Welcome to the
community.

New York

Dual Advantage

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UnitedHealthcare®
Community Plan

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Telephone Numbers

Member Services
(8 a.m. to 8 p.m., Monday – Friday) **1-800-514-4912**
. . . . . **TTY: 711**

New York State Health Dept. (Complaints) **1-866-712-7197**

New York City and Long Island

Nassau County Department of Social Services **516-227-8000**

New York City Human Resources Administration **718-557-1399**

New York City Human Resources Administration **1-877-472-8411**
(within the five boroughs)

New York Medicaid Choice **1-800-505-5678**

Website **MyUHC.com/CommunityPlan**

Your Health Providers

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Emergency Room: _____ Phone: _____

Pharmacy: _____ Phone: _____

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Welcome to
UnitedHealthcare Dual Advantage.

We are glad that you chose UnitedHealthcare Dual Advantage, UnitedHealthcare of New York, Inc.'s Medicaid Advantage program. Medicaid Advantage is a program for people who have both Medicare and Medicaid. This handbook tells you about the added health benefits UnitedHealthcare covers since you also have Medicaid and you have joined UnitedHealthcare Dual Advantage. This plan is available to members who live in the five boroughs of New York City or Nassau county in New York State.

These benefits are in addition to the Medicare benefits described in the UnitedHealthcare Medicare Evidence of Coverage. Keep this handbook with the UnitedHealthcare Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

In order to be in UnitedHealthcare for the Medicaid Advantage benefits, you must also be enrolled in UnitedHealthcare for your Medicare coverage. Enrollment in the Medicaid Advantage Program is voluntary.

Member Services.
1-800-514-4912,
TTY: 711
8 a.m. – 8 p.m., Monday – Friday

You can call to get help anytime you have a question. You can call and ask about benefits and services, to get help with referrals, replace a lost ID card, ask about any change that might affect you and your benefits, or ask for assistance with your Medicaid renewal.

The coverage explained in this handbook becomes effective on the effective date of your enrollment in UnitedHealthcare Dual Advantage.

Since you have decided to join UnitedHealthcare for your Medicaid Advantage benefits, UnitedHealthcare will cover the deductibles and co-payments that Medicare does not cover, except for chiropractic care and pharmacy items. If there is a monthly premium for benefits (see Chapter 1 of the UnitedHealthcare Medicare Evidence of Coverage), you will not have to pay that premium since you have Medicaid. We will also cover certain services that are not covered by Medicare but are covered by Medicaid.

Chapter 3 of UnitedHealthcare Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or an urgent need for care.

If you live in New York City or Nassau county, you can also call the New York Medicaid Choice HelpLine at 1-800-505-5678.

Deductibles and co-payments on Medicare covered services.
These amounts are shown in the Benefits Chart in Chapter 4 of the UnitedHealthcare Medicare Evidence of Coverage under the column "What you must pay when you get these services." Because you have joined UnitedHealthcare, and you have Medicaid, UnitedHealthcare will pay these amounts. You do not have to pay for these deductibles and co-payments except for those that apply to chiropractic care and pharmacy items.

Services Covered

Most of your health services and benefits are covered by Medicare and are described in the UnitedHealthcare Medicare Evidence of Coverage.

Because you have Medicaid, you get some extra services from our plan. These services must be medically necessary and, in some cases, you may need a referral from your Primary Care Provider (PCP). You must get these services from the providers who are in UnitedHealthcare Dual Advantage. If you cannot find a provider in our plan, please call Member Services at **1-800-514-4912**, **TTY: 711**, and we will help you find a provider that participates in the plan.

When your PCP sends you to see a specialist, he or she will give you the name of the specialist and may help make an appointment for you. Your PCP may give you a note on his or her letterhead or on a prescription form with the specialist's name and any important information the specialist needs to have when he or she sees you. If the specialist is not in the UnitedHealthcare Dual Advantage network, your PCP must call UnitedHealthcare and get permission for you to go to that doctor. This permission is called "pre-authorization." Your PCP will explain all of this to you when he or she sends you to a specialist.

Private Duty Nursing

Private duty nursing services provided in the member's home are covered only when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and must be provided in the member's home in accordance with the ordering physician's or certified nurse practitioner's written treatment plan. These services must be provided through an approved certified home health agency, a licensed home care agency, or a private practitioner. Your PCP or plan specialist must call us to get authorization for these services. Private duty nursing care is not a covered benefit on an inpatient basis in a hospital or other inpatient setting.

Non-Emergency Transportation

UnitedHealthcare wants to make sure that you get the medical care that you need. That means making sure that you are able to get to your medical appointments. We offer non-emergency transportation for our members living in Manhattan, Bronx, Kings, Queens, Richmond and Nassau counties for medical appointments only. Transportation is not provided for any non-medical appointment of any kind. Under your Medicare benefits, you are covered for 24 one-way car service trips for medical appointments. Once this 24-trip maximum has been reached, non-emergency transportation is covered under the Medicaid portion of your plan in the following way:

Members who live in New York City.

- If you live in New York City, we will provide a Metro Card for you to get to and from your appointment. The Metro Card will be mailed to you. Please request your Metro Card at least ten (10) days in advance of your appointment and we will send it to you in time for your appointment. If you need to schedule an urgent medical appointment and are unable to tell us ten (10) days before, call us as soon as you know about the appointment and we will either overnight a Metro Card to you, send it to you as reimbursement for your out-of-pocket transportation expense, or arrange for another form of transportation. To be eligible for a Metro Card, the provider's office must be 10 blocks or more from where you live. You may be eligible for a Metro Card for appointments less than 10 blocks from your home if you have a medical condition that prevents you from walking to your appointment. Your doctor will be asked to document the medical reason.
- If you have a disability or medical condition that prevents you from taking public transportation, we will arrange for car service, ambulette or stretcher transportation for you. Your PCP or other health care provider will be asked to document the medical reason why you are unable to use public transportation. If you are approved for car service, ambulette or stretcher transportation, you should request this form of transportation at least (3) three days before your appointment.
- If you require an attendant or have a young child who needs to go with you to your doctor's appointment, transportation is also covered for the attendant or child(ren). If your child(ren) requires a car seat or booster seat, you must bring your own car seat or booster with you. We do not provide car seats and boosters.

Members who live in Nassau county.

- For members who live in Nassau county, we will provide car service to get you to and from your medical appointment. You should request transportation at least three (3) days before your scheduled appointment so that we can make arrangements for you.
- If you require special transportation like ambulette or stretcher transportation, your PCP may be asked to explain the medical condition you have that requires these forms of transportation.
- If you require an attendant to go with you to your doctor's appointment or if your child is the member of the plan, transportation is also covered for the attendant or parent or guardian. If your child(ren) requires a car seat or booster seat, you must bring your own car seat or booster with you. We do not provide car seats and boosters.

In order for us to assist you with your transportation needs, please call Member Services at **1-800-514-4912**, **TTY: 711**, three (3) days before your medical appointment.

Dental Care

UnitedHealthcare believes that providing you with good dental care is important to your overall health care. We offer dental care through contracts with individual dentists who are experts in providing high-quality dental services. Covered services include regular and routine dental services such as preventive dental checkups, cleaning, X-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist.

How to access dental services.
UnitedHealthcare Dual Advantage covers dental services. You can use your UnitedHealthcare ID card to see any dentist in our network. You will not need a separate dental ID card. When you visit your dentist, you should show your plan ID card.

You may go to any plan provider or self-refer to a dental clinic that is operated by an academic dental center. If you need assistance with finding or changing a dental provider, please call UnitedHealthcare at **1-800-514-4912**, **TTY: 711**.

Home Health Care Services

Home health care services are covered under the plan. Services must be provided by a certified home health agency. Covered services include:

- Nursing services provided on a part-time or intermittent basis by a registered nurse;
- Home health aide services as ordered by a physician;
- Physical therapy, occupational therapy, or speech pathology and audiology services;
- Medical equipment and supplies.

Your physician must prescribe these services and obtain authorization from UnitedHealthcare by calling 1-866-604-3267, or your physician or health care provider may send a request in writing or by facsimile (fax) at 1-800-771-7507.

Durable Medical Equipment

Durable medical equipment (DME) coverage includes medically necessary equipment and devices as prescribed by a physician including:

- Wheelchairs, canes, and walkers.
- Prosthetic devices.
- Orthotics.
- Hearing aids.

You may contact an in-network DME provider for services. Your physician must obtain authorization for medical equipment over $500 from UnitedHealthcare by calling 1-866-604-3267, or your physician or health care provider may send a request in writing or by facsimile (fax) at 1-800-771-7507.

Inpatient Mental Health Care Over the 190-Day Lifetime Medicare Limit

If you exceed the inpatient mental health benefit limit under your Medicare Evidence of Coverage, you are eligible for up to 365 days per year under the Medicaid portion of your UnitedHealthcare Dual Advantage coverage. These services require pre-authorization from us and your physician should call us at 1-888-291-2506 to get authorization, or your physician or health care provider may send a request in writing or by facsimile (fax) at 1-800-322-9104.

Outpatient Mental Health and Substance Abuse

If you exceed the outpatient mental health benefit limit under your Medicare Evidence of Coverage, you are eligible for additional medically necessary visits. There is no visit maximum for this benefit under this portion of the plan. You may go for one (1) mental health assessment in any 12-month period. You must use a UnitedHealthcare Dual Advantage provider, but you do not need an OK from your PCP. If you need more visits, your mental health provider will arrange them with UnitedHealthcare.

You may also go for one (1) chemical dependence assessment for all inpatient detoxification, inpatient rehabilitation, or outpatient detoxification services in any 12-month period. If you need more care, your chemical dependence or detoxification program will work with UnitedHealthcare. If you want a chemical dependence assessment for any alcohol and/or substance abuse outpatient treatment services, except outpatient detoxification services, you must use your Medicaid Benefit card to go to any provider that takes Medicaid.

Hearing Services

Hearing services and products are available when medically necessary to help improve disability caused by the loss or impairment of hearing. Services include hearing evaluation and selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, ear molds, special fittings and replacement parts.

You must use a UnitedHealthcare Dual Advantage provider, but you do not need an OK from your PCP. If you need assistance with finding or changing a hearing provider, please call UnitedHealthcare at **1-800-514-4912**, **TTY: 711**.

Vision Services

Services of Optometrists, Ophthalmologists and Ophthalmic dispensers including eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed.

You must use a UnitedHealthcare Dual Advantage vision provider, but you do not need an OK from your PCP. If you need assistance with finding or changing a vision provider, please call UnitedHealthcare at **1-800-514-4912**, **TTY: 711**.

Service Authorization and Actions

Prior Authorization

There are some Medicaid treatments and services that you will need to get approved before you receive them or in order to be able to continue receiving them. This is called prior authorization. Your health care provider can ask for this on your behalf. The following treatments and services must be approved before you get them:

- Admissions to inpatient facilities (example: hospital, except for maternity).
- Home health care services.
- Durable medical equipment over $500.
- Accidental dental services.
- Experimental or investigational health care services.
- Out-of-network services.
- Mental health or substance abuse services.
- MRIs, MRAs, and PET scans.
- Services of a non-participating provider.
- Cosmetic and reconstructive surgery.
- Gastric bypass evaluations and surgery.
- Physical, occupational and speech therapy after the 20th visit. This limitation does not apply to the developmentally disabled or members suffering from traumatic brain injury.
- Skilled nursing facility.
- Hospice services, inpatient and outpatient.

Asking for approval of a treatment or service is called a service authorization request. To get approval for these treatments or services, your doctor or health care provider must call UnitedHealthcare's Prior Authorization Department at 1-866-604-3267, or your physician or health care provider may send a request in writing or by facsimile (fax) at 1-800-771-7507.

Written physician or health care provider requests can be sent to:

UnitedHealthcare Dual Advantage of New York
14141 SW Freeway, 6th Floor
Sugar Land, TX 77478

You will also need to get prior authorization if you are getting one or more of these services now, but need to continue or get more of the care. This includes a request for Medicaid covered home health care while you are in the hospital or after you have just left the hospital. This is called concurrent review.

For prior authorization for outpatient radiology, your doctor or health care provider should call 1-866-889-8054 or send a request by facsimile (fax) at 1-866-889-8061. For prior authorization for mental health or substance abuse services, your doctor or health care provider should call 1-800-291-2506 or send a request by facsimile (fax) at 1-800-322-9104.

What happens after we get your service authorization request.
The health plan has a review team to be sure you get the services that are covered by your Medicaid plan if needed. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an action. These decisions will be made by a qualified health care professional. If it is decided that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You or someone you trust can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a standard or fast track process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we receive a request for Medicaid covered home health care, we will handle the request as a fast track review. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for an appeal or fair hearing you will have if you don't agree with our decision.

Timeframes

Timeframes for prior authorization requests:

- **Standard review:** We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 3 work days. We will tell you by the third work day if we need more information.
- **If you are in the hospital or have just left the hospital**, and you ask for Medicaid covered home health care on a Friday or before a holiday, we will make a decision no later than 72 hours of when we have all the information we need.

We will attempt to tell you our decision by phone and send a written notice later.

Timeframes for concurrent review requests:

- **Standard review:** We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- With respect to requests for home health care immediately following an inpatient hospital admission, we will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request or within seventy-two (72) hours of receipt of the necessary information when the day after the request date falls on a weekend or holiday.
- **Fast track review:** We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 3 work days after we receive your request. We will tell you by the third work day if we need more information.

If we need more information to make either a standard or fast track decision about your service request, we will:

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-800-514-4912**, **TTY: 711**, or in writing or by facsimile (fax) at 1-800-771-7507.

Please send all written requests to:

UnitedHealthcare Dual Advantage of New York
14141 SW Freeway, 6th Floor
Sugar Land, TX 77478

You or someone you trust can file a complaint if you don't agree with our decision to take more time to review your request. You can file this complaint with the Health Plan by calling Member Services at **1-800-514-4912**, **TTY: 711**, or with the New York State Department of Health by calling 1-866-712-7197.

We will notify you of our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

Other Decisions About Your Care

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called retrospective review. We will tell you if we take these other actions.

Timeframes for notice of other actions:

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid, even if we later deny payment to the provider.

Medicaid Services Not Covered by Our Plan

There are some Medicaid covered services that UnitedHealthcare Dual Advantage does not provide. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at **1-800-514-4912**, **TTY: 711**, if you have a question about whether a benefit is covered by UnitedHealthcare or Medicaid.

Some of the Services Covered by Medicaid Using Your Medicaid Benefit Card Include:

Pharmacy.
Most prescription drugs are covered by UnitedHealthcare through Medicare as described in Chapter 5 and 6 of the UnitedHealthcare Medicare Evidence of Coverage (EOC). Regular Medicaid will cover certain drugs not covered by UnitedHealthcare or Medicare, such as barbiturates, benzodiazepines, some prescription vitamins and some nonprescription drugs. Medicaid may also cover drugs that we deny. This is limited to certain types of drugs: atypical antipsychotics; antidepressants; anti-retro-virals; and, under certain circumstances, anti-rejection drugs used in transplants. You can also get certain enteral formulas and some medical supplies that we do not cover from any pharmacy that takes Medicaid. Regular Medicaid co-payments may apply.

Certain mental health services, including:

- Intensive psychiatric rehabilitation treatment.
- Day treatment.
- Continuing day treatment.
- Case management for seriously and persistently mentally ill (sponsored by state or local mental health units).
- Partial hospital care not covered by Medicare.
- Assertive Community Treatment (ACT).
- Personalized Recovery Oriented Services (PROS).

Rehabilitation services to residents of OMH licensed Community Residences (CRs) and family-based treatment programs.

Certain mental retardation and developmental disabilities services, including:

- Long-term therapies.
- Day treatment.
- Medicaid service coordination.
- Services received under the home and community-based services waiver.
- Medical model (care-at-home) waiver services.

Other Medicaid services.

- Methadone treatment.
- Personal care services.
- Comprehensive Medicaid case management.
- Directly observed therapy for TB (Tuberculosis).
- Adult day treatment for persons with HIV/AIDS.
- HIV COBRA case management.
- Adult day health care.
- Personal emergency response services.
- Skilled nursing facility days not covered by Medicare.
- Out-of-network family planning services.

Family planning.

Medicaid Advantage Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

Services Not Covered by Medicaid Advantage or Medicaid

You must pay for services that are not covered by UnitedHealthcare or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by UnitedHealthcare or Medicaid are:

- Cosmetic surgery if not medically needed.
- Routine foot care unless covered by Medicare portion of the plan.
- Chiropractic care (for those 21 years and older) unless covered by Medicare portion of the plan.
- Personal and comfort items.
- Infertility treatment.
- Services of a provider that is not part of the plan (unless UnitedHealthcare sends you to that provider).
- Except for a true medical emergency, the Medicaid portion of your plan will not cover any services received outside of the plan's service area.

If you have any questions, call Member Services at **1-800-514-4912**, **TTY: 711**.

Disenrollment

You can choose to disenroll.
You can ask to leave the UnitedHealthcare Dual Advantage Program at any time for any reason. However, if you choose to disenroll from the Medicaid portion of this plan with UnitedHealthcare, you will no longer be eligible to remain enrolled in our Medicaid Advantage Plan. You must be dually enrolled in both Medicare and Medicaid with UnitedHealthcare to remain in the Medicaid Advantage Plan. If you do disenroll your Medicaid enrollment with UnitedHealthcare, you will only be covered by our Medicare Advantage Plan.

To request disenrollment, call Member Services or New York City Human Resources Administration (HRA) or in Broome, Onondaga, Jefferson and Nassau Counties call your county Department of Social Services; you will find the phone number listed in the front cover of this handbook. You can also call New York Medicaid Choice at 1-800-505-5678 for help in disenrolling or transferring. It could take up to six weeks to process, depending on when your request is received. You can ask for a faster disenrollment if you believe that a delay could harm your health. You can also ask for faster action if you leave our Medicare plan, or believe that you were enrolled in this program without your permission. Just call New York City Human Resources Administration (HRA) or in Broome, Onondaga, Jefferson and Nassau Counties call your local Department of Social Services or New York Medicaid Choice at 1-800-505-5678.

You may disenroll to regular Medicaid or join another Medicaid Advantage Plan as long as you also join that plan for your Medicare coverage.

You will have to leave UnitedHealthcare Dual Advantage if you:

- No longer are in UnitedHealthcare for your Medicare coverage.
- Permanently move out of the UnitedHealthcare Dual Advantage service area.
- Join a long-term home health care program or managed long-term care program.
- Are considered in permanent status in a nursing home or certain other institutions.
- Are incarcerated.
- Have a change in your Medicaid or become part of a program that makes you ineligible for Medicaid Advantage.

In some cases you may be “guaranteed” coverage by UnitedHealthcare. That means we will not drop you as a member of our Medicaid Advantage Program during the first six months of your enrollment — even if you are no longer eligible for Medicaid and your Medicaid case is closed. Your coverage will not be “guaranteed” if the reason you lost your Medicaid eligibility is related to death, moving out of state or incarceration. During this time, you can get the services that our Medicaid Advantage Program covers. You can also get family planning care and limited Medicaid pharmacy benefits using your Medicaid card. Guaranteed coverage does not apply if you choose to leave UnitedHealthcare Dual Advantage or if UnitedHealthcare leaves the Medicaid Advantage program.

We can ask you to leave the plan.
We will ask that you leave our Medicaid Advantage Plan if you are asked to leave our Medicare Advantage Plan.

Appeals and Complaints

What to do if you have a complaint about our plan or want to appeal a decision about your care.
As a Dually-Eligible member of our plan, the way you make complaints and appeals about your services will depend on whether UnitedHealthcare determines that the services are covered by Medicare or Medicaid.

- For complaints and appeals about a service that is covered only by Medicare (e.g., chiropractic services), you will follow the rules outlined in Chapter 9 of the UnitedHealthcare Dual Advantage Evidence of Coverage.
- For complaints and appeals about a service that is covered only by Medicaid (e.g., private duty nursing, non-emergency transportation and dental services), you will follow the Medicaid rules listed below.
- For complaints and appeals about all other services covered by UnitedHealthcare Dual Advantage, you may choose to follow either the Medicare rules outlined in Chapter 9 of the UnitedHealthcare Dual Advantage Evidence of Coverage or the Medicaid rules described below.

If you choose to follow the Medicare rules, you cannot use your Medicaid complaint and appeal rights, including the right to a State Fair Hearing regarding the complaint or appeal. But if you choose to follow the Medicaid rules, you will have up to 60 days from the day of UnitedHealthcare's notice of denial of coverage to use your Medicare complaint and appeal rights.

UnitedHealthcare will explain the complaints and appeals processes under Medicaid noted in the following sections that are available to you depending on the complaint or appeal you have. Call Member Services at **1-800-514-4912**, **TTY: 711**, to get more information on your rights and the options available to you.

Medicaid Rules for Appeals and Complaints

Action appeals.
Any decision to deny or to approve a service request or payment of a claim for an amount that is less than requested is called an action. Steps to request a review of an action include provider reconsideration and an action appeal.

Your provider can ask for reconsideration.
If we made a decision that your service authorization request was not medically necessary or was experimental or investigational and we did not talk to your doctor, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one work day.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 work days from the date of our letter/notice to you to file an appeal but no more than 90 calendar days from the notice of action to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services at **1-800-514-4912**, **TTY: 711**, if you need help filing an action appeal.
- We will not treat you any differently or act badly toward you because you file an action appeal.
- The action appeal can be made by phone or in writing. If you make an action appeal by phone, it must be followed up in writing. You must sign the written appeal that you send to us. Please send all written appeals to:

  UnitedHealthcare Dual Advantage of New York
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

Your action appeal will be reviewed under the fast track process:

- If you or your doctor asks to have your action appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health.
- If your request for fast track is denied, we will tell you and your action appeal will be reviewed under the standard process.
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.
- If your request was denied when you asked for Medicaid covered home health care after you were in the hospital.

Fast track action appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your action appeal:

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.
- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

- Before and during the action appeal you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.
- You can also provide information to be used in making the decision in person or in writing.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at 1-866-712-7197.
- If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:
  - A written statement that the service you asked for is different from the service we have in our network; and
  - Two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you and will not cause you more harm than the service we have in our network.

Timeframes for action appeals:

- **Standard action appeals:** If we have all the information we need, we will tell you our decision in thirty (30) days from your action appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.
- **Fast track action appeals:** If we have all the information we need, fast track action appeal decisions will be made in 2 work days from your action appeal. If we need more information, we will tell you within 3 work days after giving us your action appeal. We will tell you our decision by phone and send a written notice later.

If we need more information to make either a standard or fast track decision about your action appeal, we will:

- Write you and tell you what information is needed.
- Call you right away and send a written notice later if your request is in a fast track review.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-800-514-4912**, **TTY: 711**, or writing. Please send written requests to:

UnitedHealthcare Dual Advantage of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

You can ask someone you trust (such as a legal representative, a family member or friend) to file an appeal for you. If you need our help because of a hearing or vision impairment, or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing an appeal.

You or someone you trust can file a complaint if you don't agree with our decision to take more time to review your request. You can file this complaint with the Health Plan by calling Member Services at **1-800-514-4912**, **TTY: 711**, or with the New York State Department of Health by calling 1-866-712-7197.

If your original denial was because we said the service was not medically necessary or the service was experimental or investigational, or the out-of-network service was not different from a service that is available in our network, and we do not tell you our decision about your appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to continue while appealing a decision about your care.
In some cases you may be able to continue the services while you wait for your appeal case to be decided. You may be able to continue the services that are scheduled to end or be reduced if you appeal and ask for a Fair Hearing:

- Within 10 days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal or your Fair Hearing results in another denial, you may have to pay for the cost of any continued benefits that you received. The decision you receive from the Fair Hearing officer will be final.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational, or the out-of-network service was not different from a service that is available in our network, you can ask New York State for an independent external appeal. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's Medicaid benefit package, or be medically necessary or be an experimental/investigational treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an external appeal.

Additionally in January 2010, there has been a change to New York State Public Health Law about providers requesting external appeals. Providers can now ask for external appeals themselves under certain circumstances. They can also still ask for external appeals for members. If a provider's external appeal is denied because the external appeal agent says the care is not medically necessary, the provider may not ask the member to pay for the care. The member is responsible only for any applicable co-pays. This is called being "held harmless." If you get a bill from your provider after an external appeal decision, call Member Services at **1-800-514-4912**, **TTY: 711**.

Before you appeal to the state:

- You must file an action appeal with the plan and get the plan's final adverse determination; or
- If you had a fast track action appeal and are not satisfied with the plan's decision, you can choose to file a standard action appeal with the plan or go directly to an external appeal; or
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal.
- You have 4 months after you receive the plan's final adverse determination to ask for an external appeal.

If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 4 months of when you made that agreement.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Insurance within 4 months from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You can call Member Services at **1-800-514-4912**, **TTY: 711**, if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the State Insurance Department, 1-800-400-8882.
- Go to the State Insurance Department's website at **www.ins.state.ny.us**.
- Contact the health plan at **1-800-514-4912**, **TTY: 711**.

Your external appeal will be decided in 30 days. More time (up to 5 work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if your doctor says 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 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for 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.

Complaints

We hope our plan serves you well. If you have a problem, please call Member Services at **1-800-514-4912**, **TTY: 711**, or write to Member Services. Please remember that complaints about services that are a benefit only under Medicare should be handled through the UnitedHealthcare Medicare complaint process. Complaints about services covered only by Medicaid should be handled through the UnitedHealthcare Medicaid complaint process. You can choose to use either the Medicare or Medicaid complaints process for complaints about services that UnitedHealthcare determines are a benefit under both Medicare and Medicaid.

Most problems can be solved right away. Problems that are not solved over the phone and any complaint that comes in about a Medicaid service will be handled according to the procedures described below. You can ask someone you trust (such as a legal representative, a family member or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to file a complaint with the plan:
To file by phone, call Member Services at **1-800-514-4912**, **TTY: 711**. If you call us after hours, leave a message. We will call you back the next work day. We will tell you if we need more information to make a decision.

You can write us with your complaint. It should be mailed to:

UnitedHealthcare Dual Advantage of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

What happens next:
If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint.
- How to contact this person.
- If we need more information.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, you or someone you trust can file a complaint appeal with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have 60 work days from the date of our letter/notice to you to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you.
- The appeal must be made in writing. If you make an appeal by phone, it must be followed up in writing. A complaint appeal must be made in writing and sent to:

  UnitedHealthcare Dual Advantage
  Grievance and Appeals
  77 Water Street, 14th Floor
  New York, NY 10005

What happens after we get your complaint appeal:

After we get your complaint appeal, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint appeal.
- How to contact this person.
- If we need more information.

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, who were not involved in making the first decision about your complaint.

If we have all the information we need, you will know our decision within 30 work days. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the complaint appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866-712-7197.

Fair Hearings

In some cases you may ask for a Fair Hearing from New York State:

- You are not happy with a decision that your local department of social services or the State Department of Health made about your staying or leaving the Medicaid Advantage program.
- You are not happy with a decision that UnitedHealthcare made about one of the services that you were getting. You feel the decision limits your Medicaid benefits or that the plan did not make the decision in a reasonable amount of time.
- You are not happy with a decision that UnitedHealthcare made that denied services. You feel that the decision limits your Medicaid benefits or that UnitedHealthcare did not make the decision in a reasonable amount of time.
- You are not happy with a decision that your doctor would not order one of the Medicaid services that you wanted. You feel that the doctor's decision stops or limits your Medicaid benefits. You must file a complaint and an appeal with UnitedHealthcare. If UnitedHealthcare agrees with your doctor, you may ask for a State Fair Hearing.
- In some cases, you may be able to keep getting care the same way while waiting for your State Fair Hearing.

If you filed a complaint or appeal under Medicare rules, you may not then request a State Fair Hearing about the same complaint or appeal.

You can use one of the following ways to request a Fair Hearing:

- By phone. Call toll-free: 1-800-342-3334.
- By fax at 1-518-473-6735.
- By Internet at **www.otda.state.ny.us/oah/forms.asp**.
- By mail:

  Fair Hearing
  NYS Office of Temporary and Disability Assistance
  P.O. Box 1930
  Albany, NY 12201

Remember, you can file a complaint anytime to the New York State Department of Health by calling 1-866-712-7197. Call Member Services at **1-800-514-4912**, **TTY: 711**, if you have any questions.

Member Rights and Responsibilities

As a member of UnitedHealthcare Dual Advantage, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from UnitedHealthcare.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in a language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use the UnitedHealthcare complaint system to settle any complaints, or you can complain to the NY State Department of Health or the local Department of Social Services anytime you feel you were not fairly treated.
- Use the State Fair Hearing system.

- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

As a member of UnitedHealthcare Dual Advantage, you agree to:

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

If you get a bill.

UnitedHealthcare Dual Advantage provides a full range of health care services at no cost to you. You never have to pay your PCP anything. You should not be charged for any approved services offered through UnitedHealthcare Dual Advantage when you get them from a UnitedHealthcare provider.

You may be asked to pay for services that are not covered by Medicaid Advantage or Medicaid. You cannot be charged for any such service unless you understood and agreed before the care was given that you would pay for it.

If you get a medical bill, call Member Services at **1-800-514-4912**, **TTY: 711**, and a representative will help you straighten out the problem.

If you are asked to pay for a service and you are not sure whether it is covered, call Member Services at **1-800-514-4912**, **TTY: 711**, before paying for the service.

If you paid a bill and you are seeking reimbursement, call Member Services at **1-800-514-4912**, **TTY: 711**, and a representative will assist you.

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.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES.
THIS NOTICE SAYS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED. IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2015.
We[1] 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 health plan website **MyUHC.com/CommunityPlan**. 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 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 (STD) 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.

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 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, **MyUHC.com/CommunityPlan**.

Using your rights.

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-800-493-4647**, **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. REVIEW IT CAREFULLY.

Effective January 1, 2015.
We[2] 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 your health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-800-493-4647**, **TTY: 711**.

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

[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1 on this 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; OptumHealth Care Solutions, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; ProcessWorks, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare 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: January 1, 2015.
The first part of this Notice (pages 29 – 33) says how we may use and share your health information ("HI") under federal privacy rules. Other laws may limit these rights. The charts below:

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

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

Summary of Federal Laws

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

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

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	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 share 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 (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, 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

We're here for you.

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-514-4912**, **TTY: 711**. You can also visit our website at **MyUHC.com/CommunityPlan**.

UnitedHealthcare Community Plan
77 Water Street, 14th Floor
New York, NY 10005

MyUHC.com/CommunityPlan

1-800-514-4912, **TTY: 711**

UnitedHealthcare® Community Plan


UnitedHealthcare®
Community Plan