Indiana – July 2024

Welcome to the community

Indiana PathWays for Aging Member Handbook

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United Healthcare Community Plan

PathWays FOR AGING

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Welcome to Indiana PathWays for Aging

Welcome to UnitedHealthcare, your Indiana PathWays for Aging (PathWays) program health plan.

Indiana PathWays for Aging is an Indiana health coverage program for Hoosiers aged 60 and older who are eligible for Medicaid. Research shows that most older adults — 75% or more — want to age at home and in their communities. Indiana PathWays for Aging makes it possible for Hoosiers to age their way. A nursing home might be the right choice for some individuals. PathWays offers more choices that allow individuals to get nursing facility level of care at home or in a community setting, while living independently.

Contact us

Mailing address:
UnitedHealthcare
Attn: PathWays
2955 N. Meridian Street, Suite 401
Indianapolis, IN 46208

Online:
uhc.com/communityplan/indiana — Scroll down and click Plan Details for UnitedHealthcare Community Plan – Indiana PathWays for Aging

myuhc.com/CommunityPlan — Register or log in to access your secure member account, set communication preferences, see your claims, and get access to many programs and services.

Questions? Visit **uhc.com/communityplan/indiana** or **myuhc.com/CommunityPlan**, or call Member Services at **1-800-832-4643**,TTY **711**.

Hours of operation

Our Member Services call center is open Monday–Friday, 8:00 a.m.–8:00 p.m. ET. That number is shown on the bottom of each page of this Member Handbook.

We are closed on the following holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day (July 4)
- Labor Day
- Thanksgiving Day
- Christmas Day

Even when we are not open, we are here for you. You can call us at **1-800-832-4643**. TTY users may dial **711**. If you need the direct phone number for your Service Coordinator or Care Coordinator, call this number for assistance. You may choose the NurseLine option to get medical advice. The nurses can also answer questions about your PathWays benefits and coverage. Medical advice is available 24/7, 365 days a year. Please dial **911** if you have a medical emergency and need an ambulance right away.

Working with UnitedHealthcare

Service area	Phone number	Information
Member Services	**1-800-832-4643** TTY users dial **711**	**Hours:** Monday–Friday, 8:00 a.m.–8:00 p.m. ET We help you understand and connect with all PathWays people, programs, and services.
24/7 Nurseline	**1-800-832-4643** TTY users dial **711**	A nurse is available 24 hours a day, seven days a week.
Behavioral Health and Substance Use Disorder Crisis Hotline	**1-855-780-5955**	Speak to a licensed behavioral health professional when you are going through a behavioral health or substance use crisis. You can call 24 hours a day, seven days a week for confidential support.
Dental Member Services	**1-800-832-4643**	Find a dentist in your area or get help scheduling an appointment.
Indiana Family and Social Services Administration (FSSA), Division of Family Resources (DFR)	**1-800-403-0864**	Call this number to report any information changes such as your telephone number, family size, address, or income.
Indiana Tobacco Quitline	**1-800-784-8669** **Text READY to 34191 to register for free services**	Free phone-based or texting service to help smokers quit.
Program Helpline for Indiana PathWays for Aging	**1-877-284-9294**	Call this number if you have questions about the status of your PathWays program benefits or if you have a problem that cannot be solved by UnitedHealthcare and you want to change health plans.

Questions? Visit **uhc.com/communityplan/indiana** or **myuhc.com/CommunityPlan**, or call Member Services at **1-800-832-4643**,TTY **711**.

Service area	Phone number	Information
Relay Indiana	**1-800-743-3333**, TTY users dial **711**	For members with hearing or speech loss, a trained person will help them speak to someone using a standard phone.
Long Term Care State Ombudsman Program	**1-800-622-4484** or **1-317-232-7134** Fax: **1-317-972-3285**	This agency is for members living in a long-term care facility, like a nursing home. Contact them to report an issue if you are in danger or being treated badly. An Ombudsman advocates (helps) on your behalf. Email: **LongTermCareOmbudsman@ombudsman.IN.gov** Online: **Ombudsman.IN.gov**
Suicide and Crisis Hotline	**988**	Free and confidential support for those experiencing a suicidal crisis or emotional distress, available 24/7.
Transportation Services	**1-800-832-4643** TTY users dial **711** Say "Transportation" when asked about the reason for your call.	Call to set up transportation to your doctor appointments. We offer more options as noted in this handbook under the section titled **Transportation**.
Utilization Management (UM)	**1-800-832-4643** TTY users dial **711**	Member Services can answer questions about the status of a prior approval (authorization) of a medication or medical procedure. Your doctor makes the request for authorization.
Vision Member Services	**1-800-832-4643** TTY users dial **711**	Member Services is available to give you information about your vision benefits or to help you find a provider in your area.

How you became a PathWays program member

When you applied for coverage in the PathWays Medicaid program, you were asked to choose a health plan. A health plan is a health insurance company. Each health plan includes a group of health care providers (doctors, specialists, home health care providers, pharmacies, therapists, and more). This is called a "network" of providers. For most health care services, you must use the providers who are in your health plan.

If you came to PathWays with no prior Medicaid coverage, your start date with us will be effective on the date of eligibility approval. Sometimes your Medicaid coverage begins in the state fee-for-service (FFS) program. Please see the **welcome letter** you got from UnitedHealthcare to confirm your start date. You may have received health services earlier than that date. Contact us to find out who to call about services you got before you became a PathWays program member.

You have the right to make a health plan selection by calling the enrollment broker within 60 days of the start of coverage. When you do not select a plan, there will be an assignment process in place directed by the state. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the residential provider of the member (if applicable).

You are now enrolled with UnitedHealthcare as your health plan. You should have received a welcome packet within five days of your start date. The welcome packet includes your member ID card. It also shares details about us as well as additional resources. As a PathWays member, you will choose a Primary Medical Provider (PMP). Your PMP will work with you and is your primary contact when making medical decisions. Your PMP will also make referrals and help you with prior authorizations (PAs) for services that are not always covered by Medicaid.

If you already have a doctor or other primary or specialty medical provider, you will want to make sure that your provider is part of the UnitedHealthcare provider network. If you do not have a PMP, we can work with you to choose one.

Notice to Native American and Alaskan Native members

You have the right to get services from a Native American and/or Alaskan Native health care provider. You may also choose this health care provider as your PMP. If a provider you wish to see is not part of our provider network, let us know. We will ask that they join our provider network. We will also work with you to give you access to an Indian health care provider, even if that provider is located outside Indiana.

This includes providers operated by:

- Indian Health Service (IHS)
- Tribal Organization
- Urban Indian Organization
- An Indian Tribe

If you do not want to be enrolled in the PathWays program, contact the Program Helpline for Indiana PathWays for Aging at 1-877-284-9294. Let the representative know that you want to move out of managed care. The representative will confirm that you can move to Fee-for-Service Medicaid. This means your care will be managed through Indiana's Division of Disability and Rehabilitative Services rather than through a managed care entity.

Member identification

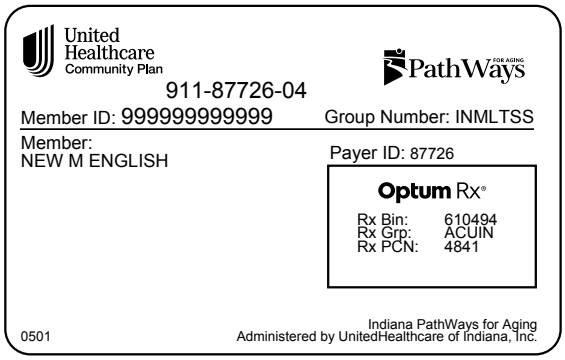
You have a 12-digit member ID number. This is also known as your Medicaid ID number. This member ID is assigned by the FSSA Division of Family Resources (DFR) through an automated system. You should have received a member identification card from UnitedHealthcare. The card will have both a PathWays and a UnitedHealthcare logo.

Member ID cards

We will send you a member ID card. Your member ID card is very important. You must have one to use your PathWays benefits. You must give your ID card to the medical staff before you use any service or see your doctor. Your ID card will have your member ID on it. If you take prescriptions, the pharmacy will also need your member ID card.

If you also have Dual Special Needs Program (D-SNP) Medicare benefits with UnitedHealthcare, you will have two member ID cards during 2024. Please make sure your providers have a copy of both cards. In 2025, members who have both D-SNP and PathWays benefits through UnitedHealthcare will be sent a single member ID card to use for all covered services.

If you need a new member ID card, we will send you one. You can call the Member Services number at the bottom of this page. This phone number is also listed on the back of your member ID card. Your member ID card is also available on the UnitedHealthcare mobile app.



Lost your member ID card?

If you or a family member loses a card, you can print a new one at **myuhc.com/CommunityPlan**. If you need a new card sent to you, call Member Services. You can also download the UnitedHealthcare mobile app on your smartphone. The mobile app includes a digital member ID card that can be used at any time.

Quick member ID card tips

- Your ID card is for your use only. Do not let others use it.
- Always carry your ID card when you need it. Keep it in a safe place.
- Do not lose your card or throw it away
- You will need your card when you get medical care or when you pick up medicine at the pharmacy
- Misusing your medical ID number, like loaning or selling the card or the information on it, is against the law
- Misusing your card or medical ID number may result in legal actions, and you could lose your Medicaid eligibility, benefits, and health care services
- If you notice others getting benefits they are not eligible for or someone misusing the medical ID card, please tell us right away. You can call Member Services at **1-800-832-4643**. The Indiana Health Coverage Programs (IHCP) also has a way to report problems. The IHCP Provider and Member Concerns Line is 1-800-457-4515. You can email them at **program.integrity@fssa.in.gov**.
- You should call UnitedHealthcare Community Plan or FSSA at 1-800-403-0864 to report any provider you believe may be giving services that are not needed or should not be given to members

 Questions? Visit **uhc.com/communityplan/indiana** or **myuhc.com/CommunityPlan**, or call Member Services at **1-800-832-4643**,TTY **711**.

Getting started

We know that health coverage can get complicated. We want to make things easy for you. For that reason, we want you to meet two very important people:

- First, you will have one Care Coordinator. This is "your" person here at UnitedHealthcare. You will have their direct phone number and email. They can answer any questions you have. They will check in with you to make sure you have what you need to meet your life goals. This includes understanding your benefits, making and reaching health goals, living in a clean and safe place, having enough groceries, getting your medications, and connecting you to resources. For more information, visit the **Care coordination** section of this handbook.
- Second, when you call our UnitedHealthcare Member Services line, you will get routed to the same Member Service Navigator (MSN) each time you call. You will also get their direct phone number. For a list of things that your MSN can help you with, visit the **Member Services** section of this handbook.

If you don't know who your people are yet, call us at **1-800-832-4643**. TTY users may dial **711**. We are open 8:00 a.m. to 8:00 p.m. ET, Monday through Friday. After hours, we have a 24/7 NurseLine who can answer questions and give you medical advice. We are ready to meet you!

Health needs screening

UnitedHealthcare wants to have access to your benefits. One of the goals of the PathWays program is to help you live in the setting of your choice. We also want to promote your well-being and quality of life. We will call or visit you during your first 30 days as a PathWays member to complete a health needs screening. This survey helps us understand how you are doing right now. You can also call Member Services and ask to take this survey. **When you complete your survey during your first 30 days as a PathWays member, you will get to choose a reward from our Member Rewards Catalog.**

Choosing a Primary Medical Provider (PMP)

As soon as you can, choose a Primary Medical Provider (PMP). Because you are enrolled in the PathWays program, you will need to choose a PMP who is part of the UnitedHealthcare provider network. This is your main doctor who sees you for annual checkups, routine sick or well visits, and immunizations (shots).

Your PMP may be any of the following:

- General practitioner
- Geriatrician
- Family medicine physician
- Internal medicine physician
- Advanced practice nurse
- Advanced practice nurse (APN) practitioner
- Physician assistant
- Endocrinologist (if their main specialty is internal medicine)
- Gynecologist

You can choose your PMP or you can have one assigned to you. If you do not have a PMP, we will assign one to you. This is based on where you live and if the PMP is taking new patients. For help finding or selecting a PMP, you can:

- Log into your member portal. You can use our provider search tool to view all of the providers in our network.
- Call UnitedHealthcare Member Services. We will help you find a provider.

Visit the state's Find a Provider Portal at **in.gov/medicaid/members/114.htm**. Use this link to see if your current doctor is a Medicaid provider. If they are not, UnitedHealthcare will not be able to pay for any services you get from them. If your doctor would like to become a Medicaid provider, they can visit the Indiana Medicaid Provider website.

If you are in the Right Choices Program, you will not be able to change your PMP on your own. Please talk to your Care Coordinator to discuss provider updates or additions.

Provider Directory

We can provide an up-to-date Provider Directory to assist you with finding a provider that is in our UnitedHealthcare provider network. We also show you which doctors are part of both our Medicare and Medicaid networks. To see our Provider Directory:

- View it online at **myuhc.com/CommunityPlan**. You may search by provider name, specialty, or location. You may look at lots of details, like languages spoken in the office and distance from a bus stop.
- Call Member Services for help finding the right provider for you
- Ask us to send you a Provider Directory by mail
- Ask us to email you a Provider Directory

Provider network updates

We share any updates to the provider network at least 30 days before a change takes place. This means if there is a change that could affect your care, we will send you a notice at least 30 business days ahead of time.

When to change your PMP

We do not make coverage decisions based on moral or religious beliefs. You may have a health need that a certain doctor or hospital cannot treat because of their moral or religious beliefs. If this happens, that doctor or hospital should tell you. You can decide if you want to go to a different doctor or hospital to get care.

Member Services can help you in finding your new PMP when:

- You have moved
- Your doctor has moved or is no longer part of the UnitedHealthcare provider network
- You are not happy with the care you are receiving from your PMP
- Someone at the PMP's office treated you rudely
- Your PMP does not return your calls
- You have trouble getting the care you want or you do not agree with care your PMP says you need

Getting information from UnitedHealthcare

Language assistance

If English is not your main language, we can connect you with an interpreter at no cost to you. We will answer your questions in your language. To request assistance, call Member Services. That phone number is shown on the bottom of this page. It is also on the back of your member ID card.

Interpreters for medical visits

Tell your doctor if you need an interpreter during your medical visits. Your provider can schedule an interpreter for American Sign Language or any other language. This service is free and can happen in person or by video chat. If your doctor has trouble getting an interpreter, call Member Services or your Care Coordinator. Call at least three days in advance to schedule in-person or video chat appointments. We will make sure you get the support you need.

Hearing and speech assistance

If you need hearing and speech help, you can call the Indiana Relay Service at 1-800-743-3333 or 711 for TDD/TTY service. This number can be used anywhere in Indiana. Ask the operator to connect you to **1-800-832-4643**.

Getting mail, email, or texts

Register for a secure member portal account at **myuhc.com/CommunityPlan**. When you sign up for the first time, you will be asked to let us know how you want to get information from us.

If you do not have internet access and want it, we can help you get that. If you do not like using the internet, call Member Services. They will collect the details about whether you want mail, email, or texts from us. Our Member Services phone number is shown on the bottom of this page. This phone number is also on the back of your member ID card.

Getting information in other formats

We offer our letters and other materials in large print, braille, audio, and other languages. You can call the Member Services number below to let us know if you want information in another format. This phone number is also listed on the back of your member ID card.

Why we contact you

When we reach out, it is because we believe you need something. We may try to call you on the phone, send you a letter, send you an email, or text you. If you like to receive information or requests in a certain way, let us know. You can share your preferences by updating your profile on the member portal, or you can contact Member Services. Our Member Services phone number is shown at the bottom of this page. This phone number is also listed on the back of your member ID card.

Below is a list of common reasons we contact you:

- During your first 30 days as a PathWays member, we collect your health needs screening. This is a very important survey. During this call or visit, we will also ask how you want to hear from us in the future.
- The second step is to meet your Care Coordinator. You will be asked to share details about your health. You can also set some goals if you want. Your Care Coordinator is the main person who will help you with all of your needs while you are a PathWays member. This person will touch base with you to make sure you are doing okay.
- There are certain letters we must send or email you that are about your benefits and coverage
- If your PathWays benefits change, we will contact you to let you know. If this changes how you get care, we will help you.
- If your PathWays network provider leaves, we will send you a notice. If you need help finding a new provider, call us. We will send you a directory or help you pick a new provider.
- If an agency providing services to you is no longer available, we will let you know. If you need help finding a new agency, we will help you.
- If you have a certain health condition, we will contact you. We will offer education and support.
- We will contact you to see if you have needs that are not about your health care. We want to make sure you have a safe place to live, have enough food, and can get to the places you need to go.
- The FSSA may ask us to contact you about certain programs or changes that are important
- If you need preventive services, we will contact you to remind you. if you have already received these services, you can let us know.
- We will let you know about special programs and services that may interest you. See the **Free programs and services from UnitedHealthcare** section of this handbook for examples.

How to get care

It is important that you are receiving the best care from UnitedHealthcare and your providers. We have an open network. This means you can see any provider who sees Indiana Medicaid members. These providers are signed up with the State of Indiana as Indiana Medicaid providers.

If you have a concern or question, call Member Services. Your MSN can help you with things like:

- Finding a doctor
- Finding care and treatment
- Understanding how your health plan works
- Answering questions about any part of your health care

You will not be treated any differently if you call with a complaint or grievance. Our Member Services phone number is shown at the bottom of this page. This phone number is also listed on the back of your member ID card.

What is a PMP?

A PMP is a primary medical provider. Your PMP is your health partner. You will call them first when you need health care. They will work with you on all your health care needs. Your PMP will usually be able to help you with whatever you need. If your PMP is unable to treat your health issue, they will refer you to another place to get care.

Your PMP may be any of the following:

- General practitioner
- Geriatrician
- Family medicine physician
- Internal medicine physician (a doctor who treats adults)
- Advanced practice nurse
- Advanced practice nurse (APN) practitioner
- Physician assistant
- Endocrinologist (if their main specialty is internal medicine)
- Gynecologist

Seeing a specialist

Your PMP may send you to a specialist for special care or treatment. They will help choose a specialist to give you the care you need. You may need permission from UnitedHealthcare to see a specialist or receive certain care. Your PMP knows when to ask for permission.

Your PMP's office staff can help you get an appointment with a specialist. Make sure to tell your PMP and specialist as much about your health as you can. If your specialist or any other provider is not in our network, they must get permission from us before they can give you care. You may also need a referral from your PMP.

If you have questions about your care plan, you have the right to ask for a second opinion. This is available at no cost to you. Asking for a second opinion can help make sure your treatment plan is right for you. To get a second opinion, call your PMP's office or call us for help. Our Member Services phone number is shown on the bottom of this page. This phone number is also on the back of your member ID card.

How to make an appointment with your provider

You have the freedom to choose any PMP who is part of our network. PathWays includes some benefits and services that are available to you on a self-referral basis. These self-referral services do not require a referral or approval from your PMP. Please read the **Self-referral services** section of this Member Handbook for more information. You may see any provider who is signed up with the State of Indiana as an Indiana Medicaid provider. We refer to this as an "open" provider network.

To make an appointment, call your provider's office and request one. Make sure to have your member ID card in your hand when you call. Tell them you are a Medicaid member and give them your member ID card information.

When you see a provider, they will help you understand your medical needs. At your first appointment, the provider or their staff will:

- Ask you questions about your current health and your medical history
- Give you information on how to maintain your health
- Schedule any tests and services you need

If you need help finding a provider or scheduling an appointment, we are here to help. Contact Member Services or your Care Coordinator. Our Member Services phone number is shown at the bottom of this page. This phone number is also listed on the back of your member ID card.

When and where to go for care

It is important to know when and where to go for the medical care you need. Sometimes it may seem difficult to decide where you should go when you or a family member don't feel well. We have many options for care. The chart below shows some options for care and when they are the best option for you to use.

Primary Medical Provider (PMP)	For checkups and physicals, immunizations, or minor aches and pains.
Telehealth (virtual visits)	For minor problems when you cannot see your PMP in-office. Telehealth is seeing your doctor remotely, usually by a video or audio call on your phone. We offer free telehealth from UnitedHealthcare Doctor Chat. The doctor's office is open 24/7. Visit **uhcdoctorchat.com** or download the mobile app today. This is a good option when you have a minor problem, like a sprain, earache, cough, cold, sore throat, or allergies. A provider is also available to talk if you are feeling down, anxious, or depressed.
Convenience care clinic	For minor problems when your PMP is unavailable. This is for things like allergies, a slight fever (less than 100 degrees), or severe cold and flu symptoms.
Urgent care	For problems that could become emergencies if left untreated for 24 hours.
Emergency room (ER)	For life-threatening emergencies.

Access to care

The chart below will provide you with an expectation of when you can obtain an appointment with your provider.

Provider type	Appointment category	Appointment standards
PMP	Routine care with physical or behavioral symptoms	Within five to seven days
	Routine care without physical or behavioral symptoms	Within 30 calendar days
	Urgent	Within 24 hours
	Emergency	Visit the emergency room or call 911 right away, 24 hours a day/seven days a week
	Routine gynecological exam/new patient	Within 30 calendar days
	Annual physical exam	Within 30 calendar days
Specialist	Routine care with physical or behavioral symptoms	Within five to seven days
	Routine care without physical or behavioral symptoms	Within 30 calendar days
	Urgent	Within 24 hours
	Emergency	Visit the emergency room or call 911 right away, 24 hours a day/seven days a week
Behavioral health	Non-life-threatening emergency	Within six hours
	Urgent	Within 24 hours
	Emergency	Visit the emergency room or call 911 right away, 24 hours a day/seven days a week
	Routine care with physical or behavioral systems	Within five to seven calendar days
	Routine care without physical or behavioral symptoms	Within 30 calendar days
	Outpatient follow-up appointment	Within seven calendar days following discharge for the inpatient behavior health hospitalization

After-hours care

PMP after-hours coverage is available to you 24 hours a day, seven days a week. We maintain standards your PMP must follow. Your PMP (or designated provider) will answer your phone call after normal business hours. After-hours coverage for your PMP may include an answering service or a shared-call service with other medical providers.

We offer more options for after-hours care:

- Call our 24/7 NurseLine at **1-800-832-4643**. TTY users may dial **711**.
- Use an urgent care clinic instead of the ER
- Get a free virtual visit in minutes using Doctor Chat. The doctor's office is open 24/7. Visit **uhcdoctorchat.com** or download the mobile app today.

Emergency services

An emergency is a medical condition with severe symptoms that may be life-threatening or cause serious damage to you. Examples of health problems needing emergency treatment include:

- Uncontrolled bleeding, major burns, seizures/convulsions
- Fainting, shortness of breath, severe chest pain, severe vomiting
- Miscarriage/pregnancy with vaginal bleeding, cases of rape or molestation
- Poisoning
- A serious accident
- Broken bones
- A strong feeling that you might hurt yourself or others

For emergency care, call 911 or go to the nearest ER. Do not call us before you call 911. This is a covered service. You do not need any approval to get emergency services. You may go to the nearest ER. You do not have to make sure it is in our provider network. While you are at the ER, you will get all the services you need. The doctors and nurses will let you know when you are stable enough to leave.

Post-stabilization services are also covered. This is any care you get after the emergency is over. If you need more tests or services, the ER staff will call us to request approval. This only happens once your condition is stable.

If you are not sure if you are having an emergency, please call your PMP. You can also call our 24-hour NurseLine at **1-800-832-4643**. TTY users may dial **711**.

The nurse can help you:

- Decide if you need to see your doctor
- Decide if you or your child should go to the ER
- Answer general questions about your health

Behavioral health and substance use disorder crisis line

If you are experiencing a mental health crisis, dial the National Suicide Prevention Lifeline at **988** or call the number on the back of your member ID card **1-800-832-4643**, press "**8**" for our dedicated crisis line at **1-855-780-5955**. Clinicians are available 24 hours a day, seven days a week to talk with you.

Phone:

- National Suicide Prevention Lifeline: **988** or **1-800-273-8255 (TALK)**
- National substance use and disorder issues referral and treatment hotline: **1-800-662-4357 (HELP)**
- NAMI (National Alliance on Mental Illness): **1-800-950-6264**
- Veterans Crisis Line: Dial **988** then press **"1"**
- Senior Help Line (24/7): **1-602-264-4357**

Text:

- Text the word **"HOME"** to **741741**
- Text the word **"HelpLine"** to **62640**

Chat: suicidepreventionlifeline.org/chat

For information online, visit suicidepreventionlifeline.org.

What if I get a bill from my doctor?

UnitedHealthcare only pays your provider for the covered services you get. Other than an amount you may owe under a waiver program, your provider cannot charge you, your family, or others for covered services.

Your provider can only bill you for non-covered services. The provider must tell you if your PathWays program benefits do not cover a service before they provide it to you. They may only charge you for the non-covered service if they told you it was not covered before providing it and you agreed to pay for it in writing.

If you get a bill for a service, you should take care of it right away. If you do not, it could be sent to a collection agency. To handle a bill, you should:

- Call your provider and make sure they know you are a Medicaid member
- Ask the provider to confirm that you were an Indiana PathWays for Aging member on the date the services were received

If the provider's office is unable to help, call Member Services. We can work with you to understand how to handle the bill. Even if you were not with UnitedHealthcare Community Plan at the time of the provider visit, we can help.

Coordination of Medicare and Medicaid services

UnitedHealthcare will coordinate all your Medicare and Medicaid services. To the greatest extent possible, this will include all reasonable efforts to coordinate care for you regardless of your Medicare service delivery system or Medicare plan benefit package. This includes traditional Medicare, unaligned Medicare Advantage plans, Chronic Conditions Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

We will ensure that services covered and provided in PathWays are provided without charge to you when you are eligible for both Medicare and Medicaid services. We are responsible for providing medically necessary Medicaid-covered services to you if the service is not covered by Medicare (even if you are also eligible for Medicare). We will work with your Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits you receive. We coordinate with state and social service agencies and community-based organizations (CBOs) as needed to better identify and address both your medical and social needs.

Programs and covered services

As your health plan for Indiana PathWays for Aging coverage, we provide the state benefits package to our members, and there are two packages of service. The first is State Plan Medicaid, which includes nursing facilities, home health, and hospice care. The second, State Plan Medicaid plus home and community-based services (HCBS), is available to some members, based on their health status. State Plan Medicaid services include, at a minimum, all benefits and services considered "medically reasonable and necessary." The State of Indiana has a list of services that are paid under the PathWays program. This includes things like office visits, lab tests, procedures, medical equipment and supplies, and hospital stays.

We make sure that the services you get meet the rules set by the State of Indiana. We compare requests to others who get similar services to make sure you are being treated fairly. We also look at medical standards to make sure the services are appropriate. When you do not understand a service that is recommended, please reach out to your Care Coordinator. You also may talk to us if you think you need a treatment that you are not getting. We will help you understand any limits to your coverage. We will also share the options you have so that you can make decisions about next steps.

The following grid is a summary of your PathWays benefits. Contact Member Services or your Care Coordinator to ask any questions about covered services.

Service	Limitations/Coverage
Adult mental health and habilitation	Covered when approved by the Division of Mental Health and Addiction (DMHA) State Evaluation Team. Services include: • Adult day services • Home and community-based habilitation • Respite • Therapy and behavioral support services • Addiction counseling • Peer support services • Supported community engagement services • Care coordination • Medication training and support

Service	Limitations/Coverage
Behavioral and primary health care coordination	Covered when approved by the Division of Mental Health and Addiction (DMHA) State Evaluation Team.
Care conferences	Covered.
Chiropractors	Covered. Limited to five visits and 50 therapeutic physical medicine treatments per member per year.
Dental services	Please read the **Dental services** section of this handbook for extra services for UnitedHealthcare Community Plan members. Covered by State plan: • Two exams and cleanings per year • One set of panorex x-rays every three years • One set of bitewing x-rays every 12 months • One comprehensive oral evaluation per lifetime per member for each provider, limited to two providers per year
Diabetes self-management training services	Covered. Limited to 16 units per member per year. Additional units may be prior authorized.

Service	Limitations/Coverage
Drugs: legend drugs	Medicaid covers legend drugs based on rules set by the State of Indiana and other government agencies. All health plans follow the same list. Visit **myuhc.com/CommunityPlan** to view the Preferred Drug List for the PathWays program. Talk to your doctor or Care Coordinator if you feel you need a drug that is not on that list. The following drugs are covered under Fee for Service Medicaid. Talk to your Care Coordinator if you take these types of medications: • Hepatitis C drugs • Hemophilia agents • Spinal Muscular Atrophy treatments • Muscular Dystrophy treatments • CAR-T therapies • Durable genetic therapy • Cystic Fibrosis agents • Sickle Cell agents
Drugs: non-legend drugs	Medicaid covers some over-the-counter drugs and supplements on its formulary. This is available via a link from the IHCP website at **inm.providerportal.catamaranrx.com/providerportal/faces/PreLogin.jsp**.
Emergency services	Covered. All medically necessary screening services provided to a member who goes to an emergency department with an emergency medical condition are covered.
Eye care, eyeglasses, and vision services	Please read the **Vision services** section of this handbook for extra services for UnitedHealthcare Community Plan members. State plan coverage for the initial vision care examination will be limited to one exam every two years unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one pair every five years unless medically necessary.

Service	Limitations/Coverage
Family planning services and supplies	Family planning services include limited history and physical examination, pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, counseling, referral, and treatment of members at risk for HIV; tubal ligation; and vasectomies. Pap smears are included as a family planning service.
Federally qualified health centers (FQHCs)	Covered.
Food supplements, nutritional supplements	Covered only when no other means of nutrition is possible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital services inpatient	Inpatient services are covered when such services are given or ordered by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital services outpatient	Outpatient services are covered when such services are given or ordered by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Home health services	Covered for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.
Hospice care	Hospice is covered if the recipient is expected to die from illness within six months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days.
Laboratory and radiology services	Covered.

Service	Limitations/Coverage
Long-term acute care hospitalization	Long-term acute care services are covered. Prior authorization is required.
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)	Covered for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.
Mental health/ behavioral health services – inpatient (state psychiatric hospital)	PathWays members are removed from the PathWays program when admitted to a state psychiatric hospital. Coverage will be made available under the fee-for-service Medicaid program. Your Care Coordinator can help you connect with the right people if you have had a change in Medicaid programs.
Mental health/ behavioral health services – inpatient	Covered.
Mental health/ behavioral health services – outpatient	Covered. Includes partial hospitalization services, Clinic Option services, mental health services provided by physicians, outpatient mental health facilities, and psychologists endorsed as Health Services Providers in Psychology.
Medicaid rehabilitation option (MRO – community mental health centers)	MRO services are available through fee-for-service Medicaid. Talk to your Care Coordinator if you have questions about how to get these services: • Adult intensive rehabilitation services (AIRS) addiction counseling • Addiction counseling • Behavioral health counseling and therapy • Behavioral health level of need redetermination • Medicaid Rehabilitation Option for case management • Medication training and support • Behavioral health assessment and intervention • Skills training and development

Service	Limitations/Coverage
Nurse-midwife services	Covered for services that the nurse-midwife is legally authorized to perform.
Nurse practitioners	Covered.
Nursing facility services (long-term)	Requires pre-admission screening for level of care determination. Coverage includes room and board; nursing care; medical and nonmedical supplies and equipment; durable medical equipment; medically necessary and reasonable therapy services; and transportation to vocational/habilitation service programs.
Nursing facility services (short-term)	Covered. Short-term services are for members in a nursing facility for fewer than 30 calendar days.
Occupational therapy	Covered when ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Therapy services provided away from the facility must meet certain rules. Prior authorization is not required for initial evaluations, for services provided within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by a physician prior to discharge, or for services provided by a nursing facility or some other facilities that include the service in their daily rate. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization. Evaluations and reevaluations are limited to three hours of service per evaluation. General strengthening exercise programs for recuperative purposes are not covered by Medicaid. Passive range of motion services as the only or primary type of therapy and occupational therapy psychiatric services are not covered by Medicaid. Therapy for rehabilitative services will be covered for a member no longer than two years from the start of the therapy unless there is a change in medical condition requiring longer therapy.
Organ transplants	Covered. Prior authorization is required.

Service	Limitations/Coverage
Orthodontics	Not covered except in cases of craniofacial deformity or cleft palate.
Out-of-state medical services	Medicaid reimbursement is available for the following services provided outside Indiana: acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies; qualifying hospice services, and diagnostic services, including genetic testing. All out-of-state services are subject to the same limitations as in-state services. Prior authorization is required, except for emergency services (however, continuing inpatient treatment and hospitalization does require prior authorization). Services may be obtained in the following designated out-of-state cities subject to the prior authorization requirements for in-state services: Louisville, Kentucky; Cincinnati, Ohio; Harrison, Ohio; Hamilton, Ohio; Oxford, Ohio; Sturgis, Michigan; Watseka, Illinois; Danville, Illinois; and Owensboro, Kentucky. Members may obtain services in Chicago, Illinois, if the member's provider determines the service is medically necessary, transportation to an appropriate Indiana facility would cause undue hardship to the member or the member's family, the service is not available in the immediate area, or the provider complies with all of the criteria set forth in accordance with the state plan and federal regulations. Prior authorization will not be approved for the following out-of-state services: nursing facilities, short-term care facilities, or home health agency services; or any other type of long-term care facility, including facilities directly associated with or part of an acute general hospital.
Physicians' surgical and medical services	Covered for reasonable services provided by an M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within scope of practice. PMP office visits limited to a maximum of 30 per calendar year per member per provider without prior authorization. New patient office visits are limited to one per recipient per provider within the last three years.

Service	Limitations/Coverage
Physical therapy	Covered when ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Prior authorization is not required for initial evaluations, for services provided within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by a physician prior to discharge, or for services provided by a nursing facility or some other facilities that include the service. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 visits in 30 calendar days without prior authorization. Evaluations are limited to three hours each.
Podiatrists (foot care)	Covered. Services include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders. Surgical procedures involving the foot, laboratory or X-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered for patients with a condition that has resulted in severe circulation issues or numbness in the legs or feet. Proof must be submitted of member visit to a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the six-month period prior to getting routine foot care services. Prior authorization is required for inpatient hospital stays and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease.
Rehabilitative unit services – inpatient	Covered. Requires prior authorization.
Residential substance use disorder (SUD) services	Prior authorization is required for all residential SUD stays. Admission criteria for residential stays for opiate use, illegal drug use, or alcohol use treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria: • ASAM Level 3.1 — Clinically managed low-intensity residential services • ASAM Level 3.5 — Clinically managed high-intensity residential services

Service	Limitations/Coverage
Respiratory therapy	Covered when ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, emergency, or oxygen equipment and supplies necessary for the delivery of oxygen; therapy within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by a physician prior to discharge; and services provided by a nursing facility or large private or short-term care facilities with an established daily rate. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization. Evaluations and reevaluations are limited to three hours of service per evaluation.
Rural health clinics	Covered for services provided by a physician, a physician assistant nurse practitioner, a clinical psychologist, or a clinical social worker. Talk to your Care Coordinator if you have trouble getting needed services. We will work to share options for assistance that are free to you. Services to a homebound individual are only available in the case of those clinics located in an area that has a shortage of home health agencies.

Self-referral services

PathWays includes some benefits and services that are available to you on a self-referral basis. These self-referral services do not require approval or a referral from your PMP.

UnitedHealthcare or your PMP may direct you to seek the services of the self-referral providers contracted in our network. We cannot require that you receive those services from our network providers, unless otherwise noted.

You may not self-refer to a provider who is not enrolled in IHCP. The following services are considered self-referral services. For these services, you may choose any licensed provider who is enrolled as an Indiana Medicaid provider. This is true even if the provider is not in our network.

- Chiropractic services
- Eye care services, except surgical services
- Routine dental services
- Podiatric (foot care) services
- Psychiatric services
- Family planning services
- Emergency services
- Urgent care services
- Immunizations
- Diabetes self-management services

Notes:

- Behavioral health services are self-referral if using a network provider. You may self-refer, within our network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse, and chemical dependency services provided by mental health specialty providers.
- If you have an emergency, call 911 or go to the nearest ER 24 hours a day, seven days a week. You do not need any prior approval to get emergency services.
- If you need family planning services, you may choose any IHCP provider. This includes getting contraceptives.

The mental health and addiction providers you can choose within our provider network are:

- Outpatient mental health clinics
- Community mental health centers
- Psychologists
- Licensed psychologists
- Licensed mental health counselor
- Licensed marriage and family therapist
- Licensed clinical addiction counselor
- Licensed social workers
- Licensed clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses qualified in psychiatric or mental health nursing
- Persons holding a master's degree in social work, marital and family therapy, or mental health counseling

Getting care outside the provider network

There are times when you may want to get care from a provider outside the UnitedHealthcare provider network. This happens if there are no providers in your area. This can be a specialist who is hard to find. All providers must be part of the IHCP network in order to give care to Indiana Medicaid members. Talk to Member Services or your Care Coordinator if you have trouble finding a provider. Our phone number is shown on the bottom of this page. This phone number is also on the back of your member ID card.

Free programs and services from UnitedHealthcare

In addition to covered benefits, we offer many programs and services. These are free to you. For details, talk to Member Services or your Care Coordinator. Our Member Services phone number is shown on the bottom of this page. This phone number is also listed on the back of your member ID card.

HERO Council

You are our HERO at UnitedHealthcare, and your voice matters! HERO stands for Health, Empowerment, Resources, and Opportunities. This is a group open to you, your informal helpers, friends, family, and organizations throughout the community.

The purpose of this council is to listen to what you say. We use your feedback to improve the way we work with our members. We will host meetings throughout the year in all areas of the state. We will also host meetings by phone. You will get a gift card, snack, and free transportation or mileage reimbursement. We can arrange an interpreter if you need one. If you need help getting to the meeting location and are traveling alone, we can plan for someone to assist you.

Our meetings will include games and prizes, community speakers, information sharing, and question and answer sessions. Sample topics include:

- Question and answer sessions about covered services, dental, vision, pharmacy, and medical equipment
- Discussions about what you like (and what is not working well) about the health care system
- Sharing ideas on how we can improve the Indiana PathWays for Aging program
- How to get the services you want, like
  - Medical appointments
  - Extra programs and services offered by UnitedHealthcare
  - Help with housing, food, clothing, and other basic needs
- How to ask questions, make a complaint, or file a grievance or appeal
- How to get information in your language or a different format (such as braille or large print)

We would like to hear from you! Call Member Services to add yourself to our invitation list. Our phone number is shown on the bottom of this page. This phone number is also listed on the back of your member ID card.

Member Rewards

When you earn a reward, you get to pick something from our Member Rewards Catalog. This catalog offers rewards that are offered based on member feedback.

How to earn a reward: New members who complete their initial health needs screening during their first 30 days with the UnitedHealthcare PathWays program earn a reward right away. Additional rewards are subject to change. A list of current rewards is available on our websites. You can also ask your Care Coordinator or Member Services.

How to redeem a reward: Our Member Rewards Catalog is available online at **myuhc.com/CommunityPlan**. We can email or send you a current catalog. Your Care Coordinator or MSN can also make a request to send you the reward of your choice.

How to suggest a reward: Share your ideas with your Care Coordinator or MSN. We collect these ideas. We use feedback to decide how to change our rewards so that you can earn things important to you.

Extras offered by UnitedHealthcare

Farmbox: Getting healthy food is important. Talk to your Care Coordinator if you cannot buy fresh fruits and vegetables often. Our Farmbox program will deliver fresh produce to your doorstep. There is also a newsletter that contains recipes and healthy eating tips.

Fitness program: Want to work out? Our One Pass program includes many gyms across Indiana. You also have access to more than 20,000 workouts using online websites. Sign up at **YourOnePass.com**. If you have a Medicare D-SNP plan with UnitedHealthcare, you get the Renew Active benefit. This program offers the same choices.

Free smartphone: We offer smartphones with talk, text, and data. This offer is limited to one per household. Apply at **AssuranceWireless.com**. Member Services can also help you apply.

Legal assistance: Do you need legal support? We can connect you with resources. Get help with a Power of Attorney or Advance Directive form. Work to remove a criminal record that makes getting work or housing a challenge. Talk to your Care Coordinator for a referral.

Member Rewards: Earn a gift by connecting with UnitedHealthcare or getting the care you need. You choose a gift from our Member Rewards Catalog. You can also give us feedback about gifts you would like to see offered in the future. Use any of our contact options at the bottom of the page to learn more about this program.

Member Support Program: We offer items and tools that support your health and personal safety goals. These are things you need but are not covered under the PathWays program. Examples include a personal medical alert, digital talking scale, hypoallergenic bedding, magnifier or grabber tool. We also offer reimbursement if you use non-traditional healing methods to control pain. Talk to your Care Coordinator to learn more.

Postbook: A Postbook creates deeper relationships with a relative or friend. Pick your Postbook pal and share postcards based on ideas in the journal. We include postage and supplies. Call Member Services, and we will send you a Postbook set.

Respite support: If you get long-term help from a friend or family member, we offer a special program to support them. We provide gift cards to help them enjoy their free time. Our Care Coordinators will work to get the care you need while your helper takes a break.

Self Care app by Able To: This is a health and well-being mobile app. Get tools to help with stress, anxiety, and coping. It is free to you and those who help you. Visit **ableto.com/begin** to get started.

Transportation: We offer a variety of transportation options. This includes free trips to the gym, food bank, curbside grocery pickup, state or county agency meetings, health-related education classes, events sponsored by UnitedHealthcare, or the pharmacy. See the **Transportation** section of this handbook for more information.

Virtual community center: It is never too late to learn how to enjoy the internet. This is a special website with lots to offer. They offer live classes for adults who are older, led by adults who are also older. Visit **myuhc.com/CommunityPlan** or call Member Services to get started. Listed below are some classes offered:

- Online banking tips
- Email scams and how to recognize them
- Arts, crafts, and hobbies
- Recipes and cooking tips
- Health and well-being sessions like meditation, coping with stress, and chair yoga

Virtual visits: Many providers offer virtual visits. Talk to your provider to see if this is an option for you. We offer dental, medical, and mental health advice when your provider is not available.

- Medical or behavioral health: Visit **uhcdoctorchat.com**. You can video chat with a provider 24 hours a day, seven days a week.
- Dental: Visit **uhcCommunity.DialCare.com**. We offer a dentist who can talk to you on the phone or by video chat. This service is also offered 24 hours a day, seven days a week.

Resources and information

Affordable Connectivity Program: This federal program offers the following discounts:

- Up to $30 per month toward internet service
- Up to $75 per month for households on qualifying Tribal lands
- One-time discount of up to $100 to buy a laptop, desktop computer, or tablet from participating providers

To learn more about this program, visit **fcc.gov/acp**. To apply or recertify, visit **affordableconnectivity.gov**.

Extra care coordination: Talk to your Care Coordinator. They will suggest additional programs and services to help you meet your goals.

Extra dental benefits: See the **Dental** section of this handbook for details.

FSSA benefits portal: Update your personal information. Check on your eligibility status. Visit **fssabenefits.in.gov/bp/#/** to make sure the State has all the information needed to keep your health coverage current.

Health and well-being portal: Visit **myuhc.com/CommunityPlan**. Visit our health and well-being portal. We have tools and articles about topics such as stress, coping, and depression.

JustPlainClear.com: The Just Plain Clear® Glossary contains thousands of health care terms defined in plain, clear language to help you make informed decisions. Visit **JustPlainClear.com** to use this free and helpful tool. This resource is currently available in English, Spanish, Burmese, Chinese, and Portuguese.

Magnifier tool: We offer a free magnifier tool to our members who have trouble reading small print. It includes a light and allows you to see a half a page at a time. We can also print and send out your letters in large font. You can also set your preference for email, large print, or braille for the documents you get from us. Call Member Services and let us know what you need.

Member Support Services program: This program is available through the State of Indiana. It is for all PathWays members to help them, their caregivers, and families ask questions or solve issues. You may call the Program Helpline for Indiana PathWays for Aging Member at **1-877-284-9294** if you need any assistance, advice, or advocacy when working with UnitedHealthcare.

NurseLine: Our NurseLine gives you 24/7 telephone access to experienced registered nurses. They can give you information, support, and education for any health-related question or concern. Call Member Services and choose the prompt to speak with NurseLine.

Providers app (formerly Fresh EBT): If you receive benefits from the Supplemental Nutrition Assistance Program (SNAP), this app helps you make healthy choices on a budget. Check your balance quickly and easily, track spending habits, find places that accept EBT, locate grocery deals, keep a shopping list, and get healthy, low-cost recipes. On your smartphone, go to the App Store or Google Play. Search for EBT. Download the Providers app for free.

Tobacco cessation: Stop using tobacco products today. You get free coaching and supplies. To get started:

- Call 1-800-QUIT-NOW (1-800-784-8669)
- Text READY to 34191
- Visit **QuitNowIndiana.com**

uhcHealthierLives.com: Visit this website to find resources in your community. You can find support for things like food, clothing, transportation, or housing. Your Care Coordinator or Member Services can also help you find the help you need. This site is available in more than 60 languages.

Extra vision benefits: See the **Vision** section of this handbook for details.

Care coordination programs and services

As a state, Indiana strives to make sure everyone who receives long-term services and support can live, learn, work, and enjoy life in the setting of their choice. The goal is for people to lead lives that are meaningful to them. To do this, we must have a person-centered support system that helps people:

- Build or maintain relationships with their families and friends
- Live as independently as possible
- Engage in productive activities, such as employment
- Participate in community life

Working with your Care Coordinator or Service Coordinator

A Care Coordinator is a person who may contact you to create a personalized care plan based on your preferences and needs. They can also help answer questions about your health care and help you with your providers.

A Service Coordinator is a person who will work with you to create a personalized service plan to help coordinate your HCBS planning. The service plan will help develop a plan of care of services and supports that best meet your needs and goals.

Based on your State-determined eligibility, you will be assigned a Care Coordinator to support your overall health needs. Based on your eligibility, you may select or be assigned a Service Coordinator who will assist you with your service plan and HCBS. You may include any informal helpers to be part of these services, like a friend or family member. Your care plan must not prioritize your provider's preferences over your preferences. If your provider is not willing or able to provide services in a way that aligns with your needs, preferences, and goals, then alternatives should be examined. The plan must be reviewed and revised every 12 months and any time there is a major change to your health, or at your request.

We monitor the service plan throughout the year through use of the monthly monitoring tool and service notes. As new information is learned, the plan will be updated and revised as needed. The plan should always reflect whether the support setting where HCBS services are delivered was selected by the individual and is integrated into and supports full access to the greater community.

We will use the results of your health needs screening and a detailed comprehensive health assessment to identify medical and behavioral health services you may need. We will work with you to ensure you are receiving appropriate services and ensure you are not at risk of overutilizing or underutilizing services.

In addition, with your permission, your Care Coordinator and/or Service Coordinator will notify others who take part in your care if you have a sudden change in your health. This includes an unexpected hospital stay. It also includes emergency treatment for urgent mental health issues. We will do this as soon as we know about it. Your assigned Coordinator will contact you when you first become eligible, and will give you their contact information. If you do not receive this phone call, contact Member Services. That phone number is shown below. You may also find our phone number on the back of your member ID card.

Your service plan is based on your needs and goals. If your provider is not willing or able to provide services in a way that matches your needs, preferences, and goals, we will help you find other service options. Your service plan is also reviewed and updated every 12 months and any time there is a change in your health. Updates can also be made at your request.

Care Coordinators want to learn more about you. They help you learn self-care and how to get help from others. They may meet with your PMP and other health resources to make sure everyone is working together. If you do not have a PMP, your Service or Care Coordinator will help you find one, and will help you with any referrals the PMP orders. Care Coordinators make sure you have all the services you need, including non-medical services like food and housing. They can add others to your team when needed, based on the needs you share and the goals you set. You may ask to include a friend or family member to your care team.

These types of services and supports help you age in place. This means you get the help you need to keep living as independently as possible.

Members who need Nursing Facility Level of Care who live in the community and receive long-term supports and services will get service coordination. Your Service Coordinator creates and maintains the PathWays program-specific person-centered support plan ("service plan"). They make sure you have access to your benefits and services long-term. They will also help you with medical, social, housing, educational, and other services. This will help to ensure your health, safety and welfare, and, as applicable, to delay or prevent moving to assisted living or a nursing home. Your Service Coordinator will work with your Care Coordinator and keep your service plan up-to-date. With your approval, your friends or family and your care team can be involved in these activities.

Asking for a new Care or Service Coordinator

If you ever feel that your Care Coordinator or Service Coordinator is not a good match for you, let us know. We can help you change to someone who may be a better fit. Call Member Services and let them know. We will confidentially connect you with a different person.

Right Choices Program

The Right Choices Program (RCP) is part of Indiana Medicaid. It is for members who need help with using their health coverage appropriately. Its goal is to make sure your medical care is happening at the right time and place. If you are placed in the RCP, it can help you learn to use your health coverage the right way.

If you are enrolled in the RCP, you will still have all your benefits. You will have one PMP. You will be assigned one pharmacy. Any special doctors you see will need approval from your PMP. Your Care Coordinator will help you if you are enrolled in RCP.

Transitions

Transition of care period: We will honor any existing authorizations you may have received from another Medicaid health plan for 90 calendar days to allow you to safely transition to our health plan without interrupting your care. As you transition either to our health plan or to another health plan, we will work together to make sure there are no disruptions in services you are receiving. Information regarding any prior authorizations and your care/service plan will be shared and honored for 90 days.

Nursing facility to community transitions: If you live in a nursing facility and wish to transition back into the community, the Service Coordinator will conduct assessments to determine what supports would be needed for a safe transition. The Service Coordinator will talk to you, your family, your health care providers, and/or your legal representative as appropriate, to develop a safe transition plan. The Service Coordinator will ensure a stable housing plan and community supports are in place before the transition occurs, as well as provide support during and after the transition.

Waiver support

If you get waiver services, you will be sent a monthly summary. This is called the Waiver Patient/ Liability Summary. A copy of the notice will be sent to you and also to any authorized representatives. The notice includes claims processed since the previous summary. Sometimes dates of the services will be out of order. The summary is a very important document. It lets you know how and to what services the waiver liability was applied. The notice informs you of the amount of your waiver liability owed to each medical provider. Except for pharmacies, medical providers may not collect payment until you are notified via the member liability summary of the amount of the bill that was applied to your waiver liability.

You should keep these notices for your records. The notices are important for personal record keeping. If you have questions about a certain amount that is shown as being owed to a certain provider, contact that provider first. If questions cannot be resolved with the provider, give us a call.

Pharmacies know the amount of the waiver liability that is credited to their claim when the prescription is dispensed. Providers are also notified via a weekly statement of how much of a waiver liability was applied to their claim. The Division of Family Resources (DFR) does not get copies of the Waiver Patient/Liability Summary. They have no information available to them. We can answer questions or resolve any problems about the information you get from us. You have the right to appeal any information in this summary.

Help with services needing prior approval (authorization)

Some services need prior authorization (PA). This is a decision by UnitedHealthcare that a health care service, treatment plan, prescription drug, or medical equipment is medically necessary. We might require PA for certain services before you receive them, except in an emergency. PA isn't a promise your health insurance or plan will cover the cost. If you do not agree with a PA decision, you have the right to make an appeal. See the **Grievances and appeals** section of this handbook for more information. If you have a question about the status of a PA, talk to your Care Coordinator. Member Services can also look up the status of a PA request.

New medical treatments and technology

If you or your doctor would like to use a new medical treatment, call your MSN or Care Coordinator. We want you to be healthy. A group of doctors and specialists will review the request from your doctor. They will let your PMP or specialist know if the treatment is medically necessary and will share the reasons for the decision. Some medical services are not yet proven to be effective. New practices, treatments, tests, and technologies are reviewed nationally by UnitedHealthcare Community Plan. The information is reviewed by a committee of UnitedHealthcare Community Plan doctors, nurses, pharmacists, and guest experts.

Long-term supports and services

We aim to support your way, to live your life your way. Your Care Coordinator and Service Coordinator are here to give you peace of mind and to share options as you continue to live as independently as possible.

Understanding how to get long-term services and supports is important. This includes members who:

- Live in a nursing facility
- Get home and community-based services (HCBS) in a private home or other community setting, such as an assisted living facility

UnitedHealthcare:

- Offers medical coverage and services to help with daily life
- Promotes independent living
- Promotes check-ups
- Supports you in person-centered care planning
- Gives you a Care Coordinator and Service Coordinator

You can call your Service Coordinator or your Care Coordinator at any time. In some cases, the same person may handle both your individualized care plan and your service plan. If you lose their direct phone number, you have two ways to connect with them:

- Call Member Services at **1-800-832-4643**. TTY users may dial **711**. Your Member Services Advocate can share the first name and direct phone number of your point of contact. This team is available 8:00 a.m. to 8:00 p.m. ET, Monday through Friday.
- Visit **myuhc.com/communityplan**. Access your care plan from the Health & Wellness tab. This will take you to your medical record. There is a menu item for Care Team. You may view the details of your care team at any time.

Care options

If you have long-term services and supports, you may get care:

- In your home
- In another place in the community (such as an assisted living facility)
- In a nursing home

To get care in your home or in the community, we will assist with accessing care. You will not have to leave the nursing home if you do not want to do so. Your Service Coordinator will discuss changes you want and help decide what setting is best to meet your needs.

You can help pick the providers who will give your care. This could be an assisted living or nursing home or the agency that will give care at home. You may also be able to choose your own personal care attendants. (This is called Self-Direction.)

If you get care in a nursing home, your Care Coordinator will:

- Be part of your care planning at the nursing home
- Perform any needs assessment that may help manage your care
- Add things to your Person-Centered Service Plan from the nursing home to help manage problems or help you get the physical, mental health, or substance use services you need
- Make face-to-face visits
- Coordinate with the nursing home when you need services that the nursing home does not provide
- See if you are interested and able to move from the nursing home back to the community and help make this happen

If you get care at home, your Care Coordinator and Service Coordinator will:

- Evaluate your health and long-term care needs. We can help you understand your options as you consider the best services for you.
- Help you develop your Person-centered Service Plan
- Make sure the right providers are consulted
- Help you pick long-term care providers
- Visit you in your home and call you to check on your services
- Make sure your Person-Centered Service Plan is carried out and works for you
- Monitor your health care and share options that may be helpful to you
- Tell you about community resources that are available in your area
- Help you manage your care and service needs

What if I live in a nursing home and want to move out?

We want to help you live in the place that is right for you. Talk to your Care Coordinator or Service Coordinator about your options.

Self-direction, or patient-directed attendant care

Self-direction means that you choose your personal care attendant. You also say how your care is given. The attendant may do things like help with dressing or cleaning. They may fix meals or help you take your medicine, etc. Ask your Service Coordinator for more details.

Home and community-based services (HCBS)

Below is a list of HCBS services, available to all PathWays members who meet the functional eligibility requirements. Not all PathWays members are eligible for HCBS. HCBS is determined when you take an assessment. Based on your level of care, you may have the option of choosing HCBS or nursing facility care. Your Care Coordinator can help you understand all of your choices.

- Adult day service
- Attendant care
- Caregiver coaching
- Home and community assistance
- Respite
- Community home share assisted living
- Community transition
- Home delivered meals
- Home modification assessment
- Home modifications
- Integrated health care coordination
- Nutritional supplements
- Participant directed attendant care
- Personal emergency response system
- Pest control
- Specialized medical equipment and supplies
- Structured family caregiving
- Transportation
- Vehicle modifications

These services must be medically necessary. This means the service meets any one of the following standards:

- May prevent the onset of an illness, condition, or disability
- May improve the physical, mental, or developmental effects of an illness, condition, injury, or disability
- Will assist you to achieve or maintain maximum functional capacity in performing daily activities; this includes your ability and what is typical for people of the same age
- Will provide the opportunity for you to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of your choice

Your Care Coordinator or Service Coordinator will work with you to identify the services that will benefit you and help you find an HCBS provider. If you want help scheduling these services, we are here for you. You may also look up HCBS providers on your own by using our Provider Directory. Visit **myuhc.com/communityplan** to view the Provider Directory. We can also send you a paper copy or email a Provider Directory upon request. Call Member Services at **1-800-832-4643** for assistance. TTY users may dial **711**.

Behavioral health and substance use disorder

Behavioral health is about how you feel and act. It is also called mental health. Your mental health is very important. All PathWays members can receive mental health and substance use disorder services. You may see any network doctor without a referral for outpatient treatment. **If you are having very negative thoughts or feel like hurting yourself or someone else, call 988 immediately for help.** If you would like to talk to someone and need support, call **1-800-832-4643**, then press "**8**." You may also call our confidential support line at **1-855-780-5955**. TTY users may dial **711**.

Mental health and substance use treatment benefits

As a member of UnitedHealthcare Community Plan, you are covered for mental health and substance use treatment. Remember to always show your current UnitedHealthcare member ID card when getting services. It confirms your coverage. If a provider tells you a service is not covered by UnitedHealthcare and you still want these services, you may be responsible for payment. You or your family can always call Member Services at **1-800-832-4643**, TTY **711**, to ask questions about benefits. The amount and length of services provided will be based on your needs and medical necessity. Services may be given in a provider's office, your home, or the community.

Individuals' needs always determine the ideal treatment settings. Our care delivery system offers multiple solutions to support members with low-severity conditions to high-severity conditions and everything in between. This allows us to provide the most effective care for your entire treatment journey.

Self-directed care by Able To

Self Care app: Self Care is a free app that can help you learn more about stress, anxiety, and depression. It has tools to track your progress. You can even connect with a large community of people and share advice, stories, and insights — anytime, anywhere. Visit **ableto.com/begin** to get started. Questions? Email or talk to your Care Coordinator.

Traditional behavioral health care: In-person behavioral health clinics and virtual visits are covered.

Virtual visits 24/7: Visit **uhcdoctorchat.com**. You can video chat with a provider at any time.

Some services need prior authorization. This means your provider must contact us before providing the service. Your provider will coordinate referrals with other doctors. You do not need a prior authorization (approval) for emergency service. We will be notified of mental health and substance use hospitalizations. That way we can help with discharge planning and coordination. Your provider will request a prior authorization when needed.

What is a mental health and substance use treatment care provider?

A mental health and substance use treatment care provider is someone qualified to do mental health and substance use treatment. This can be a substance use disorder counselor, doctor, psychiatrist, psychiatric nurse, psychologist, licensed clinical social worker, other professional counselor, care manager, or a peer support staff. They can support you by helping you create and fulfill your recovery plan and work with you before and after a crisis. They can connect you with other community services.

Peer recovery services

UnitedHealthcare Community Plan covers peer recovery services. These services provide activities that promote recovery, like being social, building a support system, and being your own advocate. These services are provided by peer support specialists. You can get these services in person or through telehealth (virtual visit). Speak to your behavioral health provider to see if they offer this service. You can also talk to your Care Coordinator to find options near you.

Substance use disorder services

Substance use services include intensive outpatient, Opioid Treatment Program (OTP), and residential substance use disorder services. These services treat needs and manage substance use symptoms and behaviors.

Substance Use Disorder (SUD) residential treatment

UnitedHealthcare offers coverage for both low and high intensity, short-term SUD residential treatment in settings of all sizes. Your doctor will get prior approval from us before you start your SUD residential stay. To qualify for SUD residential treatment, we use the criteria (rules) based on the American Society of Addiction Medicine (ASAM).

Opioid Treatment Program (OTP)

An Opioid Treatment Program (OTP) uses methadone or buprenorphine in an addiction treatment clinic for members with a severe Opioid-Use Disorder. Services also include routine drug testing, group therapy, individual therapy, medicine management, routine blood testing for wellness, pregnancy tests, follow-up examinations, case management, and one office visit every 90 days to help members meet their goals.

What to expect when getting help

You have the right to accept or refuse behavioral health services offered to you. If you want to get the behavioral health services offered, you or your legal guardian must sign a "Consent to Treatment" form. This form gives you or your legal guardian's permission for you to get behavioral health services. When you sign a "Consent to Treatment" form, you're also giving FSSA permission to access your records.

To give you certain services, your provider needs to get your permission. Your provider may ask you to sign a form or to give verbal permission to get a specific service. Your provider will give you information about the service so you can decide if you want that service or not.

This is called informed consent. Informed consent means advising a patient of the following:

- A proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure
- Alternatives to the treatment, surgical procedure, psychotropic drug, or diagnostic procedure
- Associated risks and possible complications
- And getting documented authorization or approval for the proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure from the patient or the patient's representative

Your PMP, behavioral health provider, or Care Coordinator will also talk to you about your health care needs and social needs.

Covered behavioral health services include, but may not be limited to, the following:

- Behavioral health medicines, monitoring, and adjustment
- Doctor services
- Emergency and non-emergency transportation
- Emergency behavioral health care
- Individual, group, and family therapy and counseling
- Inpatient hospital services
- Inpatient psychiatric services
- Intensive outpatient treatment
- Opioid treatment
- Partial hospitalization program
- Psychotropic medications, adjustments, and monitoring
- Screening, evaluation, and diagnosis

- Substance use (drugs and alcohol) counseling, and medication-assisted treatment
- Substance use disorder residential treatment
- Support services
- Treatment planning

You may self-refer to a behavioral health provider or be referred by providers, state agencies, or other parties. You may see a behavioral health counselor, addiction specialist, or psychologist without a referral from your PMP. To ask questions about getting behavioral health services, talk to your Care Coordinator. You may also call Member Services or visit our website.

Making a behavioral health appointment

Behavioral health appointments should be scheduled as soon as your health condition requires but no later than the following:

Urgent behavioral health appointments — Within 24 hours from the identification of need

Routine care appointments — Routine care appointments with physical or behavioral symptoms to be completed within five to seven days of a referral or request. Routine care appointments without physical or behavioral symptoms to be completed within 30 calendar days of a referral or request.

If you feel you may harm yourself or others, call 911 for emergency help. If you need help finding a provider or scheduling an appointment, call Member Services for support.

Referrals for psychotropic medications

For psychotropic medications, the need will be immediately evaluated. An appointment will be scheduled no later than 30 calendar days from the identification of need. If you are running out of medication or if your condition gets worse before starting medication, you can be seen sooner.

Resources and support

The confidential behavioral health and substance use crisis line number is **1-855-780-5955**. or call the number on the back of your member ID card **1-800-832-4643**, press "**8**" or our dedicated crisis line. We are available 24/7 to answer your questions. These may include questions about your personal health, care for a family member, coverage, cost of care, problems with drugs or alcohol, and more. We want to make it easy to get the services you or your loved one may need. Simply call us any time, day or night, and we'll be here. You can also reach us by calling Member Services at **1-800-832-4643**. That is the number on the back of your member ID card. TTY users may dial **711**.

Crisis Text Line — Crisis Text Line provides free, 24/7 support via text message. They are there for everything. This line can be used to chat about things like anxiety, stress, anger, depression, or suicide. Text **HOME** to **741741**.

KEY Warmline — A warmline is a non-crisis talk line where members with mental health challenges can talk to trained volunteers who also cope with mental health conditions. You can call the Warmline toll-free at **1-800-933-5397**. This line is open 8:00 a.m.–4:30 p.m. ET., Monday–Friday.

Live and Work Well — Find support and resources that can help you and your family. This health and wellness website can be found at **LiveAndWorkWell.com**.

If you are experiencing a behavioral health crisis, dial the National Suicide Prevention Line at **988** or call our behavioral health and substance use disorder crisis line at **1-855-780-5955**. Clinicians are available 24 hours a day, seven days a week to talk with you.

Other resources available include:

- National Suicide Prevention Lifeline (Lifeline) is accessible nationwide by dialing **1-800-273-8255**
- NAMI (National Alliance on Mental Illness): **1-800-950-6264**
- Veterans Crisis Line: Dial **988** then press **"1"**

Member Services

Member Services is here to help with your questions. We can:

- Answer questions about your physical and behavioral health benefits
- Help solve a question or concern you have with your doctor or any part of the health plan
- Help you find a medical, dental, or vision provider
- Tell you about our doctors, their backgrounds, and the health facilities in our network
- Help you if you get a medical bill for a covered service
- Tell you about community resources available to you
- Connect you with programs and services
- Help you if you speak another language, are visually impaired, or need interpreter services or American Sign Language services
- Help you connect with your Care Coordinator
- Help you get materials in an alternate format, such as braille, large print, or audio file
- Assist with scheduling doctor, dental, and vision appointments
- Schedule transportation
- Send you a copy of the Member Handbook at no cost to you
- Tell you how to renew coverage
- Help answer other questions you may have

 Questions? Visit **uhc.com/communityplan/indiana** or **myuhc.com/CommunityPlan**, or call Member Services at **1-800-832-4643**,TTY **711**.

Protecting your identity

We ask questions to check your identity. We do this to protect your privacy. This is federal and state law. Gather the following information before you call:

- Member ID number
- Current address and phone number on file with FSSA
- Date of birth

Giving permission for others to talk to us

You can ask someone to speak with us on your behalf. We can provide a form for you to share this information. This form must be updated once a year. You can change this preference at any time.

NurseLine

Our NurseLine gives you 24/7 telephone access to experienced registered nurses. They can give you information, support, and education for any health-related question or concern. Call Member Services at **1-800-832-4643** and follow the prompts to reach a nurse. TTY users may dial **711**.

Our NurseLine can answer your questions and help you make an informed decision whether to call your doctor, visit an urgent care, or go to the ER.

Member website

Our public website can be found at **uhc.com/communityplan/indiana**. The Indiana PathWays for Aging program is just a click away. You, as well as friends and family, can view this website. The public website does not require a login or password. It has basic information about UnitedHealthcare and the PathWays program. You can find things like:

- Our contact information
- How to contact the State of Indiana about your eligibility
- The most current version of our member welcome packet and handbook
- Member forms
- Member newsletters
- Extra programs for our UnitedHealthcare members

Our member website can be viewed in the following languages:

- Burmese
- Chinese
- Creole
- English
- Hmong
- Ilocano
- Korean
- S'Gaw Karen
- Somali
- Spanish
- Tagalog
- Vietnamese

Member portal

Our secure member portal is also available in all the languages listed above. Go to **myuhc.com/CommunityPlan** to register. This website keeps all of your health information in one place. Registration is easy and fast. Sign up today! Just visit **myuhc.com/CommunityPlan**. Select "Register" on the home page. Follow the prompts. You are just a few clicks away from access to all types of information. Get more from your health care.

Great reasons to use myuhc.com/CommunityPlan:

- View claims history
- View Explanation of Benefits summaries
- Look up benefits and coverage
- Print an ID card
- Tell us how you want us to reach you
- Select a new PMP
- Find a provider, hospital, urgent care center, pharmacy, or lab
- Get access to free apps and programs that we offer
- Keep track of your medical history
- Learn how to stay healthy

Mobile app

Our UnitedHealthcare® app is available for use on your smartphone. Just search **UnitedHealthcare** in the App Store or Google Play to download. You can access your digital member ID card, review health benefits, access claims information, locate doctors, and more.

Staying safe where you live

Safe and affordable housing

We want to make sure that you have access to safe and affordable housing. Our housing stability services will educate you about the various housing options available to improve your quality of life. We understand the importance of housing stability and its role in health care. We are committed to helping you navigate your housing choices and decisions.

Housing stability services include:

- Housing consultation services to help you develop a person-centered plan for housing
- Housing transition services to help you plan for, find, and move into housing
- Housing transportation services to access housing stabilization services
- Housing stability services to help you maintain safe housing

We can provide these resources for safe, affordable housing because of our ongoing relationships with community and state networks. We will complete a housing assessment with you. This will help us find the best options to support your needs. Contact your Care Coordinator for more information.

Social needs

Being healthy is not always about your medical needs. Sometimes you need help connecting to resources in the community. We call these social needs. These are things like housing, getting food every day, transportation, clothing, or feeling safe. We can also help you get access to help with paid or volunteer jobs or finishing your education. Want to find help on your own? Check out **uhcHealthierLives.com**. You can also talk to your Care Coordinator or Member Services.

Personal safety

UnitedHealthcare is committed to your personal safety. If you or someone else is in danger, it should be reported immediately. We must also report the same issue when we learn about it.

What is an endangered adult?

Indiana considers an endangered adult to be anyone who has experienced or is experiencing abuse, neglect, self-neglect, or exploitation.

Abuse: Physical, sexual, emotional, or psychological actions or threats of actions that directly influence you or another person

Neglect: Self-neglect, lack of food, clothing, shelter, or medical care

Exploitation: Unauthorized use of your money, property, or employment information

Home and community-based services (HCBS) and non-HCBS endangered adults

Endangered adults can be members who are receiving or not receiving the HCBS Medicaid waiver. This waiver allows Medicaid to fund support and services for adults with disabilities in their family homes or other community residential programs. Non-HCBS members may be living in nursing facilities, private mental health care settings, state hospitals, or other residential treatment facilities.

Talk to your Care Coordinator or Service Coordinator if you or another adult is experiencing or has experienced abuse, neglect, exploitation, unexpected death, or any of the following:

- Injury
- Unusual hospitalization or admission to a nursing facility due to significant change in health or mental status
- Lack of support or supervision that may place you or another adult in danger
- Medication errors
- Unsafe housing that may cause a threat to your health
- Suspected or witnessed criminal activity by staff, family, friend, or police arrest
- Major disturbance or threat to your public safety
- Instance of being held against your will

Reporting a concern

Indiana has a confidential and central system for reporting. If you or someone you know is in immediate danger, **call 911**. This includes threat or attempt of suicide or a person who goes missing.

If you or another adult has been or is being abused, neglected, or exploited, you can report to:

- Adult Protective Services (APS) at **1-800-992-6978** or online at **aps-govcloud.my.site.com/APSOnlineReport/s**
- Your UnitedHealthcare Care Coordinator, Service Coordinator, or Member Services
- Your PMP

Reporting for long-term care members

Long-term care facilities can report to any of the methods above or you can report to your Ombudsman. Your Ombudsman advocates for your rights as a resident living in a long-term care facility.

Call the State Ombudsman Hotline at 1-800-622-4484 or report online at **in.gov/health/ltc/contact/complaints**.

Call the Indiana Department of Health (INDOH): 1-800-382-9480.

After the report

After a report is submitted, it is sent to APS. APS will keep your report confidential. They will not disclose your name without a court order or the consent of all parties named in the report.

- APS does not discuss ongoing investigations. They will not provide you with the details or status of the investigation.
- Please understand that when adults have the ability to make their own decisions, they may refuse services and have the right to do so. APS has no authority to force someone to do anything against their will.
- UnitedHealthcare is committed to your safety. All information provided is confidential.

Resources:

For more information about APS, visit **in.gov/fssa/da/adult-protective-services**.

In addition, we will reach out to inform you about your personal safety. These outreaches may include:

- Phone calls, visits, emails, or texts that share information about how to stay safe. You may choose how we contact you.
- Online articles and checklists. You may ask us to print and send these to you.

State Ombudsman/Adult Protective Services (APS)

UnitedHealthcare will supply information to authorities as required. You have the right to be involved in the process. We have a member advocate who works closely with APS, any State Ombudsman, and you to help everyone involved in making sure the right services are in place to keep you safe.

Member Support Services program

This program is available through the State of Indiana. It is for all PathWays members to help them, their caregivers, and families ask questions or solve issues. You may call the Program Helpline for Indiana PathWays for Aging Member at **1-877-284-9294** if you need any assistance, advice, or advocacy when working with UnitedHealthcare. UnitedHealthcare also offers a Member Advocate to help you. If you have a difficult issue, that person will listen and share options. The Member Advocate steps in if you feel unheard, unsafe, or unable to get needed care.

Medical equipment

If you need medical supplies or equipment, talk to your Care Coordinator. Most medical equipment will need an order from your PMP or a specialist. We are able to help you understand the process. We can help you if you want support.

Home health

Home health services are available when services are medically necessary, ordered in writing by a physician, and performed on a part-time and intermittent basis in accordance with a written plan of treatment. Home health services include skilled nursing, home health aide services, and skilled therapies such as physical therapy, occupational therapy, and speech-language pathology. Your Care Coordinator will work with you and your physicians to identify any home health services that may be beneficial to you. Some home health services may be available through HCBS.

Hospice services

You may choose hospice services when the time is right for you. Hospice services provide comfort care and support if you have a long-term illness that will not improve over time. You can get services at home, a nursing facility, or other residential setting. Talk to your Care Coordinator to learn more about your options or how to get services.

Pharmacy information

Getting prescriptions is an important part of your health care. UnitedHealthcare covers many medications as well as over-the-counter (OTC) medicines, tobacco cessation drugs, and diabetes supplies. All health plans follow the same rules about the medications that are covered as part of the PathWays program. All PathWays health plans use the same list of approved medications. This is called the Preferred Drug List, or PDL.

You can go to any pharmacy that accepts UnitedHealthcare. Prescription drugs, including injections and infusions, certain over-the-counter drugs, and pharmacy supplements are covered by PathWays.

Visit **myuhc.com/CommunityPlan** to:

- View the PDL
- Find a pharmacy near you

You can also call Member Services. We can give you information by email, in the mail, or over the phone.

In the first year of the program, we will provide 180 days (about six months) of continuity of care for all pre-existing drug regimens for new members. After the first year of the program, we will provide 90 days (about three months) of continuity of care for all pre-existing drug regimens for all new members. This will allow time for our pharmacy team to work with your prescribing provider to negotiate future drug regimens.

Prior approval (authorization) for medications

Some covered drugs may be subject to utilization management (UM) that is no stricter than fee-for-service in amount, duration, and scope. This includes certain drugs, including some behavioral health drugs, that, for safety reasons, need approval from your doctor before you get them. This is called prior authorization (PA). If your doctor does not get a PA when it is needed, we are unable to pay for the prescription. In most cases, you may get up to a three-day (72-hour) supply of a drug while your doctor works with us to file a PA.

If you are having trouble getting a medication, contact Member Services or your Care Coordinator. We can call your provider's office. We can help share information so you get the medicine you need. Our Member Services phone number is shown on the bottom of this page. This phone number is also listed on the back of your member ID card.

Medicare Part D

Medicare Part D drug benefit plans cover prescription drugs as approved by the Centers for Medicare and Medicaid Services (CMS). For full benefit dual eligible members, Indiana Medicaid covers medically necessary, federally and state reimbursable prescription drugs that are excluded from coverage by CMS under Medicare Part D benefit plans. Drugs eligible for coverage under Medicare Part D will not be covered under Medicaid if you refuse Part D coverage.

DivvyDose

We offer a multi-dose packaging solution for our members. With this service, you can:

- Pick up all of your medications on the same day
- Get 90-day supplies delivered to your home for some medications
- Get both prescription and over-the-counter medications in a personalized and pre-sorted roll of medications delivered through the mail every four weeks
- Work with us to better understand and manage your medications

Dental care

Getting a yearly dental checkup is important to your health. The PathWays program includes:

- Two exams and cleanings per year
- One bitewing X-ray once every 12 months and one complete set of X-rays every three years
- Fillings when you have a cavity
- Extraction (having a tooth pulled)
- Periodontal care, which includes deep cleanings and treatment for gum disease every two years
- Full dentures every six years
- Sedation and nitrous oxide, if medically necessary

UnitedHealthcare Community Plan offers additional services like:

- DialCare, our virtual dentist
- Extra X-rays
- Fluoride treatments
- Extra non-surgical gum disease treatments each year
- Anesthesia

For additional details, contact your Care Coordinator about your dental care and added benefits. We can help you find a dentist. You can also call Member Services or go online. Use the phone number or websites listed at the bottom of this page.

Members with special needs

Sometimes people have a hard time going to the dentist. They may be sensitive to touch. They might need extra time or gentle care. Let us help you find the right dentist for you or your family.

The dangers of gum disease

- People with gum disease are two to three times more likely to have a heart attack or stroke
- Diabetes increases the chance of gum disease. Gum disease plus diabetes increases the danger for other health issues.
- Some germs related to gum disease can cause blood clots
- Gum disease increases bacteria in your mouth. It can make heart conditions worse.

Getting dental care

The good news is that dental problems can be treated. See your dentist two times a year for a cleaning and a checkup. Learn the right way to care for your teeth and gums. Even people who do not have teeth need to get a yearly oral cancer screen. Catching oral cancer early improves the chances to stop it or cure it completely.

Some dental services require prior authorization. This means your dentist must get an approval before the service is performed. Your dentist must make the prior authorization request.

You may see any dentist who is registered with the IHCP as a Medicaid provider. Your dentist does not have to be part of the UnitedHealthcare network. **You should not be asked to pay for any services that are part of your PathWays coverage.** If you have trouble finding a dentist, call Member Services.

If you have a dental emergency, call your dentist. If your dentist is not available, go to the urgent care center or the ER. If you are not sure if your dental need is an emergency, call our NurseLine. You can reach the NurseLine 24/7 by calling Member Services. That number is shown on the bottom of this page.

Vision care

Regular eye care is important. You are eligible for routine eye exams and prescription eyeglasses. Call your doctor to schedule a routine eye exam. You can schedule an appointment with any participating vision care provider. If you need help finding an eye doctor, call Member Services.

At UnitedHealthcare Community Plan, we offer the following vision benefits:

- One routine eye exam every 12 months (instead of once every other year)
- An allowance to cover the cost of frames and lenses or contact lenses every year (instead of every five years) when you pick from our MARCH® Vision Care kit

Talk to your Care Coordinator about your eye care. We can help you find a vision provider. You can also call Member Services or go online. Use the phone number or websites listed at the bottom of this page.

Family planning services

You can go to any family planning provider or clinic that accepts Indiana Medicaid and offers family planning services. You do not need a referral from your PMP for family planning services. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include sexually transmitted disease testing. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Family planning services include:

- Birth control devices such as condoms, IUDs, implantable contraceptive devices, and others that are available with a prescription
- Sterilization services
- HIV and sexually transmitted infection (STI) testing, treatment, and counseling
- Screenings for cancer and other related conditions

Preventive care

Seeing your doctor for preventive care is very important. Preventive care includes medical services you use to check your health to prevent and catch early symptoms of illness. It helps keep you healthy, especially as you get older.

All preventive care is covered by PathWays. You should not be asked to pay for any preventive care. You are encouraged to use all preventive care services.

See the chart below for recommended preventive care services for adult men and women. Talk to your PMP about getting preventive services.

Preventive care service	Women 50+	Men 50+
Annual physical exam	X	X
Blood glucose testing*	X	X
Cholesterol testing*	X	X
Flu shot*	X	X
Pneumococcal vaccine*	X	X
Tetanus–Diphtheria booster	X	X

Preventive care service	Women 50+	Men 50+
Colorectal cancer screening	X	X
Pap smear*	X	
Screening mammogram*	X	
Chlamydia screening	Talk to your PMP	
HPV vaccine	Talk to your PMP	
Dental exams	X	X
Eye exams	X	X

*These services are usually provided annually or as otherwise recommended by your doctor.

Talk to your doctor about the need for immunizations that may not be listed here. Depending on your age and health status, you may need other immunizations or a different schedule.

Immunizations

Immunizations are shots that protect the body from disease and illness. Some immunizations require follow-up shots or "boosters." Check with your doctor to make sure you have all the recommended shots for your age. These are some of the recommended adult immunizations:

- TDaP booster (tetanus, diphtheria, and pertussis)
- Flu
- HIB (Hemophilus influenzae type B)
- Hepatitis B
- Shingles
- Pneumococcal conjugate vaccine (PCV15 or PCV20)

Talk to your doctor about the need for immunizations that may not be listed here. Depending on your age and health status, you may need other immunizations.

These shots are given to you at certain times. They are needed to prevent disease or worsen conditions to your health. If you are not sure if you have gotten all your recommended shots, talk to your provider right away.

Transportation

Non-emergency medical transportation

If you need a ride to an appointment, ask a friend, family member, or neighbor first. If you cannot get a ride, we will help you. You may receive non-emergency medical transportation services for PathWays covered services. You are responsible for requesting these trips. Our transportation company will arrange the ride for you. You will get a confirmation once the ride has been scheduled. You and/or family may schedule non-emergency medical transportation. There is no other approval needed.

Your PathWays coverage includes rides for:

- A provider visit or health care appointment
- A pharmacy visit
- Urgent (upon approval) and recurring appointments

Non-medical transportation

We offer additional rides when you need them. There is a 25-mile limit (one way) for each trip. There is no limit to the number of trips you may schedule. We offer rides for:

- Curbside grocery pickup or food bank visits
- Health-related education classes
- Local fitness centers
- State or county agency appointments, including parole meetings
- Member events hosted by UnitedHealthcare

How to schedule a ride

To schedule a ride, you have two options:

- Call UnitedHealthcare Member Services at **1-800-832-4643**. TTY users may dial **711**. When asked to state the reason for your call, say “transportation” or “need a ride.” Your call will be transferred to our ride company.
- Visit **myuhc.com/CommunityPlan** and access the transportation scheduling tool

Please schedule a ride at least three business days before your appointment. Our Member Services phone number is shown on the bottom of this page. This phone number is also listed on the back of your member ID card.

If you have an emergency, please call **911** or go directly to the nearest ER.

When using ride services:

- Have your Medicaid ID card or ID number with you
- Wait for the driver at the curbside pickup and drop-off site. The drivers are only allowed to wait 10 minutes. If you miss that window, they will leave and you will not be able to get a ride.
- If you must cancel your ride, you must call at least two hours before your scheduled pickup time
- Know the address of your provider and the date and time of your appointment
- If you need additional support, please let the ride company know. Examples include:
  - You will have another person with you to help you during the appointments
  - You use a wheelchair, crutches, a walker, or other equipment
  - You need curb-to-curb, door-to-door, or door-through-door assistance
  - You need more than 10 minutes to get from your home to the curbside pickup location

The driver will give you a card with a phone number that can be used to schedule your trip back home. After you get care, call the number on that card to schedule your return trip. If you need to have a prescription filled, work with your doctor to do so before calling your driver for the trip home. Your driver will need to be told about a stop at the pharmacy when scheduling the trip home.

Bus passes

Do you prefer to use a bus pass to attend regular health care appointments? If so, the request is made based on your coverage:

- If you currently receive home and community-based services (HCBS), bus passes become part of your service plan. Talk to your Care Coordinator or Service Coordinator to learn more about how to get a bus pass.
- If you are a PathWays member who is not eligible for HCBS, call Member Services to request a bus pass

Friends and family mileage reimbursement

We offer a program that allows a friend or family member to be reimbursed (paid back) for mileage when they regularly take you to health care appointments. The transportation company will help with the application process. To get started, call Member Services. That phone number is listed at the bottom of this page. It is also listed on the back of your member ID card.

Community and personal attendant transportation

If you are eligible for HCBS, you will have access to additional transportation benefits. These rides must be part of your service plan. Contact your Care Coordinator or Service Coordinator to learn more.

Emergency transportation

For emergency care, call **911** or go to the nearest ER. Do not call us before you call **911**. Non-emergency medical transportation is not for emergencies.

Other plan details

Advance directives

Advance directives are instructions you give about your future medical care in case there is a time you can't speak or make decisions for yourself. Having an advance directive in place will not take away your right to decide your current health care choices. The advance directive also allows you to name a person to make decisions about your health care. They help your family and physician understand your wishes. With advance directives, you can:

- Let your doctor know if you would or would not like to use life-support machines
- Let your doctor know if you would like to be an organ donor
- Give someone else permission to say "yes" or "no" to your medical treatments

Advance directives are only used if you can't speak for yourself. It does not take away your right to make a different choice if you later become able to speak for yourself. You can make an advance directive by:

- Talking to your doctor and family
- Choosing someone to speak or decide for you, known as a health care representative
- Creating a power of attorney and/or living will

Types of advance directives recognized in Indiana

- Organ and tissue donation
- Health care representative
- Living will declaration or life-prolonging procedures declaration
- Psychiatric advance directives
- Out of Hospital Do Not Resuscitate Declaration and Physician Orders for Scope of Treatment (POST)
- Power of attorney

For more information on advance directives and to find forms available to you, visit Indiana Health Care Quality Resource Center, at **in.gov/isdh/25880.htm**. You can also talk to us if you need support. We can answer questions, send you forms, and help you find resources. Our Member Services phone number is shown on the bottom of this page. This phone number is also listed on the back of your member ID card.

You are encouraged to share your advance directives or other documents with your Care Coordinator. This will help us understand your wishes and advocate for you if needed.

How and when to report changes

We keep your information on file for many reasons. It is important that your information is up to date. When you have a change of information, you need to report it to us. In some cases, you will also need to report your changes to the Division of Family Resources (DFR).

Reporting changes to your health plan

Update us when your contact information changes. This can be things like:

- Name
- Address
- Phone number
- Email
- Change in insurance (such as getting another insurance)
- The beginning and end of a pregnancy

Reporting changes to the DFR

Update the DFR on all of your general information. See below for ways to contact the DFR.
You should call to update things like:

- Legal name
- Address
- Phone number
- Change in family size, including marriage, divorce, birth, or death of a family member who lives with you
- Change in income

Other information that should be reported to the DFR includes:

- You have given away or sold a major asset, like a piece of property or other valuable item. This may affect your Medicaid eligibility status. It is called “transfer of property.”
- Your level of care has changed. This means you are moving to a facility that offers more care, or you are leaving a facility and returning to a house or apartment.
- The member has died
- The member has been incarcerated (is in jail)

Manage your benefits

To report changes, use one of the following options:

- Use your FSSA Benefits Portal. FSSA has developed an online tool that will allow you to manage your benefits, report changes, print proof of eligibility, and view your notices/correspondence. The FSSA Benefits Portal can be found at **fssabenefits.in.gov/bp/#**.
- Write a letter and send it to:
  FSSA Document Center
  P.O. Box 1810
  Marion, IN 46952
- Your MSN can send an email to FSSA for you. The MSN must speak directly with you to verify the change.
- Call the DFR directly at **1-800-403-0864**

Plan selection period

UnitedHealthcare is your health plan. With PathWays, you must remain in your chosen health plan for a one-year period if you remain eligible. You may only change your health plan during certain times of the year or for certain reasons outlined below.

Plan selection can be made on the IHCP application or by calling the enrollment broker within 60 days of coverage start. If you did not select a health plan, you were assigned to UnitedHealthcare by the state. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered, such as your residential provider.

Individuals will have the chance to change a health plan:

- Within 60 days of starting coverage
- Any time your Medicare and Medicaid plans become unaligned (e.g., you disenroll from one MA plan to another during the quarterly Special Enrollment Period [SEP])
- Once per calendar year for any reason
- At any time using the just cause process
- During a plan selection period, which will be aligned with the Medicare open enrollment window (Oct. 15–Dec. 7) to be effective the following calendar year

Medicare election:

- To enroll, a prospective member who is eligible for Medicare must:
  - Enroll in and remain enrolled in all parts of Medicare for which the prospective member is eligible (Medicare Part A, Part B, and/or Part D), or
  - Obtain all Medicare Part A, Part B, and Part D benefits, if eligible, from a Dual Special Needs Plan.
- If a member becomes Medicare-eligible after enrollment, the member must enroll in all parts of Medicare for which the member is eligible

How to change health plans

As a PathWays member, you may change your health plan at certain times and for "just cause" reasons as outlined below.

Just cause reasons

Anytime you file a grievance with UnitedHealthcare and the State finds that you have a good reason to change health plans, you may change health plans based on "just cause." This is when you have concerns over the quality of care being provided by your health plan. You must first contact us so that we can attempt to resolve your concern. If you are still unhappy after contacting us, you can call the State at 87-PATHWAY-4 (1-877-284-9294). They will review your request.

The "just cause" reasons include, but are not limited to, the following:

- Receiving poor quality of care
- Failure to provide covered services
- Failure of UnitedHealthcare to comply with established standards of medical care administration
- Lack of access to providers experienced in dealing with your health care needs
- Significant language or cultural barriers
- Corrective action levied against UnitedHealthcare by the Office of Medicaid Policy and Planning (OMPP)
- Limited access to a primary care clinic or other health services within reasonable proximity to your residence
- A determination that another health plan's formulary is more consistent with your existing health care needs

- Lack of access to medically necessary services covered under the health plan
- A service is not covered by the health plan for moral or religious objections
- Your primary health care provider dis-enrolls from UnitedHealthcare and re-enrolls with another health plan
- Other circumstances determined by OMPP or its designee to constitute poor quality of health care coverage

If you have a just cause grievance, call UnitedHealthcare Member Services. We will answer your questions. We will file a grievance with you. A separate team will review your request. We will send you a letter that shares the results of that review. If you are still not happy, that letter will give you instructions on next steps. You may also call the PathWays program help line at 1-877-284-9294 for help filing a just cause request.

Redetermination

To continue receiving health coverage, you must renew your benefits. This is called a redetermination. You must renew your coverage every year. Prior to your health coverage ending, a letter will be mailed to you from FSSA. The letter is called a "Notice of Renewal." Be sure to carefully read the directions that come with your renewal form. You may have to sign the form and return it with some information. Contact the DFR to ask questions. It can take about 45 days to complete your redetermination process.

You will receive a notice from the DFR and UnitedHealthcare to remind you about redetermination. We can answer questions about the redetermination process. It is important to keep your address and phone number updated so you receive notices. If your phone number or address changes, contact the DFR. The phone number for the DFR is 1-800-403-0864.

Moving to Medicare

If you become eligible for Medicare, you will automatically be enrolled into a UnitedHealthcare Dual Special Needs Plan (D-SNP) for your Medicare benefits. You will be sent a notification in writing at least 60 days prior to your Medicare Part A and B effective date. This includes if you are over age 65 or have a disability.

Your PathWays coverage will not change due to enrollment in UnitedHealthcare D-SNP for your Medicare benefits. You will not have to do anything unless you do not want to be automatically enrolled in that plan.

UnitedHealthcare D-SNP is a Medicare Advantage health plan that includes prescription drug coverage and other supplemental benefits. Enrolling in the UHC dual special needs plan will allow us to coordinate all of your Medicare and PathWays benefits, including your hospital, medical, prescription drug, and long-term care needs. You will be eligible for UnitedHealthcare D-SNP as long as you have both Medicare and Medicaid coverage and continue to live within the approved plan service area. You can decide to join a different Medicare plan or Original Medicare if you do not want to get your Medicare benefits through UnitedHealthcare D-SNP.

It's important to find a plan that covers your doctor visits and prescription drugs.

You can get help comparing your plan choices if you:

- **Call the Indiana State Health Insurance Assistance Program (SHIP) at 1-800-452-4800.** Representatives provide free, personalized health insurance counseling. SHIP counselors are not affiliated with any health plan.
- **Visit Medicare.gov.** Medicare's web site has tools that can help you compare plans and answer your questions. **Click** "Find health & drug plans" to compare plans in your area.
- **Call 1-800-MEDICARE (1-800-633-4227).** Tell them you got a letter saying you have Medicaid now and are going to be eligible for Medicare. Say that you want help with your Medicare choices. This toll-free help line is available 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **Refer to your Medicare & You Handbook** for a list of all Medicare health and prescription drug plans in your area. If you want to join one of these plans, you can call the plan to get information about their costs, rules, and coverage.

Member rights and responsibilities

Member rights

As a member, you have the **right** to:

- Be treated with dignity and respect when getting health services
- Be given information on your medical benefits and plan information
- Be given privacy for you and your medical records
- Be given easy-to-understand explanations of your medical problems and treatment choices
- Stay involved in decisions about your treatment choices
- Get care 24 hours a day, seven days a week
- Get prompt answers to your complaints or appeals
- Appeal decisions made about health care you receive
- Use buildings and services that meet the standards of the Americans with Disabilities Act (ADA) — This means that persons with disabilities or physical problems can get into medical buildings and use important services.
- Get a second opinion from a different doctor
- Request and receive a copy of your medical records and request that they be changed or corrected
- Say no to treatment or therapy — If you say no, the health care provider or health plan must talk to you about what could happen, and a note must be in your medical record about the treatment refusal.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, per federal regulations — This means a doctor cannot make you do something you do not want to do. The doctor cannot try to get back at you for something that you may have done.
- Be free from any restrictions on freedom of choice among network providers
- Receive information on available treatment options and alternatives, presented in a way that is right for your condition and that you can understand

Members receiving HCBS also have the right to:

- Have and review your service plan and care plan
- Request a fair hearing if you are:
  - Not given the choice of home and community-based waiver services that allow you to live in the setting of your choice (for example, a private home instead of a long-term care facility)
  - Denied the services or providers that you choose, or whose services were denied, suspended, reduced, or stopped

Member responsibilities

As a member, you have the **responsibility** to:

- Tell your providers about your medical conditions to the best of your ability
- Call your personal doctor (PMP) for all your medical care
- Keep all your appointments — If you cannot keep an appointment, call to cancel or reschedule as soon as you can.
- Tell your doctor if you do not understand what they tell you about your condition, care, or what you need to do
- Get all childhood shots for your children
- Call your doctor if you are not sure you are having a true emergency
- Follow the rules of your provider's office

Grievances and appeals

Inquiry

When you first talk to someone and ask a question or voice a concern, we call that an inquiry. We will resolve your inquiry by the end of the next business day after we receive it. If an inquiry is not resolved in this time frame, it becomes a grievance (also known as a complaint). You may also tell us right away that you have a complaint. You do not have to wait a day to file it.

Grievance

If you have a problem or complaint about UnitedHealthcare Community Plan, ask your MSN or Care Coordinator for help. If they are able to help you, your complaint will be considered resolved. In that case, you will not get any other notice. This is called an inquiry. We must resolve your inquiries by the close of the next business day after we receive them. If an inquiry is not resolved in this time frame, it becomes a grievance.

Other plan details

If you have a complaint or problem with the care you are getting, you can file a grievance with UnitedHealthcare. A grievance can be a written letter, filed online, or a phone call. A grievance can be filed at any time after a problem happens. Your MSN or Care Coordinator can submit a grievance for you. If your provider or authorized representative has your written permission, they can file a grievance on your behalf. You can also call the Ombudsman for help.

You can first talk to your doctor or provider if you have any questions or concerns about your care. They can work with you on fixing the problem. If the problem isn't fixed, you can call us.

You may file a grievance over the phone with Member Services at **1-800-832-4643**, TTY **711**. All members can file a grievance through this process.

You may file grievances online at **member.uhc.com/CommunityPlan**.

You may also file a written grievance by sending it to:

UnitedHealthcare Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

Grievance process

- You can file grievance at any time. We will send an acknowledgment letter within three business days after we receive your grievance.
- The grievance will be reviewed quickly. UnitedHealthcare will decide within 30 calendar days of receipt and notify you in writing within five business days of our decision. This is called a standard grievance.
- If your grievance is a result of a health crisis, please request an expedited (rush) review. Your grievance will be reviewed within 48 hours. If it will be reviewed as expedited, we will try to contact you by phone so that you know the outcome.
- If your request to rush the grievance will not be accepted as expedited, it becomes a standard grievance. We will let you know verbally and in writing within two days of your request that it will be reviewed as a standard grievance.
- If you or UnitedHealthcare needs more time to get or submit information from other places, the grievance process may take up to 14 calendar days longer. If we need more information, we will give you written notice of the reason for the delay.
- Once a decision has been made, we will mail you a letter. We send that letter in your primary language and/or other format.

You have the right to ask questions about the decision letter. You can also file an appeal with UnitedHealthcare. The appeal can be submitted by written letter, online, or by phone. Member Services or your Care Coordinator can submit an appeal for you.

Appeals

If you disagree with any action that denies or delays your care, you can file an appeal. An appeal is asking for a review because you do not agree with a decision the state or UnitedHealthcare has made. You have the right to file an appeal if you disagree with the decision. If your provider or authorized representative has your written permission, they can file an appeal on your behalf. You can also call the Ombudsman for help. You do not have to pay to file an appeal. You can also appeal if Medicaid or your plan stops providing or paying for all or part of a health care service, supply, or prescription drug you think you still need.

- If you have only PathWays (Medicaid) coverage, or your Medicare coverage is also through UnitedHealthcare, you can file one appeal. You can appeal in writing, online, or over the phone by calling Member Services.
- If your Medicare coverage is not through UnitedHealthcare, you may need to file two appeals. We are here to help you work through this appeal process.
- When filing an appeal, you will continue to get any services you were already getting as long as you, or your provider with your written consent, file the appeal within 10 days of when our letter was mailed or the date the change would be effective. You must file an appeal within 60 calendar days from the date of the Notice of Adverse Benefit Determination letter. If the appeal is not decided in your favor, you may have to pay for the services you received during the appeal process.

You may file an appeal over the phone with Member Services at **1-800-832-4643**, TTY **711**. All members can file an appeal through this process.

You may file appeals online at **member.uhc.com/CommunityPlan**.

You may also file a written appeal by sending it to:

UnitedHealthcare Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

When UnitedHealthcare Community Plan gets your appeal, we will send you a letter within three business days telling you that we received your appeal.

UnitedHealthcare will decide within 30 calendar days of receipt and notify you in writing within five business days of our decision. This is called a standard appeal.

If you need your appeal reviewed more quickly, you can request an expedited (rush) appeal and will get an answer back from us within 48 hours. If it will be reviewed as expedited, we will try to contact you by phone so that you know the outcome. If your request to rush the appeal will not be reviewed as accepted as expedited, it becomes a standard appeal. We will notify you verbally and in writing within two days of your expedited request. A standard appeal will be reviewed within 30 calendar days.

If you or UnitedHealthcare need more time to get or submit information from other places, the appeal process may take up to 14 calendar days longer. If we need more information, we will give you written notice of the reason for the delay.

State Fair Hearing

Once a decision is made on your appeal, a Notice of Appeal Resolution letter will be sent to you. This letter will tell you the reason for the decision. If you feel the decision is not correct, you or your authorized representative, with your written consent, may request a State Fair Hearing. You can write a letter telling the state why you think a decision is wrong. Please make sure to also include your name and other important information, like the date of the decision, which is on the letter. You may submit your appeal in these ways:

Mail: Office of Administrative Law Proceedings – FSSA Hearings
402 W. Washington St., Room E034
Indianapolis, IN 46204

Fax: 317-232-4412

Email: **fssa.appeals@oalp.in.gov**

Appeals about eligibility decisions can be sent to the local DFR office. To find a DFR office near you, go to **in.gov/fssa/dfr**.

If you file an appeal to the state, you must do it within 120 calendar days from the date on the Notice of Appeal Resolution. Your services will **not** continue automatically during a **State Fair Hearing**. If you want your services to continue during a State Fair Hearing, you make this request within 10 (ten) calendar days from the date of the Notice of Appeal Resolution letter. If the State Fair Hearing is not decided in your favor, you may have to pay for the services you received during the State Fair Hearing.

At your appeal hearing, you can speak for yourself or have help or representation from legal counsel, a friend, a relative, or someone you trust to speak on your behalf. You will be shown your entire medical case file. You will be shown all materials used by FSSA, your county office, the provider, or UnitedHealthcare that relate to your appeal and used to make the original decision.

External Review by an Independent Review Organization

If you do not agree with the appeal decision, you may also request an External Review by an Independent Review Organization (IRO). You or your authorized representative must request the IRO review in writing within 120 calendar days of receiving your appeal decision letter. Your services will **not** continue automatically during an **External Review** by an Independent Review Organization (IRO). You must tell us if you want to continue your services during the external review process. The IRO will be conducted at no cost to you. The IRO will decide within 72 hours for expedited appeals and 15 business days for standard appeals. The decision by the IRO is binding, meaning we must obey their decision. To request the External Review by an Independent Review Organization, contact Member Services at **1-800-832-4643**, TTY **711**.

You may ask for an external review by writing a letter to:

UnitedHealthcare Community Plan
Attn: Indiana Grievance and Appeal Manager
P.O. Box 31364
Salt Lake City, UT 84131-0364

Information to include when requesting an External Review:

- Name
- Member ID number
- Phone number where you can be reached
- Reason for your appeal
- Any information you feel is important to your appeal request (examples include documents, medical records, or provider letters)

Quality

Your health and well-being, and your experience and satisfaction with Indiana PathWays for Aging are important to us. Our Quality Program helps to keep you healthy while receiving services in the setting of your choice.

Some of the ways we help are by:

- Developing service plans and delivering services, including input from you and your friends and family about your care
- Helping you when you need to move settings, like from the hospital to home or when you need to see new doctors

- Making sure you have the services you need to live safely and happily in the setting of your choice
- Having committees that you or your family and friends may join to help us understand your needs and improve the quality of your care
- Sending surveys to help us understand how to serve your family and friends better
- Listening and responding to your complaints — See the **Grievances and appeals** section of this handbook for information about filing a complaint.
- Understanding your specific needs or things that are important to keep you healthy and safe
- Understanding your specific cultural needs and working to make sure you receive information in the language or manner of your choice
- Learning about you so that you receive services in the setting of your choice while considering things like language, lifestyles, values, beliefs, and attitudes
- Helping you and reminding you to get important services, like annual visits, dental visits, eye exams, tobacco cessation aids, and immunizations — See the **Why we contact you** section of this handbook for more information.
- Rewarding you when you do things to keep yourself healthy — See the **Member Rewards** section of this handbook for more information on how these rewards work.

You can get information about the quality of health care providers by using these links below:

Medicaid

US Department of Health & Human Services: **hhs.gov**

Centers for Medicare & Medicaid Services: **cms.gov**

Hospitals

Indiana Hospital Association: **ihaconnect.org**

The Joint Commission: **jointcommission.org**

Leapfrog Hospital Safety Grade: **hospitalsafetygrade.org**

mycareINsight: **mycareinsight.org**

Providers

Healthgrades: **healthgrades.com**

American Osteopathic Association: **osteopathic.org**

Health equity program

Health equity is when people of all races, genders, locations, and life choices are able to live their healthiest lives. Equity is about fairness. It is working toward fair outcomes for everyone and their own needs. It is also removing any barriers to opportunities, resources, and health care.

To make sure we are fair to all members:

- We have a workgroup about Health Equity. The Health Equity and Cultural Competency Workgroup includes our members so we can learn about their unique needs.
- We use the culturally and linguistically appropriate services (CLAS) enhanced standards from the Department of Health and Human Services. CLAS is a way to improve the quality of services provided to all members to have health equity. CLAS is about respect and meeting our members' unique needs.
- We ensure our members receive information in the language or manner of their choice
- We provide services to people of all cultures, races, ethnic backgrounds, national origins, locations, sexual orientations, gender identities, abilities, and religions in a manner that respects the individual and protects and preserves the dignity of each person
- We train our staff and people who help us about Health Equity to serve our members fairly
- We use Community Health Workers for culturally competent care

Fraud, waste, and abuse

Fraud, waste, and abuse means breaking the rules for a personal gain. Fraud can be committed by providers, pharmacies, or members. Examples of provider fraud, waste, and abuse include doctors or other health care providers who:

- Prescribe medicine, equipment, or services that are not medically necessary
- Don't provide patients with medically necessary services due to lower reimbursement rates
- Bill for tests or services that were not provided
- Use wrong medical coding on purpose to get more money
- Schedule more frequent return visits than are medically necessary
- Bill for more expensive services than provided
- Prevent members from getting covered services, resulting in underutilization of services

Examples of pharmacy fraud, waste, and abuse include:

- Not dispensing drugs as written
- Submitting claims for an expensive brand-name drug but giving a generic drug that costs less
- Dispensing less than the prescribed quantity and then not letting the member know how to get the rest of the drug

Examples of member fraud, waste, and abuse include:

- Inappropriately using services, such as selling prescribed narcotics or trying to get controlled substances from more than one provider or pharmacy
- Changing or forging prescriptions
- Using medications you do not need
- Sharing your ID card with another person
- Not disclosing that you have other health insurance coverage
- Getting unnecessary equipment and supplies
- Receiving services or medicines under another person's ID (identity theft)
- Giving wrong symptoms and other information to providers to get treatment, drugs, etc.
- Visiting the ER repeatedly for problems that are not emergencies

Medicaid members who are proven to have abused or misused their covered benefits may:

- Be required to pay back any money we paid for services that were determined to be a misuse of benefits
- Be prosecuted for a crime and go to jail
- Lose their Medicaid benefits

Reporting fraud, waste, or abuse

If you think your doctor, pharmacy, or a member is committing fraud, waste, or abuse, you must tell us. You can call our fraud reporting line, send an email, or fill out and mail a form. See below for those contact details. You do not have to tell anyone your name if you call or write. If you do not give your personal information, we will not be able to call for other information. Do not send any sensitive personal information through email. Your report will be kept confidential to the extent allowed by law.

Fraud reporting lines

Call toll-free:	1-800-403-0864, 8:00 a.m.–4:30 p.m. Monday–Friday Select option 5. When prompted, enter your ZIP code.
Fax:	317-234-2244
Email:	**ReportFraud@fssa.IN.gov**
Fraud reporting mailing address:	FSSA Compliance Division Room E-414 402 W. Washington Street Indianapolis, IN 46204
UnitedHealthcare fraud hotline:	**1-844-359-7736**
For more information, visit:	**uhc.com/fraud**

Estate recovery

Estate recovery will be managed solely by the Indiana Division of Family Resources (DFR). Contact DFR if you have questions about information you receive by mail or phone about estate recovery.

Other requests you can make

Make a suggestion or ask a question

We are always interested in what you have to say. If you want to recommend a change to a service, program, or health plan procedure, let us know. We will also answer questions you have about how we operate. You can:

- Contact us by phone or online. Our contact information is shown on the bottom of this page.
- Send an email to **IN_HPops@uhc.com**. We will get it to the right person and will answer within one business day.
- Write a letter and send it to:

  UnitedHealthcare Community Plan
  7440 Woodland Drive
  Indianapolis, IN 46278

Culturally competent services

Culturally competent care is having knowledge and skills for positive outcomes. This includes language, lifestyles, values, beliefs, and attitudes. You may ask for culturally sensitive, translated materials or printed materials in other formats. They will be provided at no cost to you.

Provider incentive program

Your PMP participates in a program that encourages them to see our members. It focuses on making sure you receive the care you need. If you would like to receive more details about this program, contact us. You can:

- Contact us by phone or online. Our contact information is shown on the bottom of this page.
- Send an email to **IN_HPops@uhc.com**. We will get it to the right person and will answer within one business day.
- Write a letter and send it to:

  UnitedHealthcare Community Plan
  Attn: PathWays
  7440 Woodland Drive
  Indianapolis, IN 46278

Privacy notices

This notice describes how health information about you may be legally used and shared. If your information is used, we must follow all state and federal rules. You have the right to know what was shared.

Choices

You can choose what information we share and with whom we share it. You may have to give written permission to share.

If you can't choose, such as while being unconscious, UnitedHealthcare may share information if they believe it to be in your best interest.

We may not be able to share your information with others unless you give written consent. These may be people, like a family member or close friend, who pay for your care.

Uses

We use your information for different things. We use it to help get you better care, to do research, and to follow the law.

Rights

You have rights as an IHCP member. UnitedHealthcare must follow rules about your rights. Your rights include the ability to:

- Get a copy of your health and claims records
- Ask to fix your health and claims records if you think they are wrong or not complete
- Ask for private communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Give us consent to speak to someone on your behalf
- File a complaint if you feel your rights are violated
- You can file a complaint with the U.S. Department of Health and Human Services (DHSS) Office for Civil Rights by:
  - Sending a letter to:
    DHSS Office of Civil Rights
    200 Independence Avenue SW
    Washington, DC 20201
  - Calling: **1-877-696-6775**
  - Visiting the DHSS website at **hhs.gov/ocr**

Responsibilities

Your information is protected in many ways. This includes your information that is written, spoken, or available online. UnitedHealthcare is trained on how to protect your information. Very few people can access your information. We are required by law to keep the privacy and security of your health information. If a breach occurs, we will let you know quickly.

We must follow the duties and privacy practices described in this notice. We must give you a copy of it. We will not use or share your information other than as listed here unless you tell us, in writing, that we can.

You may change your mind at any time. Let us know in writing if you change your mind.

Definitions

Advance Directives or Living Will — A written explanation of a person's wishes about medical treatments. This often is called a Living Will. This makes sure wishes are done if a person cannot tell a provider.

Annual Physical — Visits to a PMP each year to check your health. This is often referred to as a wellness visit, preventive health exam, or checkup.

Appeal — A written or verbal request for a decision to be reversed.

Benefit — Health care service coverage that a Medicaid member receives for the treatment of illness, injury, or other conditions allowed by the state.

Care Coordinator — A person who may contact you to create a personalized care plan based on your preferences and needs. They can also help answer questions about your health care and help you with your providers.

Continuity of Care — A time span when your old benefits and coverage will be honored by the PathWays program.

Covered Service — Mandatory medical services required by CMS and optional medical services approved by the state that are paid for by Medicaid. Examples of covered services are prescription drug coverage and physician office visits.

Division of Family Resources (DFR) — An Indiana State agency that is responsible for establishing eligibility for Medicaid, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families benefits.

Eligible Member — A person certified by the state as eligible for medical assistance.

Explanation of Benefits (EOB) — An explanation of services given by your provider and any payments made toward those expenses.

Family and Social Services Administration (FSSA) — An agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.

Grievance — A complaint about UnitedHealthcare or our providers.

Health Assessment — A set of questions that ask about your personal behaviors, life-changing events, health goals and priorities, service coordination, and overall health. Your health plan will use health assessments to create a personalized care plan based on your preferences and needs.

Health Needs Screening (HNS) — A questionnaire members must complete so we are aware of any health conditions; this allows us to match you with the right programs and services.

Health Plan — A health insurance company. Physicians, hospitals, and other health care providers, including waiver providers, enroll with a health plan to provide care for members. The State of Indiana partners with the UnitedHealthcare health plan for its Indiana PathWays for Aging program.

Indiana Health Coverage Programs (IHCP) — The name used to describe all of Indiana's public health assistance programs, such as Medicaid, PathWays, and TANF.

Member Service Navigator (Navigator) — A person who is part of the Member Services call center team. Navigators can answer most questions about PathWays coverage and benefits.

Network — When a doctor, hospital, or other provider accepts your health insurance plan, that means they are in our network. We also call them participating providers.

Managed Care Entity (MCE) — Organizations or health plans that oversee the overall care of a patient to ensure cost-efficient, quality health care for its members.

Medicaid Identification Number — The unique number assigned to a member who is eligible for Medicaid services; this number can be found on the front of your member ID card.

Medically Necessary — Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Primary Medical Provider (PMP) — A physician or advanced practice nurse who is your main doctor. Your PMP reviews your entire medical record to understand your health status. This includes understanding the care your receive from any specialists.

Prior Authorization (PA) — An approval needed for the delivery of certain services. The medical services contractor and state medical consultants review PAs for medical necessity, reasonableness, and other criteria. The PA must be obtained before the service for benefits that are provided within a certain time period, except in certain allowed instances.

Service Coordinator — A person who will work with you to create a personalized Service Plan to help coordinate your Home and Community-Based Services (HCBS). The Service Plan will help develop a plan of care of services and supports that best meet your needs and goals.

Other plan details

Service Plan — A support plan, developed by a Service Coordinator, for assisting you in gaining access to long-term care services, as well as medical, social, housing, educational, and other supports. Not everyone in PathWays will need a service plan.

Social Needs — A daily life need, like food, housing, clothing, transportation, safety, education, or employment. We help you find resources where you live to help with these needs.

Well Visit — An annual check-up with your PMP.

Discrimination is against the law. UnitedHealthcare Community Plan of Indiana complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, religion, or sex.

UnitedHealthcare Community Plan of Indiana provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

UnitedHealthcare Community Plan of Indiana provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call Member Services at **1-800-832-4643**, TTY **711**, 8 a.m.–8 p.m. EST, Monday–Friday.

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by **UnitedHealthcare Community Plan of Indiana**. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Email: **UHC_Civil_Rights@uhc.com**

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

Online: **hhs.gov/civil-rights/filing-a-complaint/index.html**

By mail: U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

By phone: **1-800-368-1019** (TDD **1-800-537-7697**)

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ATTENTION: If you speak English language assistance services, free of charge, are available to you. Call **1-800-832-4643, TTY 711.**

ATENCIÓN: Si habla español (Spanish), tiene a su disposición servicios de asistencia gratuitos en su idioma. Llame al **1-800-832-4643, TTY 711.**

注意：如果您說中文 (Chinese)，您可獲得免費語言協助服務。請致電 **1-800-832-4643，聽障專線 (TTY) 711。**

HINWEIS: Wenn du Deutsch (German) sprichst, stehen dir kostenlose Sprachdienste zur Verfügung. Anrufe unter **1-800-832-4643, TTY 711.**

Attention: Vann du Pennsylvania Deitsh (Pennsylvania Dutch) shvetsht, dann kansht du hilf greeya funn ebbah es deitsh shvetzt, un's kosht dich nix. **Call 1-800-832-4643, TTY 711.**

သတိမူရန်- သင်သည် မြန်မာ (Burmese) စကားပြောတတ်လျှင်၊ ဘာသာစကားအကူအညီအား အခမဲ့ရယူနိုင်ပါသည်။ ခေါ်ဆိုရန် **1-800-832-4643, TTY 711.**

تنبيه: إذا كنت تتحدث العربية (Arabic)، فتتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم **1-800-383-2464، الهاتف النصي TTY 711.**

참고: 한국어(Korean)를 구사하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-800-832-4643(TTY는 711)번으로 문의하십시오.**

LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-800-832-4643, TTY 711.**

ATTENTION : si vous parlez français (French), vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-800-832-4643, TTY 711.**

注意：日本語 (Japanese) をお話しになる場合は、言語支援サービスを無料でご利用いただけます。電話番号 **1-800-832-4643、または TTY 711 までご連絡ください。**

LET OP: Als u Nederlands (Dutch) spreekt, kunt u gratis gebruikmaken van taalhulpdiensten. Bel **1-800-832-4643, TTY 711.**

ATENSYON: Kung nagsasalita ka ng Tagalog (Tagalog), may magagamit kang mga serbisyo na pantulong sa wika na walang bayad. Tumawag sa **1-800-832-4643, TTY 711.**

ВНИМАНИЕ: Если Вы говорите по-русски (Russian), Вы можете бесплатно воспользоваться помощью переводчика. Позвоните: **1-800-832-4643, TTY 711.**

ਸਾਵਧਾਨ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। **1-800-832-4643, TTY 711 ਤੇ ਕਾਲ ਕਰੋ।**

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-832-4643, TTY 711** पर कॉल करें।

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, 2024

By law, we[1] must protect the privacy of your health information ("HI"). We must send you this notice. It tells you:

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

By law, we must follow the terms of this 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. We will notify you of a breach of your HI.

How we collect, use, and share your information

We collect, use, and share your HI with:

- You or your legal 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. This may include coordinating benefits.
- **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 your 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 underwriting decisions. We will not use your genetic HI 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, health care or payments.

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 protective services.
- **For Workers' Compensation.** If you were hurt at work or to comply with labor 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 to identify the person who died, why they died, or to meet certain law. We also may give HI to funeral directors.
- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissue.

- **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 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.

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

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

[1] This Medical Information Notice of Privacy Practices applies to 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, 2024

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information we collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and security

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

Questions about this notice

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

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to 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**.

We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-832-4643**, TTY **711**. You can also visit our website at **uhc.com/communityplan/indiana** or **myuhc.com/CommunityPlan**.

UnitedHealthcare Community Plan
Attn: PathWays
2955 N. Meridian Street, Suite 401
Indianapolis, IN 46208

uhc.com/communityplan/indiana
or **myuhc.com/CommunityPlan**

1-800-832-4643, TTY **711**

United Healthcare
Community Plan

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