New York

Welcome to the community

Health and Recovery Plan Member Handbook
Wellness4Me

2021

United Healthcare Community Plan

CSNY20MC4888422_000

United Healthcare Community Plan

NOTICE OF NON-DISCRIMINATION

UnitedHealthcare Community Plan complies with Federal civil rights laws. UnitedHealthcare Community Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UnitedHealthcare Community Plan provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the toll-free member phone number listed on your member ID card.

If you believe that UnitedHealthcare Community Plan has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Civil Rights Coordinator by:

Mail:	Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UTAH 84130
Email:	**UHC_Civil_Rights@uhc.com**
Phone:	**1-866-433-3413**, TTY **711**

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

Web:	Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
Mail:	U.S. Dept. of Health and Human Services 200 Independence Avenue SW, Room 509F, HHH Building Washington, D.C. 20201
Phone:	Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at **1-866-433-3413**, TTY **711**, 24 hours a day, 7 days a week.

LANGUAGE ASSISTANCE

ATTENTION: Language assistance English services, free of charge, are available to you. Call 1-866-433-3413 TTY 711

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-433-3413 TTY 711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-433-3413 TTY 711.	Spanish/Español
注意：您可以免費獲得語言援助服務。請致電 1-866-433-3413 TTY 711。	Chinese/中文
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-433-3413 رقم هاتف الصم والبكم TTY 711	Arabic/اللغة العربية
주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-866-433-3413 TTY 711로 전화하시기 바랍니다.	Korean/한국어
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-433-3413 (телетайп: TTY 711).	Russian/Русский
ATTENZIONE: Nel caso in cui la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il 1-866-433-3413 TTY 711.	Italian/Italiano
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-433-3413 TTY 711.	French/Français
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-433-3413 TTY 711.	French Creole/ Kreyòl ki soti nan Fransè
אכטונג: אויב איר רעדט אידיש, זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-866-433-3413 TTY 711	Yiddish/אידיש
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-433-3413.	Polish/Polski
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyong pantulong sa wika nang walang bayad. Tumawag sa 1-866-433-3413 TTY 711	Tagalog
দৃষ্টি আকর্ষণ: যদি আপনার ভাষা "Bengali বাংলা" হয় তাহলে আপনি বিনামূল্যে ভাষা সহায়তা পাবেন। 1-866-433-3413 TTY 711 নম্বরে ফোন করুন।	Bengali/বাংলা
KUJDES: Ju vendosen në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-433-3413.	Albanian/Shqip
Προσοχή: Στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε «1-866-433-3413» TTY 711.	Greek/ Ελληνικά
توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان سے متعلق مدد کی خدمات مفت دستیاب ہیں۔ کال کریں 1-866-433-3413 TTY 711.	Urdu/اردو

Important phone numbers

Member Services Department	**1-866-433-3413**
(open 24 hours a day, 7 days a week)	
TDD/TTY (for the hearing impaired)	**711**
Your Primary Care Physician:	See Your UnitedHealthcare Community Plan ID Card
NurseLine	**1-877-597-7801**
Prior Authorization Department	**1-866-604-3267**
Pharmacy Department	**1-800-310-6826**
New York State Department of Health's Home	**1-518-473-5569**
Behavioral Health Services	**1-800-493-4647**
New York State Department of Health (Complaints)	**1-800-206-8125**
New York Medicaid CHOICE	**1-800-505-5678**
New York State Growing Up Healthy Hotline	**1-800-522-5006**
Domestic Violence Hotline	
English	**1-800-942-6906**
Spanish	**1-800-942-6908**
Hearing Impaired	**1-800-810-7444**
NYS HIV/AIDS Hotline	
English	**1-800-541-AIDS (2437)**
Spanish	**1-800-233-SIDA (7432)**
TDD	**1-800-369-AIDS (2437)**
New York State Fair Hearing	**1-800-342-3334**
New York State Department of Financial Services	**1-800-342-3736**
Upstate County Departments of Social Services:	
Albany County Department of Social Services	**1-518-447-7300**
Broome County Department of Social Services	**1-607-778-2669**
Cayuga County Department of Social Services	**1-315-253-1011**
Chautauqua County Department of Social Services	**1-716-661-8200**
Chemung County Department of Social Services	**1-607-737-5309**
Chenango County Department of Social Services	**1-607-337-1500**
Clinton County Department of Social Services	**1-518-565-3222**
Columbia County Department of Social Services	**1-518-828-9411**
Dutchess County Department of Social Services	**1-845-486-3000**
Erie County Department of Social Services	**1-716-858-8000**
Essex County Department of Social Services	**1-518-873-3450**
Franklin County Department of Social Services	**1-518-483-6770**

Upstate County Departments of Social Services (continued)**:**

Fulton County Department of Social Services	**1-518-736-5640**
Genesee County Department of Social Services	**1-585-344-2580**
Greene County Department of Social Services	**1-518-943-3200**
Herkimer County Department of Social Services	**1-315-867-1291**
Jefferson County Department of Social Services	**1-315-782-9030**
Lewis County Department of Social Services	**1-315-376-5105**
Livingston County Department of Social Services	**1-585-243-7300**
Madison County Department of Social Services	**1-315-366-2211**
Monroe County Department of Social Services	**1-585-753-2740**
Niagara County Department of Social Services	**1-716-439-7600**
Oneida County Department of Social Services	**1-315-798-5632**
Onondaga County Department of Social Services	**1-315-435-2928**
Ontario County Department of Social Services	**1-585-396-4060**
Orange County Department of Social Services	**1-845-291-4000**
Orleans County Department of Social Services	**1-585-589-7000**
Oswego County Department of Social Services	**1-315-963-5000**
Rensselaer County Department of Social Services	**1-518-270-3928**
Rockland County Department of Social Services	**1-845-364-2000**
Seneca County Department of Social Services	**1-315-539-1865**
Schenectady County Department of Social Services	**1-518-388-4470**
St. Lawrence County Department of Social Services	**1-315-379-2276**
Tioga County Department of Social Services	**1-877-882-8313**
Ulster County Department of Social Services	**1-845-334-5000**
Warren County Department of Social Services	**1-518-761-6300**
Wayne County Department of Social Services	**1-315-946-4881**
Westchester County Department of Social Services	**1-800-549-7650**
Wyoming County Department of Social Services	**1-585-786-8900**
Yates County Department of Social Services	**1-315-536-5183**

New York City and Long Island:

Nassau County Department of Social Services	**1-516-227-8000**
New York City Human Resources Administration	**1-718-557-1399**
New York City Human Resources Administration (within the 5 boroughs)	**1-877-472-8411**
Suffolk County Department of Social Services (Hauppauge)	**1-631-853-8730**
Suffolk County Department of Social Services (Riverhead)	**1-631-852-3710**
Suffolk County Department of Social Services (Ronkonkoma)	**1-631-854-9700**

Other helpful resources

Office on Addiction Services and Supports (OASAS): https://oasas.ny.gov/
To make a program complaint, call **1-800-553-5790**.
For counselor complaints, call **1-800-482-9564**, Option **5**.

Office of Children and Family Services (OCFS): http://ocfs.ny.gov/main/

Office of Mental Health (OMH): https://www.omh.ny.gov/omhweb/about/
To make a complaint, call OMH Customer Relations toll-free at **1-800-597-8481**.

Office for People with Developmental Disabilities (OPWDD): https://www.opwdd.ny.gov

Independent Consumer Advocacy Network (ICAN): www.icannys.org
Phone: **1-844-614-8800** (TTY Relay Service: **711**)
Email: **ican@cssny.org**

CHAMP New York State's Community Health Access to Addiction & Mental Healthcare Project:
Phone: **1-888-614-5400**
Email: **Ombuds@oasas.ny.gov**

Website myuhc.com/CommunityPlan

Other health provider(s)

Your PCP:_____ Phone:_____

Your nearest emergency room:_____ Phone:_____

Local pharmacy:_____ Phone:_____

Table of contents

Welcome to UnitedHealthcare Community Plan Health and Recovery Plan

We are glad that you enrolled in UnitedHealthcare Community Plan. UnitedHealthcare Community Plan is a Health and Recovery Plan, or HARP, approved by New York State. HARPs are a new kind of plan that provide Medicaid members with their health care, plus care for behavioral health. In this handbook, behavioral health means mental health, substance use disorder and rehabilitation.

We are a special health care plan with providers who have a lot of experience treating persons who may need mental health and/or substance use care to stay healthy. We also provide care management services to help you and your health care team to work together to keep you as healthy as possible.

This handbook will be your guide to the full range of health care services available to you.

You are eligible to join this plan if you live in the following New York State counties:

Albany, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Oswego, Rensselaer, Rockland, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester and Wyoming counties; and New York City including Bronx, Kings, Queens, Richmond and New York counties

We want to be sure you get off to a good start as a new member of UnitedHealthcare Community Plan. In order to get to know you better, we will get in touch with you in the next two weeks. You can ask us any questions you have, or get help making appointments. If you want to speak with us sooner, just call us at **1-866-433-3413**, TTY **711**. You can also visit our website at **myuhc.com/CommunityPlan** to get more information about UnitedHealthcare Community Plan.

How health and recovery plans work

The plan, our providers, and you

You may have seen or heard about the changes in health care. Many consumers get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now those services may be available through UnitedHealthcare Community Plan.

As a member of UnitedHealthcare Community Plan, you will have all the benefits available in regular Medicaid, plus you can also get specialty services to help you reach your health goals. We offer extended services to help you get and stay healthy, and help with your recovery.

UnitedHealthcare Community Plan offers new services, called Behavioral Health Home and Community Based Services (BHHCBS), to members who qualify.

BHHCBS may help you:

- Find housing
- Live independently
- Return to school
- Find a job
- Get help from people who have been there
- Manage stress
- Prevent crises

As a member of UnitedHealthcare Community Plan, you will also have the opportunity to enroll in a Health Home and meet with a Care Manager who will work with all your physical and behavioral health providers to pay special attention to your whole health care needs. The Health Home Care Manager will help make sure you get the medical, behavioral health and social services you may need, such as help to get housing and food assistance.

You may be using your Medicaid card to get a service that is now available through UnitedHealthcare Community Plan. To find out if a service you already get is now provided by UnitedHealthcare Community Plan, contact Member Services at **1-866-433-3413**, TTY **711**.

You and your health care team will work together to make sure you enjoy the best physical and emotional health possible. You can get special services for healthy living, such as nutrition classes and help to stop smoking.

UnitedHealthcare Community Plan has a contract with the New York State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care, mental health and substance use providers to help us meet your needs. These doctors and specialists, hospitals, clinics, labs, case managers, and other health care facilities make up our **provider network**. You will find a list in our provider directory. If you do not have a provider directory, call Member Services at **1-866-433-3413**, TTY **711** to get a copy or visit our website at **myuhc.com/CommunityPlan**.

When you join UnitedHealthcare Community Plan, one of our providers will take care of you. Most of the time that person will be your **Primary Care Provider (PCP)**. You may want to choose a PCP from your mental health or substance use clinic. If you need to have a test, see another specialist, or go into the hospital, your Primary Care Provider will arrange it.

Your Primary Care Provider is available to you everyday, day and night. If you need to speak to him or her after-hours or weekends, leave a message and how you can be reached. Your Primary Care Provider will get back to you as soon as possible. Even though your Primary Care Provider is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 24 for details.

You may be restricted to certain plan providers if you are:

- Getting care from several doctors for the same problem
- Getting medical care more often than needed
- Using prescription medicine in a way that may be dangerous to your health
- Allowing someone other than yourself to use your plan ID card

Confidentiality

We respect your right to privacy. UnitedHealthcare Community Plan recognizes the trust needed between you, your family, your doctors and other care providers. UnitedHealthcare Community Plan will never give out your medical or behavioral health history without your written approval. The only persons that will have your clinical information will be UnitedHealthcare Community Plan, your Primary Care Provider, your Health Home Care Manager and other providers who give you care, and your authorized representative. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider and/or Health Home Care Manager. UnitedHealthcare Community Plan staff have been trained in keeping strict member confidentiality.

How to use this handbook

This handbook will tell you how your new health care plan will work and how you can get the most from UnitedHealthcare Community Plan. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time. When you have a question, check this handbook or call our Member Services unit at **1-866-433-3413**, TTY **711**. You can also call the New York Medicaid Choice Helpline at 1-800-505-5678.

You can call Member Services to get help **any time you have a question**. You may call us to choose or change your Primary Care Provider (PCP for short), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report that you are pregnant, the birth of a new baby or ask about any change that might affect your benefits.

We're proud to have you as a member of UnitedHealthcare Community Plan. We look forward to making your health care experience as easy as possible, **starting today**.

Our Member Advocates can answer questions you may have about benefits covered under your plan and help you choose a new PCP if you don't have one. We can even help you schedule a wellness visit with your doctor.

As a new Member, You will receive a call from one of our highly trained Member Advocates to welcome you to our plan. Our Member Advocates will be able to answer any questions you may have about your benefits and doctors available to you, as well as help you complete your Health Assessment.

What you need to know about your Health Assessment

- A Health Assessment is a short and easy survey that asks you simple questions about your lifestyle and health
- It helps us to get to know you better
- It helps you get the most from your health plan
- It helps us match you with the many benefits and services available to you
- Your answers are confidential
- They will not reduce your health care coverage in any way
- It takes just a few minutes to complete!

Miss our welcome call?

Our Member Advocates are available 8:00 a.m.–6:00 p.m., Monday–Friday. Just call **1-800-493-4647**, TTY **711**. We can answer any questions you may have and help you complete your Health Assessment in just a few minutes.

If you would like to meet with a UnitedHealthcare Representative in person to learn more about your health plan coverage. Please contact one of our local Community Offices to schedule an appointment to meet with a representative. We have 12 convenient community locations:

Bronx County

151 East Burns de Avenue
Bronx, NY 10453
Location hours:
9:30 a.m.–5:00 p.m., Monday–Friday

Jefferson County

237 State Street
Watertown, NY 13601
Location hours:
9:00 a.m.–4:00 p.m., Monday–Friday

Kings County

6402 8th Avenue, Suite 107
Brooklyn, NY 11220
Location hours:
9:00 a.m.–5:30 p.m., Monday–Friday

2343 86th Street
Brooklyn, NY 11220
Location hours:
9:00 a.m.–5:30 p.m., Monday–Friday

Nassau County

250 Fulton Avenue, Suite 121
Hempstead, NY 11550
Phone: 516-247-6352
Location hours:
9:00 a.m.–4:00 p.m., Monday–Friday

Niagara County

810 Portage Road
Niagara Falls, NY 14301
Phone: 716-285-8568
Location hours:
9:00 a.m.–4:30 p.m., Monday–Friday

New York County

161 Canal Street
New York, NY 10013
Location hours:
9:00 a.m.–5:30 p.m., Monday–Friday

27 East Broadway, 2nd Floor
New York, NY 10002
Location hours:
9:00 a.m.–5:30 p.m., Monday–Friday

558 W 181 Street
New York, NY 10033
Phone: 212-781-3960
Location hours:
10:00 a.m.–5:00 p.m., Monday–Friday

Onondaga County

7608 Oswego Road
Liverpool, NY 13090
Phone: 315-221-5114 or 315-221-5115
Location hours:
9:00 a.m.–4:00 p.m., Monday–Friday

Queens County

136-02 Roosevelt Avenue
Flushing, NY 11354
Location hours:
9:00 a.m.–5:30 p.m., Monday–Friday

Suffolk County

462 Suffolk Avenue
Brentwood, NY 11717
Phone: 631-231-0180 or 631-231-0181
Location hours:
9:00 a.m.–4:00 p.m., Monday–Friday

If you do not speak English, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can speak to you in your language.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:

- TTY/TDD machine (Our TTY phone number is TTY **711**)
- Information in large print
- Case Management
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

If you are getting care in your home now, your nurse or attendant may not know you have joined our plan. **Call us right away** to make sure your home care does not stop unexpectedly.

Help from Member Services

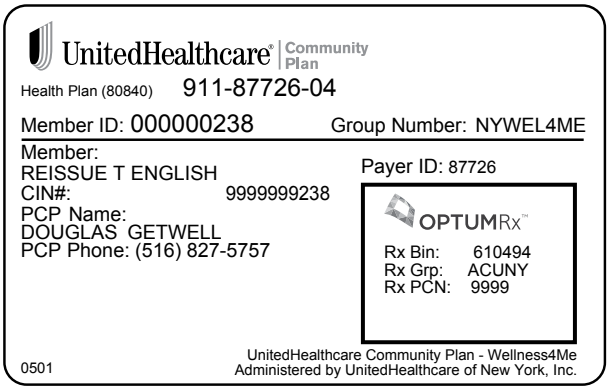
1-866-433-3413, TTY **711**

There is someone to help you at Member Services 24 hours a day, 7 days a week.
Call **1-866-433-3413**, TTY **711**.

Your health plan ID card

After you enroll, we will send you a **Welcome Letter**. Your UnitedHealthcare Community Plan ID card should arrive within 14 days after your enrollment date. Your card has your PCP's (Primary Care Provider's) name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong on your UnitedHealthcare Community Plan ID card, call us right away. Your ID card does not show that you have Medicaid or that UnitedHealthcare Community Plan is a special type of health plan.

Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your Welcome Letter is proof that you are a UnitedHealthcare Community Plan member. **You should also keep your Medicaid benefit card. You will need your Medicaid card to get services that UnitedHealthcare Community Plan does not cover.**


UnitedHealthcare® | Community Plan

Health Plan (80840) 911-87726-04

Member ID: 000000238 Group Number: NYWEL4ME

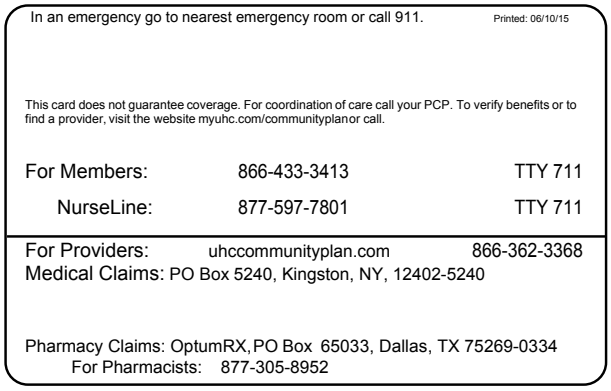
Member:
REISSUE T ENGLISH
CIN#: 9999999238
PCP Name:
DOUGLAS GETWELL
PCP Phone: (516) 827-5757

Payer ID: 87726

OPTUMRx™
Rx Bin: 610494
Rx Grp: ACUNY
Rx PCN: 9999

0501

UnitedHealthcare Community Plan - Wellness4Me
Administered by UnitedHealthcare of New York, Inc.


In an emergency go to nearest emergency room or call 911. Printed: 06/10/15

This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website myuhc.com/communityplanor call.

For Members: 866-433-3413 TTY 711
NurseLine: 877-597-7801 TTY 711

For Providers: uhccommunityplan.com 866-362-3368
Medical Claims: PO Box 5240, Kingston, NY, 12402-5240

Pharmacy Claims: OptumRX, PO Box 65033, Dallas, TX 75269-0334
For Pharmacists: 877-305-8952

Part I – First things you should know

How to choose your Primary Care Provider (PCP)

The primary care provider (PCP) listed on your member ID card is your assigned primary care provider.

What does this mean for you?

You will only be able to get primary care services from the PCP on your member ID card or another primary care provider in the same practice where you see your assigned PCP. Your PCP will provide routine health care and make referrals to other doctors when needed.

What do you need to do?

Check your member ID card to make sure the PCP listed on your ID card is correct. If your ID card has a different PCP or you want to choose another PCP, please call Member Services at **1-866-433-3413**, TTY **711**, 24 hours a day, 7 days a week. If you need to change the name of the PCP listed on your member ID card, we will send you a replacement card with the new information.

Why should I see a Primary Care Provider?

Regular health care means exams, regular checkups, shots or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away.

Questions?

If you have any questions or want to change your PCP, please call us toll-free at **1-866-433-3413**, TTY **711**, 24 hours a day, 7 days a week.

You may want to find a doctor that:

- You have seen before
- Understands your health problems
- Is taking new patients
- Can speak to you in your language
- Is easy to get to
- Is at a clinic you go to

You may also be able to choose a PCP at your behavioral health clinic

With this handbook, you should have a provider directory. This is a list of all the providers, clinics, hospitals, labs, and others who work with UnitedHealthcare Community Plan. It lists the name, address, and phone, as well as professional qualifications, specialty, medical school attended, residency, and Board certification status of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP. You can also get a list of providers on our website at **myuhc.com/CommunityPlan**.

Women do not need to select a Primary OB/GYN. Women can get care from any participating OB/GYN doctor. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if there is a problem, and regular care during pregnancy. There are no visit limits for OB/GYN care.

We also contract with FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or you can sign up with a primary care physician at one of the FQHCs that we work with; they are listed in the Provider Directory. Just call Member Services toll-free at **1-866-433-3413**, TTY **711** for help.

In almost all cases, your doctors will be UnitedHealthcare Community Plan providers. There are four instances when you can still **see another provider that you had before you joined UnitedHealthcare Community Plan**. In these cases, your provider must agree to work with UnitedHealthcare Community Plan. You can continue to see your provider if:

- You are more than 3 months pregnant when you join UnitedHealthcare Community Plan and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through postpartum care.
- At the time you join UnitedHealthcare Community Plan, you have a life-threatening disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.
- At the time you join UnitedHealthcare Community Plan, you are being treated for a behavioral health condition. In that case, you can ask to keep your provider through treatment for up to 2 years.
- At the time you join UnitedHealthcare Community Plan, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days. UnitedHealthcare Community Plan must tell you about any changes to your home care before the changes take effect.

If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change three times per year without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to which your PCP has referred you.

If your provider leaves UnitedHealthcare Community Plan, we will tell you within 5 days from when we know about this. If you wish, you may be able to see that provider **if** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor through postpartum care. If you are seeing a doctor regularly for a special medical problem, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with UnitedHealthcare Community Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at **1-866-433-3413**, TTY **711**.

Health Home Care Management

UnitedHealthcare Community Plan is responsible for providing and coordinating your physical health care and your behavioral health services. We use Health Homes to coordinate services for our members. It is your choice if you want to join a Health Home, and we encourage you to join a Health Home for your Care Management.

UnitedHealthcare Community Plan can help you enroll with a Health Home that will assign your personal Health Home Care Manager. Your Health Home Care Manager can help you make appointments, help you get social services, and keep track of your progress.

Your Health Home is responsible for giving you an assessment to see what Behavioral Health Home and Community Based Services you may need. Using the assessment, you and your Health Home Care Manager will work together to make a Plan of Care that is designed especially for you.

Your Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your physical and behavioral health care;
- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Support you getting social services, like SNAP (food stamps) and other social service benefits;
- Develop a plan of care with you to help identify your needs and goals;
- Help with appointments with your PCP and other providers;
- Help managing ongoing medical issues like diabetes, asthma, and high blood pressure;
- Help you find services to help with weight loss, healthy eating, exercise and to stop smoking;
- Support you during treatment;
- Identify resources you need that are located in your community;
- Help you with finding or applying for stable housing;
- Help you safely return home after a hospital stay; and
- Make sure you get follow-up care, medications, and other needed services.

Your Health Home Care Manager will be in touch with you right away to find out what care you need and to help you with appointments. Your Health Home Care Manager or someone from your Health Home provider is available to you 24 hours a day, 7 days a week, **1-866-433-3413**, TTY **711**.

If you are already enrolled in a Health Home or interested in joining a Health Home and receiving Care Management services, please call Member Services at **1-866-433-3413**, TTY **711** to find out more about enrolling in a Health Home or if you are eligible for Case Management Services.

If you are in crisis and need to talk to someone right away, call **1-866-433-3413**, TTY **711**.

Regular health care

Your health care will include regular checkups for all your health care needs. We provide referrals to hospitals or specialists. We want new members to see his or her Primary Care Provider for a first medical visit soon after enrolling in UnitedHealthcare Community Plan. This will give you a chance to talk with your Primary Care Provider about your past health issues, the medicines you take, and any questions that you have.

Day or night, your PCP is only a phone call away. Be sure to call your PCP whenever you have a medical question or concern. If you call after-hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

You can call UnitedHealthcare Community Plan twenty-four (24) hours a day, seven (7) days a week at **1-866-433-3413**, TTY **711** if you have questions about getting services or if for some reason you cannot reach your Primary Care Provider.

Your care must be **medically necessary** — The services you get must be needed:

- To prevent, or diagnose and correct what could cause more suffering, or
- To deal with a danger to your life, or
- To deal with a problem that could cause illness, or
- To deal with something that could limit your normal activities.

Your PCP will take care of most of your health care needs. You should have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know.

As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within 4 weeks of your joining the plan. If you have the need for treatment over the coming weeks, make your first appointment in the first week of joining UnitedHealthcare Community Plan. Your Health Home Care Manager can help you make and get ready for your first appointment.

If you need care before your first appointment, call your PCP's office to explain your concern. He or she will give you an earlier appointment for this concern. (You should still keep your first appointment to discuss your medical history and ask questions.)

Use the following list as a guide for the longest time you may have to wait after you ask for an appointment. Your Care Manager can also help you make or get appointments.	
Urgent care	Within 24 hours
Non-urgent sick visits	Within 3 days
Routine, preventive care	Within 4 weeks
First pre-natal visit	Within 3 weeks during 1st trimester (2 weeks during 2nd trimester, 1 week during 3rd trimester)
First family planning visit	Within 2 weeks
Follow-up visit after mental health/substance use ER or inpatient visit	5 days
Non-urgent mental health or substance use specialist visit	Within 2 weeks
Adult baseline and routine physicals	Within 4 weeks

Behavioral Health Care and Home and Community Based Services (BHHCBS)

Behavioral health care includes mental health and substance use treatment services. You have access to services that can help you with emotional health. You can also get help with alcohol or other substance use issues.

If you need help to support your living in the community, UnitedHealthcare Community Plan provides additional services, called Behavioral Health Home and Community Based Services (BHHCBS). These services can help you stay out of the hospital and live in the community. Some services can help you reach life goals for employment, school, or for other areas of your life you may like to work on.

To be eligible for these services, you will need to get an assessment. To find out more, call us at **1-866-433-3413**, TTY **711**, or ask your Care Manager about these services.

See pages 42–44 of this handbook for more information about these services and how to get them.

How to get specialty care and referrals

If you need care that your PCP cannot give, he or she will REFER you to other specialists who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are UnitedHealthcare Community Plan providers. Talk with your PCP to be sure you know how referrals work.

If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.

There are some treatments and services that your PCP must ask our plan to approve **before** you can get them. Your PCP will be able to tell you what they are.

If you are having trouble getting a referral you think you need, contact Member Services at **1-866-433-3413**, TTY **711**.

If we do not have a specialist in the UnitedHealthcare network who can give you the care you need, we will get you the care you need from a specialist outside the UnitedHealthcare network. This is called an out-of- network referral. Your PCP or plan provider must ask UnitedHealthcare Community Plan for approval before you can get an out-of-network referral. If you or your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except an copayments as described in this handbook. Your PCP must call

UnitedHealthcare's Prior Authorization Department at 1-866-604-3267, to get authorization for you to go to a specialist that is not part of the UnitedHealthcare network. The specialist must agree to work with UnitedHealthcare, and accept our payments as payment in full. This permission is called "pre-authorization." Your PCP will explain all of this to you when he or she sends you to a specialist who is not in the UnitedHealthcare network. Please refer to the **Service Authorization and Actions** section for more information on what documentation your request to see a provider who is not in the UnitedHealthcare network should include. If UnitedHealthcare Community Plan approves the use of a provider who is not in the UnitedHealthcare network, you are not responsible for any of the costs, except any copayments as described in this handbook.

Sometimes we may not approve an out-of-network referral because we have a provider in UnitedHealthcare Community Plan that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **plan appeal**. See page 61 to find out how.

You will need to ask your doctor to send the following information with your plan appeal:

1. A statement in writing that says UnitedHealthcare Community Plan's provider does not have the right training and experience to meet your needs, and
2. That recommends an out-of-network provider with the right training and experience who is able to treat you.

Your doctor must be a board certified or board eligible specialist who treats people who need the treatment you are asking for.

Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from UnitedHealthcare Community Plan's provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a **plan appeal**. See page 61 to find out how.

You will need to ask your doctor to send the following information with your plan appeal:

1. A statement in writing from your doctor that the out-of-network treatment is very different from the treatment you can get from UnitedHealthcare Community Plan's provider. Your doctor must be a board certified or board eligible specialist who treats people who need the treatment you are asking for, and
2. Two medical or scientific documents that prove the treatment you are asking for is more helpful to you and will not cause you more harm than the treatment you can get from UnitedHealthcare Community Plan's provider.

If your doctor does not send this information, we will still review your action appeal. However, you may not be eligible for an external appeal. See page 66 for more information about external appeals.

You may need to see a specialist for ongoing care of a medical or behavioral health condition. Your PCP may be able to refer you for a specified number of visits or length of time (a standing referral). If you have a **standing referral**, you will not need a new referral for each time you need care.

If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:

- Your specialist to act as your PCP; or
- A referral to a specialty care center that deals with the treatment of your illness.

You can also call Member Services for help in getting access to a specialty care center.

If you want your specialist to serve as your PCP, you should discuss this with your Specialist and ask the doctor if he or she is willing to serve as your PCP. That means your specialist would be responsible for managing your overall health needs, coordinate referrals for lab testing, x-rays and other specialist visits. If your specialist agrees, please ask them to send a letter in writing confirming that he or she wishes to serve as your PCP and the reason why to:

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

We will review your request and let you know when we have made the change effective.

If you ever want to see a different specialist, talk to your PCP or call Member Services at **1-866-433-3413**, TTY **711**.

Get these services from our plan without a referral

Women's health care

You do not need a referral from your PCP to see one of our providers **if**:

- You are pregnant, or
- You need OB/GYN services, or
- You need family planning services, or
- You want to see a midwife, or
- You need to have a breast or pelvic exam.

Family planning

You can get the following family planning services: advice about birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, or an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam.

You **do not need a referral** from your PCP to get these services. In fact, you can choose where to get these services. You can **use your UnitedHealthcare Community Plan ID card** to see one of our family planning providers. Check the plan's Provider Directory or call Member Services for help in finding a provider.

Or, you can **use your Medicaid card** if you want to go to a doctor or clinic outside our plan. Ask your PCP or call Member Services at **1-866-433-3413**, TTY **711** for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

HIV and STI screening

Everyone should know their HIV status. HIV and sexually transmitted infection screenings are part of your regular health care.

- You can get an HIV or STI test any time you have an office or clinic visit
- You can get an HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with any family planning provider. If you want an HIV or STI test, but **not as part of a family planning service**, your PCP can provide or arrange it for you.
- Or, if you'd rather not see one of our UnitedHealthcare Community Plan providers, you can use your Medicaid card to see a family planning provider outside UnitedHealthcare Community Plan. For help in finding either a Plan provider or a Medicaid provider for family planning services, call Member Services at **1-866-433-3413**, TTY **711**.
- Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

Some tests are "rapid tests" and the results are ready while you wait. The provider who gives you the test will explain the results and arrange for follow-up care if needed. You will also learn how to protect your partner. If your test is negative, we can help you learn to stay that way.

HIV prevention services

Many HIV prevention services are available to you. We will talk with you about any activities that might put you or others at risk of transmitting HIV or getting sexually transmitted diseases. We can help you learn how to protect yourself. We can also help you get free male and female condoms and clean syringes.

If you are HIV positive, we can help you talk to your partners. We can help you talk to your family and friends and help them understand HIV and AIDS and how to get treatment. If you need help talking about your HIV status with future partners, UnitedHealthcare Community Plan staff will assist you. We can even help you talk to your children about HIV.

Eye care

The covered service includes the needed services of an ophthalmologist, optometrist, and an ophthalmic dispenser and includes an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period. You just choose one of our participating providers.

New eyeglasses, with Medicaid approved frames, are usually provided once every two years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses or broken eyeglasses that can't be fixed will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Behavioral health (mental health and substance use)

We want to help you get the mental health and substance use services that you may need.

If at any time you think you need help with mental health or substance use, you can see any behavioral health provider in our network to see what services you may need. This includes services like clinic and detox services. **You do not need a referral from your PCP.**

Smoking cessation

You can get medication, supplies, and counseling if you want help to quit smoking. You do not need a referral from your PCP to get these services.

Maternal depression screening

If you are pregnant and think you need help with depression, you can get a screening to see what services you may need. You do not need a referral from your PCP. You can get a screening during pregnancy and for up to a year after your delivery.

Emergencies

You are always covered for emergencies. In New York State, an emergency means a medical or behavioral condition:

- That comes on all of a sudden, and
- Has pain or other symptoms.

An emergency would make a person with an average knowledge of health be afraid that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop or a bad burn
- Broken bones
- Trouble breathing/convulsions/loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever, or vomiting
- Drug overdose

Examples of non-emergencies are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

Non-emergencies may also be family issues, a breakup, or wanting to use alcohol or other drugs. These may feel like an emergency, but they are not a reason to go to the emergency room.

Remember:

You do not need prior approval for emergency services.

Use the emergency room **only** if you have a **True Emergency**.

The emergency room should NOT be used for problems like flu, sore throats, or ear infections.

If you have questions, call your PCP or our plan at **1-866-433-3413**, TTY **711**.

If you have an emergency, here's what to do:

If you believe you have an emergency, call 911 or go to the emergency room. You do not need UnitedHealthcare Community Plan or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

If you're not sure, call your PCP or Behavioral Health Professional or UnitedHealthcare Community Plan. Tell the person you speak with what is happening. Your PCP or Behavioral Health Professional or UnitedHealthcare Community Plan representative will:

- Tell you what to do at home, or
- Tell you to come to the health care provider's office,
- Tell you about community services you can get, like 12-step meetings or a shelter, or
- Tell you to go to the nearest emergency room.

You can also contact UnitedHealthcare Community Plan Member Services at 1-866-433-3413, TTY 711, 24 hours a day, 7 days a week if you are in crisis or need help with a mental health or drug use situation.

If you are out of the area when you have an emergency:

- Go to the nearest emergency room or call 911
- Call UnitedHealthcare Community Plan as soon as you can (within 48 hours if you can)

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care.

- This could be the flu or if you need stitches
- It could be a sprained ankle, or a bad splinter you can't remove

You can get an appointment for an urgent care visit for the same or next day. If you are at home or away, call your PCP anytime, day or night. If you cannot reach your PCP, call us at **1-866-433-3413**, TTY **711**. Tell the person who answers what is happening. They will tell you what to do.

Care outside of the United States

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

We want to keep you healthy

Besides the regular checkups and the shots you need, here are some other services we provide and ways to keep you in good health:

- Stop-smoking classes
- Prenatal care and nutrition
- Grief/Loss support
- Breastfeeding and baby care
- Stress management
- Weight control
- Cholesterol control
- Diabetes counseling and self-management training
- Asthma counseling and self-management training
- Sexually Transmitted Infection (STI) Testing and Protecting Yourself from STIs
- Domestic Violence Services

Call Member Services at **1-866-433-3413**, TTY **711** or visit our website at **myuhc.com/CommunityPlan** to view a list of classes and programs located near you.

Part II – Your Benefits and Plan Procedures

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

Benefits

Health and Recovery Plans provide a number of services you get in addition to those you get with regular Medicaid. We will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning; HIV testing; mobile crisis services; and specific self-referral services, including those you can get from within UnitedHealthcare Community Plan and some that you can choose to go to any Medicaid provider of the service.

Services covered by our plan

You must get these services from the providers who are in our plan. All services must be medically or clinically necessary and provided or referred by your PCP (primary care provider). Please call our Member Services department at **1-866-433-3413**, TTY **711** if you have any questions or need help with any of the services below.

Regular medical care

- Office visits with your PCP
- Referrals to specialists
- Eye/hearing exams
- Help staying on schedule with medicines
- Coordination of care and benefits

Preventive care

- Regular checkups
- Access to free needles and syringes
- Smoking cessation counseling
- HIV education and risk reduction
- Referral to Community Based Organizations (CBOs) for supportive care
- Smoking cessation care
- Allergy services, including RAST (radioallergosorbent test)

Infertility Services

UnitedHealthcare Community Plan covers some drugs for infertility. This benefit is limited to coverage for 3 cycles of treatment per lifetime.

UnitedHealthcare Community Plan also covers services related to prescribing and monitoring the use of such drugs. The infertility benefit includes:

- Office visits
- X-ray of the uterus and fallopian tubes
- Pelvic ultrasound
- Blood testing

Eligibility:
You may be eligible for infertility services if you meet the following criteria:

- You are 21–34 years old and are unable to get pregnant after 12 months of regular, unprotected sex
- You are 35–44 years old and are unable to get pregnant after 6 months of regular, unprotected sex

To learn more about these services, call Member Services at **1-866-433-3413**, TTY **711**.

Maternity care

- Pregnancy care
- Doctors/midwife and hospital services
- Screening for depression during pregnancy and up to a year after birth

Telehealth services

UnitedHealthcare Community Plan Medicaid Managed Care covers Telehealth services. This is also called Telemedicine. It means the use of electronic technology to communicate. It is used when you and a provider are not in the same place.

Telehealth may involve:

- A live video conference with you and a provider
- Sending information about you from your doctor to another provider
- Remote patient monitoring of blood pressure and other vital signs

Telehealth services may be covered in a clinic, medical or mental health center. It may also be covered at your home if you have monitoring equipment. The services must meet certain plan requirements.

Home health care

- Must be medically needed and arranged by UnitedHealthcare Community Plan
- One medically necessary postpartum home health visit, additional visits as medically necessary for high-risk women
- Other home health care visits as needed and ordered by your PCP/specialist

Personal care/Home attendant/Consumer Directed Personal Assistance Services (CDPAS)

- Must be medically needed and arranged by UnitedHealthcare Community Plan
- Personal Care/Home Attendant — Help with bathing, dressing and feeding, and help preparing meals and housekeeping
- CDPAS — Help with bathing, dressing and feeding, help preparing meals and housekeeping, plus home health aide and nursing. This is provided by an aide chosen and directed by you. If you want more information, contact UnitedHealthcare Community Plan at **1-866-433-3413**, TTY **711**.

Personal Emergency Response System (PERS)

This is an item you wear in case you have an emergency and need help. To qualify and get this service, you must be receiving personal care/home attendant or CDPAS services.

Adult day health care

- Must be recommended by your Primary Care Provider (PCP)
- Provides health education, nutrition, nursing and social care, help with daily living, rehabilitative therapy, pharmacy services, plus referrals for dental and other specialty care

Therapy for tuberculosis (TB)

- This is help with taking your medication for TB and follow-up care

National Diabetes Prevention Program (NDPP) Services

If you are at risk for developing Type 2 diabetes, UnitedHealthcare Community Plan covers services that may help.

UnitedHealthcare Community Plan covers diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit covers 22 NDPP group training sessions over the course of 12 months.

The **National Diabetes Prevention Program** is an educational and support program designed to assist at-risk people from developing Type 2 diabetes. The program consists of group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach.

Eligibility:
You may be eligible for diabetes prevention services if you have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

And, you meet one of the following criteria:

- You have had a blood test result in the prediabetes range within the past year, or
- You have been previously diagnosed with gestational diabetes, or
- You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test.

Talk to your doctor to see if you qualify to take part in the NDPP. To learn more about these services, call Member Services at **1-866-433-3413**, TTY **711**.

Hospice care

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death
- Must be medically needed and arranged by UnitedHealthcare Community Plan
- Provides support services and some medical services to patients who are ill and expect to live for one year or less
- You can get these services in your home or in a hospital

Dental care

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

You may be able to get dental implants as part of your Medicaid managed care benefit. UnitedHealthcare Community Plan's Wellness4Me Plan will cover dental implants when your doctor and dentist agrees they are needed.

UnitedHealthcare Community Plan's Wellness4Me Plan will cover dental implants when:

- Your doctor says that you need dental implants to ease your medical problem; and
- Your dentist says that dental implants are the only thing that will fix your dental problem.

How to access dental services

You do not need to select a primary care dentist as part of UnitedHealthcare Community Plan. You can choose any participating dentist (who is part of the UnitedHealthcare Community Plan network) by selecting a dentist listed in the provider directory or you can call Member Services for assistance at **1-866-433-3413**, TTY **711**. Please present your UnitedHealthcare Community Plan member ID card whenever you receive dental services.

Show your UnitedHealthcare Community Plan member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your UnitedHealthcare Community Plan member ID card.

You can also go to a dental clinic that is run by an academic dental center without a referral. Please call Member Services toll-free at **1-866-433-3413**, TTY **711** for the locations of academic dental centers.

Vision care

- Services of an ophthalmologist, ophthalmic dispenser and optometrist
- Coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider.
- Eye exams, generally every two years, unless medically needed more often
- Glasses, with new pair of Medicaid approved frames every two years, or more often if medically needed
- Low vision exam and vision aids ordered by your doctor
- Specialist referrals for eye diseases or defects

Pharmacy

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Emergency contraception (6 per calendar year)
- Medical and surgical supplies

A pharmacy copayment may be required for some people, for some medications and pharmacy items. There are no copayments for the following members or services:

- Consumers who are pregnant: during pregnancy and for the two months after the month in which the pregnancy ends
- Family Planning drugs and supplies like birth control pills, male or female condoms, syringes and needles
- Consumers in a Comprehensive Medicaid Care Management (CMCM) or Service Coordination Program
- Consumers in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program
- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI)

- Drugs to treat mental illness (psychotropic) and tuberculosis

Copayments

Prescription item	Copayment amount	Copayment details
Brand name prescription drugs	$3.00/$1.00	Refer to the Preferred Drug List
Generic prescription drugs	$1.00	Refer to the Preferred Drug List
Over-the-counter drugs	$0.50	Refer to the Preferred Drug List

- If you have a copay, there is a copayment for each new prescription **and** each refill
- If you have a copay, you are responsible for a maximum of $50 each quarter year

  The copay maximum re-sets each quarter, regardless of the amount you paid last quarter. The quarters are:

  - First quarter: January 1 – March 31
  - Second quarter: April 1 – June 30
  - Third quarter: July 1 – September 30
  - Fourth quarter: October 1 – December 31

  If you are unable to pay the requested copay you should tell the provider. The provider cannot refuse to give you services or goods because you are unable to pay the copay. (Unpaid copays are a debt you owe the provider.)

  To learn more about these services, call Member Services at **1-866-433-3413**, TTY **711**.
- If you transferred to a new plan during the calendar year, keep your receipts as proof of your copayments or you may request proof of paid copayments from your pharmacy. You will need to give a copy to your new plan.
- Certain drugs may require that your doctor get prior authorization before writing your prescription. Your doctor can work with UnitedHealthcare Community Plan to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.
- You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with our plan. For more information on your options, please contact Member Services at **1-866-433-3413**, TTY **711**.

90 day supply benefit

Your plan now covers 90 day supplies of select medications at the retail pharmacy. With a 90 day supply, you won't need to get a refill every month.

If you would like to participate in this benefit:

- Talk with your doctor to see if your medications qualify for this benefit. Your doctor can write you a new prescription for a 90 day supply of the same medication you are taking now.
- Talk to your pharmacist. Your pharmacist can call your doctor to get a new prescription for a 90 day supply.

For a complete list of medications included in this benefit, go to **myuhc.com/CommunityPlan**, or call Member Services at **1-866-433-3413**, TTY **711**.

How to get a prescription drug

Take your prescription and your UnitedHealthcare Community Plan member ID card to any participating pharmacy. The participating pharmacies are listed in the Provider Directory, by visiting **myuhc.com/CommunityPlan**, or you can call Member Services toll-free at **1-866-433-3413** for assistance. You will have to pay for the drug yourself if you do not use a participating pharmacy.

There is a copayment for each new Prescription and each refill. If you are required to pay a copay, you are responsible for a maximum of $50 per quarter year. If you transferred plans during the calendar year, keep your receipts as proof of your copayments or you may request proof of paid copayments from your pharmacy. You will need to give a copy to your new plan.

You have a choice in where you fill your prescriptions. You can find the names of participating pharmacies in the provider directory, by visiting **myuhc.com/CommunityPlan**, or you can call Member Services at **1-866-433-3413**.

All medications that are on our Preferred Drug List (PDL) will be covered when medically necessary. You should have received the Preferred Drug List with your welcome packet, or you can call Member Services at **1-866-433-3413** to request a copy.

Prior authorization

Certain medications may require that your doctor get a prior authorization from us, before writing your prescription. This means the prescription must be approved before you can go to your pharmacy to get the medication. When a drug needs prior authorization, your doctor must contact our Pharmacy department. They will review your doctor's request and you, and your doctor, will be told the decision for the request. If the drug you are prescribed needs prior authorization and your doctor does not get it, you will not be able to get your prescription. Your doctor needs to call our **pharmacy department at 1-800-310-6826** to request a prior authorization. **Your pharmacist may be able to give you a 3-day emergency supply**, until we process the request. If we do not approve the request, we will tell you how you can appeal.

Step therapy

Some drugs on the Preferred Drug List require other drugs to be used first. This is called Step Therapy. Step Therapy drugs are covered if the required drug(s) has been tried first. If the required drug has not been tried, your doctor must get prior authorization. We will ask your doctor to explain why you can't use the required drug first. If we do not approve the request, we will tell you how you can appeal.

Brand-name drugs instead of generic equivalents

UnitedHealthcare Community Plan requires that generic drugs be used when available. Generic drugs have the same active ingredients as brand names. Generic drugs are as safe and as effective as brand names. If your doctor thinks you need a brand name instead of the generic, your doctor must get **prior authorization by calling 1-800-310-6826**. We will ask your doctor for information to explain why you can't use the generic drug. If we do not approve the request, we will tell you how you can appeal.

Specialty medications

A specialty pharmacy drug is typically a high-cost medication (taken by mouth or injected) that treats rare, complex or chronic diseases. (These include, for example, medications for rheumatoid arthritis, growth hormone, and oral cancer medications.) These drugs usually require frequent monitoring (to make sure they are working and to avoid side effects) and the patients taking them may need extra support or help to manage their treatment. Certain specialty medications require prior authorization. Once approved, a specialty pharmacy calls the member to arrange delivery. The pharmacy will call the member before each refill is due. If preferred, members can get their specialty medications through their local network pharmacy. If you need assistance, please call Member Services at **1-866-433-3413**.

Medications not on UnitedHealthcare Community Plan's Preferred Drug List (PDL)

If your prescription is not on our PDL, your doctor must get a prior authorization. If your doctor does not do this, you will not be able to get the drug. A list of drugs on the PDL was included in your welcome packet, and it is also available at **myuhc.com/CommunityPlan**, or you can call Member Services at **1-866-433-3413**. If the doctor chooses not to use a drug on the PDL, your doctor must get prior authorization from the Pharmacy department. The review takes 24 hours. You and your doctor will be told the outcome (the decision). If we do not approve the request, we will tell you how to appeal.

These items are covered:

- Legend drugs (drugs that need a prescription per federal law)
- Compounds using a legend drug
- Disposable blood or urine glucose testing agents
- Disposable insulin needles or syringes
- Growth hormones
- Insulin
- Lancets
- Legend (prescription) contraceptives
- Fluoride supplements
- Vitamins and minerals
- Legend (prescription) prenatal vitamins

These items are not covered:

- Anabolic steroids
- Anorectics (drugs used for weight loss)
- Anti-wrinkle agents
- Dietary supplements
- Select prescription vitamin and mineral products
- Drugs for baldness
- Select non-legend (over-the-counter) drugs
- Pigmenting agents
- Drugs for cosmetic purposes
- Drugs designated less than effective by the FDA per the Drug Efficacy Study. Or drugs made by firms that do not have rebate agreements with the government per OBRA'90.

Your doctor can work with UnitedHealthcare to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.

Hospital care

- Inpatient care
- Outpatient care
- Lab, X-ray, other tests

Emergency care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on your need, you may be treated in the emergency room, in an inpatient hospital room, or in another setting. This is called **Post Stabilization Services**.
- For more about emergency services, see page 27

Gender reassignment coverage

UnitedHealthcare Community Plan Medicaid Managed Care now covers transition care for persons diagnosed with gender dysphoria. This is when a person has major distress over the gender they are born with. They do not identify with this gender. This may result in a strong desire to be treated as the other gender. It may mean a desire to be rid of one's sex traits. It may include feelings typical of the other gender.

Based on the gender goals of the patient, care may include:

- Counseling
- Hormone therapy. (This is covered for members 18 and older.)
- Gender reassignment surgery. (This is covered for members 18 and older or 21 and older if it will result in sterilization.)

Specialty care

Includes the services of other practitioners, including:

- Occupational and speech therapists — UnitedHealthcare Community Plan covers medically necessary OT and ST visits that are ordered by a doctor or other licensed professional. To learn more about these services, call Member Services at **1-866-433-3413**, TTY **711**. Prior Authorization is required for these therapy services to determine whether the site of care is medically necessary.
- Physical therapists — UnitedHealthcare Community Plan covers medically necessary PT, visits that are ordered by a doctor or other licensed professional. To learn more about these services, call Member Services at **1-866-433-3413**, TTY **711**. Prior Authorization is required for these therapy services to determine whether the site of care is medically necessary.
- Audiologist
- Midwives
- Cardiac rehabilitation
- Podiatrists, if you are diabetic

Residential health care facility care (nursing home)

- Includes short-term, or rehab stays
- Must be ordered by a physician and authorized by UnitedHealthcare Community Plan

If you are in need of long-term placement in a nursing home, your local department of social services must determine if you meet certain Medicaid income requirements. UnitedHealthcare Community Plan and the nursing home can help you apply. We do not cover services related to rest cures, permanent custodial care in a nursing home.

You must get this care from a nursing home that is in UnitedHealthcare Community Plan's provider network. If you choose a nursing home outside of UnitedHealthcare Community Plan's network, you will have to transfer to another plan. Call New York Medicaid Choice at **1-800-505-5678** for help with questions about nursing home providers and plan networks.

Call **1-866-433-3413**, TTY **711**, for help finding a nursing home in our network.

Behavioral health care

Behavioral health care includes mental health and substance use disorder services. All of our members have access to behavioral health services which include:

Mental health care

- Psychiatric services
- Psychological services
- Continuing Day Treatment (CDT)
- Inpatient and outpatient mental health treatment
- Injections for behavioral health related conditions
- Partial hospitalization
- Rehab services if you are in a community home or in family-based treatment
- Individual and group counseling through Office of Mental Health (OMH) clinics
- Crisis intervention services
- Comprehensive Psychiatric Emergency Program (CPEP) including extended observation bed
- Assertive Community Treatment (ACT)
- Personalized Recovery Oriented Services (PROS)

Residential crisis support

This is a program for people who are age 21 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.

Intensive crisis residence

This is a treatment program for people who are age 21 or older who are having severe emotional distress.

Substance Use Disorder Services for Adults age 21+

- Crisis Services
  - Medically managed withdrawal management
  - Medically supervised withdrawal management (Inpatient/Outpatient*)
- Inpatient treatment services (hospital or community based)
- Residential treatment services
  - Stabilization in residential setting
  - Rehabilitation in residential setting

- Outpatient treatment services
  - Intensive outpatient treatment
  - Outpatient rehabilitation services
  - *Outpatient withdrawal management
  - Medication assisted treatment
- Opioid Treatment Programs (OTP)
  - Including Methadone Maintenance and other forms of Medically Assisted treatments

Harm Reduction Services

Harm Reduction Services will offer a complete patient-oriented approach to the health and wellness of substance users. Your plan will cover harm reduction services that are recommended by a physician or other licensed professional. These services include:

- A plan of care developed by a person experienced in working with substance users
- Individual supportive counseling that assists in achieving your goals
- Group supportive counseling in a safe space to talk with others about issues that affect your health and well-being
- Counseling to help you with taking your prescribed medication and continuing treatment
- Support groups to help you better understand substance use and identify coping techniques and skills that will work for you

If you are currently receiving harm reduction services from a provider, your care will not change; you can still go to the same provider to receive these services.

Behavioral Health Home and Community Based Services (BHHCBS)

BHHCBS can help you with life goals such as employment, school, or other areas of your life you want to work on. To find out if you qualify, a Health Home Care Manager must complete a brief screening with you that will show if you can benefit from these services. If the screening shows you can benefit, the Care Manager will complete a full assessment with you to find out what your whole health needs are, including physical, behavioral and rehabilitation services.

BHHCBS includes:

- Psychosocial Rehabilitation (PSR) — helps you improve your skills to reach your goals
- Community Psychiatric Support and Treatment (CPST) — is a way to get treatment services you need for a short time at a location of your choosing, such as your own home. CPST helps connect you with a licensed treatment program
- Habilitation Services — helps you learn new skills in order to live independently in the community

- Family Support and Training — is to teach skills to help the people in your life support you in your recovery
- Short-Term Respite — gives you a safe place to go when you need to leave a stressful situation
- Intensive Respite — helps you stay out of the hospital when you are having a crisis by providing a safe place to stay that can offer you treatment
- Education Support Services — helps you find ways to return to school to get education and training that will help you get a job
- Pre-Vocational Services — helps you with skills needed to prepare for employment
- Transitional Employment Services — gives you support for a short time while trying out different jobs. This includes on-the-job training to strengthen work skills to help keep a job at or above minimum wage.
- Intensive Supported Employment Services — helps you find a job at or above minimum wage and keep it
- Ongoing Supported Employment Services — helps you keep your job and be successful at it
- Empowerment Services – Peer Supports — people who have been there help you reach your recovery goals
- Non-Medical Transportation — transportation to non-medical activities related to a goal in your plan of care

Other covered services

- Durable medical equipment (DME)/hearing aids/prosthetics/orthotics
- Court-ordered services
- Social support services (help in getting community services)
- FQHC or similar services

Benefits you can get from our plan or with your Medicaid card

For some services, you can choose where to get your care. You can get these services by using your UnitedHealthcare Community Plan membership card. You can also go to providers who will take your Medicaid Benefit card. **You do not need a referral from your PCP to get these services.** Call Member Services if you have questions at **1-866-433-3413**, TTY **711**.

Family planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. Or you can visit one of our family planning providers. Either way, you do not need a referral from your PCP.

You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

HIV and STI screening

You can get this service anytime from your PCP or UnitedHealthcare Community Plan doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

Everyone should talk to their doctor about having an HIV test. To access free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

TB diagnosis and treatment

You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

Benefits using your Medicaid card only

There are some services UnitedHealthcare Community Plan does not provide. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit card.

Non-emergency transportation

If you live in the counties of Albany, Broome, Bronx, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Fulton, Genesee, Greene, Herkimer, Jefferson, Kings (Brooklyn), Lewis, Livingston, Madison, Monroe, Nassau, New York (Manhattan), Niagara, Oneida, Onondaga, Ontario, Orange, Oswego, Queens, Rensselaer, Richmond (Staten Island), Rockland, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, or Wyoming, you can get transportation by calling Medical Answering Services, LLC (MAS) or LogistiCare Solutions.

Non-emergency medical transportation will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call Medical Answering Services, LLC (MAS) or LogistiCare Solutions depending upon which county you live in.

If possible, you or your provider should call the regional transportation vendor at least 3 work days before your medical appointment, and provide your Medicaid identification number (e.g., AB12345C), appointment date and time, address where you are going, and name of the doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

Contact number	County	Who provides transportation
855-360-3549	**Albany County**	Medical Answering Service – MAS
844-666-6270	**Bronx County**	Medical Answering Service – MAS
855-852-3294	**Broome County**	Medical Answering Service – MAS
866-932-7743	**Cayuga County**	Medical Answering Service – MAS
855-733-9405	**Chautauqua County**	Medical Answering Service – MAS
855-733-9399	**Chemung County**	Medical Answering Service – MAS
855-733-9396	**Chenango County**	Medical Answering Service – MAS
866-753-4435	**Clinton County**	Medical Answering Service – MAS
855-360-3546	**Columbia County**	Medical Answering Service – MAS
845-486-3000	**Dutchess County**	Medical Answering Service – MAS

Contact number	County	Who provides transportation
716-858-8000	Erie County	Medical Answering Service – MAS
866-753-4442	Essex County	Medical Answering Service – MAS
855-360-3550	Fulton County	Medical Answering Service – MAS
855-733-9404	Genesee County	Medical Answering Service – MAS
518-943-3200	Greene County	Medical Answering Service – MAS
866-753-4524	Herkimer County	Medical Answering Service – MAS
866-558-0757	Jefferson County	Medical Answering Service – MAS
844-666-6270	Kings County (Brooklyn)	Medical Answering Service – MAS
800-430-6681	Lewis County	Medical Answering Service – MAS
585-243-7300	Livingston County	Medical Answering Service – MAS
855-852-3286	Madison County	Medical Answering Service – MAS
866-932-7740	Monroe County	Medical Answering Service – MAS
844-678-1103	Nassau County	LogistiCare Solutions
844-666-6270	New York County	Medical Answering Service – MAS
866-753-4430	Niagara County	Medical Answering Service – MAS
855-852-3288	Oneida County	Medical Answering Service – MAS
855-852-3287	Onondaga County	Medical Answering Service – MAS
866-733-9402	Ontario County	Medical Answering Service – MAS
855-360-3543	Orange County	Medical Answering Service – MAS
855-733-9395	Oswego County	Medical Answering Service – MAS
844-666-6270	Queens County	Medical Answering Service – MAS
866-666-8653	Rensselaer County	Medical Answering Service – MAS

Contact number	County	Who provides transportation
844-666-6270	Richmond County (Staten Island)	Medical Answering Service – MAS
855-360-3542	Rockland County	Medical Answering Service – MAS
866-753-4437	Seneca County	Medical Answering Service – MAS
866-722-4135	St. Lawrence County	Medical Answering Service – MAS
844-678-1103	Suffolk County	LogistiCare Solutions
855-733-9398	Tioga County	Medical Answering Service – MAS
866-287-0983	Ulster County	Medical Answering Service – MAS
855-360-3541	Warren County	Medical Answering Service – MAS
855-852-3295	Wayne County	Medical Answering Service – MAS
866-883-7865	Westchester County	Medical Answering Service – MAS
585-786-8900	Wyoming County	Medical Answering Service – MAS

Emergency transportation

How you get emergency transportation will not change. If you have an emergency and need an ambulance, call 911.

Developmental disabilities

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Services not covered

These services are not available from UnitedHealthcare Community Plan or Medicaid. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Services from a provider that is not part of UnitedHealthcare Community Plan unless it is a provider you are allowed to see as described elsewhere in this handbook, or UnitedHealthcare Community Plan or your PCP sends you to that provider. We do not Cover services related to rest cures, permanent custodial care in a Nursing Home. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

You may have to pay for any service that your PCP does not approve. Or, if you agree to be a "private pay"or "self-pay" patient before you get a service, you will have to pay for the service.

This includes:

- Non-covered services (listed above)
- Unauthorized services
- Services provided by providers not part of UnitedHealthcare Community Plan

If you get a bill

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call UnitedHealthcare Community Plan at **1-866-433-3413**, TTY **711** right away. UnitedHealthcare Community Plan can help you understand why you may have gotten a bill. If you are not responsible for payment, UnitedHealthcare Community Plan will contact the provider and help fix the problem for you.

You have the right to ask for a fair hearing if you think you are being asked to pay for something Medicaid or UnitedHealthcare Community Plan should cover. See the **Fair Hearings** section later in this handbook.

If you have any questions, call Member Services at 1-866-433-3413, TTY 711.

Information for members in UnitedHealthcare Community Plan of New York: Emergency services and "surprise" bills

UnitedHealthcare Community Plan (UHCCP) provides a full range of health care services at no cost to you. You never have to pay your PCP or any other UHCCP provider for services that we approve. If a UHCCP provider asks you to pay for services, tell them you are covered by UnitedHealthcare Community Plan. Show them your member ID card. You can also call Member Services at **1-866-433-3413** for help. You do not have to submit a claim for us to pay for your covered and approved services.

You may be asked to pay for services that are not covered by UHCCP's Medicaid, Child Health Plus, Managed Long Term Care, or Medicaid Advantage plans. You cannot be charged for any such service unless you agreed to this before the care was given.

You may get what is called a "surprise bill." This is what you need to know about "surprise" bills:

What is a surprise bill?

This is a bill you get for services from an out-of-network provider when:

1. The out-of-network provider gave you care at a network hospital or surgery center and:
   - A network doctor was not available at the time; or
   - An out-of-network provider gave you care without your knowledge.
2. A network provider sends you to an out-of-network provider without your written consent. If the service did not need a referral, a surprise bill can occur only in certain cases. Here are two examples: During your office visit a network doctor brings in an out-of-network provider. Or the doctor sends your blood work to an out-of-network laboratory without your written consent.

A surprise bill does not mean a bill for services when you choose to see an out-of-network provider.

What is an out-of-network provider?

An out-of-network provider is a doctor, provider or facility who is not part of the UHCCP network.

What happens when I use an out-of-network provider without approval?

There are no out-of-network benefits except in a few cases. See your member handbook for times when you can go to an out-of-network provider. A facility must tell you if an out-of-network provider will be involved in your care. If you are not told, you will not be liable for payment. A surprise bill does not mean a bill for services when you agree to see an out-of-network provider. Be sure you read any agreements you get on care or billing from an out-of-network provider.

If I go to a network hospital, will all of the providers be in the network?

Maybe. Some specialists, like ER doctors or radiologists, may not be in your network. If you get an X-ray at a network hospital, the doctor who reads it may not be in the network. You do not have to pay for these services. We will resolve payment with these providers. Call the Member Services number on the back of your ID card if you get a bill.

How do I make sure I get care from a network provider?

Ask if all services you get are from network providers. If not, ask if we have approved the services. Check that any new provider is in the UHCCP network.

To find a network provider:

- Log on to **http://www.uhc.com/find-a-physician**
- Select Find a Physician or Facility; or
- Call us at the phone number on your plan ID card. We will be happy to help.

What if I have an emergency?

Go to the nearest emergency room for care.

How much do I have to pay for emergency and surprise bills?

You do not have to pay for a surprise bill. You do not have to pay for the cost of emergency services.

What should I do if I get a surprise bill or a bill for emergency services?

If you get a surprise bill or a bill for emergency services, do not pay it. Call the number on your plan ID card.

What if the provider disagrees with the amount paid?

The provider must work with us to settle the bill. They may ask for a review. This is done by New York's Independent Dispute Resolution (IDR). The doctor may ask you to complete an Assignment of Benefit (AOB) form for the IDR. Neither this AOB form nor any other form for the IDR process applies to Child Health Plus (CHP) or Medicaid. In these cases, the health plan will settle with the provider.

What is the Independent Dispute Resolution process?

The State of New York picks an Independent Dispute Resolution Entity (IDRE) to review disputed claims. The IDRE gets information from the provider and UHCCP. The IDRE will determine a fee for the services. The IDRE will accept our payment or the provider's charge. The health plan may have to pay something. But no payment will be due from you.

If you have questions, call the member number on your plan ID card.

Utilization management

UnitedHealthcare Community Plan does not want you to get too little care or care you don't need. We also have to make sure that the care you get is a covered benefit. The process to do this is called utilization management (UM). We do not reward providers or staff for denying coverage. We do not give incentives for UM decisions.

There are also some services we need to review before you can get them. Your providers know what they are. They take care of letting us know to review them. The review we do is called Utilization Review. Only doctors and pharmacists do UM. We do not reward anyone for saying no to needed care. If you have questions about UM, call Member Services at **1-866-433-3413**, TTY **711**. Language help is available.

Service authorization and actions

Prior authorization

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Admissions to inpatient facilities (example: hospital, except for maternity and inpatient substance use disorder services)
- Home health care services
- Personal Care Services
- Durable medical equipment (DME) over $500
- All power wheelchairs regardless of cost
- Topical Oxygen requests
- Prosthetic and orthotic devices over $500
- Cosmetic and reconstructive surgery
- Gastric bypass evaluations and surgery
- Hospice services, inpatient and outpatient
- Advanced radiology services including MRI, MRA and PET scans
- Accidental dental services

- Experimental or investigational health care services
- Out-of-network or out-of-state services
- Requests to use a non-participating provider
- Transplant evaluations and listing
- Treatment of erectile dysfunction, drug therapies, devices and/or surgery
- Medical injectables including IVIG, Botox, Acthar HP and Makena
- Private duty nursing on an outpatient basis
- Sleep studies for members over age 6, inpatient and/or outpatient
- Cross-sex hormone therapy
- Gender reassignment surgery
- Gender ressignment post transitional therapy

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services, your doctor or health care provider must call UnitedHealthcare's Prior Authorization Department at 1-866-604-3267, or your physician or health care provider may send a request in writing or by fax at 1-866-950-4490. Written physician or health care provider requests can be sent to:

UnitedHealthcare Community Plan of New York
P.O. Box 1037
New York, NY 10268-1037

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

What happens after we get your service authorization request

The health plan has a review team to be sure you get the services we promise. We check that the service you are asking for is covered under your health plan. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

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

After we get your request, we will review it under either a **standard** or a **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function
- Your provider says the review must be faster
- You are asking for more a service you are getting right now

In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision. (See also the **Plan Appeals** and **Fair Hearing** sections later in this handbook.)

Timeframes for prior authorization requests:

Standard review: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

Fast track review: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests:

Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.

Fast track review: We will make a decision within 1 work day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 work day if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care we will make a decision within 72 hours of your request
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request
- If you are asking for an outpatient prescription drug we will make a decision within 24 hours of your request
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision with 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

In all cases, you will hear from us no later than 72 hours after we received your request. We will tell within 72 hours if we need more information.

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-866-433-3413**, TTY **711**, or fax at 1-800-771-7507. Written physician or health care provider requests can be sent to:

UnitedHealthcare Community Plan of New York
P.O. Box 1037
New York, NY 10268-1037

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review the request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If we do not respond to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. See the **Plan Appeals** section later in this handbook.

Other decisions about your care

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

Timeframes for other decisions about your care:

In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.

We must tell you at least 10 days before we make any decision about long-term services and supports, such as home health care, personal care, CDPAS, and adult day health care, and nursing home care.

If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by the plan or Medicaid even if we later deny payment to the provider.**

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: www.icannys.org
Email: ican@cssny.org

How our providers are paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at **1-866-433-3413**, TTY **711** if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a **salary**. The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many — or even none at all. This is called **capitation**.
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the Plan.
- Providers may also be paid by **fee-for-service**. This means they get a Plan-agreed-upon fee for each service they provide.

You can help with plan policies

We value your ideas. You can help us develop policies that best serve our members. If you have ideas, tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at **1-866-433-3413**, TTY **711** to find out how you can help.

Information from Member Services

Here is information you can get by calling Member Services at **1-866-433-3413**, TTY **711**.

- A list of names, addresses, and titles of UnitedHealthcare Community Plan's Board of Directors, Officers, Controlling Parties, Owners and Partners
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses
- A copy of the most recent individual direct pay subscriber contract
- Information from the Department of Financial Services about consumer complaints about UnitedHealthcare Community Plan
- How we keep your medical records and member information private
- In writing, we will tell you how our plan checks on the quality of care to our members

- We will tell you which hospitals our health providers work with
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by UnitedHealthcare Community Plan
- If you ask us in writing, we will tell you the qualifications needed and how health care providers can apply to be part of our UnitedHealthcare Community Plan
- If you ask, we will tell you 1) if our contracts or subcontracts include physician incentive arrangements that affect the use of referral services; and, if so, 2) the types of arrangements we use; and 3) if stop loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works

Keep us informed

Call Member Services at **1-866-433-3413**, TTY **711** whenever these changes happen in your life:

- You change your name, address or telephone number
- You have a change in Medicaid eligibility
- You are pregnant
- You give birth
- There is a change in insurance for you
- When you enroll in a new case management program or receive case management services in another community-based organization

If you no longer get Medicaid, check with your local Department of Social Services. You **may** be able to enroll in another program.

Disenrollment and transfers

1. If you want to leave the plan

You can try us out for 90 days. You may leave UnitedHealthcare Community Plan and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in UnitedHealthcare Community Plan for nine more months, **unless** you have a good reason (good cause).

Some examples of good cause include:

- Our health plan does not meet New York State requirements and members are harmed because of it
- You move out of our service area
- You, the plan, and the LDSS all agree that disenrollment is best for you
- You are or become exempt or excluded from managed care
- We do not offer a Medicaid managed care service that you can get from another health plan in your area
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk
- We have not been able to provide services to you as we are required to under our contract with the State

To change plans:

- Call the Managed Care staff at your local Department of Social Services
- Call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.

You may be able to disenroll or transfer to another plan over the phone. If you have to be in managed care, you will have to choose another health plan.

It may take between two and six weeks to process, depending on when your request is received. You will get a notice that the change will take place by a certain date. UnitedHealthcare Community Plan will provide the care you need until then.

You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid Choice.

2. You could become ineligible for Medicaid managed care and health and recovery plans

You may have to leave UnitedHealthcare Community Plan if you:

- Move out of the County or service area,
- Change to another managed care plan,
- Join an HMO or other insurance plan through work,
- Go to prison, or
- Otherwise lose eligibility.

If you have to leave UnitedHealthcare Community Plan or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home. Call New York Medicaid Choice at **1-800-505-5678** right away if this happens.

3. We can ask you to leave UnitedHealthcare Community Plan

You can also lose your UnitedHealthcare Community Plan membership, if you often:

- Refuse to work with your PCP in regard to your care
- Don't keep appointments
- Go to the emergency room for non-emergency care
- Don't follow UnitedHealthcare Community Plan's rules
- Do not fill out forms honestly or do not give true information (commit fraud)
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems

You can also lose your UnitedHealthcare Community Plan membership, if you cause abuse or harm to plan members, providers or staff.

4. No matter what reason you disenroll, we will prepare a discharge plan for you to help you get services you need.

Plan appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination**.

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

You can file a plan appeal

If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a Plan Appeal.

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal
- You can call Member Services **1-866-433-3413**, TTY **711** if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal

You can call or write to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service
- Any specific information we said we needed in the Initial Adverse Determination notice
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling **1-866-433-3413**.

Give us your information and materials by phone, mail:

Phone: **1-866-433-3413**

Mail: Member Complaints, Grievances and Appeals
UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing.

If you are asking for out of network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
  1. A statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
  2. Two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

- If you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:
  1. A statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
  2. That recommends an out of network provider with the correct training and experience who is able to provide the service.

  Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the **External Appeals** section later in this handbook.

Your plan appeal will be reviewed under the fast track process if:

- If you or your doctor ask to have your plan appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- If your request was denied when you asked for home health care after you were in the hospital; **or**
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

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

What happens after we get your plan appeal

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call UnitedHealthcare at **1-866-433-3413**, TTY **711** if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision

- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call **1-866-433-3413**, TTY **711** if you are not sure what information to give us.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.
- **If you think our Final Adverse Determination is wrong:**
  1. You can ask for a Fair Hearing. See the **Fair Hearings** section of this handbook.
  2. For some decisions, you may be able to ask for an External Appeal. See the **External Appeals** section of this handbook.
  3. You may file a complaint with the New York State Department of Health at OHIP DHPCO 1CP-1609 New York Department of Health, Albany, NY 12237, 1- 800-206-8125.

Timeframes for Plan Appeals

- **Standard Plan appeals:** If we have all the information we need, we will tell you our decision **within thirty calendar days** from when you asked for your Plan Appeal.
- **Fast track appeals:** If we have all the information we need, fast track Plan Appeal decisions will be made in 2 working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
  1. We will tell you within in 72 hours if we need more information.
  2. If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
  3. We will tell you our decision by phone and send a written notice later.

Your Plan Appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your Plan Appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your Plan Appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; or

- If your request was denied when you asked for home health care after you were in the hospital; or
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast track decision about your Plan Appeal we will:

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

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help you decide your case. This can be done by calling **1-866-433-3413**, TTY **711** or writing.

Please send written requests to:

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

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your plan appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See the **Fair Hearings** section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:

- Not medically necessary
- Experimental or investigational
- Not different from a service that is available in our network
- Available from a participating provider who has the training and experience to meet your needs

The original denial against you will be reversed. This means your service authorization request will be approved.

Aid to continue while appealing a decision about your care

If we decided to reduce, suspend or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. **You must ask for your Plan Appeal:**

- Within **ten days** from being told that care is changing; or
- By the date the change in services is scheduled to occur, whichever is later.

If your Plan Appeal is results in another denial you may have to pay for the cost of any continued benefits that you received.

External appeals

You have other appeal rights if we said the service you are asking for was:

- Not medically necessary;
- Experimental or investigational;
- Not different from care you can get in the plan's network; or
- Available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State for an independent **External Appeal**. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an external appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
- If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited External Appeal is necessary; **or**
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have 4 months after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an external appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at **1-866-433-3413**, TTY **711** if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at **www.dfs.ny.gov**
- Contact the health plan at **1-866-433-3413**, TTY **711**

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

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health, or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- You ask for a fast track Plan Appeal within 24 hours, **and**
- You ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Plan Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

You may ask for a fair hearing from New York State.

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving UnitedHealthcare Community Plan.
- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with UnitedHealthcare Community Plan. If UnitedHealthcare Community Plan agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.
- You are not happy about a decision we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:

  1. Reduce, suspend or stop care you were getting; or
  2. Deny care you wanted;
  3. Deny payment for care you received; or
  4. Did not let you dispute a copay amount, other amount you owe or payment you made for your health care.

  You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

  If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later. However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.
- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

The decision you receive from the fair hearing officer will be final.

If you receive a bill for health care services, you may contact Member Services at **1-866-433-3413**, TTY **711** for assistance and confirm your right to a State fair hearing if you disagree with the determination to deny payment for a health care service. UnitedHealthcare Community Plan will continue to ensure prompt response to your or your designee's, request to see your case file (a case file contains information related to a specific service request and information reviewed by UnitedHealthcare Community Plan in the process of reaching a coverage determination). UnitedHealthcare Community Plan will adhere to confidentiality requirements and, where required by law or regulation, obtain appropriate authorization prior to release of protected health information that may be included in your case file.

You must file a complaint with UnitedHealthcare Community Plan. If UnitedHealthcare Community Plan agrees with your doctor, you may ask for a State fair hearing. The decision you receive from the fair hearing officer will be final.

You can use one of the following ways to request a fair hearing:

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

   NYS Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   Managed Care Hearing Unit
   P.O. Box 22023
   Albany, NY 12201-2023

When you ask for a fair hearing about a decision UnitedHealthcare Community Plan made, we must send you a copy of the **evidence packet**. This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call **1-866-433-3413**, TTY **711** to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: **www.icannys.org**
Email: **ican@cssny.org**

Complaint process

Complaints

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services, you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can call Member Services **1-866-433-3413** if you need help filing a complaint, or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to:

Complaint Unit, Bureau of Consumer Services
OHIP DHPCO 1CP-1609
New York State Department of Health
Albany, New York 12237

You may also contact your local Department of Social Services with your complaint at any time. You may also call the New York State Department of Financial Services at 1-800-342-3736 if your complaint involves a billing problem.

How to file a complaint with our plan

You can file a complaint, or you can have someone else, like a family member, friend, doctor or lawyer, file the complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you.

To file a complaint by phone, call Member Services at **1-866-433-3413**, TTY **711**, 24 hours a day, 7 days a week. If we need more information to make a decision, we will tell you.

You can write to us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Complaints, Grievances and Appeals
UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

What happens next

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

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

You can also provide information to be used reviewing your complaint in person or in writing. Call UnitedHealthcare at **1-866-433-3413** if you are not sure what information to give us.

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

After we review your complaint

We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.

When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 working days.

You will be told how to appeal our decision if you are not satisfied, and we will include any forms you may need.

If we are unable to make a decision about your complaint because we don't have enough information, we will send you a letter and let you know.

Complaint Appeals

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

How to make a complaint appeal

If you are not satisfied with what we decide, you have at least 60 working days after hearing from us to file a complaint appeal.

You can do this yourself or ask someone you trust to file the complaint appeal for you.

The complaint appeal must be made in writing. If you make an appeal by phone, it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal

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

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

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

If we have all the information we need, you will know our decision in 30 working days. If a delay would risk your health, you will get our decision in 2 working days of when we have all the information we need to decide the appeal.

You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: www.icannys.org
Email: ican@cssny.org

Member rights and responsibilities

Your rights

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

- Be cared for with respect, dignity and privacy without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation
- Follow plans and instructions for care that you have agreed to with your practitioner
- Be told about all the kinds of treatment options, provided in a way appropriate to your condition and ability to understand regardless of cost or benefit coverage
- Get a second opinion about your care
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Refuse enrollment into a Health Home and be told how to receive your physical and behavioral health care needs without having an assigned Health Home Care Manager
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval
- Use the UnitedHealthcare Community Plan complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated
- Use the State Fair Hearing system
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints
- Make recommendations regarding the organization's member rights and responsibilities policy

Your responsibilities

As a member of UnitedHealthcare Community Plan, you agree to:

- Work with your care team to protect and improve your health
- Follow plans and instructions for care that you have agreed to with your practitioner
- Understand health problems and participate in developing mutually agreed-upon treatment goals
- Supply information that the organization and its practitioners and providers need in order to provide care
- Treat health care staff with the respect you expect yourself
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies
- Call your PCP when you need medical care, even if it is after-hours

New technology

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

Advance Directives

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

Health care proxy

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

CPR and DNR

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

Organ donor card

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

Health Plan Notices of Privacy Practices

THIS NOTICE SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2019.

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 to access your HI

By law, we must follow the terms of this notice.

HI is information about your health or health care services. We have the right to change our privacy practices for handling HI. If we change them, we will notify you by mail or email. We will also post the new notice at this website **(www.uhccommunityplan.com)**. We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

How We Use or Share Your Information

We must use and share your HI with:

- You or your legal representative
- Government agencies

We have the right to use and share your HI for certain purposes. This must 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.** We may use or share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. 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.** 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.** We may use your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may use your HI to send you appointment reminders and information about your health benefits.

We may use or share your HI as follows

- **As Required by Law.**
- **To Persons Involved With Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates if needed to give you services.** Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.

- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
  1. Alcohol and Substance Abuse
  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 your HI as described here or with your written consent. We will get your written consent to share psychotherapy notes about you. 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 promotional mailings. If you let us share your HI, the recipient may further share it. You may take back your consent. To find out how, call the phone number on your ID card.

Your Rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. 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. You can have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete, you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.

- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared 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 **(www.uhccommunityplan.com)**.

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or TTY **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 the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Inc.; Symphonix Health Insurance, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is completed as of the effective date of this notice. For a current list of health plans subject to this notice go to **www.uhc.com/privacy/entities-fn-v2-en** or call the number on your health plan ID card.

Financial Information Privacy Notice

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

Effective January 1, 2019.

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 your health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-633-2446**, or TTY **711**.

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; Lifeprint East, Inc.; Lifeprint Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women's and Children's Health, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services LLC; and UnitedHealthcare Services Company of the River Valley, 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. This list of health plans is completed as of the effective date of this notice. For a current list of health plans subject to this notice, go to **www.uhc.com/privacy/entities-fn-v2-en** or call the number on your health plan ID card.