Welcome to the
community.

Maryland HealthChoice
Member Handbook

2015 – 2016 (effective December 2015)

CSMD16MC3832227_000

UnitedHealthcare®
Community Plan

Important Telephone Numbers

UnitedHealthcare Member Services . . . . . **1-800-318-8821, TTY: 711**
Monday through Friday 8:00 a.m. to 7:00 p.m.

24/7 NurseLine℠ Services **1-877-440-0251**

Website **myuhc.com/CommunityPlan**

Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) Name: _____

Address: _____

Phone: _____

UnitedHealthcare®
Community Plan

Getting started.

We want you to get the most from your health plan right away.
Start with these three easy steps:

1

Call your Primary Care Provider (PCP) and schedule a checkup.
Regular checkups are important for good health. Your PCP's phone number is listed on the member ID card that you recently received in the mail. If you don't know your PCP's number, or if you'd like help scheduling a checkup, call Member Services at **1-800-318-8821, TTY: 711**. We're here to help.

2

Register online and learn more about your plan.
Go to **myuhc.com/CommunityPlan** to sign up for Web access to your account. This secure website keeps all of your health information in one place. In addition to plan details, the site includes useful tools that can help you.

3

Get to know your health plan.
Start with the Health Plan Highlights section on page 7 for a quick overview of your new plan. And be sure to keep this booklet handy, for future reference.

Thank you for choosing UnitedHealthcare. We help people live healthier lives.

At UnitedHealthcare, we want you to be healthy and stay healthy. Your benefits include medical, prescription, and vision services to help you be and stay healthy. We also have a network of over 7,000 providers who will help you get the care you need.

Your Primary Care Provider (PCP) wants to learn about your health and take care of you. So, it is important for you to visit your PCP. If your PCP cannot get you the care you need, he or she will refer you to a specialty doctor. You can find the name and phone number of your PCP on your ID card.

As a member, please do the following things:

- Read all the materials in this packet. Find out about all your benefits and how to get care.
- Make an appointment with your PCP right away.
- Children under 21 and pregnant women receive dental benefits through the Maryland Healthy Smiles Program. Please call 1-855-934-9812 right away to make an appointment.
- Get a referral from your PCP for any specialty care you think you need.
- Use our website at **myuhc.com/CommunityPlan** to find a network provider near you. Use the Find-A-Doctor tool to match your needs to a doctor.

If you have questions, call UnitedHealthcare's Member Services Department, Monday through Friday 8:00 a.m. to 7:00 p.m., at **1-800-318-8821**, **TTY: 711**.

Welcome to the UnitedHealthcare family, and thank you for being a member.

UnitedHealthcare Community Plan of Maryland

Table of Contents

Benefits at a Glance

As a UnitedHealthcare Community Plan member, you have a variety of health care benefits and services available to you. Here is a brief overview. You'll find a complete listing in the Benefits section.

Primary Care Services.
You are covered for all visits to your Primary Care Provider (PCP). Your PCP is the main doctor you will see for most of your health care. This includes checkups, treatment for colds and flu, health concerns and health screenings.

Large Provider Network.
You can choose any PCP from our large network of providers. Our network also includes specialists, hospitals and drug stores — giving you many options for your health care. Find a complete list of network providers at **myuhc.com/CommunityPlan** or call **1-800-318-8821**, **TTY: 711**.

Specialist Services.
Your coverage includes services from specialists. Specialists are doctors or nurses who are highly trained to treat certain conditions. You may need a referral from your PCP first.

Medicines.
Your plan covers prescription drugs for members of all ages. Also covered: insulin, needles and syringes, birth control, coated aspirin for arthritis, iron pills and chewable vitamins.

Hospital Services.
You're covered for hospital stays. You're also covered for outpatient services. These are services you get in the hospital without spending the night.

Laboratory Services.
Covered services include tests and X-rays that help find the cause of illness.

I. Health Plan Highlights

Well-Child Visits.
All well-child visits and immunizations are covered by your plan.

Maternity and Pregnancy Care.
You are covered for doctor visits before and after your baby is born. That includes hospital stays. If needed, we also cover home visits after the baby is born.

Family Planning.
You are covered for services that help you manage the timing of pregnancies. These include birth control products and procedures.

Vision Care.
Your vision benefits include routine eye exams and glasses.

Dental Care.
Dental care available for children under 21 and pregnant women.

Manage Your Health Care Information 24/7 on myuhc.com

As a member of a UnitedHealthcare Community Plan, you're just a click away from everything you need to take charge of your health benefits. Register on **myuhc.com**. The tools and new features can save you time and help you stay healthy. Registration on the site is free.

Great reasons to use myuhc.com.

- Look up your benefits.
- Find a doctor.
- Print an ID Card.
- Find a hospital.
- View claims history.
- Keep track of your medical history, prescriptions and more on your Personal Health Record.
- Take your own Health Assessment.
- Learn how to stay healthy.

Learn how to stay healthy.

- Improve your health with an online Health Assessment.
- Chat with a nurse in real-time.

Register on myuhc.com today.

Registration is easy and fast. Sign up today! Just visit **myuhc.com/CommunityPlan**. Select "Register" on the Home Page. Follow the simple prompts. You're just a few clicks away from access to all types of information. Get more from your health care.

You can view and print your ID Card online at **myuhc.com/CommunityPlan**.

II. Access Your Information Online

UnitedHealthcare Health4Me™.
UnitedHealthcare Community Plan has a new member app. It's called UnitedHealthcare Health4Me. The app is available for Apple® or Android® tablets and smartphones. Health4Me makes it easy to:

- Find a doctor, ER or urgent care center near you.
- View your ID card.
- Read your handbook.
- Learn about your benefits.
- Contact Member Services.

Download the free Health4Me app today. Use it to connect with your health plan wherever you are, whenever you want.

Use Group ID: MDCAID to register.

III. Rights and Responsibilities

As a member of UnitedHealthcare Community Plan, you have the right to:

- Be treated with respect, dignity and privacy. UnitedHealthcare Community Plan has policies in place to protect your privacy including oral, written and electronic protected health information (PHI). See our Privacy Notices on page 72.
- Receive information, including information on treatment options and alternatives in a manner you can understand.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive information about the Plan, its services, its practitioners and providers, and member rights and responsibilities.
- An open discussion about medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the health plan's member rights and responsibilities policy.
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
- Exercise your rights and to know that the exercise of those rights will not adversely affect the way UnitedHealthcare or our providers treat you.
- File appeals and grievances with us. See page 44.
- File appeals and grievances with the State. See page 46.
- State Fair hearings. See page 47.
- Request that ongoing benefits be continued during an appeal or State Fair Hearing; however, you may have to pay for the continued benefits, if our decision is upheld in the appeal or hearing. See page 46.
- Receive a second opinion from another doctor in the UnitedHealthcare provider network if you don't agree with your doctor's opinion about the services that you need. Contact UnitedHealthcare's Member Services at **1-800-318-8821**, **TTY: 711**, for help with this.
- Receive other information about us, such as how we are managed. You may request this information by calling UnitedHealthcare's Member Services at **1-800-318-8821**, **TTY: 711**.

III. Rights and Responsibilities

As a UnitedHealthcare Community Plan member, it is important that you:

- Cooperate with those providing you with health care services.
- Provide all information as needed to the professional staff caring for you.
- Follow instructions and guidelines given by those providing health care services.
- Call after your enrollment to make an appointment for your health assessment.
- Call for appointments to minimize waiting time.
- Inform your doctor's office at least 48 hours in advance if you need to cancel your appointment.
- Call Member Services if you are not sure if you should call your doctor or go to the emergency room.
- If problems arise concerning the medical care you receive, make your feelings known. Every effort will be made to solve your problem.
- Learn more about keeping well and better managing any health care problems by taking advantage of health education services and classes available to you.
- Understand health problems and participate in developing mutually agreed upon treatment goals.
- Report any other health insurance coverage to your doctor or UnitedHealthcare.
- Report any public health problems such as Tuberculosis to your doctor.

A. HealthChoice Benefits

This table shows the health care services and benefits that all HealthChoice enrollees can get when they need them. We may offer other services not listed here. See page 18. For a few special benefits, you have to be certain ages or have a certain kind of problem. We will never charge you for any of the health care services we provide, except for pharmacy co-pays when applicable. This table lists the basic benefits that you can get through UnitedHealthcare when you need them. If you have a question or are confused about whether we offer a certain benefit, you can call the Enrollee Help Line at 1-800-284-4510 or UnitedHealthcare Member Services at **1-800-318-8821**, **TTY: 711**, for help.

Benefit	What it is	Who can get this benefit	What you don't get with this benefit
Primary Care Services	These are all of the basic health services you need to take care of your general health needs, and are usually provided by your "Primary Care Provider," or "PCP," a doctor or advanced practice nurse.	All enrollees.	
EPSDT Services for Children	Regular well-child checkups, immunizations (shots), and checkups to look for illness. Whatever is needed to take care of sick children and to keep healthy children well.	Under age 21.	
Pregnancy-Related Services	Medical care during and after pregnancy, including hospital stays and, when needed, home visits after delivery.	Women who are pregnant, and for two months after the birth.	
Family Planning	Family planning office visits, lab tests, birth control pills and devices (includes latex condoms and emergency contraceptives from the pharmacy, without a doctor's order) and permanent sterilizations.	All enrollees.	

IV. Benefits and Services

Benefit	What it is	Who can get this benefit	What you don't get with this benefit
Primary Mental Health Services	Primary mental health services are basic mental health services provided by your PCP or another provider in UnitedHealthcare. If more than just basic mental health services are needed, your PCP will refer you to or you can call the Public Behavioral Health System at 1-800-888-1965 for specialty mental health services.	All enrollees.	You do not get specialty mental health services from UnitedHealthcare. For example, for treatment of serious emotional problems like schizophrenia, your PCP or specialist will refer you or you can call the Public Behavioral Health System at 1-800-888-1965.
Pharmacy Services	Prescription drugs, insulin, needles and syringes, birth control pills and devices, coated aspirin for arthritis, iron pills (ferrous sulfate), and chewable vitamins for children younger than age 12. You can get latex condoms and emergency contraceptives from the pharmacy without a doctor's order.	All enrollees. Adults 21 and older have a co-pay of $1 for generic drugs and $3 for brand name drugs. Children and pregnant women do not pay.	Non-prescription drugs except for coated aspirin, iron pills, and chewable vitamins for children under age 12. Non-authorized prescription drugs.
Specialist Services	Health care services provided by specially trained doctors or advanced practice nurses. You might have to get a referral from your PCP before you can see a specialist.	All enrollees.	
Laboratory and Diagnostic Services	Lab tests and X-rays to help find out the cause of an illness.	All enrollees.	

Benefit	What it is	Who can get this benefit	What you don't get with this benefit
Case Management	A case manager may be assigned to help you plan for and receive health care services. The case manager also keeps track of what services are needed and what has been provided.	Special Populations: 1. Children with special health care needs; 2. Pregnant and postpartum women; 3. Individuals with HIV/AIDS; 4. Individuals who are homeless; 5. Individuals with physical or developmental disabilities; 6. Children in State-supervised care	
Diabetes Care	Special services, medical equipment, and supplies for enrollees with diabetes.	Enrollees who have been diagnosed with diabetes.	
Podiatry	Foot care when medically needed. Includes special shoes, supports, and routine foot care.	Available to enrollees under age 21 or individuals with diabetes and circulatory problems.	

IV. Benefits and Services

Benefit	What it is	Who can get this benefit	What you don't get with this benefit
Vision Care	**Eye exams** • Under 21: one exam every year. • 21 and older: one exam every two years. **Glasses** • Under 21 only. • Contact lenses if there is a medical reason why glasses will not work.	**Exams** All enrollees. **Glasses and contact lenses** Enrollees under age 21.	More than one pair of glasses per year unless lost, stolen, broken or new prescription needed.
Home Health Services	In-home health care services, including nursing and home health aide care.	Those who need skilled nursing care in their home, usually after being in a hospital.	No personal care services (help with daily living).
Oxygen and Respiratory Equipment	Treatment to help breathing problems.	All enrollees.	
Hospital Services	Inpatient and outpatient services are covered.	All enrollees with authorization or as an emergency.	
Hospice Care	Support services for people who are terminally ill.	All enrollees.	
Rehabilitation Outpatient	Rehabilitation services, including physical therapy, occupational therapy and speech therapy (without a hospital stay).	All enrollees. (See Section IV C for enrollees under age 21).	

Benefit	What it is	Who can get this benefit	What you don't get with this benefit
Nursing Home	Full-time nursing care in a nursing home.	Available to all enrollees. After 30 days, State pays, instead of UnitedHealthcare.	
Chronic Hospital	Full-time hospital care for long-term illness.	Available to all enrollees. After 30 days, State pays, instead of UnitedHealthcare.	
Blood and Blood Products	Blood used during an operation, etc.	All enrollees.	
Dialysis	Treatment for kidney disease.	All enrollees.	
DME and DMS	Durable medical equipment (DME) and disposable medical supplies (DMS) are things like crutches, walkers, wheelchairs, and finger stick supplies (for people who do blood testing at home).	All enrollees.	
Transplants	Medically necessary transplants.	All enrollees.	No experimental transplants.
Clinical Trials	Enrollees' costs for studies to test the effectiveness of new treatments or drugs.	Enrollees with life-threatening conditions.	Must be authorized by UnitedHealthcare.

B. Optional Benefits and Applicable Terms and Conditions

Vision care.
Adults will receive one eye exam per year and one pair of glasses or contacts every two years with one replacement pair of glasses if lost, stolen or broken in a two-year period. Please call UnitedHealthcare's Member Services for a participating eye doctor in your area at **1-800-318-8821**, **TTY: 711**.

Weight loss treatment.
UnitedHealthcare is responsible for medically necessary and appropriate treatments for morbid obesity.

Prescriptions.
Adults 21 and older have a $1 co-pay for generic drugs and a $3 co-pay for brand name drugs.

C. Benefits and Services Not Offered by UnitedHealthcare Community Plan but Offered by the State

These are benefits and services that we do not provide. People who need these services can get them through the State using their red and white Medical Assistance or dental card.

Dental services for children under 21 and pregnant women — General dentistry including regular and emergency treatment is offered. Dental services are provided by the Maryland Healthy Smiles Dental Program. If you are eligible for the Dental Services Program, you will receive information and a dental card. If you have not received your dental ID card or you have questions about your dental benefits, call the Maryland Healthy Smiles Dental Program at 1-855-934-9812.

Specialty mental health services — We offer only the basic primary mental health services that your PCP can provide. If these services are not enough to take care of your problem, you, your PCP, or your specialist doctor can request specialty mental health services through the Public Behavioral Health System by calling **1-800-888-1965**.

ICF-MR services — This is treatment in a care facility for people who have an intellectual disability and need this level of care.

Skilled personal care services — This is skilled help with daily living activities.

Medical day care services — This is help to improve daily living skills in a center licensed by the state or local health department, which includes medical and social services.

Transportation services — We do not have to pay for your transportation to medical services, unless we send you to a faraway county to get treatment that you could not get in a closer county. We will help you arrange non-emergency transportation, if needed for a medical visit or treatment, through your city or county government (usually the county health department). Emergency transportation is provided by local fire companies ("911" emergency service), but this is only for real emergencies.

Nursing home and long-term care services — We do not have to pay for your care in a nursing home, chronic rehabilitation hospital, or chronic hospital after the first 30 days. After that, the services are considered "long-term care." After the first 30 days, you will not have to leave the nursing home or long-term hospital, you just will not be in UnitedHealthcare anymore. (This is something the State and UnitedHealthcare will take care of for you.) Once you are out of UnitedHealthcare, the State will pay for the medical treatment you need, including nursing home and other long-term care.

Abortion services — This medical procedure to end certain kinds of pregnancies is covered by the State only if:

1. The patient will probably have serious physical or mental health problems, or could die, if she has the baby;
2. She is pregnant because of rape or incest, and reported the crime; or
3. The baby will have very serious health problems.

Women eligible for HealthChoice only because of their pregnancy are not eligible for abortion services.

Occupational, physical, and speech therapy, and audiology for children under the age of 21 — The State pays for these services if medically needed. For help in finding a provider, you can call the State's Hotline at 1-800-492-5231.

HIV/AIDS — Certain diagnostic services for HIV/AIDS are paid for by the State (viral load testing, genotypic, phenotypic or other HIV/AIDS resistance testing). Most HIV/AIDS drugs are also paid for by the State.

Speech Augmenting Devices — Equipment that helps people with speech impairments to communicate.

Substance Use Disorder Services — Comprehensive assessments, individual and group counseling, methadone treatment, detox treatment, intensive outpatient, partial hospitalization and opiod maintenance. These services can be requested through the Public Behavioral Health System by calling 1-800-888-1965.

D. Benefits and Services Not Offered by UnitedHealthcare Community Plan or the State

These are benefits and services that we are not required to offer. We offer a few of them anyway. See page 18. The State will not offer any of the benefits on this list.

Anything that you do not have a medical need for.

Anything experimental unless part of an approved clinical trial.

Autopsies.

Shots for travel outside the continental United States or medical care outside the United States.

Diet and exercise programs, to help you lose weight.

Fertility treatment services, including services to reverse a voluntary sterilization.

Cosmetic surgery. Operations to make you look better, but you do not need for any medical reason.

Private hospital room. For people without a medical reason, such as having a contagious disease.

Private duty nursing. For people over 21 years old.

Orthodontist services. Braces to straighten teeth, for people 21 years old and older or children who do not have a serious problem that makes it difficult for them to speak or eat.

Special (orthopedic) shoes and supports. For people who do not have diabetes or circulation problems or are older than age 21.

Routine foot care. For people who do not have diabetes or circulation problems or are older than age 21.

Non-prescription drugs. (Except coated aspirin for arthritis, insulin, iron pills, and chewable vitamins for children younger than age 12.)

Hearing aids. For people over age 21.

E. Self-Referral Services

What are self-referral services?
You will go to your PCP for most of your health care, or your PCP will send you to a specialist who belongs to UnitedHealthcare Community Plan. For some types of services, you can choose a health care provider who is not part of our network, and we will still pay for the service as long as the provider agrees to see you and accept payment from us. These are called "self-referral services." We will also pay for any related lab work and medicine received at the same site that you receive the self-referral visit. The following are self-referred services.

Family planning services.
If you choose to do so, you can go to a provider who is not a part of UnitedHealthcare Community Plan for any of these family planning services:

- Family planning office visit.
- Pap smear.
- Special contraceptive supplies.
- Diaphragm fitting.
- IUD insertion and removal.
- FDA approved contraceptives including emergency contraceptives.

Emergency services.
If you have a real medical emergency, you do not need a referral from your PCP to go to the emergency department (ED). If you're not sure if you should go to the ED, call your PCP for advice. After you are treated for an emergency condition, you may need additional services to make sure the emergency condition does not return. These are called post-stabilization services. We will work with the hospital staff to decide if you need these services. If you would like additional information about how this is decided, contact UnitedHealthcare Community Plan Member Services at **1-800-318-8821**, **TTY: 711**.

School-based health center services.
For children enrolled in schools that have a health center, there are a number of services that they can receive from the school health center.

- Office visits and treatment for acute or urgent physical illness, including needed medicine.
- Follow-up to EPSDT visits when needed.
- Self-referred family planning services (listed above).

Pregnancy services.
If you were pregnant when you joined UnitedHealthcare Community Plan, and had already seen a provider, who is not in the UnitedHealthcare network, for at least one complete prenatal checkup, then you can choose to keep seeing that provider all through your pregnancy, delivery, and for two months after the baby is born for follow-up, as long as the provider agrees to continue to see you.

Baby's first checkup before leaving hospital.
It is best to select your baby's doctor before you deliver. If the UnitedHealthcare Community Plan doctor you selected or another UnitedHealthcare doctor does not see your newborn baby for a checkup before the baby is ready to go home from the hospital, we will pay for the on-call doctor to do the checkup in the hospital.

Checkup for children entering state custody.
Children entering foster care or kinship care are required to have a checkup within 30 days. The foster parent can choose a convenient provider to self-refer to for this visit.

Certain providers for children with special health care needs.
Children with special health care needs may self-refer to providers outside of the UnitedHealthcare Community Plan network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care, and ensure that appropriate plans of care are in place. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in a Managed Care Organization (MCO). Medical services directly related to a special needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- **New enrollee:** A child who at the time of initial enrollment was receiving these services as part of a current plan of care may continue to receive these specialty services provided that the pre-existing out-of-network provider submits the plan of care to us for review and approval within 30 days of the child's effective date of enrollment in UnitedHealthcare, and we approve the services as medically necessary.
- **Established enrollee:** A child who is already enrolled in UnitedHealthcare when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network provider. We must grant the request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services.

If we deny, reduce, or terminate the services, you can file an appeal. See pages 46 and 47 for information about appeals.

Diagnostic Evaluation Service (DES).
One annual diagnostic evaluation service (DES) visit for any enrollee diagnosed with HIV/AIDS, which we are responsible for facilitating on your behalf.

Renal dialysis.
Some people with kidney disease need to have their blood cleaned. This is called "renal dialysis." A person who needs renal dialysis does not have to go to a UnitedHealthcare Community Plan provider for this treatment, but can choose any provider, either inside or outside of our MCO. People needing this service may be eligible for the Rare and Expensive Case Management Program (REM). (See page 32 for information about REM.)

Birthing centers.
Services performed at a birthing center, including an out-of-state center located in a contiguous (a state that borders Maryland) state.

F. Notice of Stopping or Changing Benefits, Services, or Health Care Locations

Can my coverage be terminated?
Your health care coverage may be terminated if you move away from the UnitedHealthcare Community Plan service area or you become ineligible for enrollment per the State of Maryland. Notification to the members will be by letter. Members are notified by letter within 90 days before benefits or services change.

Choosing a Primary Care Provider.
When you join UnitedHealthcare Community Plan, you and each eligible member of your family will be asked to select a PCP from our list of participating private practice providers if you have not already selected a Primary Care Provider (PCP).

UnitedHealthcare provides health services to you and your family at medical sites staffed by contracting medical groups or in private physicians' offices. Our goal is to provide quality medical care. Through prevention, diagnosis and treatment, we strive to protect your health and the health of your family. When you make your choice to enroll in UnitedHealthcare, choose a participating physician's office that is most convenient for you. Choose carefully, because all services must be administered or arranged by Primary Care Providers at the physician's office that you choose, including referrals to medical specialists and hospitals.

Changing your Primary Care Provider.
If you wish to change your PCP, please call UnitedHealthcare Community Plan's Member Services at **1-800-318-8821**, **TTY: 711**, for help in making a change. You shouldn't use your new PCP until you receive a new member ID card (within 7 – 10 days of changing PCPs) indicating that the change has been made. However, if you must make an appointment before then, contact Member Services for assistance at **1-800-318-8821**, **TTY: 711**.

G. New Technology

Your health plan follows a process for looking at new medical procedures, treatments and medications once they are determined to be safe and are approved for use by a recognized national group of medical experts; for example, the Food and Drug Administration (FDA). Once this occurs, there is an internal review and approval process that is used to put the new procedures, treatments and medications into production so that it will become a covered benefit for you.

A. What Is a PCP, a Specialist, and What Is Specialty Care?

A Primary Care Provider, or PCP, is a provider that you see for routine care, or when you're not feeling well (or are sick). A PCP can be a doctor; family practitioner; general practitioner; internal medicine doctor; or a physician assistant. A specialist is a doctor that specializes in a specific area of care. Your PCP may refer you to a specialist for further evaluation. To help you with your medical needs, your Primary Care Provider and staff are available to you by telephone for advice or an appointment. He or she should:

- Refer you to a specialist when necessary.
- Give you advice or appointments.
- Admit you to a hospital if medically necessary.
- Be called whenever possible if an emergency happens.

A woman may go to a participating OB/GYN provider **without a referral** from her Primary Care Provider for:

- Gynecological checkups.
- Prenatal and postnatal care during pregnancy.
- Medical conditions that require gynecological care.

If you are pregnant, you should visit an OB/GYN provider in the next 10 days (or as soon as possible) for your first prenatal visit.

B. Ask Me 3® – Good Questions for Your Good Health

Health information is not clear at times. The Ask Me 3® program run by the National Patient Safety Foundation can help. The program gives you three questions to ask your healthcare provider during a health care visit, either for yourself or for a loved one. They are:

- **What is my main problem?**
- **What do I need to do?**
- **Why is it important for me to do this?**

Asking questions can help you be an active member of your health care team. For more information on Ask Me 3® and to view a helpful video on how to use the questions, please visit **www.npsf.org/askme3**.

Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF). UnitedHealthcare Community Plan is not affiliated with nor endorsed by NPSF.

C. Information About Your PCP and Specialists

If you want to know more about a PCP and/or specialist including other services such as occupational, speech, physical therapy, X-rays or labs, call Member Services at **1-800-318-8821**, **TTY: 711**.

For female enrollees, if your PCP is not a women's health specialist, you have the right to see a women's health specialist within UnitedHealthcare Community Plan network without a referral.

D. Selecting or Changing Providers

If you need assistance with selecting or changing your Primary Care Provider, please call UnitedHealthcare Community Plan Member Services at **1-800-318-8821**, **TTY: 711**, for help in making a change. You should not use your new PCP until you receive your new member ID card (within 7 – 10 days of changing PCPs) indicating that the change has been made. However, if you must make an appointment before then, contact UnitedHealthcare Member Services for assistance at **1-800-318-8821**, **TTY: 711**.

Out-of-Network — If none of the Plan's providers can give a covered service, the Plan must cover it from a non-network provider.

Out-of-Network Cost to Member — If non-network care is allowed, payment is set up by the Plan. There will be no cost to members.

Second opinions.
You can get a second opinion for your health care at no cost. Call your PCP if you want a second opinion. You can also call Member Services at **1-800-318-8821**, **TTY: 711**.

E. List of Primary and Specialty Care Providers

For a list of Primary and Specialty Care providers, please visit our website at **myuhc.com/CommunityPlan** for an up-to-date listing of providers. To find a provider, use the Find-A-Doctor tool.

F. List of Hospital Providers

For a list of participating hospitals, please visit our website at **myuhc.com/CommunityPlan** for an up-to-date listing.

G. List of Pharmacy Providers

As a UnitedHealthcare Community Plan member, you may fill your prescriptions through one of our participating retail pharmacies. Whenever you need a covered prescription, visit any participating pharmacy and present your UnitedHealthcare member ID card.

Area-wide pharmacies:

- CVS Pharmacy
- Giant Food Pharmacy
- K-Mart Pharmacy
- Sam's Club Pharmacy
- Shoppers Food and Pharmacy
- Shoprite Pharmacy
- Target
- Walmart

For a complete list of pharmacies, please visit our website at **myuhc.com/CommunityPlan** and use the Find a Pharmacy tool in the "For Members" section. You may also call Member Services for assistance at **1-800-318-8821**, **TTY: 711**.

H. Paper Copy of Provider Directory

If you would like a paper copy of the provider directory mailed to you, contact Member Services at **1-800-318-8821**, **TTY: 711**.

A. Interpreter for Those Who Do Not Speak English

Request for special services such as interpretation services for members who do not speak English should be directed to Member Services at **1-800-318-8821**, **TTY: 711**. They can help with accessing the Language Line.

B. Interpreter for Those Who Are Hearing Impaired

Request for special services such as an interpreter for members who are hearing impaired should be directed to Member Services at **1-800-318-8821**, **TTY: 711**.

C. MCO Transportation Services

Request for transportation services should be directed to your local health department. If they are unable to help you, call UnitedHealthcare Member Services at **1-800-318-8821**, **TTY: 711**.

D. Services for Special Needs Populations

The State has named certain groups as needing special support from the MCO. These groups are called "special needs populations" and include:

- Children with special health care needs.
- Adults or children with a physical disability.
- Adults or children with a developmental disability.
- Pregnant women and women who have just given birth.
- Adults and children who are homeless.
- Adults and children with HIV/AIDS.
- Children in State-supervised care.

We have a process to let you know if you are in a special needs population. If you have a question about your special needs, contact UnitedHealthcare Member Services at **1-800-318-8821**, **TTY: 711**.

Services every special needs population receives.
If you are in one or more of these special needs populations, you are eligible to receive the services below to help you get the right amount and the right kind of care:

A case manager — A case manager will be a nurse or a social worker or other professional that may be assigned to your case soon after you join UnitedHealthcare Community Plan. This person will help you and your Primary Care Provider (PCP) plan the treatment and services you need. The case manager will not only help plan the care, but will help keep track of the health care services you receive during the year and help those who give you treatment to work together.

Specialists — Having special needs requires you to see providers who have the most experience with your condition. Your PCP and your case manager will work together to be sure to send you to the right specialists. This will include specialists for supplies and equipment you might need.

Follow-up when visits are missed — If your PCP or specialist finds that you keep missing visits, they will let us know and someone will try to get in touch with you by mail, telephone or will plan a visit to your home to remind you to call for another appointment. If you still miss appointments, you may be visited by someone from the local health department near where you live.

Special needs coordinator — We have a Special Needs Coordinator on staff. The Special Needs Coordinator will educate you about your condition and will suggest places in your area where you can get support from people who know about your needs.

As a member of a special needs population, you will receive all of the services above. Some groups will receive other special services. These are listed below:

Adults and children with HIV/AIDS.
HIV/AIDS case management — We have special case managers trained in dealing with HIV/AIDS issues and linking persons with the services that they need.

Diagnostic Evaluation Service (DES) assessment visits once every year — One annual diagnostic evaluation service (DES) visit for any enrollee diagnosed with HIV/AIDS, which we are responsible for facilitating on the enrollee's behalf.

Substance Use Disorder services — Anyone with HIV/AIDS who needs treatment for a substance use disorder will immediately be referred to the Behavioral Health System.

VI. Special Services

Adults and children with physical and developmental disabilities.

Materials prepared in a way you can understand — We have our materials reviewed by people with experience in the needs of people with disabilities. This means that the information will be presented using the right methods so that people with disabilities can understand, whether in writing or by voice translation. Our staff is trained on the special communications needs of individuals with developmental disabilities.

DDA services — Enrollees who currently receive services through the Developmental Disabilities Administration (DDA) or under the DDA waiver can continue to receive those services.

Medical equipment and assistive technology — Our providers have the experience and training for both adults and children to provide medical equipment and assistive technology services.

Case management — Case managers are experienced in working with people with disabilities.

Pregnant women and women who have just given birth.

Appointments — The provider must schedule an appointment within 10 days of your request. If you cannot get an appointment, call UnitedHealthcare Member Services Line at **1-800-318-8821**, **TTY: 711**, or the HealthChoice Enrollee Help Line at 1-800-284-4510.

Link to a pediatric provider — Every pregnant woman will be linked with a children's doctor that she chooses before giving birth. A children's doctor may be a family practice doctor, pediatrician, or nurse practitioner.

Prenatal risk evaluation — Every pregnant woman should have a prenatal risk evaluation at the time of the first visit with the prenatal provider. If there is a risk that may affect the pregnancy and a healthy baby, someone from the Local Health Department or UnitedHealthcare will contact the pregnant woman and offer to visit her.

Length of hospital stay — The length of hospital stay after delivery is 48 hours for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery. If you elect to be discharged earlier, a home visit must be provided within 24 hours after discharge. If you must remain in the hospital after childbirth for medical reasons, you may request that your newborn remain in the hospital while you are hospitalized. Additional hospitalization up to four (4) days is covered for your newborn.

Follow-up — We are required to schedule the newborn for a follow-up visit two weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

Dental — Pregnant women receive diagnostic, emergency, preventive, and therapeutic dental services for oral diseases. These services are provided by the Maryland Healthy Smiles Dental Program. Contact them at 1-855-934-9812 if you have questions about your dental benefits.

Substance Use Disorder services — Any pregnant or postpartum (2 months after delivery) woman who needs treatment for a substance use disorder will immediately be referred to the Specialty Behavioral Health System.

HIV testing and counseling — All pregnant women will be offered a test for HIV and will receive information on HIV infection and its affect on the unborn child.

Nutrition counseling — All pregnant women will be offered nutritional information to teach them to eat healthy.

Smoking counseling — All pregnant women will be provided information and support on ways to stop smoking.

EPSDT screening appointments — Adolescents who are pregnant should receive EPSDT screening services in addition to prenatal care.

Children with special health care needs.

Work with schools — We will work closely with the schools that provide education and family services programs to children with special needs.

Keeping certain non-UnitedHealthcare Community Plan providers — Children with special health care needs may self-refer to providers outside of our network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care, and ensure that appropriate plans of care are in place. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in an MCO. Medical services directly related to a special needs child's medical condition may be accessed out-of-network only if specific conditions are satisfied. (See page 22.)

State supervised care — Foster and Kinship Care — We will ensure that children in State supervised care (foster care or kinship care) get the services they need from providers by having one person at UnitedHealthcare responsible for organizing all services. If a child in State supervised care moves out of the area and needs another MCO, the State and the UnitedHealthcare Community Plan will work together to quickly find the child new providers close to where the child has moved, or if needed, the child can change to another MCO.

Screening for abuse or neglect — Any child thought to have been abused physically, mentally or sexually will be referred to a specialist who is able to determine if abuse has occurred. In the case of possible sexual abuse, we will be sure that the child is examined by someone who knows how to find and keep important evidence.

Individuals who are homeless.

If you are homeless, we will provide a case manager to coordinate your health care services.

E. Rare and Expensive Case Management Program (REM)

What is the Rare and Expensive Case Management Program?
The Rare and Expensive Case Management Program, REM for short, is a program provided by the State for people who have very expensive and very unusual medical problems. To enter the REM Program, you must have one of the problems (diagnoses) on the REM diagnosis list. Most of the REM diagnoses are found in children under the age of 21; however, a few are found in adults as well.

How do I know if I belong in this program?
Your Primary Care Provider (PCP) and UnitedHealthcare have a list of the REM diagnoses and will let you know if you or any of your children should consider entering the REM Program. You will be informed by telephone, by mail, or by a visit from a REM Case Manager. If you do not want to join the REM Program, you can stay in UnitedHealthcare.

Will I keep the same benefits?
The REM Program offers Medicaid benefits plus other specialty services needed for your special medical problem. The State will pay for this care instead of us.

Do REM enrollees keep their MCO and their PCP?
Entering the REM Program means not being in an MCO anymore. This change will happen automatically. You will work with a REM Case Manager who will become very familiar with the care you or your child needs and will help you select the right provider. The REM Case Manager will work with you or your child to see that you continue with the same PCP and specialists if possible, even though you will no longer be in UnitedHealthcare. If your child under age 21 was getting medical care from a specialty clinic or other setting before going into the REM Program, you can choose for your child to keep getting services there after joining the REM Program.

How do I get more information about the REM Program?
Call the REM Program at 1-800-565-8190.

A. UnitedHealthcare Community Plan Continuity of Health Care Notice

You may be a new enrollee moving from another managed care organization ("MCO") or another company's health benefit plan to UnitedHealthcare Community Plan's coverage. If you currently are receiving treatment, you have special rights in Maryland.

For example, if your old company gave you pre-approval to have surgery or to receive other services, you may not need to receive new approval from us to proceed with the surgery or to continue receiving the same services. Also, if you are seeing a doctor or other health care provider who is an in-network provider with your old company, and that provider is not an in-network provider under your new plan, you may continue to see your provider for a limited period of time as though the provider were an in-network provider with us.

The rules on how you can qualify for these special rights are described below.

Prior approval for health care services.
If you previously were covered under another company's plan, a prior approval (also called "preauthorization") for services that you received under your old plan may be used to satisfy a prior approval requirement for those services if they are covered under your new plan with us.

To be able to use the old prior approval under this new plan, you will need to contact us at 1-800-318-8821, TTY: 711, to let us know that you have a prior approval for the services and provide us with a copy of the prior approval. Your parent, guardian, designee, or health care provider may also contact us on your behalf about the prior approval.

There is a time limit for how long you can rely on the prior approval. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care practitioner after the baby is born.

Limitation on Use of Prior Approvals: Your special right to use a prior approval does not apply to:

- Dental services;
- Mental health services;
- Substance use disorder services; or
- Benefits or services provided through the Maryland Medical Assistance fee-for-service program.

If you do not have a copy of the prior approval, contact your old company and request a copy. Under Maryland law, your old company must provide a copy of the prior approval within 10 days of your request.

Right to use non-network providers.
If you have been receiving services from a health care provider who was an in-network provider with your old company, and that provider is a non-network provider under your new health plan with us, you may be able to continue to see your provider as though the provider were an in-network provider. You must contact us at **1-800-318-8821**, **TTY: 711**, to request the right to continue to see the non-network provider as if the provider were an in-network provider with us. Your parent, guardian, designee, or health care provider may also contact us on your behalf to request the right for you to continue to see the non-network provider.

This right applies only if you are being treated by the non-network provider for covered services for one or more of the following types of conditions:

1. Acute conditions;
2. Serious chronic conditions;
3. Pregnancy; or
4. Any other condition upon which we and the out-of-network provider agree.

Examples of the conditions listed above include bone fractures, joint replacements, heart attacks, cancer, HIV/AIDS and organ transplants.

There is a time limit for how long you can continue to see a non-network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care practitioner after the baby is born.

Example of how the right to use non-network providers works:
You broke your arm while covered under Company A's health plan and saw a Company A network doctor to set your arm. You changed health plans and are now covered under Company B's plan. Your doctor is not a network provider with Company B. You now need to have the cast removed and want to see the original doctor who put on the cast.

In this example, you or your representative need to contact Company B so that Company B can pay your claim as if you are still receiving care from a network doctor. If the non-network doctor will not accept Company B's rate of payment, the doctor may decide not to provide services to you.

Limitation on Use of Non-Network Providers: Your special right to use a non-network provider does not apply to:

- Dental services;
- Mental health services;
- Substance use disorder services; or
- Benefits or services provided through the Maryland Medical Assistance fee-for-service program.

Appeal Rights:
If we deny your right to use a prior approval from your old company or your right to continue to see a provider who was an in-network provider with your old company, you may appeal this denial by contacting us at **1-800-318-8821**, **TTY: 711**.

If we deny your appeal, you may file a complaint with the Maryland Medical Assistance Program by calling the HealthChoice Help Line at 1-800-284-4510.

If you have any questions about this notice, please contact us at **1-800-318-8821**, **TTY: 711**.

B. Making or Canceling an Appointment

Do I need to make an appointment?

- Whenever possible, schedule your appointment in advance. You may call the number on your ID card to make an appointment. This will save you time. Making an appointment allows your doctor's office to prepare for your visit. If you think you have a medical problem that needs your Primary Care Provider's attention quickly, make sure you tell the person who is scheduling your appointment.
- Give the name of the patient and the UnitedHealthcare Community Plan number exactly as it appears on the patient's UnitedHealthcare ID card.
- Once you have scheduled your appointment, write down the name of your doctor and the date and time of the appointment. Keep this written information handy.
- If you cannot keep an appointment, call your doctor to cancel at least 48 hours ahead so that someone else can be given your appointment time. Being seen on an emergency basis does not automatically cancel appointments you still hold for that condition.
- Please remember to cancel this appointment, or have someone do it on your behalf, as soon as possible.
- If the physician recommends a follow-up appointment at the time of your visit, please confirm this with the receptionist before you leave the office.

C. Referral to a Specialist or Specialty Care

What if I need to see a specialist?
Your primary care provider (PCP) may send you to a specialist for additional care that you need. This is called a referral. A specialist is a doctor that specializes in a specific area of care. There are many different types of specialists that can provide care. Effective October 15, 2015 you will need a referral from your PCP in order to get most specialists. Your PCP will need to get a referral number from UnitedHealthcare. You will need the referral number from your PCP in order to make an appointment with the specialist.

Do all specialty providers or services require a referral?
There are some doctors and services that are considered self-referred services that you will not need a referral for such as:

- Emergency services at an emergency room or hospital, in or outside the network.
- Urgent care visits.
- Routine women's health care, screening mammograms, Pap tests, and pelvic exams.
- Prenatal care.
- Family Planning Services.
- Kidney dialysis services from a certified dialysis facility.

See page 21 for a complete list of self-referred services.

You will also be able get the following in network services without a referral from your PCP:

- OB/GYN services.
- Routine eye exams, eyeglasses, contacts.
- Diabetic foot care by a Podiatrist.
- Home Health services such as durable medical equipment (DME).
- Lab and radiology services with the appropriate medical order.
- If you have any questions please call Member Services for assistance.

Can I keep the same specialist even if he is not participating with UnitedHealthcare Community Plan?
Depending on your illness, you may be able to keep your non-participating specialist. Please call Member Services for assistance.

D. After Hours, Urgent Care, and Emergency Care

If I cannot get an appointment, can I just go to the emergency room?
Emergency rooms are for emergencies only. Your doctor is aware of your health care needs and is the best coordinator of your health care. If your doctor decides emergency care is needed, he or she will make the necessary arrangements. Your doctor knows you, and he or she can plan follow-up care.

E. Out-of-Service-Area Coverage

How do I obtain out-of-area care?
UnitedHealthcare Community Plan provides emergency out-of-area care. If you have an emergency, go to the nearest hospital.

No medical coverage outside of the United States.
Any health care services you receive while out of the country will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services you receive outside of the United States.

What do I do if I have a medical emergency while away?
Anytime you or a member of your family is out of the UnitedHealthcare service area and need medical care, you should use whatever doctor or emergency room is convenient.

What if I need a prescription while away?
Prescriptions are covered outside of the service area if they are related to emergency care. There is no coverage for ongoing prescriptions or "maintenance" drugs while you are away from home. Please show your UnitedHealthcare membership card.

Do I have to pay for emergency services outside of the area?
No. Providers should bill UnitedHealthcare for emergency services you receive while you are eligible for Medicaid and enrolled as a UnitedHealthcare member. Be sure to show your UnitedHealthcare ID card whenever you receive services. If, for some reason, you pay for services, be sure to request an itemized billing that shows diagnoses, services and the billed amount for each service. Submit a copy of your itemized billing and receipt to UnitedHealthcare for reimbursement. Routine medical care, such as checkups and non-emergency visits, are not covered unless authorized by UnitedHealthcare.

F. What Should I Do in a Medical Emergency?

It is important to follow proper procedures in emergencies. You can reach your Primary Care Provider 24 hours a day, 365 days a year by calling the emergency phone number, which appears on your membership card. Emergencies are those circumstances that endanger life or can cause permanent disablement. Examples of such conditions include:

- Suspected heart attack.
- Heavy bleeding.
- Poisoning.
- Loss of consciousness.
- Severe shortness of breath.
- Suspected overdose of medication.
- Serious burns.
- Vomiting blood.

If you have time to call the emergency number listed on your membership card, inform the personnel of the emergency, and receive instructions. In many of these situations, you may not be able to call. You should go immediately to the nearest emergency facility, or call an ambulance if one is required. When you arrive at the emergency room, please show your UnitedHealthcare ID card. This will enable emergency care personnel to communicate with a UnitedHealthcare provider and will also provide UnitedHealthcare with the correct billing address.

How do I know if I need emergency services?

If you are suffering from an emergency that prevents you from calling your Primary Care Provider, go to the nearest emergency room. If not, call your Primary Care Provider. It is important that you contact your doctor first if you have been sick for several days, or if you are sick during your doctor's office hours. If you cannot call your Primary Care Provider, call UnitedHealthcare's NurseLine 24 hours a day, 7 days a week. You can talk to a nurse, day or night, to get advice on your medical problems. A nurse can also help you decide if you can wait to see your Primary Care Provider or if you should seek immediate care. Call NurseLine toll-free at 1-877-440-0251.

G. Wellness Care for Children (Healthy Kids – EPSDT)

Preventive health care is important to your family's health. Your Primary Care Provider can provide you and your family with regular, routine medical checkups. Listed below are the health appointments your child should receive:

Maryland Healthy Kids Preventive Health Schedule

Components	Infancy (months)							Early Childhood (months)							Late Childhood (yrs)						Adolescence (yrs)								
Health History and Development	**Birth**	**3-5 d**	**1**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**24**	**30**	**36**	**48**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19/20**
Medical and family history/update	X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peri-natal history	X	X	X	→	→	→	→	→	→	→																			
Psycho-social/environmental assessment/update	X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Surveillance (Subjective)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Screening (Standard Tools)[1]							X	→	→	X	X	→																	
Autism Screening										X	X	→																	
Mental health/behavioral assessment													X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance abuse assessment																					X	X	X	X	X	X	X	X	X
Depression Screening																					X	X	X	X	X	X	X	X	X
Physical Exam																													
Systems exam	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vision/hearing assessments[2]	O[2]	S	S	S	S	S	S	S	S	S	S	S	S/O	S/O	S/O	S/O	S	S/O	S	S/O	S	S/O	S	S	S/O	S	S	S	S
Oral/dentition assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing: Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing: Head Circumference	X	X	X	X	X	X	X	X	X	X	X																		
Measurements and graphing: BMI											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure[3]													X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Risk Assessments by Questionnaire																													
Lead assessment by questionnaire						X	X	X	X	X	X	X	X	X	X														
Tuberculosis *			X	→	→	→	→	X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Heart disease/cholesterol *											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sexually transmitted infections (STI) *																					X	X	X	X	X	X	X	X	X
Anemia *																					X	X	X	X	X	X	X	X	X
Laboratory Tests																													
Hereditary/metabolic hemoglobinopathy	X		X	→																									
Blood lead Test								X	→	→	X	→	→	→	→														
Anemia Hgb/Hct								X	→	→	X	→	→	→	→														
Dyslipidemia Test																			X	→	→							X	→
Immunizations																													
History of immunizations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vaccines given per schedule	X	→	→	X	X	X	→	X	X	X	→	→	→	→	→	→	→	→	→	→	X	X	→	→	→	→	→	→	→
Health Education																													
Age-appropriate education/guidance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counsel/referral for identified problems	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental education/referral								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Scheduled return visit	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Key : X Required
→ Required if not previously done
S Subjective by history /observation
O Objective by standardized testing
*** Counseling/testing required when positive**

The Schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly preventive care visits between ages 3 years through 20 years. [1]Refer to AAP 2006 Policy Statement referenced in the Healthy Kids Program Manual.-Screening required using standardized tools. [2]Newborn Hearing Screen follow-up required for abnormal results. [3]Blood Pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

H. Care for Women During Pregnancy and Two Months After Delivery

If you are pregnant, it is very important for you to get medical care for yourself and your unborn baby. We take special care of all of our moms-to-be. We have a special Prenatal Program that provides information and support for you.

If you are or may be pregnant:

- We can help you with your pregnancy.
- Our Prenatal Program will provide education and support to help reduce problems while you are pregnant.
- See your PCP (Primary Care Provider) or an OB/GYN (Obstetrician and Gynecologist). **You don't have to see your PCP first.**

Here's how:

- Make an appointment with an OB/GYN. **You should visit in the next 10 days (or as soon as possible) for your first prenatal visit.**
- The OB/GYN you select MUST be in our provider network.
- It is important for pregnant women to see their doctor many times while pregnant. Even if this is not your first child.
- If you do not have an OB/GYN already, please call **Member Services Monday through Friday 8:00 a.m. to 7:00 p.m. at 1-800-318-8821**, **TTY: 711**.

I. Healthy First Steps

Our Healthy First Steps program makes sure that both mom and baby get good medical attention.

We will help:

- Get good advice on nutrition, fitness and safety.
- Get supplies, including breast pumps for nursing moms.
- Choose a doctor or nurse midwife.
- Schedule visits and exams.
- Arrange rides to doctor's visits.
- Connect with community resources such as Women, Infants and Children (WIC) services.
- Get care after your baby is born.
- Choose a pediatrician (child's doctor).
- Get family planning information.

Call us toll-free at **1-877-813-3417**, **TTY: 711**, Monday through Friday, from 7:00 a.m. to 6:00 p.m. Central.

Follow us on Twitter **@UHCPregnantCare**.

It's important to start pregnancy care early. Be sure to go to all of your doctor visits, even if this isn't your first baby.

J. Family Planning

(See Section IV. E., Self-Referral Services)

What family planning services are available?
There are some services you can get anytime from any doctor or clinic that accepts Medicaid. You do not have to go to a plan participating provider to receive routine family planning services. You can get birth control advice, birth control prescriptions, a pregnancy test, and outpatient sterilization. According to the Maryland Family Planning "Free Access Policy" members enrolled in UnitedHealthcare are allowed to utilize providers or family planning services without a referral from their Primary Care Provider.

K. Dental Care

Dental services are provided for children under 21 and pregnant women. General dentistry including regular and emergency treatment is offered. Dental services are provided by the Maryland Healthy Smiles Dental Program. If you are eligible for the dental services program, you will receive information and a dental ID card. If you have not received your dental ID card or have questions about your dental benefits, call the Maryland Healthy Smiles Dental Program at 1-855-934-9812.

This benefit is at no additional cost to you. Please visit our website at **myuhc.com/CommunityPlan** or call Member Services for further details on your dental benefit at **1-800-318-8821**, **TTY: 711**.

L. Health Education Programs

UnitedHealthcare's health educators are a resource for enrollees and providers in need of assistance with locating or coordinating health education materials and services. Call 1-855-817-5624 to request assistance in obtaining health education materials and services for you and your family. The health education program is intended to improve or preserve the continuing health and quality of life for individuals with routine or special health care needs. You can find out more about the health education programs available to you from one of the resources listed below:

- Provider web portal.
- Health education/HEDIS staff.
- Provider manual.
- Special mailings.
- Your case manager.
- UHC displays and education materials at community events.

How Do I Get Specialty Mental Health or Substance Use Disorder Services?

If you think you have mental health or substance use problems and need help, call the Public Behavioral Health System at 1-800-888-1965, call our member services hotline, or speak with your PCP. Your PCP may help refer you to the Public Behavioral Health System. Their toll-free help line is open 24-hours a day, 7 days a week. The staff members are trained to handle your call and will help you get the services you need.

If you have received mental health care or substance use disorder services in the past and would like to see the same provider, let the staff know and every effort will be made to get you to the same provider.

If the Public Behavioral Health System finds that you do not need a specialist to handle your behavioral health needs, your PCP (with your permission) will be informed so that you can receive any needed follow-up care.

A. MCO Consumer Services and Hotline Information

UnitedHealthcare Community Plan wants to quickly resolve questions and/or complaints about services or the payment of services. If you have an appeal, complaint or grievance about your health care services, call Member Services at **1-800-318-8821**, **TTY: 711**, or send a letter to UnitedHealthcare. If you prefer, Member Services will mail you a complaint form to complete. If you need help with submitting a complaint in writing (by letter or on the form), Member Services is available to help you. Questions regarding medical emergencies will be addressed within 24 hours. Other medical care issues will be addressed within 5 working days. Administrative issues will be addressed within 30 days. If you are not happy with a response to your complaint, you can have it reviewed again. Someone else at UnitedHealthcare will look at your case and make a decision. Remember if you have questions, call Member Services and they will be happy to explain the process to you.

B. UnitedHealthcare Community Plan's Internal Grievance Procedures

If you have a complaint, you can contact us at **1-800-318-8821**, **TTY: 711**.

Requests for an interpreter for members who do not speak English should be directed to Member Services at **1-800-318-8821**, **TTY: 711**.

Appeals.
If your complaint is about a service you or a provider feels you need but we will not cover, you can ask us to review your request again. This is called an appeal.

If you want to file an appeal, you have to file it within 90 days from the date that you receive the letter saying that we would not cover the service you wanted.

You can call us to file your appeal or you may also send your appeal in writing. We have a simple form you can use to file your appeal. Just call **1-800-318-8821**, **TTY: 711**, to get one. We will mail or fax the appeal form to you and provide assistance if you need help completing it.

Once you complete the form, you should mail it to:

UnitedHealthcare Member Appeals
P.O. Box 31364
Salt Lake City, UT 84131

Your doctor can also file an appeal for you if you sign a form giving him or her permission. Other people can also help you file an appeal, like a family member or a lawyer.

When you file an appeal, be sure to let us know any new information that you have that will help us make our decision. We will send you a letter letting you know that we received your appeal within 5 business days. While your appeal is being reviewed, you can still send or deliver any additional information that you think will help us make our decision.

When reviewing your appeal we will:

- Use doctors who know about the type of illness you have.
- Not use the same people who denied your request for a service.
- Make a decision about your appeal within 30 days.

The appeal process may take up to 44 days if you ask for more time to submit information or we need to get additional information from other sources. We will send you a letter if we need additional information.

If your doctor or UnitedHealthcare feels that your appeal should be reviewed quickly due to the seriousness of your condition, you will receive a decision about your appeal within 3 business days.

If we do not feel that your appeal needs to be reviewed quickly, we will try to call you and send you a letter letting you know that your appeal will be reviewed within 30 days.

If your appeal is about a service that was already authorized and you were already receiving, you may be able to keep getting the service while we review your appeal. Contact us at **1-800-318-8821**, **TTY: 711**, if you would like to keep getting services while your appeal is reviewed. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

Once we complete our review, we will send you a letter letting you know our decision. If we decide that you should not receive the denied service, that letter will tell you how to file another appeal or ask for a State Fair Hearing.

Grievances.
If your complaint is about something other than not receiving a service, this is called a grievance. Examples of grievances would be not being able to find a doctor, trouble getting an appointment, or not being treated fairly by someone who works at UnitedHealthcare Community Plan or at your doctor's office.

If your grievance is:

- About an urgent medical problem you are having, it will be solved within 24 hours.
- About a medical problem but it is not urgent, it will be solved within 5 days.
- Not about a medical problem, it will be solved within 30 days.

If you would like a copy of our official complaint procedure or if you need help filing a complaint, please call **1-800-318-8821**, **TTY: 711**.

C. The State's Complaint Process

Getting help from the HealthChoice Enrollee Help Line.
If you have a question or complaint about your health care and we have not solved the issue to your satisfaction, you can ask for help from the State's HealthChoice Enrollee Help Line. To reach the HealthChoice Enrollee Help Line, call **1-800-284-4510 Monday through Friday between 7:30 a.m. and 5:30 p.m.** (or you can leave a recorded message at any other time).

When you call the Help Line, you can ask your question or explain your problem to one of the Action Line staff, who will:

- Answer your questions;
- Work with us to discuss what you need; or
- Send your complaint to the Complaint Resolution Unit nurses, who may:
- Ask us to provide information about your case within five days;
- Work with your provider and us to assist you in getting what you need;
- Help you to get more community services, if needed; or
- Help you to appeal denials and send you the fair hearing process in writing.

D. The State's Appeal Process

Asking the state to review our decision.
When you do not agree with our decision to deny, stop, or reduce a service, you can ask the State to review the decision. This is called an appeal.

You can contact the Enrollee Help Line at 1-800-284-4510 and tell the representative that you would like to appeal our decision. Your appeal will be sent to a nurse in the Complaint Resolution Unit.

The Complaint Resolution Unit will attempt to resolve your issue with us in 10 business days. If it cannot be resolved in 10 business days, you will be sent a notice that gives you a choice to request a fair hearing or wait until the Complaint Resolution Unit has finished its review.

When the Complaint Resolution Unit is finished working on your appeal, you will be notified of their findings.

- If the State thinks we should provide the requested service, it can order us to give you the service; or
- If the State thinks that we do not have to give you the service, you will be told that the State agrees with us.

If you do not agree with the State's decision, which you will receive in writing, you will again be given the opportunity to request a State Fair Hearing.

Types of state decisions you can appeal.
You have the right to appeal three types of decisions made by the State. When the State:

- Agrees with us that we should not cover a requested service;
- Agrees with us that a service you are currently receiving should be stopped or reduced; or
- Denies your request to enroll in the Rare and Expensive Case Management (REM) Program.

Continuing services during the appeal.
If your appeal is about a service that was already authorized and you were already receiving, you may be able to keep getting the service while the State reviews your appeal. Contact the Enrollee Help Line at 1-800-284-4510 if you would like to keep getting services while your appeal is reviewed. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

Fair Hearings.
To appeal one of the State's decisions, you must request that the State file a notice of appeal with the Office of Administrative Hearings on your behalf. This will be your appeal against the State. We usually will not be involved in the appeal, but our providers and staff members may appear as witnesses for the State at the appeal hearing.

The Office of Administrative Hearings will set a date for the hearing based on the type of decision being appealed.

- If the appeal is about us reducing or not giving you a service because both the State and UnitedHealthcare Community Plan thinks you do not have a medical need for the service, the Office of Administrative Hearings will set a hearing date within 20 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.
- For all other appeals, the Office of Administrative Hearings will set a hearing date within 30 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.

You can ask for an expedited appeal. If the State thinks your hearing should be held more quickly due to the seriousness of your health condition, a hearing will be held and a decision will be made within 3 days.

The Board of Review.
If the Office of Administrative Hearings decides against you, you may appeal to the State's Board of Review. You will get the information on how to appeal to the Board of Review with the decision from the Office of Administrative Hearings.

Judicial appeal.
If the Board of Review decides against you, you may appeal to the Circuit Court.

E. How to Make Suggestions for Changes in Policies or Procedures

If you have a suggestion for changes in policies or procedures, you can contact:

1. UnitedHealthcare Member Consumer Advisory Board; or
2. UnitedHealthcare Complaint and Appeals Department; or
3. Visit one of UnitedHealthcare Community Hubsites.

For more information, call UnitedHealthcare Member Services at **1-800-318-8821**, **TTY: 711**.

X. Fraud and Abuse

People who are dishonest on purpose to get HealthChoice may lose their health care benefits, be fined or jailed.

Fraud and abuse for HealthChoice members can be things like:

- Providing false information or hiding facts to get or keep HealthChoice.
- Letting someone else use your HealthChoice ID card.
- Selling or giving your prescription medicines to anyone else.

Fraud and abuse for HealthChoice providers can be things like:

- Billing UnitedHealthcare for services that were never given, or billing twice for the same service.

If you know of fraud and abuse in the HealthChoice program, you must tell HealthChoice about it. But you don't have to tell them your name. If you report fraud, you will not be treated any differently.

How to report fraud and abuse.
Tell us in one of the following ways:

- UnitedHealth Group maintains a 24-hour toll-free telephone line, known as the Compliance Help Line, at 1-800-455-4521. Callers may choose to remain anonymous.
- Call HealthChoice Fraud Hotline at 1-866-770-7175.
- Online at **www.dhmh.state.md.us**, then click on "Report Fraud."
- Write the DHMH Medicaid Program Integrity, Recipient Fraud and Abuse Unit, 201 West Preston Street, Room 520, Baltimore, Maryland 21201, Fax: 410-333-5326 or 410-333-7194 (TTY).

A. When Can I Change My MCO?

1. During the first 90 days of enrollment.
You can request to change your MCO one time during the first 90 days if you are new to the HealthChoice Program as long as you are not hospitalized at the time of the request. You can also make this request within 90 days if you are automatically assigned to an MCO.

2. Once a year.
You may change your MCO if you have been in the same MCO for 12 or more months.

3. When there is an approved reason to change MCOs.
You may change your MCO and join another MCO near where you live for any of the following reasons at any time:

- If you move to another county where we do not offer care.
- If you become homeless and find that there is another MCO closer to where you live or have shelter which would make getting to appointments easier.
- If you or any member of your family has a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO.
- If a child is placed in foster care and the foster care children or the family members receive care by a doctor in a different MCO than the child being placed, the child being placed can switch to the foster family's MCO.
- You desire to continue to receive care from your Primary Care Provider (PCP) and the MCO terminated the PCP's contract for one of the following reasons:

  a) For reasons other than quality of care;

  b) The provider and the MCO cannot agree on a contract for certain financial reasons; or

  c) Your MCO has been purchased by another MCO.

B. Reasons the State Will Disenroll You From an MCO

The State will remove you (disenroll you) from an MCO if you:

- Are placed in a long-term care facility for more than 30 days straight;
- Are admitted into an intermediate facility for persons with intellectual disabilities;
- Are approved for the Rare and Expensive Case Management Program;
- Are no longer qualified for State benefits;
- Are no longer qualified to be in an MCO because you are now in another State program which does not enroll its members in MCOs;
- Are in an MCO that no longer has a contract to provide care in the State of Maryland; or
- Should not have been enrolled in an MCO.
- Are 65 or older.
- Are eligible for Medicare.
- You are incarcerated.

C. How Do I Change My MCO?

If you decide to change your MCO, you should contact the State's Enrollment Broker at 1-800-977-7388.

NOTE: If you temporarily lose your Medicaid eligibility but are approved again within 120 days, you will automatically be enrolled with UnitedHealthcare.

XII. Procedures for Verification of Citizenship and Identity

A. Use one of the following documents to prove both citizenship and identity:

1. U.S. passport (current or expired), or
2. Certificate of Naturalization (N-550 or N-570), or
3. Certificate of Citizenship (N-560 or N-561), OR

B. One document from the proof of citizenship list AND one document from the proof of identity list.

Proof of citizenship	Proof of identity
• U.S. Birth Certificate. • Data match by DHMH to document a birth record. • SAVE data match — for naturalized citizens only. • For child under 16: a record created near the date of birth, or 5 years before initial MA/MCHP application, and showing U.S. place of birth on hospital letterhead or other medical record. • Record showing U.S. place of birth, if created at least 5 years before initial MA/MCHP application: record on hospital letterhead or other medical record created near the date of birth, institutional admission papers, signed statement by physician or midwife who attended the birth, Vital Statistics notice of birth registration, insurance record. • Final adoption decree for child born in U.S. • Certificate of citizen born abroad (DS-1350, FS-240, FS-545).	• Photo driver's license or MVA ID card. • Data match to document identity (current or past TCA, Food Stamps, TDAP, SSI eligibility). • Photo school ID card. • Photo ID issued by a federal, state, or local government. • U.S. military ID card, discharge document, or draft record. • Native American Tribal Document. • U.S. Coast Guard Merchant Mariner card. • For children under 16: clinic, doctor, hospital, or school record (e.g., DHR/FIA 604 or 604-A form), nursery or day care record including pre-school health forms and Form 1131. School records may include report cards but these records must be verified with the issuing school.

XII. Procedures for Verification of Citizenship and Identity

Proof of citizenship	Proof of identity
• Early school record — must show a U.S. place of birth, the date of admission to the school, date of birth (or age at the time the record was made), and the name(s) and place(s) of birth of the applicant's parent(s). • Religious record — recorded in the U.S. within three months of birth showing U.S. birth, and either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization, not the family bible. • U.S. military service record showing U.S. place of birth. • Evidence of U.S. civil service employment before 6/1/76. • Federal or state census record for 1900 – 1950 showing U.S. citizenship or U.S. place of birth. • ID card for naturalized citizen (I-179 or I-197). • Affidavits (can also be used for naturalized citizens). Three written and signed affidavits. Two completed by citizens who have personal knowledge of the person's citizenship, one of whom is not a relative. Both signers must be U.S. citizens. Another affidavit completed by the person, representative, or someone else knowledgeable to explain why the proof isn't available.	• Three or more corroborating documents to prove identity such as marriage licenses, divorce decrees, high school and college diplomas, property deeds/titles, and employer ID cards. This process can be used if they are unable to produce a single, more reliable document such as a driver's license. (These may only be used if the individual did not use affidavits to verify citizenship.) **Note:** Recently expired identity documents are usable as long as there is no reason to believe the document does not match the individual. • Affidavits can be used for the following: For Children under 16: written affidavit signed by parent or guardian — but only if an affidavit was not used as proof of citizenship. Disabled individuals (Adult/Child) in long-term care or rehabilitative residential care facilities; signed by Facility Director or Administrator.

Maryland Advance Directive

Planning for Future Health Care Decisions.

A Guide to Maryland Law on Health Care Decisions.
(Forms Included)

Dear Fellow Marylander:

I am pleased to send you an advance directive form that you can use to plan for future health care decisions. The form is optional; you can use it if you want or use others, which are just as valid legally. If you have any legal questions about your personal situation, you should consult your own lawyer. If you decide to make an advance directive, be sure to talk about it with those close to you. The conversation is just as important as the document. Give copies to family members or friends and your doctor. Also make sure that, if you go into a hospital, you bring a copy. Please do not return completed forms to this office.

Life-threatening illness is a difficult subject to deal with. If you plan now, however, your choices can be respected and you can relieve at least some of the burden from your loved ones in the future. You may also use another enclosed form to make an organ donation or plan for arrangements after death. Here is some related, important information:

- If you want information about Emergency Medical Services (EMS) Palliative Care/Do Not Resuscitate (DNR) Orders, please contact the Maryland Institute for Emergency Medical Services Systems directly at 410-706-4367. An EMS/DNR Order is a physician's instruction to emergency medical personnel (911 responders) to provide comfort care instead of resuscitation. The EMS/DNR Order can be found on the Internet at: **http://www.miemss.org**. From that page, click on "EMS Forms."
- The Maryland Department of Health and Mental Hygiene makes available an advance directive focused on preferences about mental health treatment. This can be found on the Internet at: **http://www.dhmh.state.md.us/mha**. From that page, click on "MHA Forms."

I hope that this information is helpful to you. **I regret that overwhelming demand limits us to supplying one set of forms to each requester.** But please feel free to make as many copies as you wish. Additional information about advance directives can be found on the Internet at: **http://www.oag.state.md.us/healthpol/advancedirectives.htm**.

State of Maryland
Office of the Attorney General

Health Care Planning Using Advance Directives

(Optional form included)

Your right to decide.
Adults can decide for themselves whether they want medical treatment. This right to decide (to say yes or no to proposed treatment) applies to treatments that extend life, like a breathing machine or a feeding tube. Tragically, accident or illness can take away a person's ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will. These decisions should reflect your own values and priorities.

A Maryland law called the Health Care Decisions Act says that you can do health care planning through "advance directives." An advance directive can be used to name a health care agent. This is someone you trust to make health care decisions for you. An advance directive can also be used to say what your preferences are about treatments that might be used to sustain your life.

The State offers a form to do this planning, included with this pamphlet. The form as a whole is called "Maryland Advance Directive: Planning for Future Health Care Decisions." It has three parts to it: Part I, Selection of Health Care Agent; Part II, Treatment Preferences ("Living Will"); and Part III, Signature and Witnesses. This pamphlet will explain each part.

The advance directive is meant to reflect your preferences. You may complete all of it, or only part, and you may change the wording. You are not required by law to use these forms. Different forms, written the way you want, may also be used. For example, one widely praised form, called Five Wishes, is available (for a small fee) from the nonprofit organization Aging With Dignity. You can get information about that document from the Internet at **www.agingwithdignity.org** or write to: Aging with Dignity, P.O. Box 1661, Tallahassee, FL 32302.

This optional form can be filled out without going to a lawyer. But if there is anything you do not understand about the law or your rights, you might want to talk with a lawyer. You can also ask your doctor to explain the medical issues, including the potential benefits or risks to you of various options. You should tell your doctor that you made an advance directive and give your doctor a copy, along with others who could be involved in making these decisions for you in the future.

In Part III of the form, you need two witnesses to your signature. Nearly any adult can be a witness. If you name a health care agent, though, that person may not be a witness. Also, one of the witnesses must be a person who would not financially benefit by your death or handle your estate. You do not need to have the form notarized.

This pamphlet also contains a separate form called "After My Death." Like the advance directive, using it is optional. This form has four parts to it: Part I, Organ Donation; Part II, Donation of Body; Part III, Disposition of Body and Funeral Arrangements; and Part IV, Signature and Witnesses.

Once you make an advance directive, it remains in effect unless you revoke it. It does not expire, and neither your family nor anyone except you can change it. You should review what you've done once in a while. Things might change in your life, or your attitudes might change. You are free to amend or revoke an advance directive at any time, as long as you still have decision-making capacity. Tell your doctor and anyone else who has a copy of your advance directive if you amend it or revoke it.

If you already have a prior Maryland advance directive, living will, or a durable power of attorney for health care, that document is still valid. Also, if you made an advance directive in another state, it is valid in Maryland. You might want to review these documents to see if you prefer to make a new advance directive instead.

Part I of the Advance Directive

Selection of health care agent.
You can name anyone you want (except, in general, someone who works for a health care facility where you are receiving care) to be your health care agent. **To name a health care agent, use Part I of the advance directive form.** (Some people refer to this kind of advance directive as a "durable power of attorney for health care.") Your agent will speak for you and make decisions based on what you would want done in your best interests. You decide how much power your agent will have to make health care decisions. You can also decide when you want your agent to have this power: right away, or only after a doctor says that you are not able to decide for yourself.

You can pick a family member as a health care agent, but you don't have to. Remember, your agent will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care agent. Also, consider picking one or two back-up agents, in case your first choice isn't available when needed. Be sure to inform your chosen person and make sure that he or she understands what's most important to you. When the time comes for decisions, your health care agent should follow your written directions.

We have a helpful booklet that you can give to your health care agent. It is called *"Making Medical Decisions for Someone Else: A Maryland Handbook."* You or your agent can get a copy on the Internet by visiting the Attorney General's home page at: **http://www.oag.state.md.us**, then clicking on "Guidance for Health Care Proxies." You can also request a copy by calling 410-576-7000.

The form included with this pamphlet does not give anyone power to handle your money. We do not have a standard form to send. Talk to your lawyer about planning for financial issues in case of incapacity.

Part II of the Advance Directive

Treatment preferences ("Living Will").
You have the right to use an advance directive to say what you want about future life-sustaining treatment issues. You can do this in Part II of the form. If you both name a health care agent and make decisions about treatment in an advance directive, it's important that you say (in Part II, paragraph G) whether you want your agent to be strictly bound by whatever treatment decisions you make.

Part II is a living will. It lets you decide about life-sustaining procedures in three situations: when death from a terminal condition is imminent despite the application of life-sustaining procedures; a condition of permanent unconsciousness called a persistent vegetative state; and end-stage condition, which is an advanced, progressive, and incurable condition resulting in complete physical dependency. One example of end-stage condition could be advanced Alzheimer's disease.

Frequently Asked Questions About Advance Directives in Maryland

1. **Must I use any particular form?**

   No. An optional form is provided, but you may change it or use a different form altogether. Of course, no health care provider may deny you care simply because you decided not to fill out a form.

2. **Who can be picked as a health care agent?**

   Anyone who is 18 or older except, in general, an owner, operator, or employee of a health care facility where a patient is receiving care.

3. **Who can witness an advance directive?**

   Two witnesses are needed. Generally, any competent adult can be a witness, including your doctor or other health care provider (but be aware that some facilities have a policy against their employees serving as witnesses). If you name a health care agent, that person cannot be a witness for your advance directive. Also, one of the two witnesses must be someone who (i) will not receive money or property from your estate and (ii) is not the one you have named to handle your estate after your death.

4. **Do the forms have to be notarized?**

   No, but if you travel frequently to another state, check with a knowledgeable lawyer to see if that state requires notarization.

5. Do any of these documents deal with financial matters?

No. If you want to plan for how financial matters can be handled if you lose capacity, talk with your lawyer.

6. When using these forms to make a decision, how do I show the choices that I have made?

Write your initials next to the statement that says what you want. Don't use checkmarks or X's. If you want, you can also draw lines all the way through other statements that do not say what you want.

7. Should I fill out both Parts I and II of the advance directive form?

It depends on what you want to do. If all you want to do is name a health care agent, just fill out Parts I and III, and talk to the person about how they should decide issues for you. If all you want to do is give treatment instructions, fill out Parts II and III. If you want to do both, fill out all three parts.

8. Are these forms valid in another state?

It depends on the law of the other state. Most state laws recognize advance directives made somewhere else.

9. How can I get advance directive forms for another state?

Contact Caring Connections (NHPCO) at 1-800-658-8898 or on the Internet at: **http://www.caringinfo.org**.

10. To whom should I give copies of my advance directive?

Give copies to your doctor, your health care agent and back-up agent(s), hospital or nursing home if you will be staying there, and family members or friends who should know of your wishes. Consider carrying a card in your wallet saying you have an advance directive and who to contact.

11. Does the federal law on medical records privacy (HIPAA) require special language about my health care agent?

Special language is not required, but it is prudent. Language about HIPAA has been incorporated into the form.

12. Can my health care agent or my family decide treatment issues differently from what I wrote?

It depends on how much flexibility you want to give. Some people want to give family members or others flexibility in applying the living will. Other people want it followed very strictly. Say what you want in Part II, Paragraph G.

XIII. Advance Directives

13. Can my doctor override my living will?

Usually, no. However, a doctor is not required to provide a "medically ineffective" treatment even if a living will asks for it.

14. If I have an advance directive, do I also need an Emergency Medical Services Palliative Care/Do Not Resuscitate Order?

Yes. If you don't want ambulance personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have an EMS Palliative Care/DNR Order signed by your doctor.

15. Does the EMS Palliative Care/DNR Order have to be in a particular form?

Yes. Ambulance personnel have very little time to evaluate the situation and act appropriately. So, it is not practical to ask them to interpret documents that may vary in form and content. Instead, a standardized order form has been developed. Have your doctor or health care facility contact the Maryland Institute for Emergency Medical Services System at 410-706-4367 to obtain information on EMS Palliative Care/DNR Orders.

16. Can I fill out a form to become an organ donor?

Yes. Use Part I of the "After My Death" form.

17. What about donating my body for medical education or research?

Part II of the "After My Death" form is a general statement of these wishes. The State Anatomy Board has a specific donation program, with a pre-registration form available. Call the Anatomy Board at 1-877-463-3464 for that form and additional information.

If you have other questions, please talk to your doctor or your lawyer. Or, if you have a question about the form that is not answered in this pamphlet, you can call the Health Policy Division of the Attorney General's office at 410-576-6327 or email us at **adforms@oag.state.md.us**.

More information about Advance Directives can be obtained from our website at:
http://www.oag.state.md.us/healthpol/

Maryland Advance Directive: Planning for Future Health Care Decisions

By:_____ **Date of Birth:** _____
(Print Name) (Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. **Make sure you talk to your health care agent (and any back-up agents) about this important role.** Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes and then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

Part I: Selection of Health Care Agent

A. Selection of Primary Agent.
I select the following individual as my agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Numbers: _____
(home and cell)

B. Selection of Back-up Agents.
(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

Telephone Numbers: _____
(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

Telephone Numbers: _____
(home and cell)

C. Powers and Rights of Health Care Agent.
I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
4. I also want my agent to:
   a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
   b. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

This power is subject to the following conditions or limitations: (Optional; form valid if left blank)

_____

_____

_____

D. How My Agent Is to Decide Specific Issues.
I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult.
(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make decisions.

Name(s): _____ Telephone Number(s): _____

_____ _____

_____ _____

_____ _____

F. In Case of Pregnancy.
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

_____

_____

_____

_____

_____

_____

_____

_____

G. Access to My Health Information — Federal Privacy Law (HIPAA) Authorization.

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.
2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.
3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of This Part.

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to. _____

   OR

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability **temporarily,** or my attending physician and a consulting doctor agree that I have lost this ability **permanently.**

   _____

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, go to Part II. Also consider becoming an organ donor, using the separate form for that.

Part II: Treatment Preferences ("Living Will")

A. Statement of Goals and Values.
(Optional: Form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

_____

_____

_____

_____

_____

_____

_____

B. Preference in Case of Terminal Condition.
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
   _____

   OR
2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. _____

   OR
3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. _____

C. Preference in Case of Persistent Vegetative State.
(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means. _____

   OR

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. _____

   OR

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. _____

D. Preference in Case of End-Stage Condition.
(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means. _____

   OR

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. _____

   OR

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. _____

E. Pain Relief.
No matter what my condition, give me the medicine or other treatment I need to relieve pain.

F. In Case of Pregnancy.
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____

_____

_____

_____

G. Effect of Stated Preferences.

(Read both of these statements carefully. Then, initial **one** only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest. _____

   OR

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better. _____

Part III: Signature and Witnesses

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

_____ _____

(Signature of Declarant) (Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s)

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s)

(**Note:** Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law does not require this document to be notarized.)

After My Death

(This document is optional. Do only what reflects your wishes.)

By:_____ **Date of Birth:**_____
(Print Name) (Month/Day/Year)

Part I: Organ Donation

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate:

Any needed organs, tissues, or eyes. _____

Only the following organs, tissues, or eyes:

_____

_____

_____

_____

I authorize the use of my organs, tissues, or eyes:

For transplantation _____

For therapy _____

For research _____

For medical education _____

For any purpose authorized by law _____

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. **This document is not intended to change anything about my health care while I am still alive.** After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

Part II: Donation of Body

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program. _____

Part III: Disposition of Body and Funeral Arrangements

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my advance directive. _____

OR

This person:

Name: _____

Address: _____

_____

_____

Telephone Number(s): _____
(home and cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

_____

_____

_____

_____

Part IV: Signature and Witnesses

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

_____ _____

(Signature of Donor) (Date)

The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

_____ _____

(Signature of Witness) (Date)

_____

Telephone Numbers

_____ _____

(Signature of Witness) (Date)

_____

Telephone Numbers

Did You Remember to ...

- ☐ Fill out Part I if you want to name a health care agent?
- ☐ Name one or two back-up agents in case your first choice as health care agent is not available when needed?
- ☐ Talk to your agents and back-up agent about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions in the advance directive?
- ☐ If you want to make specific decisions, fill out Part II, choosing carefully among alternatives?
- ☐ Sign and date the advance directive in Part III, in front of two witnesses who also need to sign?
- ☐ Look over the "After My Death" form to see if you want to fill out any part of it?
- ☐ Make sure your health care agent (if you named one), your family and your doctor know about your advance care planning?
- ☐ Give a copy of your advance directive to your health care agent, family members, doctor, and hospital or nursing home if you are a patient there?

Advance Directives Information Sheet

What you should know about advance directives.
Everyone has the right to make personal decisions about health care. Doctors ask whether you will accept a treatment by discussing the risks and benefits and working with you to decide. But what if you can no longer make your own decisions? Anyone can wind up hurt or sick and unable to make decisions about medical treatments. An advance directive speaks for you if you are unable to and helps make sure your religious and personal beliefs will be respected. It is a useful legal document for an adult of any age to plan for future health care needs. While no one is required to have an advance directive, it is smart to think ahead and make a plan now. If you don't have an advance directive and later you can't speak for yourself, then usually your next of kin will make health care decisions for you. But even if you want your next of kin to make decisions for you, an advance directive can make things easier for your loved ones by helping to prevent misunderstandings or arguments about your care.

What can you do in an advance directive?
An advance directive allows you to decide who you want to make health care decisions for you if you are unable to do so yourself. You can also use it to say what kinds of treatments you do or do not want, especially the treatments often used in a medical emergency or near the end of a person's life.

1. **Health care agent.** Someone you name to make decisions about your health care is called a "health care agent" (sometimes also called a "durable power of attorney for health care," but, unlike other powers of attorney, this is not about money). You can name a family member or someone else. This person has the authority to see that doctors and other health care providers give you the type of care you want, and that they do not give you treatment against your wishes. Pick someone you trust to make these kinds of serious decisions and talk to this person, to make sure he or she understands and is willing to accept this responsibility.
2. **Health care instructions.** You can let providers know what treatments you want to have or not to have. (Sometimes this is called a "living will," but it has nothing to do with an ordinary will about property.) Examples of the types of treatment you might decide about are:
   a. Life support — such as breathing with a ventilator
   b. Efforts to revive a stopped heart or breathing (CPR)
   c. Feeding through tubes inserted into the body
   d. Medicine for pain relief

Ask your doctor for more information about these treatments. Think about how, if you become badly injured or seriously ill, treatments like these fit in with your goals, beliefs, and values.

How do you prepare an advance directive?
Begin by talking things over, if you want, with family members, close friends, your doctor, or a religious advisor. Many people go to a lawyer to have an advance directive prepared. You can also get sample forms yourself from many places, including the ones given as examples at the end of this information sheet. There is no one form that must be used. You can even make up your own advance directive document.

To make your advance directive valid, it must be signed by you in the presence of two witnesses, who will also sign. If you name a health care agent, make sure that person is not a witness. Maryland law does not require the document to be notarized. You should give a copy of your advance directive to your doctor, who will keep it in your medical file, and to others you trust to have it available when needed. Copies are just as valid as the originals.

You can also make a valid advance directive by talking to your doctor in front of a witness.

When would your advance directive take effect?
Usually, your advance directive would take effect when your doctor certifies in writing that you are not capable of making a decision about your care. If your advance directive contains health care instructions, they will take effect depending on your medical condition at the time. If you name a health care agent, you should make clear in the advance directive when you want the agent to be able to make decisions for you.

Can you change your advance directive?
Yes, you can change or take back your advance directive at any time. The most recent one will count.

Where can you get forms and more information about advance directives?
There are many places to get forms, including medical, religious, aging assistance, and legal organizations. Four places are shown below, but these are just examples. Any of these forms are valid in Maryland, but not all may be in keeping with your beliefs and values. Your advance directive does not have to be on any particular form.

Call the Maryland Attorney General's Office
410-576-7000 or 1-888-734-0023 **www.oag.state.md.us/healthpol/adirective.pdf**

Call Caring Connections (NHPCO)
1-800-658-8898 **www.caringinfo.org**

Call Aging With Dignity
1-800-594-7437 **www.agingwithdignity.org**

Maryland Department of Health and Mental Hygiene
410-767-6500 or 1-877-463-3464 **www.dhmh.state.md.us/**

XIV. 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 January 1, 2016.
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 access your HI.

We must by law follow the terms of this notice.

"Health information" (or HI) in this notice means information related to your health or health care services that can be used to identify you. We have the right to change our privacy practices. If we change them, we will notify you by mail or e-mail, as permitted by law. If we maintain a website for your health plan, we will also post the new notice on **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 your information.
We must use and share your HI with:

- You or your legal representative.
- The Secretary of the Department of Health and Human Services.

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

- **For Payment.** We may use or share your HI to process premium payments and claims. 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.** We may share your HI with providers to help them give you care.
- **For Health Care Operations Related to Your Care.** 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.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer plan sponsor. We may give them other HI if they agree to limit its use as required by 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.** We may use your HI to send you information on your health benefits or care and doctor's 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. If you pass away, we may share HI with family members or friends who helped with your care prior to your death unless doing so would go against wishes that you shared with us before your death.
- **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. The attached "Federal and State Amendments" document describes those laws in more detail.

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. If we maintain a website for your health plan, 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 **1-800-318-8821** or **TTY: 711**.
- **To Submit a Written Request.** Mail to:

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

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

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

Effective January 1, 2016.

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.

XIV. Privacy Notices

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 **1-800-318-8821** or **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: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; Connextions HCI, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC,; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; 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 healthplans in states that provide exceptions.

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

Revised: January 1, 2016.

The first part of this Notice (pages 72 – 76) 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 disclosure information regarding certain public assistance programs except for certain purposes	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

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

HIV/AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, 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 **1-800-318-8821**, **TTY: 711**. You can also visit our website at **myuhc.com/CommunityPlan**.

UnitedHealthcare Community Plan
6220 Old Dobbin Road
Columbia, MD 21045

myuhc.com/CommunityPlan

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