Street, 3rd Floor, New York, NY – or 14 Boerum Place, 1st Floor, Brooklyn, NY.
4. **To Write for a Fair Hearing:** Fill in the information on your denial notice and send a copy of all pages to:

Fair Hearing Section

NYS Office of Temporary and

Disability Assistance

Fair Hearings

P.O. Box 22023

Albany, NY 12201-2023

Leaving the Plan

Voluntary Disenrollment (If You Wish to Leave the Plan)

You can choose to disenroll from UnitedHealthcare Personal Assist at any time, for any reason. You may initiate disenrollment through either verbal or written notice to UnitedHealthcare Personal Assist. If you disenroll verbally, we will send you a letter confirming your disenrollment request.

If your decision to disenroll is due to dissatisfaction with plan services or processes, we would like to have the opportunity to resolve the circumstance that led up to your decision to request disenrollment. Your Care Coordinator can discuss your decision with you. If we are unable to resolve your issue, we will help you to plan for your care following your disenrollment.

The effective date of disenrollment is the first day of the month following the month in which HRA/LDSS or NY Medicaid Choice processes the disenrollment request. We will continue to provide services to you until the date that the disenrollment takes effect. We will notify you in writing of the proposed disenrollment date.

If you are in need of continuing services that are to be provided by HRA/LDSS,

the date of disenrollment will be subject to HRA/LDSS's ability to determine and approve the request for services.

Any UnitedHealthcare Personal Assist member who joins and/or receives services from another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, or a Comprehensive Medicaid Case Management Program or OPWDD Day Treatment Program is considered to have initiated disenrollment from UnitedHealthcare Personal Assist.

Transfers Out of the Plan

You may choose to move to another managed long-term care plan if you would like. This is considered a transfer. If you transfer to another managed long-term care plan, you can continue to receive home and community-based services. To transfer, call New York Medicaid Choice at 1-888-401-6582 or TTY: 1-888-329-1541 and tell them the plan you wish to transfer to.

***Important Note:** If you choose to disenroll from a managed long-term care plan and choose not to enroll in another managed long-term care plan, you will **not** be able to keep your home and community-based services.

Involuntary Disenrollment (Plan-Initiated Disenrollment)

Involuntary disenrollment is a disenrollment that is initiated by the plan without your agreement.

Following are the reasons why UnitedHealthcare Personal Assist **must** initiate involuntary disenrollment:

- You no longer reside in the plan's service area
- You have been out of the plan's service area for more than thirty (30) consecutive days
- You are hospitalized or entered an OMH, OPWDD or OASAS residential program for 45 days or longer
- You clinically require nursing home care but are not eligible for such care under the Medicaid program's institutional rules
- You are no longer eligible for Medicaid benefits
- You no longer require more than 120 days for home and community-based services
- You are incarcerated

Please call New York Medicaid Choice at 1-888-401-6582 or TTY: 1-888-329-1541 with any questions or for help in selecting a new plan.

Following are the reasons that UnitedHealthcare Personal Assist **may** initiate involuntary disenrollment:

- You, your family members or other persons in your home engaged in conduct or behavior that seriously impaired UnitedHealthcare Personal Assist from furnishing services to you or another member
- You failed to pay or make arrangements to pay the amount owed to UnitedHealthcare Personal Assist as spend-down/surplus or Net Available Monthly Income (NAMI) within thirty (30) days after the due date
- You knowingly failed to complete and submit any necessary consent or release
- You provided false information to the plan or engaged in fraudulent conduct with respect to any substantive aspect of your plan membership

Involuntary disenrollments will **not** be processed without approval by the HRA/LDSS or NY Medicaid Choice, as applicable. An involuntary disenrollment confirmation letter will be sent to the member to notify them that the plan has received approval from the HRA/LDSS or NY Medicaid Choice, as applicable, for involuntary disenrollment with the effective date.

If you disagree with the involuntary disenrollment, you can file a fair hearing. If you request a fair hearing with continuing aid, you will remain enrolled in the health plan until a fair hearing is completed and the hearing decision is made.

Payment for Services

UnitedHealthcare Personal Assist Funding and Payment

For each member who enrolls in UnitedHealthcare Personal Assist, the plan receives a single monthly payment from Medicaid to provide and pay for all of the member's covered services. No premiums, co-payments or deductibles will be charged to members.

How Our Providers Get Paid

All network providers are under contract with UnitedHealthcare Personal Assist for the services they provide and are paid by the plan for services rendered the members. This is called fee-for-service. Providers are only paid for giving you care that is medically necessary. UnitedHealthcare Personal Assist will also pay its providers for services that require a prior authorization if you or your doctor gets an okay from the plan before you get those services. These decisions are based on medical necessity and the appropriateness of care and service. UnitedHealthcare Personal Assist providers should never charge you a co-pay. If you receive a bill directly from a provider for a covered service, please call the Member Services department at **877-512-9354 (TTY/TDD 711)** and they will assist you in resolving the situation.

What Happens if You Have a Medicaid Surplus (Spend-Down)

In New York State, you can receive Medicaid even if your monthly income is over the Medicaid limit, as long as you are willing to pay what Medicaid calls a spend-down. The monthly spend-down is an amount determined by HRA/LDSS. UnitedHealthcare Personal Assist is responsible to collect the spend-down amount from you each month. If you have a monthly spend-down, we will send you a monthly bill for the spend-down amount due. If you do not pay the amount of spend-down owed within thirty (30) days from receipt of the bill, UnitedHealthcare Personal Assist has the right to initiate disenrollment.

Coordination of Benefits (COB)

If you have coverage with both UnitedHealthcare Personal Assist and another health plan such as Medicare, both plans will share the cost of any services you get. UnitedHealthcare Personal Assist will coordinate with other payers. Medicare and other third-party insurances will be billed by providers before UnitedHealthcare Personal Assist will pay for the services. You are not liable for payment for covered services.

Member Rights and Responsibilities

Your Rights include:

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the Right to get information in a language you understand; you can get oral translation services free of charge.
- You have the Right to get information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and dignity.
- You have the Right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.

- You have the Right to be told where, when and how to get the services you need from your managed long-term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to make advance directives and plans about your care.

Your Responsibilities include:

- Receiving all covered services through UnitedHealthcare Personal Assist
- Using UnitedHealthcare Personal Assist network providers for covered services
- Obtaining prior authorization for covered services, except for pre-approved covered services
- Being seen by your physician if a change in your health status occurs
- Sharing complete and accurate health information with your health care providers
- Informing UnitedHealthcare Personal Assist staff of any changes in your health and making it known if you do not understand or are unable to follow instructions

Member Rights and Responsibilities (cont.)

- Following the patient-centered service plan recommended by UnitedHealthcare Personal Assist
- Notifying UnitedHealthcare Personal Assist within two (2) business days, preferably before, or if not then after, receiving either non-covered services or pre-approved covered services
- Notifying UnitedHealthcare Personal Assist in advance whenever you will not be home to receive services or care that have been arranged for you
- Informing UnitedHealthcare Personal Assist before permanently moving out of the service area, or of any lengthy absence from the service area
- Making every effort to pay UnitedHealthcare Personal Assist any Medicaid surplus amount owed
- Maintaining Medicaid eligibility

Fraud and Abuse

It is a criminal act if anyone deliberately gets Medicaid coverage based on false information.

It is also against the law:

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

If found guilty, penalties range from paying back Medicaid and UnitedHealthcare Personal Assist for payments made for a person's health care to jail time. Health care providers can be banned from taking part in the Medicaid program, as well as other penalties.

Some common examples of Fraud and Abuse are:

- Billing or charging you for services your health plan covers
- Offering you gifts or money to get treatment or services
- Offering you free services, equipment or supplies in exchange for your Medicaid number

- Giving you treatment or services you don't need
- Physical, mental or sexual abuse by medical staff
- Someone using another person's Medicaid or UnitedHealthcare Personal Assist identification card

If you suspect provider fraud or abuse, call UnitedHealthcare Personal Assist's anonymous reporting hotline at 866-242-7727. You do not have to give your name. If you do give your name, the provider will not be told that you called.

You can also anonymously report provider fraud to the **New York State Office of Medicaid Inspector General (NYS OMIG)** in the following ways:

Telephone:

Toll-Free 877-873-7283 or
518-402-1378

Mail:

NYS OMIG
Bureau of Medicaid
Fraud Allegations
800 North Pearl Street
Albany, NY 12204

Fax: 518-408-0480

E-mail: bmfa@omig.ny.gov

Internet: www.omig.ny.gov

Privacy Notices

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE SAYS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED. IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. READ IT CAREFULLY.

Effective September 23, 2013

We¹ must by law protect the privacy of your health information (“HI”). We must send you this notice. It tells you:

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

We must by law follow the terms of this notice.

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

We have the right to make the changed notice apply to HI that we have now and to future information. We will follow the law and give you notice of a breach of your HI.

We collect and keep your HI so we can run our business. HI may be oral, written or electronic. We limit access to all types of your HI to our employees and service providers who manage your coverage and provide services. We have physical, electronic and procedural safeguards per federal standards to guard your HI.

How We Use or Share Information

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

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

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

- **For Payments.** This also may include coordinating benefits. For example, we may tell a doctor if you are eligible for coverage and how much of the bill may be covered.
- **For Treatment** or managing care. For example, we may share your HI with providers to help them give you care.
- **For Health Care Operations** related to your care. For example, we may suggest a disease management or wellness program. We may study data to see how we can improve our services.
- **To tell you about Health Programs or Products.** This may be other treatments or products and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment and summary HI to an employer plan sponsor. We may give them other HI if they agree to limit its use per federal law.
- **For Underwriting Purposes.** We may use your HI to make underwriting decisions but we will not use your genetic HI for underwriting purposes.

- **For Reminders** on benefits or on care, such as appointment reminders.

We may use or share your HI as follows:

- **As Required by Law.**
- **To Persons Involved With Your Care.** This may be to a family member. This may happen if you are unable to agree or object. Examples are an emergency or when you agree or fail to object when asked. If you are not able to object, we will use our best judgment. Special rules apply for when we may share HI of people who have died.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability, as allowed by law.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) To give health care; (2) To protect your health and the health of others; (3) For the security of the institution.
- **To Our Business Associates** if needed to give you services. Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.
- **Other Restrictions.** Federal and state laws may limit the use and sharing of highly confidential HI. This may include state laws on:
 1. HIV/AIDS
 2. Mental health
 3. Genetic tests
 4. Alcohol and drug abuse
 5. Sexually transmitted diseases and reproductive health
 6. Child or adult abuse or neglect or sexual assault

If stricter laws apply, we aim to meet those laws. Attached is a "Federal and State Amendments" document.

Privacy Notices (cont.)

Except as stated in this notice, we use your HI only with your written consent. This includes getting your written consent to share psychotherapy notes about you, to sell your HI to other people, or to use your HI in certain promotional mailings. If you allow us to share your HI, we do not promise that the person who gets it will not share it. You may take back your consent, unless we have acted on it. To find out how, call the phone number on the back of your ID card.

Your Rights

You have a right:

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others involved in your care or payment for it. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. (For example, at a P.O. Box instead of your home.) We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI that we use to make decisions about you. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you will have the right to ask for an electronic copy to be sent to you. You can ask to 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: (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 require us to track.
- **To get a paper copy of this notice.** You may ask for a copy at any time. Even if you agreed to get this notice electronically, you have a right to a paper copy. You may also get a copy at our website, www.UHCCCommunityPlan.com.

Using Your Rights

- **To Contact Your Health Plan. Call the phone number on the back of your ID card.** Or you may contact the UnitedHealth Group Call Center at 1-866-675-1607 (TTY: 711).
- **To Submit a Written Request.**
Mail to:
UnitedHealthcare Government Programs Privacy Office
MN006-W800
P.O. Box 1459
Minneapolis, MN 55440

- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

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

Effective September 23, 2013

We² protect your “personal financial information” (“FI”). This means non-health information about someone with health care coverage or someone applying for coverage. It is information that identifies the person and is generally not public.

Information We Collect

We get FI about you from:

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

Sharing of FI

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

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

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

Confidentiality and Security

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

Questions About This Notice

If you have any questions about this notice, please **call the toll-free member phone number on the back of your health plan ID card** or contact the UnitedHealth Group Customer Call Center at 1-866-675-1607 (TTY: 711).

Privacy Notices (cont.)

¹ This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Maryland, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD – Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of New York, Inc.; Physicians Health Choice of Texas, LLC; Preferred Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of 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 North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

² For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physicians Choice Insurance Services, LLC; ProcessWorks, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

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

Revised: September 23, 2013

The first part of this Notice (pages 1 – 4) says how we may use and share your health information (“HI”) under federal privacy rules. Other laws may limit these rights. The charts below:

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

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

Summary of Federal Laws

Alcohol & Drug Abuse Information

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

Genetic Information

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

Privacy Notices (cont.)

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA

Summary of State Laws (continued)

Genetic Information

We are not allowed to disclose genetic information without your written consent.	CA, CO, IL, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT

HIV / AIDS

We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR

Mental Health

We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Child or Adult Abuse

We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI
--	--

Information the Plan Will Provide Upon Request

The following information will be provided upon request to a member or prospective member:

- Names, addresses, and positions of the Officers and Board of Directors
- Information on the structure and operation of UnitedHealthcare Personal Assist
- Most recent certified financial statement
- Procedures for protecting the confidentiality of medical records and other member information
- Quality management program and procedures
- Health care provider hospital affiliations, if any
- Clinical review criteria for particular conditions and diseases and other clinical information that is used in utilization review
- Provider application procedures and minimum qualifications requirements for health care providers to be considered by UnitedHealthcare Personal Assist

