



Florida



# Welcome to the community

**UnitedHealthcare Community Plan**  
Medicaid Member Handbook

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# Language help

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

## **Spanish:**

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

## **French:**

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

## **Haitian Creole:**

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

## **Italian:**

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

## **Russian:**

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

## **Vietnamese:**

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

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## Important contact information

**Member Services Help Line** – Available 24 hours

**MMA Member Services** ..... **1-888-716-8787**  
**LTC Member Services** ..... **1-800-791-9233**

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

**Website** ..... [myuhc.com/CommunityPlan](https://myuhc.com/CommunityPlan)

**Address** ..... **7901 SW 6th Street, Suite 400**  
**Plantation, FL 33324**

**Transportation services: non-emergency**

**MTM Health MMA or LTC** ..... **1-888-777-6528**  
See page 114 for app information.

**Vision** ..... **1-888-716-8787**

**Dental**

Contact your case manager directly or at ..... **1-888-716-8787**  
for help with arranging these services.  
Please note routine dental benefits are not provided by this plan.

**To report suspected cases of abuse, neglect, abandonment,**

**or exploitation of children or vulnerable adults** . . . . **1-800-96-ABUSE (1-800-962-2873)**  
**TTY 711 or 1-800-955-8771**

<https://www.myflfamilies.com/services/abuse/abuse-hotline/how-report-abuse>

**For Medicaid eligibility** ..... **1-866-762-2237**

**TTY 711 or 1-800-955-8771**

<https://www.myflfamilies.com/medicaid#ME>

**To report Medicaid fraud and/or abuse** ..... **1-888-419-3456**

<https://apps.ahca.myflorida.com/mpi-complaintform/>

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

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- To file a complaint about a health care facility ..... 1-888-419-3456  
[http://ahca.myflorida.com/MCHQ/Field\\_Ops/CAU.shtml](http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml)
- To request a Medicaid Fair Hearing ..... 1-877-254-1055  
 1-239-338-2642 (fax)  
[MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)
- To file a complaint about Medicaid services ..... 1-877-254-1055  
 TDD 1-866-467-4970  
<http://ahca.myflorida.com/Medicaid/complaints/>
- To find information for elders ..... 1-800-96-ELDER (1-800-963-5337)  
<https://elderaffairs.org/programs-services/>
- To find out information about domestic violence ..... 1-800-799-SAFE, 1-800-799-7233  
 TTY 1-800-787-3224  
<http://www.thehotline.org/>
- To find information about health facilities  
 in Florida ..... <https://quality.healthfinder.fl.gov/>
- To find information about urgent care  
 MMA ..... 1-888-716-8787, TTY 711  
 LTC ..... 1-800-791-9233, TTY 711
- For an emergency ..... 9-1-1  
 Or go to the nearest emergency room

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# Welcome to UnitedHealthcare's Statewide Medicaid Managed Care Plan

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

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

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

If you are a participant in the Intellectual Developmentally Disabled (IDD) Pilot Program, most of the information in this handbook applies to you. We will let you know if something does not apply or if there is information that applies to IDD enrollees.

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

# Section 1:


## Your plan identification card (ID card)

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

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

Your ID card will look like this:


### MMA (Managed Medical Assistance) – Your ID card will look like this:

	Health Plan (80840) 911-87726-04
Member ID: 9999999921	Group Number: FLMMMA
Member: NEW A ENGLISH	Payer ID: 87726
PCP Name: DOUGLAS GETWELL PCP Phone: (717)851-2521	<b>Optum Rx*</b> Rx Bin: 610494 Rx Grp: ACUFL Rx PCN: 4300
Effective Date 06/01/2017	
Copay: OFFICE/SPEC/ER/UrgCare \$0/\$0/\$0/\$0	
PCP referral required for specific specialty services DOI -0501	MMA Underwritten by UnitedHealthcare of Florida, Inc.

In an emergency go to nearest emergency room or call 911.		Printed: 09/26/25
This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website <a href="http://www.uhccommunityplan.com">www.uhccommunityplan.com</a> or call.		
For Members:	888-716-8787	TTY 711
AHCA:		888-419-3456
Behavioral Health:		888-716-8787
NurseLine:		877-552-8105
For Providers:	UHCprovider.com	877-842-3210
Medical Claims:	PO Box 31365, Salt Lake City, UT 84131-0365	
Health Plan:	7901 SW 6th Street, Suite 400 Plantation, FL 33324	
Pharmacy Claims:	OptumRX, PO Box 650334, Dallas, TX 75265-0334	
For Pharmacists:	844-567-6857	Rx Prior Auth: 800-310-6826


## Section 1: Your plan identification card (ID card)

### LTC (Long Term Care) Plan – Your ID card will look like this:

	
Health Plan (80840) <b>911-87726-04</b>	
Member ID: <b>999999910711</b>	Group Number: <b>FL LTC</b>
Member: <b>NEW ENGLISH</b>	Payer ID: <b>87726</b>
Effective Date 06/01/2017	
<small>Health and Home Connection Underwritten by UnitedHealthcare of Florida, Inc.</small>	
DOI -0501	

<small>In an emergency go to nearest emergency room or call 911.      Printed: 09/26/25</small>	
<small>This card does not guarantee coverage. For coordination of care, call your case manager. To verify benefits or to find a provider, visit the website <a href="http://www.uhccommunityplan.com">www.uhccommunityplan.com</a> or call.</small>	
For Members:	800-791-9233      TTY 711
AHCA:	888-419-3456
Behavioral Health:	800-791-9233
NurseLine:	877-552-8105
For Providers:	UHCprovider.com      877-842-3210
Medical Claims:	PO Box 31365, Salt Lake City, UT 84131-0365
Health Plan:	7901 SW 6th Street, Suite 400 Plantation, FL 33324

### Comprehensive MMA + LTC (Managed Medical Assistance + Long Term Care) Your ID card will look like this:

	
Health Plan (80840) <b>911-87726-04</b>	
Member ID: <b>9999999913</b>	Group Number: <b>FLMMA</b>
Member: <b>NEW R ENGLISH</b>	Payer ID: <b>87726</b>
PCP Name: DOUGLAS GETWELL PCP Phone: (610)863-5378 Effective Date 06/01/2017 Copay: OFFICE/SPEC/ER/UrgCare \$0/\$0/\$0/\$0 <small>PCP referral required for specific specialty services</small>	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <b>Optum Rx<sup>®</sup></b>                      Rx Bin: 610494                      Rx Grp: ACUFL                      Rx PCN: 4300                 </div>
<small>Comprehensive MMA &amp; LTC Underwritten by UnitedHealthcare of Florida, Inc.</small>	
DOI -0501	

<small>In an emergency go to nearest emergency room or call 911.      Printed: 09/26/25</small>	
<small>This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website <a href="http://www.uhccommunityplan.com">www.uhccommunityplan.com</a> or call.</small>	
For Members:	888-716-8787      TTY 711
AHCA:	888-419-3456
Behavioral Health:	888-716-8787
NurseLine:	877-552-8105
For Providers:	UHCprovider.com      877-842-3210
Medical Claims:	PO Box 31365, Salt Lake City, UT 84131-0365
Health Plan:	7901 SW 6th Street, Suite 400 Plantation, FL 33324
Pharmacy Claims:	OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists:	844-567-6857      Rx Prior Auth: 800-310-6826

If you have both, take advantage of your MMA and LTC coverage by reviewing each benefit.

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

# Section 2:

## Your privacy

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

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

### Health Plan Notices of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective January 1, 2025

By law, we<sup>1</sup> must protect the privacy of your health information (“HI”). We must send you this notice. It tells you:

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

By law, we must follow the terms of our current notice.

HI is information about your health or medical services. We have the right to make changes to this notice of privacy practices. If we make important changes, we will notify you by mail or e-mail. We will also post the new notice on our website. Any changes to the notice will apply to all HI we have. We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

### How We Collect, Use, and Share Your Information

#### We collect, use and share your HI with:

- You or your legal or personal representative.
- Certain Government agencies. To check to make sure we are following privacy laws.

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

- **For Payment.** To process payments and pay claims. For example, we may tell a doctor whether we will pay for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment or Managing Care.** To help with your care. For example, we may share your HI with a hospital you are in, to help them provide medical care to you.
- **For Health Care Operations.** To run our business. For example, we may talk to your doctor to tell him or her about a special disease management or wellness program available to you. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** If you receive health insurance through your employer, we may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** To make health insurance underwriting decisions. We will not use your genetic information for underwriting purposes.
- **For Reminders on Benefits or Care.** We may send reminders about appointments you have and information about your health benefits.
- **For Communications to You.** We may contact you about your health insurance benefits, healthcare or payments.

## Section 2: Your privacy

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### We may collect, use, and share your HI as follows.

- **As Required by Law.** To follow the laws that apply to us.
- **To Persons Involved with Your Care.** A family member or other person that helps with your medical care or pays for your care. This also may be to a family member in an emergency. This may happen if you are unable to tell us if we can share your HI or not. If you are unable to tell us what you want, we will use our best judgment. If allowed, after you pass away, we may share HI with family members or friends who helped with your care or paid for your care.
- **For Public Health Activities.** For example, to prevent diseases from spreading or to report problems with products or medicines.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with certain 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,** for example, 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.** To public health agencies or law enforcement, for example, in an emergency or disaster.
- **For Government Functions.** For military and veteran use, national security, or certain protection services.
- **For Workers' Compensation.** If you were hurt at work or to comply with employment laws.
- **For Research.** For example, to study a disease or medical condition. We also may use HI to help prepare a research study.
- **To Give Information on Decedents.** For example, to a coroner or medical examiner who may help identify the person who died, why they died, or to meet certain laws. We also may give HI to funeral directors.
- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissues.
- **To Correctional Institutions or Law Enforcement.** For persons in custody, for example: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates.** To give you services, if needed. These are companies that provide services to us. They agree to protect your HI.

- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
  1. Alcohol and Substance Use Disorder
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive or Sexual Health
  11. Sexually Transmitted Diseases

We will only use or share your HI as described in this notice or with your written consent. We will get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your health insurance ID card.

### Your Rights

You have the following rights for your medical information.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.** Your request to limit our use or sharing must be made in writing.
- **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 as allowed by state and federal law. We take verbal requests but may ask you to confirm your request in writing. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy of certain HI.** You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. 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.

## Section 2: Your privacy

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- **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. We will respond to your request in the time we must do so under the law. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of when we shared your HI in the six years prior to your request. This will not include when we shared HI for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website.
- **In certain states, you may have the right to ask that we delete your HI.** Depending on where you live, you may be able to ask us to delete your HI. We will respond to your request in the time we must do so under the law. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

### Using Your Rights

- **To Contact your Health Plan.** If you have questions about this notice, or you want to use your rights, **call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at 1-866-633-2446, or TTY/RTT 711.
- **To Submit a Written Request.** Mail to:  
UnitedHealthcare Privacy Office  
MN017-E300, P.O. Box 1459, Minneapolis MN 55440
- **To File a Complaint or Grievance.** If you think your privacy rights have been violated, you may send a complaint or grievance 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.

<sup>1</sup> This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to <https://www.uhc.com/privacy/entities-fn-v2>.

# Financial Information Privacy Notice

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

Effective January 1, 2025

We<sup>2</sup> protect your “personal financial information” (“FI”). FI is non-health information. FI identifies you and is generally not public.

## Information We Collect

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

## Sharing of FI

We will only share FI as permitted by law.

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

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

## Confidentiality and Security

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

## Section 2: Your privacy

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### Questions About This Notice

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

<sup>2</sup> For purposes of this Financial Information Privacy Notice, “we” or “us” refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Health Care Solutions, Inc.; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. For a current list of health plans subject to this notice go to <https://www.uhc.com/privacy/entities-fn-v2>.

**Notice of Availability of Language Assistance Services and Alternative Formats:**  
<https://www.uhc.com/communityplan/non-discrimination-notice>

# Section 3:

## Getting help from our Member Services

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

### Contacting Member Services

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

### Contacting Member Services after hours

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

# Section 4:

## Do you need help communicating?

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### If you do not speak English

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

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

### For people with disabilities

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

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

All of these services are provided free to you.

# Section 5:

## When your information changes

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

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

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

# Section 6:

## Changes to your health plan

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If your health plan experiences a significant change that affects you as an enrollee, it is the plan's responsibility to inform you (the enrollee) at least 30 days before the intended effective date of the change.

# Section 7:

## Your Medicaid eligibility

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

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

### If you lose your Medicaid eligibility

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

### If you have Medicare

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

## Section 7: Your Medicaid eligibility

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### If you are having a baby

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

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

# Section 8:

## Enrollment in our plan

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### Initial enrollment

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

### Open enrollment period

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

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

## Section 8: Enrollment in our plan

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### Enrollment in the SMMC Long-Term Care program

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

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

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

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

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

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

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



# Aging and Disability Resource Centers (ADRC)

## PSA 1

Northwest Florida Area Agency on Aging, Inc.  
5090 Commerce Park Circle  
Pensacola, FL 32505  
850-494-7101  
[www.nwflaaa.org](http://www.nwflaaa.org)

## PSA 2

Advantage Aging Solutions  
2414 Mahan Drive  
Tallahassee, FL 32308  
850-488-0055  
<https://www.advantageaging.org/>

## PSA 3

Elder Options  
100 SW 75th Street, Suite 301  
Gainesville, FL 32607  
352-378-6649  
[www.agingresources.org](http://www.agingresources.org)

## Section 8: Enrollment in our plan

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### PSA 4

ElderSource,  
The Area Agency on Aging  
of Northeast Florida  
10688 Old St. Augustine Road  
Jacksonville, FL 32257  
904-391-6600  
[www.myeldersource.org](http://www.myeldersource.org)

### PSA 5

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

### PSA 6

Senior Connection Center, Inc  
8928 Brittany Way  
Tampa, FL 33619  
813-740-3888  
[www.seniorconnectioncenter.org](http://www.seniorconnectioncenter.org)

### PSA 7

Senior Resource Alliance  
3319 Maguire Boulevard, Suite 100  
Orlando, FL 32803  
407-514-1832  
[www.seniorresourcealliance.org](http://www.seniorresourcealliance.org)

### PSA 8

Area Agency on Aging  
for Southwest Florida, Inc.  
2830 Winkler Avenue, Suite 112  
Fort Myers, FL 33916  
239-652-6900  
[www.aaaswfl.org](http://www.aaaswfl.org)

### PSA 9

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

### PSA 10

Aging and Disability Resource Center  
of Broward County, Inc.  
5300 Hiatus Road  
Sunrise, FL 33351  
954-745-9567  
[www.adrcbroward.org](http://www.adrcbroward.org)

### PSA 11

Alliance for Aging, Inc.  
760 NW 107th Avenue, Suite 214, 2nd Floor  
Miami, FL 33172  
305-670-6500  
[www.allianceforaging.org](http://www.allianceforaging.org)

# Section 9:

## Leaving our plan (disenrollment)

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

You can leave our plan at any time for the following reasons (also known as **For Cause Disenrollment** reasons<sup>1</sup>):

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

You can also leave our plan for the following reasons, if you have completed our grievance and appeal process<sup>2</sup>:

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

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

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

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

<sup>2</sup> To learn how to ask for an appeal, please turn to Section 17, Member Satisfaction, on page 101.

## Section 9: Leaving our plan (disenrollment)

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### Removal from our plan (involuntary disenrollment)

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

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

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

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

# Section 10:

## Managing your care

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

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

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

### Changing case managers

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

## Section 10: Managing your care

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### Important things to tell your case manager

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

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

### Request to put your services on hold

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

### New technology

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

### Utilization management services

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

### Utilization management programs

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

### Utilization review policy and procedures

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

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

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

# Section 11:

## Accessing services

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

### Providers in our plan

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

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

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

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

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

### Providers not in our plan

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

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

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

### When we pay for your dental services

Your dental plan will cover most of your dental services, but some services may be covered by UnitedHealthcare Community Plan. The table below will help you understand which plan pays for a service. Routine dental benefits are not provided by this plan.

Type of dental service(s)	Dental plan covers	Medical plan covers
Dental Services	Covered when you see your dentist or dental hygienist.	Covered when you see your doctor or nurse.
Scheduled dental services in a hospital or surgery center	Covered for dental services by your dentist.	Covered for doctors, nurses, hospitals, and surgery centers.

## Section 11: Accessing services

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Type of dental service(s)	Dental plan covers	Medical plan covers
Hospital visit for a dental problem	Not covered.	Covered.
Prescription drugs for a dental visit or problem	Not covered.	Covered.
Transportation to your dental service or appointment	Not covered.	Covered.
Anesthesia for services in a hospital or surgery center.	Not covered.	Covered.

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

## What do I have to pay for?

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

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

## Services for children<sup>4</sup>

We must provide all medically necessary services for our members who are ages 0–20 years old. This is the law. This is true even if we do not cover a service or the service has a limit.

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<sup>4</sup> Also known as “Early and Periodic Screening, Diagnosis, and Treatment” or “EPSDT” requirements.

## Section 11: Accessing services

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As long as your child's services are medically necessary, services have:

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

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

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

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

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

This Agency web page provides details about each of the services listed above and how to access these services: [http://ahca.myflorida.com/Medicaid/Policy\\_and\\_Quality/Policy/Covered\\_Services\\_HCBS\\_Waivers.shtml](http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/Covered_Services_HCBS_Waivers.shtml).

## **Moral or religious objections**

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

# Section 12:

## Helpful information about your benefits

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### Choosing a Primary Care Provider (PCP)

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

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

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

### Choosing a PCP for your child

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

## Section 12: Helpful information about your benefits

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

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

### Specialist care and referrals

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

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

### Second opinions

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

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

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<sup>5</sup> For more information about the screenings and assessments that are recommended for children, please refer to the “Recommendations for Preventative Pediatric Health Care – Periodicity Schedule” at **Periodicity Schedule** ([aap.org](http://aap.org)).

## Section 12: Helpful information about your benefits

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### Urgent care

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

If you need Urgent Care after office hours and you cannot reach your PCP, you can talk to a primary care doctor with UHC Doctor Chat or go to the nearest emergency room.

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

### UHC Doctor Chat®

When you're feeling ill or have health questions and can't get to your primary care doctor, you can talk to one in seconds, 24/7, with UHC Doctor Chat. Get the answers, treatment and follow-up care you need., when you need it- at no cost to you. Please note this is a different app from the UnitedHealthcare app. To download it, search for "UnitedHealthcare Doctor Chat" on the App Store or Google Play, or visit [uhcdoctorchat.com](https://uhcdoctorchat.com).

### Hospital care

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

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

### Emergency care

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

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

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

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

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

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

### Filling prescriptions

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

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

## Section 12: Helpful information about your benefits

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

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

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

### Specialty pharmacy information

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

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

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

UnitedHealthcare Community Plan  
7901 SW 6th Street, Suite 400  
Plantation, FL 33324

### Behavioral health services

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

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

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

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

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

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

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

## Section 12: Helpful information about your benefits

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### Member reward programs

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

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

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

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

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

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

# Chronic disease management programs

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

- Cancer and cancer prevention
- Diabetes and diabetes prevention
- Depression and depression prevention (including suicide prevention)
- Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and HIV prevention
- Chronic kidney disease
- Hypertension

# End of life issues, including information on Advance Directives

## The patient's right to decide

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

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

## What is an Advance Directive?

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

- A Living Will
- Health Care Surrogate Designation

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

## Section 12: Helpful information about your benefits

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### **What is a Living Will?**

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

### **What is a Health Care Surrogate Designation?**

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

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

### **Which is better?**

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

### **Do I have to write an Advance Directive under Florida law?**

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

### **Can I change my mind after I write a Living Will or designate a Health Care Surrogate?**

Yes, you may change or cancel these documents at any time. Any change should be written, signed and dated.

## Section 12: Helpful information about your benefits

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### What should I do with My Advance Directive if I choose to have one?

Make sure that someone, such as your primary doctor, lawyer, or family member knows that you have an Advance Directive and where it is located. Consider the possibilities listed below:

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

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

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

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

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

## Section 12: Helpful information about your benefits

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### How can I make an Advance Directive?

You can speak with your primary care physician, an attorney or go to <http://flsenate.gov/Statutes>.

#### For more information

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

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

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

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

**AARP Fulfillment**  
606 E Street NW  
Washington, D.C. 20049  
1-888-687-2277

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

### Quality enhancement programs

We want you to get quality health care. We offer additional programs that help make the care you receive better. The programs are:

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

Please call Customer Service to verify covered services. Services that are considered experimental and cosmetic are not covered. For a counseling or referral service that the health plan does not cover because of moral or religious objections, the health plan need not furnish information on how and where to obtain the service. You also have a right to tell us about changes you think we should make.

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

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

# Section 13:

## Your plan benefits – Managed Medical Assistance services

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

There may be some services we do not cover but might be covered by Medicaid. There are some services your State has determined are medically appropriate and can be provided in place of a covered service or setting under the State plan. These are called “In Lieu of Services (ILOS).” To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call MTM Health 1-888-777-6528 to schedule a ride. See page 114 for MTM Link app information.

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

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

\* Indicates In Lieu of Behavioral Health Services

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

<sup>6</sup> You can find the definition for Medical Necessity at [http://ahca.myflorida.com/medicaid/review/General/59G\\_1010\\_Definitions.pdf](http://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf).

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Allergy Services</b>	Services to treat conditions such as sneezing or rashes that are not caused by an illness.	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots.	No
<b>Ambulance Transportation Services</b>	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities.	Covered as medically necessary.	No
<b>*Ambulatory Detoxification Services</b>	Services provided to people who are withdrawing from drugs or alcohol.	As medically necessary and recommended by us.	Yes
<b>Ambulatory Surgical Center Services</b>	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient).	Covered as medically necessary.	Prior authorization may be required.
<b>Anesthesia Services</b>	Services to keep you from feeling pain during surgery or other medical procedures.	Covered as medically necessary.	No
<b>Assistive Care Services</b>	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication.	We cover 365/366 days of services per year, as medically necessary.	Prior authorization may be required.

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Behavior Analysis (BA)</b>	Structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.	We cover recipients under the age of 21 years requiring medically necessary services.	Yes
<b>Behavioral Health Assessment Services</b>	Services used to detect or diagnose mental illnesses and behavioral health disorders.	<p>We cover, as medically necessary:</p> <ul style="list-style-type: none"> <li>• One initial assessment per year</li> <li>• One reassessment per year</li> <li>• Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)</li> </ul> <p>See Expanded Benefits section below for additional information.</p>	No
<b>Behavioral Health Overlay Services</b>	Behavioral health services provided to children (ages 0–18) enrolled in a DCF program.	We cover 365/366 days of medically necessary services per year, including therapy, support services and aftercare planning.	Yes

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>*Behavioral Health Telehealth Services</b>	Outpatient mental health and substance use disorder services delivered via synchronous televideo visits.	Members with primary mental health or substance use disorder diagnosis and meets the requirements for this level of care.	Yes
<b>Cardiovascular Services</b>	Services that treat the heart and circulatory (blood vessels) system.	<p>We cover the following as prescribed by your doctor, when medically necessary:</p> <ul style="list-style-type: none"> <li>• Cardiac testing</li> <li>• Cardiac surgical procedures</li> <li>• Cardiac devices</li> </ul>	Yes
<b>Child Health Services Targeted Case Management</b>	<p>Services provided to children (ages 0-3) to help them get health care and other services.</p> <p>Or</p> <p>Services provided to children (ages 0-20) who use medical foster care services.</p>	<p>Your child must be enrolled in the DOH Early Steps program.</p> <p>Or</p> <p>Your child must be receiving medical foster care services.</p>	No
<b>Chiropractic Services</b>	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles and organs.	<p>We cover, as medically necessary:</p> <ul style="list-style-type: none"> <li>• 24 patient visits per year, per member</li> <li>• X-rays</li> </ul>	Yes

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Clinic Services</b>	Health care services provided in a county health department, federally qualified health center or a rural health clinic.	Visits to a federally qualified health center or rural health clinic visit, medically necessary.	No
<b>*Community Based Wrap Around Services</b>	An intensive level of community-based services provided by a mental health team to help members and prevent residential treatment.	Coverage for ages 0 to 21 based on medical necessity.	Yes
<b>*Crisis Stabilization Unit Services</b>	Emergency mental health services that are performed in a facility that is not a regular hospital.	As medically necessary and recommended by us.	No
<b>Dialysis Services</b>	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies and other supplies that help treat the kidneys.	We cover the following as prescribed by your treating doctor, when medically necessary: <ul style="list-style-type: none"> <li>• Hemodialysis treatments</li> <li>• Peritoneal dialysis treatments</li> </ul>	No
<b>*Drop-In Center Services</b>	Services provided in a center that helps homeless people get treatment or housing.	As medically necessary and recommended by us.	No

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Durable Medical Equipment and Medical Supplies Services</b>	<p>Medical equipment is used to manage and treat a condition, illness or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches and other items. Medical supplies are items meant for one-time use and then thrown away.</p>	<p>As medically necessary, some service and age limits apply. Call Member Services at <b>1-888-716-8787</b> for more information.</p>	<p>Prior authorization required only in outpatient settings, to include patient's home and must be more than \$500.</p>
<b>Early Intervention Services</b>	<p>Services to children ages 0–3 who have developmental delays and other conditions.</p>	<p>We cover medically necessary:</p> <ul style="list-style-type: none"> <li>• One initial evaluation per lifetime, completed by a team</li> <li>• Up to 3 screenings per year</li> <li>• Up to 3 follow-up evaluations per year</li> <li>• Up to 2 training or support sessions per week</li> </ul>	<p>Prior authorization may be required.</p>
<b>Emergency Transportation Services</b>	<p>Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency.</p>	<p>Covered as medically necessary.</p>	<p>No</p>

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Evaluation and Management Services</b>	Services for doctor’s visits to stay healthy and prevent or treat illness.	We cover medically necessary: <ul style="list-style-type: none"> <li>• One adult health screening (checkup) per year</li> <li>• Well-child visits are provided based on age and developmental needs</li> <li>• One visit per month for people living in nursing facilities</li> <li>• Up to two office visits per month for adults to treat illnesses or conditions</li> </ul>	No
<b>Family Therapy Services</b>	Services for families to have therapy sessions with a mental health professional.	We cover medically necessary: <ul style="list-style-type: none"> <li>• Up to 26 hours per year</li> </ul>	No
<b>*Family Training for Child Development</b>	Services for families of children with behavioral needs for education to promote the child’s development.	Coverage for ages 0 up to 21 based on medical necessity.	No
<b>*First Episode Psychosis Program</b>	Early intervention services for members experiencing first episode psychosis.	Coverage for all ages based on medical necessity.	Yes

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>*Functional Family Therapy</b>	Short-term, intensive therapeutic model that offers in-home family counseling to address juvenile delinquency and referring behaviors from a family-based perspective.	Covered as medically necessary.	Yes
<b>Gastrointestinal Services</b>	Services to treat conditions, illnesses, or diseases of the stomach or digestion system.	We cover: <ul style="list-style-type: none"> <li>• Covered as medically necessary</li> </ul>	Yes
<b>Genitourinary Services</b>	Services to treat conditions, illnesses or diseases of the genitals or urinary system.	We cover: <ul style="list-style-type: none"> <li>• Covered as medically necessary</li> </ul>	Prior authorization may be required.
<b>Group Therapy Services</b>	Services for a group of people to have therapy sessions with a mental health professional.	We cover medically necessary: <ul style="list-style-type: none"> <li>• Up to 39 hours per year</li> </ul> See Expanded Benefits section below for additional information.	No

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Hearing Services</b>	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs.	<p>We cover hearing tests and the following as prescribed by your doctor, when medically necessary:</p> <ul style="list-style-type: none"> <li>• Cochlear implants</li> <li>• One new hearing aid per ear, once every 3 years</li> <li>• Repairs</li> </ul>	Yes
<b>Home Health Services</b>	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury.	<p>We cover, when medically necessary:</p> <ul style="list-style-type: none"> <li>• Up to 4 visits per day for pregnant recipients and recipients ages 0–20</li> <li>• Up to 3 visits per day for all other recipients</li> </ul>	Prior authorization may be required.
<b>Hospice Services</b>	Medical care, treatment and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	<p>Covered as medically necessary.</p> <p>Copayment: See information on Patient Responsibility for copayment information; you may have Patient Responsibility for hospice services whether living at home, in a facility or in a nursing facility.</p>	No

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Individual Therapy Services</b>	Services for people to have one-to-one therapy sessions with a mental health professional.	We cover medically necessary: <ul style="list-style-type: none"> <li>• Up to 26 hours per year</li> </ul> See Expanded Benefits section below for additional information.	No
<b>Inpatient Hospital Services</b>	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	We cover the following inpatient hospital services based on age and situation, when medically necessary: <ul style="list-style-type: none"> <li>• Up to 365/366 days for recipients ages 0-20</li> <li>• Up to 45 days for all other recipients (extra days are covered for emergencies)</li> </ul>	Admission requires prior authorization.
<b>Integumentary Services</b>	Services to diagnose or treat skin conditions, illnesses or diseases.	Covered as medically necessary.	Prior authorization may be required.
<b>*Intensive Outpatient Program for Mental Health and SUD</b>	Intensive outpatient treatment provided for members working to recover from mental health disorders.	Covered as medically necessary.	Yes

## Section 13: Your plan benefits – Managed Medical Assistance services

<b>Service</b>	<b>Description</b>	<b>Coverage/Limitations</b>	<b>Prior authorization</b>
<b>Laboratory Services</b>	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases.	Covered as medically necessary.	Prior authorization may be required.
<b>Medical Foster Care Services</b>	Services that help children with health problems who live in foster care homes.	Must be in the custody of the Department of Children and Families.	No
<b>Medication-Assisted Treatment Services</b>	Services used to help people who are struggling with drug addiction.	Covered as medically necessary.	No
<b>Medication Management Services</b>	Services to help people understand and make the best choices for taking medication.	Covered as medically necessary.	No
<b>*Mental Health Partial Hospitalization Program Services</b>	Group and individual treatment provided 4-6 hours per day and up to 5 times per week for members working to recover from mental health disorders.	Coverage for all ages based on medical necessity.	Yes
<b>Mental Health Targeted Case Management</b>	Services to help get medical and behavioral health care for people with mental illnesses.	Covered as medically necessary.	No

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>*Mobile Crisis Assessment and Intervention Services</b>	A team of health care professionals who provide emergency mental health services, usually in people’s homes.	As medically necessary and recommended by us.	Prior authorization may be required.
<b>*Multi-Systemic Therapy</b>	An intensive home/ family and community-based service for youth who are at risk of out-of-home placement.	Coverage for ages 11 to 17.	Yes
<b>Neurology Services</b>	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system.	Covered as medically necessary.	Prior authorization may be required.
<b>Non-Emergency Transportation Services</b>	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi or other kinds of vehicles.	We cover the following services for recipients who have no transportation: <ul style="list-style-type: none"> <li>• Out-of-state travel</li> <li>• Transfers between hospitals or facilities</li> <li>• Escorts when medically necessary</li> </ul>	Prior authorization may be required.

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Nursing Facility Services</b>	Medical care or nursing care that you get while living full time in a nursing facility. This can be a short-term rehabilitation stay or long term.	<p>We cover 365/366 days of services in nursing facilities as medically necessary.</p> <p>Copayment: See information on Patient Responsibility for room and board copayment information.</p>	Admission requires prior authorization.
<b>Occupational Therapy Services</b>	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself and using items around the house.	<p>We cover for children ages 0–20 and for adults under the \$1,500 outpatient services cap, as medically necessary:</p> <ul style="list-style-type: none"> <li>• One initial evaluation per year</li> <li>• Up to 210 minutes of treatment per week</li> <li>• One initial wheelchair evaluation per 5 years</li> </ul> <p>We cover for people of all ages, as medically necessary:</p> <ul style="list-style-type: none"> <li>• Follow-up wheelchair evaluations, one at delivery and one 6 months later</li> </ul>	Yes

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Oral Surgery Services</b>	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity.	Covered as medically necessary.	Prior authorization may be required.
<b>Orthopedic Services</b>	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints.	Covered as medically necessary.	Prior authorization may be required.
<b>Outpatient Hospital Services</b>	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	Emergency services are covered as medically necessary.  Non-emergency services cannot cost more than \$1,500 per year for recipients ages 21 and over.	Yes
<b>Pain Management Services</b>	Treatments for long-lasting pain that does not get better after other services have been provided.	Covered as medically necessary.  Some service limits may apply.	Yes
<b>*Partial Hospitalization in a Hospital</b>	Group and individual treatment provided 4-6 hours per day and up to 5 times per week for members working to recover from mental health disorders.	Covered as medically necessary.	Yes

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Physical Therapy Services</b>	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition.	We cover for children ages 0–20 and for adults under the \$1,500 outpatient services cap, as medically necessary: <ul style="list-style-type: none"> <li>• One initial evaluation per year</li> <li>• Up to 210 minutes of treatment per week</li> <li>• One initial wheelchair evaluation per 5 years</li> </ul> We cover for people of all ages, as medically necessary: <ul style="list-style-type: none"> <li>• Follow-up wheelchair evaluations, one at delivery and one 6 months later</li> </ul>	Yes
<b>Podiatry Services</b>	Medical care and other treatments for the feet.	We cover, as medically necessary: <ul style="list-style-type: none"> <li>• Up to 24 office visits per year</li> <li>• Foot and nail care</li> <li>• X-rays and other imaging for the foot, ankle and lower leg</li> <li>• Surgery on the foot, ankle or lower leg</li> </ul>	No

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Prescribed Drug Services</b>	This service is for drugs that are prescribed to you by a doctor or other health care provider.	We cover, as medically necessary: <ul style="list-style-type: none"> <li>• Up to a 34-day supply of drugs, per prescription</li> <li>• Refills, as prescribed</li> </ul>	Prior authorization may be required.
<b>Private Duty Nursing Services</b>	Nursing services provided in the home to people ages 0 to 20 who need constant care.	We cover, as medically necessary: <ul style="list-style-type: none"> <li>• Up to 24 hours per day</li> </ul>	Yes
<b>*Psychiatric Specialty Hospital Services</b>	Emergency mental health services that are performed in a facility that is not a regular hospital.	As medically necessary and recommended by us.	Yes
<b>Psychological Testing Services</b>	Tests used to detect or diagnose problems with memory, IQ or other areas.	We cover, as medically necessary: <ul style="list-style-type: none"> <li>• 10 hours of psychological testing per year</li> </ul> See Expanded Benefits section below for additional information.	Prior authorization may be required.
<b>Psychosocial Rehabilitation Services</b>	Services to assist people to re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores.	We cover, as medically necessary: <ul style="list-style-type: none"> <li>• Up to 480 hours per year</li> </ul>	No

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Radiology and Nuclear Medicine Services</b>	Services that include imaging such as X-rays, MRIs or CAT scans. They also include portable X-rays.	Covered as medically necessary.	Yes
<b>Regional Perinatal Intensive Care Center Services</b>	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions.	Covered as medically necessary.	Admission requires authorization.
<b>Reproductive Services</b>	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family.	We cover medically necessary family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under age 18.	No
<b>Respiratory Services</b>	Services that treat conditions, illnesses or diseases of the lungs or respiratory system.	We cover medically necessary: <ul style="list-style-type: none"> <li>• Respiratory testing</li> <li>• Respiratory surgical procedures</li> <li>• Respiratory device management</li> </ul>	Prior authorization may be required.

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Respiratory Therapy Services</b>	Services for recipients ages 0–20 to help you breathe better while being treated for a respiratory condition, illness or disease.	We cover medically necessary: <ul style="list-style-type: none"> <li>• One initial evaluation per year</li> <li>• One therapy re-evaluation per 6 months</li> <li>• Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)</li> </ul>	Prior authorization may be required.
<b>*Self-Help/Peer Services</b>	Services to help people who are in recovery from an addiction or mental illness.	As medically necessary and recommended by us	No
<b>Specialized Therapeutic Services</b>	Services provided to children ages 0–20 with mental illnesses or substance use disorders.	We cover the following medically necessary: <ul style="list-style-type: none"> <li>• Assessments</li> <li>• Foster care services</li> <li>• Group home services</li> </ul>	Yes

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Speech-Language Pathology Services</b>	Services that include tests and treatments to help you talk or swallow better.	<p>We cover the following medically necessary services for children ages 0-20:</p> <ul style="list-style-type: none"> <li>• Communication devices and services</li> <li>• Up to 210 minutes of treatment per week</li> <li>• One initial evaluation per year</li> </ul> <p>We cover the following medically necessary services for adults:</p> <ul style="list-style-type: none"> <li>• One communication evaluation per 5 years</li> </ul>	Yes
<b>Statewide Inpatient Psychiatric Program Services</b>	Services for children with severe mental illnesses who need treatment in the hospital.	Covered as medically necessary for children ages 0-20.	Yes
<b>*Substance Abuse Intensive Outpatient Program Services</b>	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorder.	As medically necessary and recommended by us.	Prior authorization may be required.
<b>*Substance Abuse Short-Term Residential Treatment Services</b>	Treatment for people who are recovering from substance use disorders.	As medically necessary and recommended by us.	Prior authorization may be required.

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>*Tenancy Sustaining Services for people at risk for homelessness and SMI and SUD</b>	Services to help members who are recovering from mental health and substance use disorders provided to members with substance use and/or mental health conditions to support increasing members' ability to maintain housing.	Covered as medically necessary.	No
<b>Therapeutic Behavioral On-Site Services</b>	Services provided by a team to prevent children ages 0–20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility.	We cover medically necessary services: <ul style="list-style-type: none"> <li>• Up to 9 hours per month</li> </ul> See Expanded Benefits section below for additional information.	No
<b>Transplant Services</b>	Services that include all surgery and pre- and post-surgical care.	Covered as medically necessary.	Yes

## Section 13: Your plan benefits – Managed Medical Assistance services

Service	Description	Coverage/Limitations	Prior authorization
<b>Visual Aid Services</b>	Visual aids are items such as glasses, contact lenses and prosthetic (fake) eyes.	We cover the following medically necessary services when prescribed by your doctor: <ul style="list-style-type: none"> <li>• 2 pairs of eyeglasses for children ages 0-20</li> <li>• 1 frame every 2 years and 2 lenses every 365 days for adults ages 21 and older</li> <li>• Contact lenses</li> <li>• Prosthetic eyes</li> </ul>	No
<b>Visual Care Services</b>	Services that test and treat conditions, illnesses and diseases of the eyes.	Covered as medically necessary.	No

## Your plan benefits: Pathways to prosperity

The Plan shall assess members who may be experiencing barriers to employment, economic self-sufficiency, and independence gain access to care coordination/case management services and health-related social needs, such as housing assistance, food sustainability, vocational training, and educational support services.

# Section 14:

## Long-Term Care (LTC) program helpful information

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(Read this section if you are in the LTC program.  
If you are not in the LTC program, skip to Section 16)

### Starting services

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

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

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

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

### Developing a plan of care

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

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

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

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

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

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

## Section 14: Long-Term Care program – Helpful information

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### Updating your plan of care

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

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

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

### Your back-up plan

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

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

# Section 15:

## Your plan benefits – LTC services

The table below lists the Long-Term Care services covered by our Plan. Remember, services must be medically necessary in order for us to pay for them.<sup>7</sup>

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

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

Service	Description	Prior authorization
<b>Adult Companion Care</b>	This service helps you fix meals, do laundry and light housekeeping.	Yes
<b>Adult Day Health Care</b>	Supervision, social programs and activities provided at an adult day care center during the day. If you are there during meal times, you can eat there.	Yes
<b>Assistive Care Services</b>	These are 24-hour services if you live in an adult family care home.	Yes
<b>Assisted Living</b>	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, eating, medication assistance and social programs.	Yes

<sup>7</sup> You can find a copy of the Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy at [http://ahca.myflorida.com/medicaid/review/Specific/59G-4.192\\_LTC\\_Program\\_Policy.pdf](http://ahca.myflorida.com/medicaid/review/Specific/59G-4.192_LTC_Program_Policy.pdf).

## Section 15: Your plan benefits – Long-Term Care services

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

## Section 15: Your plan benefits – Long-Term Care services

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

## Section 15: Your plan benefits – Long-Term Care services

Service	Description	Prior authorization
<b>Nursing Facility Services</b>	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy and speech-language pathology.	Yes
<b>Personal Care</b>	These are in-home services to help you with: <ul style="list-style-type: none"> <li>• Bathing</li> <li>• Dressing</li> <li>• Eating</li> <li>• Personal hygiene</li> </ul>	Yes
<b>Personal Emergency Response Systems (PERS)</b>	An electronic device that you can wear or keep near you that lets you call for emergency help anytime.	Yes
<b>Respite Care</b>	This service lets your caregivers take a short break. You can use this service in your home, an assisted living facility or a nursing facility.	Yes
<b>Occupational Therapy</b>	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself and using items around the house.	Yes
<b>Physical Therapy</b>	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition.	Yes
<b>Respiratory Therapy</b>	Respiratory therapy includes treatments that help you breathe better.	Yes

## Section 15: Your plan benefits – Long-Term Care services

Service	Description	Prior authorization
<b>Speech Therapy</b>	Speech therapy includes tests and treatments that help you talk or swallow.	Yes
<b>*Structured Family Caregiving</b>	Services provided in your home to help you live at home instead of in a nursing facility.	We may offer the choice to use this service instead of nursing facility services.
<b>Transportation</b>	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi or other kinds of vehicles.	Yes

## Section 15: Your plan benefits – Long-Term Care services

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### Long-Term Care Participant Direction Option (PDO)

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

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

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

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

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

\* PDO is not an available option for Intellectual and Developmental Disabilities Waiver program participants.

# Section 16:

## Your plan benefits – Expanded benefits

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

Expanded benefits: Medical and long-term care			
Service	Description	Coverage/Limitations	Prior authorization
<b>Over-the-Counter (OTC) Medications and Supplies</b>	Allowance to purchase OTC products.	The Managed Care Plan shall provide a monthly OTC benefit limit of sixty-five dollars (\$65) per household.	No
<b>Adult Visual Aid Services</b>	Contact lens, frame, eye exam.	Contact lens – 6 months’ supply with prescription; Frame, eye exam – 1 per year.  For members ages 21 and older.	No
<b>Adult Additional Primary Care Services</b>	Primary care provider visits.	Unlimited.  For members ages 21 and older.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Prenatal Services</b>	Hospital grade breast pump; breast pump; antepartum management; postpartum care.	Max of 1 per year (rental, PA is required); 1 per 2 years (rental, no PA required); 14 visits for low- risk pregnancies and 18 visits for high-risk pregnancies; 3 visits within 90 days following delivery, and 1 well-woman visit between 90 days and 12 months following delivery in preparation to transition back to the primary care medical home.  For members ages 21 and older.	No
<b>Durable Medical Equipment (DME) Services and Supplies</b>	Automatic blood pressure monitor.	For members ages 21 and older.	No
<b>Physical Therapy for Adults</b>	Physical therapy evaluation; physical therapy re-evaluation; physical therapy treatment visit; application of casting or strapping; wheelchair evaluation and fitting by a physical therapist.	One evaluation per year; up to 7 therapy treatment units per week.  For members ages 21 and older.	Yes

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Newborn Circumcision</b>	Circumcision neonate.	One per lifetime. Your male baby is covered up to 28 days old.	No
<b>Hearing Services for Adults</b>	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs.	One per every 2 years. For members ages 21 and older.	Yes
<b>Occupational Therapy for Adults</b>	Occupational therapy evaluation low to high complexity; occupational therapy re evaluation; occupational therapy treatment visit; application of casting or strapping; wheelchair evaluation and fitting by an occupational therapist.	One evaluation per year; up to 7 therapy treatment units per week. For members ages 21 and older.	Yes

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Expanded benefits: Maternal health – Prenatal through postpartum</b>			
<b>Wellhop Virtual Support Group</b>	Group video conversations.	<p>Group video conversations with a trained facilitator and members at the same stage in pregnancy. Evidence-based information on pregnancy and postpartum, educational articles, videos, podcasts and more.</p> <p>For members ages 13 and older.</p>	No
<b>Peer Support Doula Program</b>	Certified Behavioral Health (BH) and Substance Use Disorder (SUD) peer supports.	<p>Access to certified BH and SUD peer supports who are trained and certified maternity peer doulas who support their pregnant peers living with SUD and SMI throughout the prenatal and postpartum processes to enhance health and well-being.</p> <p>For members ages 13 and older.</p>	Notification only

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Doula Program</b>	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring. Home visit for postnatal assessment and follow-up care. Home visit for newborn care and assessment. Unlisted home visit service or procedure.	<p>Doulas are nonclinical support professionals providing emotional, informational and physical support before, during and after labor. They assist with relaxation techniques, breathing exercises, massages, positioning suggestions and other comfort measures, while providing education on childbirth options and pain management. Support provided before, during, and after pregnancy.</p> <p>For members ages 13 and older.</p>	Notification only
<b>Babyscripts and Healthy First Steps® Rewards</b>	Member rewards for healthy baby milestones.	<p>The program ends at 15 months post-delivery. Enrollees receive rewards at specific milestones, including gift cards and baby-related items ranging in value from \$10 to \$30.</p> <p>For members ages 13 and older.</p>	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Diaper Starter Pack</b>	Diaper assistance.	New mothers during the first 12 months, post-delivery. Maximum \$50 for diapers, one time per child.  For members ages 13 and older.	No
<b>Expanded benefits: Children and adolescents with a serious mental illness and/or substance use disorder</b>			
<b>Condition-Specific DME</b>	Durable Medical Equipment.	DME and other supplies to help children manage their symptoms, like additional weighted blankets or enuresis alarms. Limited to \$100 annually.  For members up to age 18.	No
<b>Sensory Toys for Children Living With ADHD</b>	Sensory toys.	Sensory toys can help children living with ADHD with their focus, relaxation and overall development.  For members ages 6 to 14.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>TAY (Transitional Age Youth) Flex Fund</b>	Incidentals such as cash assistance for rental deposit(s), rent, utilities, moving expenses, etc.	Provides a maximum of \$250 per year to support the completion of necessary, required health care services through virtual connectivity, with the criteria that the enrollee must be in a n emerging health risk level or higher, and the support must help strengthen their natural system of care.  For members ages 14 to 25.	Yes

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Expanded benefits: Children with complex medical needs currently living in a skilled nursing facility</b>			
<b>Nursing Facility Transition Assistance Benefit</b>	<p>UnitedHealthcare Community Plan offers a Nursing Facility Transition benefit to help families of children living in a nursing facility to bring their child home. The benefit will provide assistance to the children and their families to help overcome barriers preventing the child from living at home with their family.</p> <p>This benefit is available for individuals currently residing in a nursing facility and are either under 21 years old or under 30 years of age and have been living in a nursing facility before turning 21 years old.</p> <p>The Nursing Facility Transition benefit may include the following:</p> <ul style="list-style-type: none"> <li>• Home renovations</li> <li>• Purchase of a generator to provide power medical equipment during outages</li> <li>• Home additions to give the child space for all necessary medical equipment and care needs</li> <li>• Addition of an accessible bathroom</li> <li>• Adaptations to or purchase of a vehicle equipped to meet the child’s transportation needs</li> <li>• Deposits to help with the transition (like rental security deposits or move-in fees)</li> <li>• Home repairs or services to ensure a healthy living space</li> <li>• Funding to help with moving costs</li> </ul> <p>Eligible members may receive up to \$75,000 to assist with the transition home. This benefit is a once in a lifetime.</p> <p>You should talk to your case manager if you think this benefit can help. They can tell you more and help you figure out what to do next.</p> <p>If you need assistance with contacting your case manager, please call Member Services at <b>1-888-716-8787</b>, TTY <b>711</b>, from 8:00 a.m. to 7:00 p.m. Eastern time, Monday through Friday.</p>		

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Expanded benefits: Enrollees in a home- and community-based (HCBS) setting, such as people with developmental disabilities, familial dysautonomia, or people in long-term care settings</b>			
<b>Assisted Living Facility/Adult Family Care Home – Bed Hold Days</b>	Up to 30-day bed hold.	This benefit allows enrollees who are temporarily absent from their rehabilitation facility, assisted living facility or adult family care home to hold their bed for up to 30 days so the enrollee does not lose their placement in the facility.  For members ages 18 and older.	Yes
<b>Individual Therapy for Caregivers</b>	Behavioral health therapy.	Up to 2 therapeutic behavioral services sessions per calendar year.  For members ages 18 and older.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Nursing Facility to Community Setting Transition Assistance</b>	Transition assistance.	We support enrollees transitioning to a community setting by providing home essentials like furniture, safety equipment or assistance to secure housing. Up to a maximum of \$5,000 per enrollee per lifetime.  For members ages 18 and older.	Yes
<b>Caregiver Transportation</b>	Transportation.	Caregivers of enrollees in an HCBS setting can access 4 one-way trips to visit an enrollee residing in an assisted living or nursing facility.  For members ages 18 and older.	Yes

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<p><b>Careforth for Caregivers</b></p>	<p>Caregiver support.</p>	<p>Careforth coaches design a person-centered program for each enrollee after completing an assessment that evaluates the knowledge, skills and needs of the caregiver and the enrollee’s health risks and behavioral challenges. Caregivers of enrollees in an HCBS setting have access to clinical recommendations and caregiver support services and coaching.</p> <p>For members ages 18 and older.</p>	<p>No</p>
<p><b>Massage Therapy</b></p>	<p>Massage therapy to enhance health and well being.</p>	<p>Hot and cold pack therapy. Neuromuscular therapy. 15-minute massage, including mobilization, manipulation, manual lymphatic drainage, manual traction, 1 or more regions, 15-minute massage, including effleurage, petrissage and tapotement.</p> <p>For members ages 21 and older.</p>	<p>Yes</p>

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Nutritional Counseling</b>	Visits with a dietician to help with a nutrition plan and healthy eating habits.	<p>A comprehensive approach to medical nutrition therapy (MNT) services, provided by registered dietitians or other qualified health care professionals. This program evaluates an enrollee’s nutritional status and develops personalized nutrition plans while educating them on healthy eating habits. Three MNT visits per year, no more than 1 unit per day.</p> <p>For members ages 21 and older.</p>	Yes

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Acupuncture</b>	A non-traditional pain management alternative.	<p>One or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient. Additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles.</p> <p>One or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.</p> <p>For members ages 21 and older.</p>	Yes

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Expanded benefits: General expanded benefits</b>			
<b>Waived Copayments</b>	No copays for certain services.	For members ages 21 and older, no copays for chiropractor services, community behavioral health services, home health services, hospital outpatient services, federally qualified health center visits, independent laboratory services, non-emergency transportation services, nurse practitioner services, optometrist services, physician and physician assistant services, podiatrist services, portable X-ray services, rural health clinic visits and use of the hospital emergency department for non-emergency service.	N/A
<b>Chiropractic Services</b>	A non-traditional pain management alternative involving spine manipulation.	<p>Unlimited with prior authorization.</p> <p>For members ages 21 and older.</p> <p>This benefit removes chiropractic limits for services covered under MMA plan benefits.</p>	Yes

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Outpatient Hospital Services</b>	No limits for: PET scan, pharmacy services, professional, PT/OT therapy, radiology services, routine dental services, sleep studies, speech therapy, sterilization services, supplies – med surg, therapeutic radiology, therapeutic, transplant, treatment/OBS room services, and urgent care services.	Unlimited with prior authorization.  For members ages 21 and older.	Yes
<b>Cellular Phone Services</b>	No-cost smartphone and service packages are provided in partnership with Assurance Wireless through the federal Lifeline program.	New, low-cost cell phone. Or you can bring your own phone.  Unlimited talk and text; 10 GB of data.  For members ages 18 and older.	Yes
<b>Targeted Case Management</b>	Targeted case management.	Unlimited.  For members ages 21 and older.	No
<b>Assessment/Evaluation Services – Behavioral</b>	Various assessment, evaluation and testing codes.	Unlimited.  For members ages 21 and older.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Behavioral Health Day Services/Day Treatment</b>	Behavioral health day services/day treatment, day care services, adult: per diem.	Unlimited. For members ages 21 and older.	Yes
<b>Behavioral Health Medical Services (Drug Screening)</b>	Behavioral health medical services (alcohol and other drug screening specimen collection).	Unlimited. For members ages 21 and older.	No
<b>Behavioral Health Medical Services (Medication Management)</b>	Medication management.	Unlimited. For members ages 21 and older.	No
<b>Behavioral Health Medical Services (Verbal Interaction)</b>	Behavioral health medical services (verbal interaction), mental health/substance abuse.	Unlimited. For members ages 21 and older.	No
<b>Behavioral Health Screening Services</b>	Behavioral health screening services.	Unlimited. For members ages 21 and older.	No
<b>Medication-Assisted Treatment Services</b>	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program).	Unlimited. For members ages 21 and older.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Psychosocial Rehabilitation</b>	Psychosocial rehabilitation services.	Unlimited. For members ages 21 and older.	No
<b>Speech Therapy</b>	Various assessment, evaluation and testing codes.	One evaluation per year, up to 7 therapy treatment units per week.  One evaluation per year, up to 4 30-minute AAC fitting adjustment and training sessions per year.  For members ages 21 and older.	Yes
<b>Therapy/ Psychotherapy (Group)</b>	Group therapy, brief group medical therapy.	Unlimited. For members ages 21 and older.	No
<b>Therapy/ Psychotherapy (Individual/ Family)</b>	Individual and family therapy, brief individual psychotherapy, training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more).	Unlimited. For members ages 21 and older.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<p><b>PDN – Careforth, Transportation and Community Setting Transitions</b></p>	<p>Transition assistance.</p>	<p>We support enrollees transitioning to a community setting by providing home essentials like furniture, safety equipment or assistance to secure housing, up to a maximum of \$10,000 per enrollee per lifetime. Requires prior authorization.</p> <p>Caregivers of enrollees in an HCBS setting can access 4 one-way trips to visit an enrollee residing in an assisted living or nursing facility. Careforth coaches design a person-centered program for each enrollee after completing an assessment that evaluates the knowledge, skills and needs of the caregiver and the enrollee’s health risks and behavioral challenges. Caregivers of enrollees in an HCBS setting have access to clinical recommendations and caregiver support services and coaching.</p> <p>For members ages 18 and older.</p>	<p>Yes</p>

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Home Visit by a Clinical Social Worker</b>	Various.	One additional visit per day.  For members ages 21 and older.	No
<b>Expanded benefits – Pathways to prosperity</b>			
<b>Housing Assistance</b>	Services that support a member in the preparation for and transition into housing.	Assistance to all enrollees seeking safe and stable housing.	No
<b>Housing Assistance</b>	Peer support promoting skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills with the assistance of a peer support specialist.	Peer support to promote skills to support coping and managing housing needs.	No
<b>Housing Assistance</b>	Incidentals such as cash assistance for rental deposit(s), rent, utilities, moving expenses, etc.	Covering one-time incidentals like shut-off notices, moving expenses, rental deposits, utilities, etc.	No
<b>Food Assistance</b>	Medical nutrition group meals per diem; not otherwise specified.	Enrollees diagnosed with SMI who are discharged from a hospital or facility, access to 14 home-delivered meals per year.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Food Assistance</b>	Medical nutrition group meals per diem; not otherwise specified.	New mothers returning home after giving birth to a newborn.  Access to 14 home-delivered meals per year.	No
<b>Food Assistance</b>	Medical nutrition group meals per diem; not otherwise specified.	Enrollees with a primary diagnosis of congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD), cancer and recently discharged from a hospital stay.  Access to 14 home-delivered meals per year.	No
<b>Non-Medical Transportation</b>	Non-medical transportation assistance in search of employment.	Transportation assistance beyond required non-emergency services for adults 18 and older.  Trips must be approved and within a 30-mile radius of the enrollee's home; 20 one-way or 10 round trips per year.	No
<b>Non-Medical Transportation</b>	Public transportation pass after employment.	Sixty-day bus pass stipend after job is secured, once per year for adults 18 and older.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Non-Medical Transportation</b>	Gas reward card – No public transportation after employment.	Gas reward card (\$50) after job secured in geographies where public transportation is unavailable.  For adults 18 and older.	No
<b>Tutoring, Vocational Training, and/or Job Readiness</b>	GED Program.	<b>GEDWorks:</b> GED testing, education advisors, study frameworks and exam preparation.  Study materials and testing available in English and Spanish.  For members ages 18 and older.	No
<b>Tutoring, Vocational Training, and/or Job Readiness</b>	Goodwill.	<b>Goodwill:</b> Employment advisory services, technical assistance and support to job seekers in finding employment or advancing enrollee careers. Access to career navigators, connecting enrollees to employers in their community.  For members ages 18 and older.	No

## Section 16: Your plan benefits – Expanded benefits

Service	Description	Coverage/Limitations	Prior authorization
<b>Tutoring, Vocational Training, and/or Job Readiness</b>	My Secure Advantage.	<p><b>Secure Advantage:</b>            Enrollees can receive guidance and support from a money coach who provides objective information and clear action steps to help them make informed decisions about their finances.</p> <p>For members ages 18 and older.</p>	No

# Section 17:

## Member satisfaction

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### Complaints, grievances, and plan appeals

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

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

	What you can do:	What we will do:
If you are not happy with us or our providers, you can file a <b>Complaint</b>	<p>You can:</p> <ul style="list-style-type: none"> <li>• Call us at any time</li> </ul> <p>MMA: <b>1-888-716-8787, TTY 711</b>            LTC: <b>1-800-791-9233, TTY 711</b></p>	<p>We will:</p> <ul style="list-style-type: none"> <li>• Try to solve your issue within 1 business day</li> </ul>
If you are not happy with us or our providers, you can file a <b>Grievance</b>	<p>You can:</p> <ul style="list-style-type: none"> <li>• Write us or call us at any time</li> <li>• Call us to ask for more time to solve your grievance if you think more time will help</li> </ul> <p>UnitedHealthcare Community Plan Appeals and Grievance Unit            P.O. Box 31364            Salt Lake City, UT 84131</p> <p>MMA: <b>1-888-716-8787, TTY 711</b>            LTC: <b>1-800-791-9233, TTY 711</b></p>	<p>We will:</p> <ul style="list-style-type: none"> <li>• Review your grievance and send you a letter with our decision within 30 days</li> </ul> <p>If we need more time to solve your grievance, we will:</p> <ul style="list-style-type: none"> <li>• Send you a letter with our reason and tell you about your rights if you disagree</li> </ul>

## Section 17: Member satisfaction

	What you can do:	What we will do:
<p>If you do not agree with a decision we made about your services, you can ask for an <b>Appeal</b></p>	<p>You can:</p> <ul style="list-style-type: none"> <li>• Write us, or call us and follow up in writing, within 60 days of our decision about your services</li> <li>• Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply.</li> </ul> <p>UnitedHealthcare Community Plan Appeals and Grievance Unit P.O. Box 31364 Salt Lake City, UT 84131</p> <p>MMA: <b>1-888-716-8787</b>, TTY <b>711</b> LTC: <b>1-800-791-9233</b>, TTY <b>711</b></p>	<p>We will:</p> <ul style="list-style-type: none"> <li>• Send you a letter within 5 business days to tell you we received your appeal</li> <li>• Help you complete any forms</li> <li>• Review your appeal and send you a letter within 30 days to answer you</li> </ul>
<p>If you think waiting for 30 days will put your health in danger, you can ask for an <b>Expedited</b> or <b>“Fast” Appeal</b></p>	<p>You can:</p> <ul style="list-style-type: none"> <li>• Write us or call us within 60 days of our decision about your services</li> </ul> <p>UnitedHealthcare Community Plan Appeals and Grievance Unit P.O. Box 31364 Salt Lake City, UT 84131</p> <p>MMA: <b>1-888-716-8787</b>, TTY <b>711</b> LTC: <b>1-800-791-9233</b>, TTY <b>711</b></p>	<p>We will:</p> <ul style="list-style-type: none"> <li>• Give you an answer within 48 hours after we receive your request</li> <li>• Call you the same day if we do not agree that you need a fast appeal, and send you a letter within 2 days</li> </ul>

## Section 17: Member satisfaction

	What you can do:	What we will do:
If you do not agree with our appeal decision, you can ask for a <b>Medicaid Fair Hearing</b>	<p>You can:</p> <ul style="list-style-type: none"><li>• Write to the Agency for Health Care Administration Office of Fair Hearings</li><li>• Ask us for a copy of your medical record</li><li>• Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply.</li></ul> <p>* You must finish the appeal process before you can have a Medicaid Fair Hearing.</p>	<p>We will:</p> <ul style="list-style-type: none"><li>• Provide you with transportation to the Medicaid Fair Hearing, if needed</li><li>• Restart your services if the State agrees with you</li></ul> <p>If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.</p>

### Fast plan appeal

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

### Medicaid Fair Hearings (for Medicaid members)

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

Agency for Health Care Administration  
Medicaid Fair Hearing Unit  
P.O. Box 7237  
Tallahassee, FL 32314-7237

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

[MedicaidFairHearingUnit@ahca.myflorida.com](mailto:MedicaidFairHearingUnit@ahca.myflorida.com)

**Questions?** Call MMA Member Services at **1-888-716-8787**, TTY **711**, 103  
or LTC Member Services at **1-800-791-9233**, TTY **711**.

## Section 17: Member satisfaction

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

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

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

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

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

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

### Review by the State (for MediKids members)

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

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

Agency for Health Care Administration  
P.O. Box 7237  
Tallahassee, FL 32314-7237

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

[MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)

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

### Continuation of benefits for Medicaid members

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

If your services are continued, and our decision is not in your favor, we may ask you to pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during your appeal or fair hearing, you must file your appeal and ask to continue services within this timeframe, whichever is later:

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

# Section 18:

## Your member rights

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

### You have the right to:

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

## Section 18: Your member rights

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

### **LTC members have the right to:**

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

**Questions?** Call MMA Member Services at **1-888-716-8787**, TTY **711**, 107  
or LTC Member Services at **1-800-791-9233**, TTY **711**.

# Section 19:

## Your member responsibilities

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

### **You have the responsibility to:**

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

### **LTC members have the responsibility to:**

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

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

# Section 20:

## Other important information

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

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

To learn more about patient responsibility, you can talk to your LTC case manager, contact the DCF by calling 1-866-762-2237 toll-free or visit the DCF web page at <https://www.myflfamilies.com/medicaid>. (Scroll down to the Aged or Disabled Individuals not Currently Eligible section and select “SSI-Related Facts Sheets”).

### Indian Health Care Provider (IHCP) protection

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

### Emergency disaster plan

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

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

**Questions?** Call MMA Member Services at **1-888-716-8787**, TTY **711**, 109  
or LTC Member Services at **1-800-791-9233**, TTY **711**.

## Section 20: Other important information

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### Tips on how to prevent Medicaid fraud and abuse

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

### Fraud/abuse/overpayment in the Medicaid program

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: <https://apps.ahca.myflorida.com/mpi-complaintform/>.

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

### Abuse/neglect/exploitation of people

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

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

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

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

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

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

## Section 20: Other important information

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

### Getting more information

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

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

# Section 21:

## Additional resources

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### Floridahealthfinder.gov

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

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

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit <https://quality.healthfinder.fl.gov/Facility-Provider/Medicaid-ReportCard?&type=-13>. You may choose to view the information by each Plan or all Plans at once.

### Elder Housing Unit

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

## MediKids information

For information on MediKids coverage please visit: [http://ahca.myflorida.com/medicaid/Policy\\_and\\_Quality/Policy/program\\_policy/FLKidCare/MediKids.shtml](http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/MediKids.shtml).

## Aging and Disability Resource Center

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

## Independent Consumer Support Program

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

## UnitedHealthcare's Partnership with GEDWorks

UnitedHealthcare Community Plan of Florida is now offering our eligible members the opportunity to earn your GED through a partnership with GEDWorks at no cost to you. Study materials and testing available in English and Spanish. Email [flged@uhc.com](mailto:flged@uhc.com) for more information.

## Section 21: Additional resources

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# Schedule nonemergency medical rides with the MTM Link app

The MTM Link app gives you the flexibility to schedule a nonemergency medical ride whenever and wherever you like, directly from a smartphone or tablet.

You can find find the MTM Link app on Google Play® or the Apple App Store®.

The MTM Link app streamlines the trip booking experience, helps schedule multiple future trips, and allows trip changes or cancellations.

With the app you can book a standard or mileage reimbursement trip, submit a mileage reimbursement claim, or cancel a trip.

# Section 22:

## Forms

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### Living Will

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

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

\_\_\_\_\_ (initial) I have a terminal condition.

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

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

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

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

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_

ZIP Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**Questions?** Call MMA Member Services at **1-888-716-8787**, TTY **711**, 115  
or LTC Member Services at **1-800-791-9233**, TTY **711**.



## Authorized Representative form

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

### Section A: Enrollee information

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

Enrollee Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Enrollee ID Number: \_\_\_\_\_

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

### Section B: Authorized use and/or disclosure, intended use or disclosure

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

## Section 22: Forms

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### Authorized Representative #1:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

### Authorized Representative #2:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

### Authorized Representative form:

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

### Limitations on disclosure:

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**Section C: Expiration and revocation**

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

**Section D: Signature/Authorization**

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Please return the signed authorization form to:**

**UnitedHealthcare Health and Home Connection  
7901 SW 6th Street, Suite 400  
Plantation, FL 33324**

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## Notice of nondiscrimination

Our Companies comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call **1-888-716-8787**, TTY **711**, 8 a.m.–7 p.m., Monday–Friday.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UT 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

Optum Civil Rights Coordinator  
1 Optum Circle  
Eden Prairie, MN 55344  
[Optum\\_Civil\\_Rights@Optum.com](mailto:Optum_Civil_Rights@Optum.com)

If you need help filing a complaint, call **1-888-716-8787**, TTY **711**, 8 a.m.–7 p.m., Monday–Friday.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Phone: **1-800-368-1019, 800-537-7697** (TDD)  
Mail: U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

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

This notice is available at: <https://www.uhc.com/nondiscrimination-med>  
<https://www.optum.com/en/language-assistance-nondiscrimination.html>

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**Questions?** Call MMA Member Services at **1-888-716-8787**, TTY **711**, 121  
or LTC Member Services at **1-800-791-9233**, TTY **711**.

## Notice of availability of language assistance services and alternate formats

**ATTENTION:** Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card. Call member services at 1-888-716-8787, TTY 711, 8 a.m.–7 p.m., Monday–Friday.

**ATENSYON:** Kung nagsasalita ka ng **Tagalog, (Tagalog)**, may makukuha kang mga serbisyong libreng tulong sa wika at mga libreng komunikasyon sa mga ibang anyo, tulad ng malaking print. Tawagan ang mga serbisyo sa miyembro sa 1-888-716-8787, TTY 711, 8 a.m. – 7 p.m., Lunes – Biyernes.

**ATENCIÓN:** Si habla **español (Spanish)**, tiene acceso a servicios gratuitos de asistencia lingüística y a materiales gratuitos en otros formatos, como letra grande. Llame a Servicios para Miembros al 1-888-716-8787, TTY 711, de lunes a viernes, de 8 a.m. a 7 p.m.

**ВНИМАНИЕ:** Если Вы говорите по-**русски, (Russian)**, Вы можете бесплатно воспользоваться помощью переводчика и информационными материалами в альтернативных форматах, например, крупным шрифтом. Звоните в отдел обслуживания участников по телефону 1-888-716-8787, TTY 711, с 8 а.м. до 7 р.м., с понедельника по пятницу.

**ATANSYON:** Si ou pale **Kreyòl Ayisyen, (Haitian Creole)**, gen sèvis asistans lengwistik gratis ak kominikasyon gratis ki nan lòt fòm, tankou gwo karaktè, ki disponib pou ou. Rele Sèvis Manm yo nan 1-888-716-8787, TTY 711, 8 a.m.– 7 p.m., Lendi jiska Vandredi.

**تنبيه:** إذا كنت تتحدث اللغة العربية، الترجمة (**Arabic**) للغة، فتوجد هناك خدمات مساعدة لغوية مجاناً ورسائل مجانية بتنسيقات أخرى، مثل الطباعة بحروف كبيرة. ما عليك سوى الاتصال بقسم خدمات الأعضاء على الرقم 1-888-716-8787، أو عبر الهاتف النصي 711، من الساعة 8 صباحاً إلى الساعة 7 مساءً، من يوم الإثنين إلى الجمعة.

**CHÚ Ý:** Nếu quý vị nói tiếng **Việt, (Vietnamese)**, quý vị sẽ nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí và nhận các tài liệu truyền thông miễn phí ở các định dạng khác như chữ in lớn. Gọi cho bộ phận dịch vụ hội viên theo số 1-888-716-8787, TTY 711, từ 8 giờ sáng đến 7 giờ tối, Thứ Hai đến Thứ Sáu.

**ATTENZIONE:** se parla **italiano, (Italian)**, sono disponibili servizi gratuiti di assistenza linguistica e comunicazioni gratuite in altri formati, come la stampa a caratteri grandi. Chiama il servizio soci al numero 1-888-716-8787, TTY 711, dalle 8.00 alle 19.00, dal lunedì al venerdì.

**ATENÇÃO:** se você fala **português do Brasil, (Brazilian Portuguese)**, serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como letras grandes, estão disponíveis para você. Ligue para o serviço do associado no número 1-888-716-8787, TTY 711, das 8 a.m. às 7 p.m., de segunda à sexta-feira.

**HINWEIS:** Wenn Sie **Deutsch** sprechen, (**German**) stehen Ihnen kostenlose Sprachdienste und kostenlose Mitteilungen in anderen Formaten, beispielsweise in Großdruck, zur Verfügung. Rufen Sie den Mitglieder-Service an, unter 1-888-716-8787, TTY 711, verfügbar von Montag bis Freitag zwischen 8:00 Uhr und 19:00 Uhr.

**注意：**如果您說中文，(**Chinese**)，您可獲得免費語言協助服務和其他格式（例如大字版）的免費通訊。請致電 1-888-716-8787 與會員服務部聯絡，聽障專線 (TTY) 711，服務時間週一至週五上午 8 時至晚上 7 時。

**참고:** 귀하가 **한국어 (Korean)**을 구사하시는 경우, 무료 언어 지원 서비스와 다른 형식의 무료 커뮤니케이션(예, 큰 활자체로 된 정보)을 이용하실 수 있습니다. 가입자 서비스부 (1-888-716-8787, TTY 711, 월요일 - 금요일, 오전 8 시 - 오후 7 시 사이)에 전화하십시오.

**ATTENTION :** Si vous parlez **français (French)**, des services d'assistance linguistique gratuits et des communications gratuites dans d'autres formats, tels que du texte en gros caractères, sont à votre disposition. Veuillez appeler le département des services aux membres au 1-888-716-8787, TTY 711, de 8 h à 19 h, du lundi au vendredi.

**UWAGA:** Jeśli mówi Pan/Pani w języku **polskim, (Polish)**, dostępne są bezpłatne usługi pomocy językowej i komunikacji w innych formatach, np. duży druk. Prosimy zadzwonić do działu obsługi klienta pod numer 1-888-716-8787, TTY 711, w godzinach od 8:00 do 19:00, od poniedziałku do piątku.

**ધ્યાન આપો:** જો તમે **ગુજરાતી, (Gujarati)** બોલતા હો, તો મફત ભાષા સહાય સેવાઓ અને મોટા પ્રિન્ટ જેવા અન્ય ફોર્મેટમાં મફત સંદેશાવ્યવહાર તમારા માટે ઉપલબ્ધ છે. સોમવાર-શુક્રવાર, સવારે 8 થી સાંજે 7 વાગ્યા સુધી, 1-888-716-8787, TTY 711 પર સભ્ય સેવાઓનો સંપર્ક કરો.

**โปรดทราบ:** หากคุณพูดภาษาไทย (**Thai**) คุณมีสิทธิได้รับบริการช่วยเหลือด้านภาษาโดยไม่มีค่าใช้จ่ายรวมถึงการสื่อสารในรูปแบบอื่น เช่น ตัวพิมพ์ขนาดใหญ่ โดยไม่มีค่าใช้จ่ายเช่นกัน โทรติดต่อบริการสมาชิกได้ที่ 1-888-716-8787 และ TTY 711 ตั้งแต่เวลา 8.00 น.-19.00 น. วันจันทร์-วันศุกร์

**Questions?** Call MMA Member Services at **1-888-716-8787, TTY 711,** 123  
or LTC Member Services at **1-800-791-9233, TTY 711.**

## Notice of nondiscrimination

Our Companies comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the **1-800-791-9233**, TTY **711**, 8 a.m.–8 p.m., Monday–Friday.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UT 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

Optum Civil Rights Coordinator  
1 Optum Circle  
Eden Prairie, MN 55344  
[Optum\\_Civil\\_Rights@Optum.com](mailto:Optum_Civil_Rights@Optum.com)

If you need help filing a complaint, call **1-800-791-9233**, TTY **711**, 8 a.m.–8 p.m., Monday–Friday.

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Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Phone: **1-800-368-1019, 800-537-7697** (TDD)  
Mail: U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

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

This notice is available at: <https://www.uhc.com/nondiscrimination-med>  
<https://www.optum.com/en/language-assistance-nondiscrimination.html>

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

## Notice of availability of language assistance services and alternate formats

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**ATENCIÓN:** Si habla **español (Spanish)**, tiene acceso a servicios gratuitos de asistencia lingüística y a materiales gratuitos en otros formatos, como letra grande. Llame a Servicios para Miembros al 1-800-791-9233, TTY 711, de lunes a viernes, de 8 a.m. a 8 p.m.

**ВНИМАНИЕ:** Если Вы говорите по-**русски, (Russian)**, Вы можете бесплатно воспользоваться помощью переводчика и информационными материалами в альтернативных форматах, например, крупным шрифтом. Звоните в отдел обслуживания участников по телефону 1-800-791-9233, TTY 711, с 8 а.м. до 8 р.м., с понедельника по пятницу.

**ATANSYON:** Si ou pale **Kreyòl Ayisyen, (Haitian Creole)**, gen sèvis asistans lengwistik gratis ak kominikasyon gratis ki nan lòt fòm, tankou gwo karaktè, ki disponib pou ou. Rele Sèvis Manm yo nan 1-800-791-9233, TTY 711, 8 a.m.- 8 p.m., Lendi jiska Vandredi.

**تنبيه:** إذا كنت تتحدث اللغة العربية، الترجمة (**Arabic**) للغة، فتوجد هناك خدمات مساعدة لغوية مجاناً ورسائل مجانية بتنسيقات أخرى، مثل الطباعة بحروف كبيرة. ما عليك سوى الاتصال بقسم خدمات الأعضاء على الرقم 1-800-791-9233، أو عبر الهاتف النصي 711، من الساعة 8 صباحاً إلى الساعة 8 مساءً، من يوم الإثنين إلى الجمعة.

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**ATTENZIONE:** se parla **italiano, (Italian)**, sono disponibili servizi gratuiti di assistenza linguistica e comunicazioni gratuite in altri formati, come la stampa a caratteri grandi. Chiama il servizio soci al numero 1-800-791-9233, TTY 711, dalle 8.00 alle 20.00, dal lunedì al venerdì.

**Questions?** Call MMA Member Services at **1-888-716-8787, TTY 711,** 125  
or LTC Member Services at **1-800-791-9233, TTY 711.**

**ATENÇÃO:** se você fala **português do Brasil, (Brazilian Portuguese)**, serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como letras grandes, estão disponíveis para você. Ligue para o serviço do associado no número 1-800-791-9233, TTY 711, das 8 a.m. às 8 p.m., de segunda à sexta-feira.

**HINWEIS:** Wenn Sie **Deutsch** sprechen, (**German**) stehen Ihnen kostenlose Sprachdienste und kostenlose Mitteilungen in anderen Formaten, beispielsweise in Großdruck, zur Verfügung. Rufen Sie den Mitglieder-Service an, unter 1-800-791-9233, TTY 711, verfügbar von Montag bis Freitag zwischen 8:00 Uhr und 20:00 Uhr.

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**참고:** 귀하가 **한국어 (Korean)**을 구사하시는 경우, 무료 언어 지원 서비스와 다른 형식의 무료 커뮤니케이션(예, 큰 활자체로 된 정보)을 이용하실 수 있습니다. 가입자 서비스부 (1-800-791-9233, TTY 711, 월요일 - 금요일, 오전 8 시 - 오후 8 시 사이)에 전화하십시오.

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**UWAGA:** Jeśli mówi Pan/Pani w języku **polskim, (Polish)**, dostępne są bezpłatne usługi pomocy językowej i komunikacji w innych formatach, np. duży druk. Prosimy zadzwonić do działu obsługi klienta pod numer 1-800-791-9233, TTY 711, w godzinach od 8:00 do 20:00, od poniedziałku do piątku.

**ધ્યાન આપો:** જો તમે **ગુજરાતી, (Gujarati)** બોલતા હો, તો મફત ભાષા સહાય સેવાઓ અને મોટા પ્રિન્ટ જેવા અન્ય ફોર્મેટમાં મફત સંદેશાવ્યવહાર તમારા માટે ઉપલબ્ધ છે. સોમવાર-શુક્રવાર, સવારે 8 થી સાંજે 8 વાગ્યા સુધી, 1-800-791-9233, TTY 711 પર સભ્ય સેવાઓનો સંપર્ક કરો.

**โปรดทราบ:** หากคุณพูดภาษาไทย (**Thai**) คุณมีสิทธิได้รับบริการช่วยเหลือด้านภาษาโดยไม่มีค่าใช้จ่ายรวมถึงการสื่อสารในรูปแบบอื่น เช่น ตัวพิมพ์ขนาดใหญ่ โดยไม่มีค่าใช้จ่ายเช่นกัน โทรติดต่อบริการสมาชิกได้ที่ 1-800-791-9233 และ TTY 711 ตั้งแต่เวลา 8.00 น.-20.00 น. วันจันทร์-วันศุกร์



# We're here for you

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

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

You can also visit our website at [myuhc.com/CommunityPlan](https://myuhc.com/CommunityPlan).

**UnitedHealthcare Community Plan**  
7901 SW 6th Street, Suite 400  
Plantation, FL 33324

**United  
Healthcare®**  
Community Plan

**Questions?** Call MMA Member Services at **1-888-716-8787**, TTY **711**, 127  
or LTC Member Services at **1-800-791-9233**, TTY **711**.

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