



New York

Three thick, dark blue wavy lines originate from the left edge of the page and curve downwards and to the right, meeting at a point. A fourth, wider blue wave continues from that point, curving downwards and to the right across the bottom of the page.

Welcome to the community

Medicaid Managed Care Member Handbook

Revised 2021

**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: **1-800-493-4647, 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 **1-800-493-4647, TTY 711, 8 a.m. – 6 p.m., Monday – Friday.**

2 UnitedHealthcare Community Plan® is the brand name of UnitedHealthcare of New York, Inc.

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services, free of charge, are available to you. English
 Call 1-800-493-4647 TTY 711

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-493-4647 TTY 711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-493-4647 TTY 711.	Spanish/Español
注意：您可以免費獲得語言援助服務。請致電 1-800-493-4647 TTY 711。	Chinese/中文
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-493-4647 رقم هاتف الصم والبكم TTY 711	Arabic/اللغة العربية
주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-800-493-4647 TTY 711로 전화하시기 바랍니다.	Korean/한국어
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-493-4647 (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 1-800-493-4647 TTY 711.	Italian/Italiano
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-493-4647 TTY 711.	French/Français
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-493-4647 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 1-800-493-4647 TTY 711	Yiddish/אידיש
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-493-4647.	Polish/Polski
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyong pantulong sa wika nang walang bayad. Tumawag sa 1-800-493-4647 TTY 711	Tagalog
দৃষ্টি আকর্ষণ: যদি আপনার ভাষা “Bengali বাংলা” হয় তাহলে আপনি বিনামূল্যে ভাষা সহায়তা পাবেন। 1-800-493-4647 TTY 711 নম্বরে ফোন করুন।	Bengali/বাংলা
KUJDES: Ju vendosen në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-493-4647	Albanian/Shqip
Προσοχή: Στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε «1-800-493-4647» TTY 711.	Greek/ Ελληνικά
توجه دین: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان سے متعلق مدد کی خدمات مفت دستیاب ہیں۔ کال کریں 1-800-493-4647 TTY 711	Urdu/اردو

Important phone numbers

Member Services Department	1-800-493-4647
(8:00 a.m.–6:00 p.m., Monday–Friday)	
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

4 **Questions?** Call Member Services **1-800-493-4647**, TTY **711**
(For a mental health or substance use crisis, press 8)

Upstate County Departments of Social Services (continued):

Franklin County Department of Social Services	1-518-483-6770
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

Questions? Call Member Services **1-800-493-4647**, TTY 711 5
(For a mental health or substance use crisis, press 8)

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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: _____

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Welcome to UnitedHealthcare Community Plan's Medicaid Managed Care Program

We are glad that you enrolled in UnitedHealthcare Community Plan. This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at **1-800-493-4647**.

How managed care plans work

The plan, our providers, and you

You may have 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.

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, Franklin, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Rensselaer, Rockland, Schenectady, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, Wyoming and Yates counties; and New York City including Bronx, Kings, Queens, Richmond and New York counties

UnitedHealthcare Community Plan has a contract with the State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs 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 **1-800-493-4647** to get a copy or visit our website at myuhc.com/CommunityPlan.

Welcome

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). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.

Your PCP 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 PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 22 for details.

You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are examples of why you may be restricted:

- 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 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 or your Health Home Care Manager, if you have one. UnitedHealthcare Community Plan staff have been trained in keeping strict member confidentiality.

How to use this handbook

This handbook will help you, when you join a managed care plan. It will tell you how your new health care system 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. You can also call the managed care staff at your local Department of Social Services. Please see the front inside cover for a list of Local Department of Social Services telephone numbers.

If you live in New York City, Albany, Cayuga, Chemung, Chenango, Clinton, Columbia, Essex, Franklin, Fulton, Genesee, Jefferson, Lewis, Madison, Monroe, Nassau, Onondaga, Ontario, Orange, Orleans, Oswego, Rockland, Schenectady, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, or Yates counties, you can also call the New York Medicaid Choice Help Line at 1-800-505-5678. Member Services is available Monday–Friday, 8:00 a.m.–6:00 p.m. at **1-800-493-4647**. If you have trouble hearing, call AT&T TDD Relay Service at **711**.

Welcome

Help from Member Services

There is someone to help you at Member Services. Just call toll-free **1-800-493-4647**, 8:00 a.m.–6:00 p.m., Monday–Friday to reach Member Services. If you have trouble hearing, call AT&T TTY/TDD Relay Service at **711**.

You can call Member Services to get help **when you have a question** or need assistance with choosing or changing 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 the birth of a new baby or ask about any change that might affect you or your family's benefits. If you have questions about your medical care or behavioral health care, after normal business hours, you may call the Nurse Line at 1-877-597-7801 to speak with a Nurse.

If you are or become pregnant, your child will become part of UnitedHealthcare Community Plan on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your LDSS right away if you become pregnant and let us help you to choose a doctor for your **newborn baby** before he or she is born.

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!

12 **Questions?** Call Member Services **1-800-493-4647**, TTY **711**
(For a mental health or substance use crisis, press 8)

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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

Welcome

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

For members living in upstate counties, please call our Syracuse office to make an appointment to meet with a UHC rep regarding a complaint.

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 serve 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 machine (Our TTY phone number is **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 or your child 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.

Your health plan ID card

After you enroll, we will send you a Welcome Letter. Your UnitedHealthcare Community Plan identification 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 member. You should keep your Medicaid benefit card. You will need the card to get services that UnitedHealthcare Community Plan does not cover.


Medicaid only



Health Plan (80840) **911-87726-04**

Member ID: **001000002** Group Number: **NYCDFHP**

Member:
REISSUE ENGLISH Payer ID: **87726**
 CIN#: **9999999222**



Rx Bin: **610494**
 Rx Grp: **ACUNY**
 Rx PCN: **4800**

PCP Name:
DOUGLAS GETWELL
 PCP Phone: **(718)260-4600**

0501 UnitedHealthcare Community Plan for Families
 Administered by UnitedHealthcare of New York, Inc.

In an emergency go to nearest emergency room or call 911. Printed: 10/30/19


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/communityplan or call.

For Members:	800-493-4647	TTY 711
NurseLine:	877-597-7801	TTY 711

For Providers: **UHCprovider.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**


Medicaid with behavioral health



Health Plan (80840) **911-87726-04**

Member ID: **001000092** Group Number: **NYCDFHP**

Member:
REISSUE ENGLISH Payer ID: **87726**
 CIN#: **9999999434**



Rx Bin: **610494**
 Rx Grp: **ACUNY**
 Rx PCN: **4800**

PCP Name:
DOUGLAS GETWELL
 PCP Phone: **(718)338-1616**

0501 UnitedHealthcare Community Plan for Adults
 Administered by UnitedHealthcare of New York, Inc.

In an emergency go to nearest emergency room or call 911. Printed: 10/30/19

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/communityplan or call.

For Members:	800-493-4647	TTY 711
NurseLine:	877-597-7801	TTY 711

For Providers: **UHCprovider.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**

Questions? Call Member Services 1-800-493-4647, TTY 711 15
 (For a mental health or substance use crisis, press 8)

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 **1-800-493-4647**, TTY **711**, 8:00 a.m.–6:00 p.m., Monday–Friday. 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 **1-800-493-4647**, TTY **711**, 8:00 a.m.–6:00 p.m., Monday–Friday.

You may want to find a doctor that:

- You have seen before,
- Understands your health problems,
- Is taking new patients,
- Can serve you in your language, or
- Is easy to get to.

Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can help you choose a PCP.

You can locate UnitedHealthcare Community Plan participating providers by calling Member Services by telephone or through our online website at myuhc.com/CommunityPlan and using the Find-a-Doc search tool. If you would like a printed directory mailed to your home, you must call Member Services to request one. You can also learn information about network doctors, such as board certifications, and languages they speak, at myuhc.com/CommunityPlan, or by calling Member Services.

We can tell you the following information:

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board certification status

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 **1-800-493-4647** for help.

Questions? Call Member Services **1-800-493-4647**, TTY 711 17
(For a mental health or substance use crisis, press 8)

Part I – First things you should know

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 doctor if:

- You are more than three months pregnant when you join UnitedHealthcare Community Plan and you are getting prenatal care. In that case, you can keep your provider 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 have a long-lasting illness, like HIV/AIDS or other long term health problems, you may be able to choose a specialist to act as your PCP.

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 your PCP three times during the year without cause, or more often if you have a good reason. You can also change your specialist to whom your PCP has referred you.

If your **provider leaves UnitedHealthcare Community Plan**, we will tell you within 15 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 for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with the Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at **1-800-493-4647**.

How to get regular health care

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. Be sure to call him or her 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.

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

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

Your PCP will take care of most of your health care needs, but you must 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 three months of your joining the plan.

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. You should still keep the first appointment to discuss your medical history and ask questions.

Part I – First things you should know

Appointment standards

Use the following list as an appointment guide for our limits on how long you may have to wait after your request for an appointment:

Adult baseline and routine physicals	within 12 weeks
Urgent care	within 24 hours
Non-urgent sick visits	within 3 days
Routine, preventive care	within 4 weeks
First prenatal visit	within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
First newborn visit	within 2 weeks of hospital discharge
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 visit	2 weeks

How to get specialty care and referrals

If you need care that your PCP cannot give, he or she will REFER you to a specialist 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 a 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 UnitedHealthcare Community Plan to approve **before** you can get them. Your PCP will be able to tell you what they are.

Part I – First things you should know

If you are having trouble getting a referral you think you need, contact Member Services at **1-800-493-4647**.

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 out-of-network referral. 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 “preauthorization.” 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” 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 69 to find out how.

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 United Health Care’s provider. You can ask 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 69 to find out how.

If you need to see a specialist for ongoing care, 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.

Part I – First things you should know

If you want your specialist or participating Behavioral Health provider to serve as your PCP, you should discuss this with your specialist or participating Behavioral Health provider and ask the doctor if he or she is willing to serve as your PCP. That means your specialist or participating Behavioral Health provider would be responsible for managing your overall health needs, coordinate referrals for lab testing, x-rays and other specialist visits. If your specialist or participating Behavioral Health provider 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.

Get these services from UnitedHealthcare Community 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
- You need OB/GYN services
- You need family planning services
- You want to see a midwife
- 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 Member Services at **1-800-493-4647** 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 **1-800-493-4647**.
- 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.

Part I – First things you should know

HIV counseling and testing

UnitedHealthcare wants to promote HIV/AIDS prevention. There is information available for people who are at risk for HIV. We can provide you information on how the infection is spread, how to protect yourself if you do not have the infection and how to protect others if you do have the infection. We can provide you information on how to get tested and receive counseling for you and your partner. There are many doctors who specialize in the care of people with HIV.

If you want more information about HIV prevention and how UnitedHealthcare can assist you, or you would like to learn more about UnitedHealthcare's special program designed to assist members who have HIV, call Member Services at **1-800-493-4647** and ask to speak with someone from the Case Management department.

- You can get HIV testing and counseling any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with one of our family planning providers.
- Or, if you'd rather not see one of UnitedHealthcare Community Plan's providers, you can use your Medicaid card to see a family planning provider outside the UnitedHealthcare Community Plan network. For help in finding either a Plan provider or a Medicaid provider for family planning services, call Member Services at **1-800-493-4647**.
- If you want HIV testing and counseling but not as part of a family planning service, your PCP can provide or arrange it for you. Or you can visit an anonymous HIV testing and counseling site. For information, call the New York State HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS.
- If you need HIV treatment after the testing and counseling service, your PCP will help you get follow-up care

Eye care

The covered benefits include the needed services of an ophthalmologist, optometrist and an ophthalmic dispenser, and include 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 drug or alcohol 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 that accepts Medicaid 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. UnitedHealthcare Community Plan will cover as many smoking cessation counseling sessions as are medically necessary.

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 for depression during pregnancy and for up to a year after your delivery.

Emergencies

You are always covered for emergencies. 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 fear 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, or 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.

Part I – First things you should know

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 an emergency.

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

If you have questions, call your PCP or UnitedHealthcare Community Plan at **1-800-493-4647**.

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 your plan's 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 UnitedHealthcare Community Plan. Tell the person you speak with what is happening. Your PCP or Member Services representative will:

- Tell you what to do at home,
- Tell you to come to the PCP's office, or
- Tell you to go to the nearest emergency room.

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

- Go to the nearest emergency room

Urgent Care

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

- This could be a child with an earache who wakes up in the middle of the night and won't stop crying
- 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. Whether you are at home or away, call your PCP anytime, day or night. If you cannot reach your PCP, call us at **1-800-493-4647**. 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, and it will not be covered by UnitedHealthcare Community Plan.

Part I – First things you should know

We want to keep you healthy

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

- Classes for you and your family
- 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 **1-800-493-4647** or visit our website at myuhc.com/CommunityPlan to find out more and get a list of upcoming classes.

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

Medicaid Managed Care provides a number of services you get in addition to those you get with regular Medicaid. UnitedHealthcare Community Plan 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 and counseling; 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. Please call our Member Services department toll-free at **1-800-493-4647**, if you have any questions or need help with any of the services below.

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.

Services covered by UnitedHealthcare Community Plan

You must get these services from the providers who are in UnitedHealthcare Community 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 **1-800-493-4647** 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

Preventive care

- Well-baby care
- Well-child care
- Regular checkups
- Shots for children from birth through childhood
- Access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years
- Eight smoking cessation counseling sessions per calendar year
- Access to free needles and syringes
- HIV education and risk reduction

Mammograms

In Network: Covered.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are medically necessary.

Screening mammograms — Covered once every 12 months — 11 full months must have passed since the last screening (per CMS).

If you are unable to get pregnant, UnitedHealthcare Community Plan covers services that may help.

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 **1-800-493-4647**, TTY **711**.

Maternity care

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

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
- At least 2 visits to high-risk infants (newborns)
- Other home health care visits as needed and ordered by your PCP/specialist

Part II – Your benefits and plan procedures

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 with preparing meals and housekeeping.
- **CDPAS** – Help with bathing, dressing and feeding, help preparing meals and housekeeping, plus home health aide and nursing tasks. This is provided by an aide chosen and directed by you.
- If you want more information, contact Member Services toll-free at **1-800-493-4647**

Personal Emergency Response System (PERS)

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

Adult day health care services

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

AIDS adult day health care services

- Must be recommended by your Primary Care Provider (PCP)
- Provides general medical and nursing care, substance use supportive services, mental health supportive services, nutritional services, plus socialization, recreational and wellness/health promotion activities

Therapy for tuberculosis

- This is help 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 **1-800-493-4647**, 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 or nursing home

Children under age twenty-one (21) who are getting hospice services can also get medically needed curative services and palliative care.

If you have any questions about this benefit, you can call Member Services toll-free at **1-800-493-4647**.

Part II – Your benefits and plan procedures

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!**

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 **1-800-493-4647**. 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 **1-800-493-4647** for the locations of academic dental centers.

If you need to find a dentist or change your dentist, visit our website at myuhc.com/CommunityPlan, or call Member Services at **1-800-493-4647**. Member Services Representatives are there to help you. Many speak your language or have a contract with Language Line Services.

Dental implants

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

UnitedHealthcare Community 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.

Orthodontic care

UnitedHealthcare Community Plan will cover braces for children up to age 21 who have a severe problem with their teeth, such as: can't chew food due to severely crooked teeth, cleft palate or cleft lip.

Vision care

- Services of an ophthalmologist, ophthalmic dispenser and optometrist, and 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 (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
- Enteral formula
- 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 copays for the following members or services:

- Consumers younger than 21 years old
- Consumers who are pregnant. Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.

Part II – Your benefits and plan procedures

- 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)
- Family Planning drugs and supplies like birth control pills and male or female condoms
- Drugs to treat mental illness (psychotropic), substance use disorders, and tuberculosis

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

- 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 **1-800-493-4647**, TTY **711**

- 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.
- Certain medications may require that your doctor get prior authorization from us 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.

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 **1-800-493-4647**, 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 **1-800-493-4647** 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 **1-800-493-4647**.

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 **1-800-493-4647** 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.

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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 **1-800-493-4647**.

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 **1-800-493-4647**. 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
- Infertility drugs
- 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 the 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 25

Specialty care

Includes the services of other practitioners, including:

- Occupational, physical and speech therapists — Limited to twenty (20) visits for occupational and speech therapy and forty (40) visits for physical therapy, per calendar year, except for children under age 21, or if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury. Prior Authorization is required for these therapy services to determine whether the site of care is medically necessary.
- Audiologists
- Midwives
- Cardiac rehabilitation
- Podiatrists, if you are diabetic
- Psychiatrists
- Psychologists
- Licensed social workers
- Psychotherapists

Residential health care facility care (nursing home)

- Includes short term, or rehab, stays and long-term care
- Must be ordered by a physician and authorized by UnitedHealthcare Community Plan
- Covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy, and speech-language pathology

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.

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 may 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 **1-800-493-4647**, TTY **711** for help finding a nursing home in our network.

Rehabilitation

UnitedHealthcare Community Plan covers short-term, or rehab stays, in a skilled nursing home facility.

Long-term placement

UnitedHealthcare Community Plan covers long-term placement in a nursing home facility for members 21 years of age and older.

Long-term placement means you will live in a skilled nursing home.

Eligible veterans, spouses of eligible veterans, and Gold Star parents of eligible veterans may choose to stay in a veterans’ nursing home.

Covered nursing home services include:

- Medical supervision
- 24-hour nursing care
- Assistance with daily living
- Physical therapy
- Occupational therapy
- Speech-language pathology and other services

Part II – Your benefits and plan procedures

To get these nursing home services:

- The services must be ordered by your physician, and
- The services must be authorized by UnitedHealthcare Community Plan.

You must also be found financially eligible for long-term nursing home care by your County Department of Social Services to have Medicaid and/or UnitedHealthcare Community Plan pay for these services.

When you are eligible for long-term placement, you must select one of the nursing homes that is in UnitedHealthcare Community Plan's network.

If you want to live in a nursing home that is not part of UnitedHealthcare Community Plan's network, you may transfer to another plan that works with the nursing home you have chosen to receive your care.

UnitedHealthcare Community Plan does not have a Veterans' Home in its network. If you are an eligible veteran, a spouse of an eligible veteran, or a Gold Star parent of an eligible veteran and you want to live in a Veterans' Home, you may transfer to another Medicaid Managed Care health plan that has a Veterans' Home in its network.

If you have any questions about these benefits, call our Member Services department toll-free Monday–Friday, 8:00 a.m. to 6:00 p.m., at **1-800-493-4647**, TTY **711**.

Durable Medical Equipment (DME)

Durable medical equipment, including the services listed below, is available through any participating DME provider. Participating DME providers are listed in the Provider Directory, or you can call Member Services at **1-800-493-4647** for the location and phone number of a provider near you. The items listed below cannot be obtained through a participating pharmacy; they can only be obtained through a participating DME provider. Some Durable Medical Equipment that costs more than \$500, will require prior authorization. Please call 1-866-604-3267 to see if your DME requires authorization.

- Hearing aids
- Prosthetics
- Orthotics

Physical therapy, occupational therapy and speech therapy

For physical, occupational and speech therapy, your primary care physician will be required to obtain a Prior Authorization for these therapy services to determine whether the site of care is medically necessary. Site of care reviews will be conducted only if the service will be performed in an outpatient hospital. UnitedHealthcare Community Plan covers medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional.

To learn more about these services, call Member Services at **1-800-493-4647**, TTY **711**.

Foot care

Includes routine foot care provided by qualified provider types when any Enrollee's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.

Services provided by a podiatrist for persons under twenty-one (21) are covered upon referral of a physician, registered physician assistant, certified nurse practitioner or licensed midwife.

- Services provided by a podiatrist for adults with diabetes mellitus are covered
- Members can see a podiatrist for all medically necessary foot care
- Routine foot care services (example: trimming of corns, callouses, trimming of nails, cleaning and soaking of feet) are not considered medically necessary and are not covered for members in the absence of a pathology condition by a Podiatrist

Part II – Your benefits and plan procedures

Telehealth

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 videoconference 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.

Gender reassignment

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, even if sterilization will result.)

Medically necessary hormone treatment and/or GRS may be covered for individuals age 18 and older. Payment will not be made for any procedures that are performed solely for the purpose of improving an individual's appearance, unless justification of medical necessity is provided and prior authorization is received.

Blood clotting factor

UnitedHealthcare Community Plan Medicaid Managed Care covers blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies on an inpatient and outpatient basis. We will pay for medically necessary blood clotting factor products and services when infusion occurs in an outpatient setting or in the home. We will cover blood clotting factor services during an inpatient stay.

Mosquito repellent coverage

UnitedHealthcare Community Plan will provide some coverage for mosquito repellent. It must be prescribed to a member who is traveling to or from an area of Zika transmission. These areas are listed by the Centers for Disease Control (CDC) at: <https://wwwnc.cdc.gov/travel/page/zika-information>.

For a full list of covered products, please go to <https://www.uhccommunityplan.com/ny/medicaid/medicaid-uhc-community-plan/lookup-tools#collapse-1551303021>. A quantity limit of 2 cans per month will be applied to all these products.

Zika is a serious illness. To stop the spread of the Zika virus, UnitedHealthcare will pay for repellent until the CDC states that Zika is no longer a risk.

Case management

UnitedHealthcare has a special care management program designed to assist members with serious and complex medical conditions, including:

- HIV/AIDS
- Kidney Failure
- High Blood Pressure
- Emphysema (COPD)
- Diabetes
- Asthma
- Sickle Cell Anemia
- Congestive Heart Failure
- Heart Disease
- Hemophilia
- Cancer
- High-Risk Pregnancy

If you would like information about how these programs may help you, call Member Services **1-800-493-4647**, TTY **711**, and ask to speak with someone from the Case Management department.

Part II – Your benefits and plan procedures

Case Management programs are typically available for members who need help managing chronic illnesses. If you are interested in joining a Case Management program, UnitedHealthcare Community Plan will conduct an assessment to determine if you are eligible for Case Management. Case Management services will be provided for as long as medically necessary or until your medical condition can be self-managed.

Health Home Care Management

UnitedHealthcare Community Plan wants to meet all of your health needs. If you have multiple health issues, you may benefit from Health Home Care Management to help coordinate all of your health services. The goal of the Health Home program is to make sure its members get the care and services they need. This may mean fewer trips to the emergency room or less time spent in the hospitals, getting regular care and services from doctors and providers, finding a safe place to live, and finding a way to get the medical appointments.

A Health Home Care manager can:

- Work with your PCP and other providers to coordinate all of your health care;
- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Help with appointments with your PCP and other providers; and
- Help manage on going medical issues like diabetes, asthma, and high blood pressure.

To learn more about Health Homes, contact Members Services at **1-800-493-4647**. In order to be eligible for Health Home services, the individual must be enrolled in Medicaid and must have:

- Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*); or
- One single qualifying chronic condition: HIV/AIDS; or
- Serious Mental Illness (SMI) (Adults); or
- Serious Emotional Disturbance (SED) or Complex Trauma (Children).

If an individual has HIV or SMI, they do not have to be determined to be at risk of another condition to be eligible for Health Home services. Substance use disorders (SUDS) are considered chronic conditions and do not by themselves qualify an individual for Health Home services. Individuals with SUDS must have another chronic condition to qualify. Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice, etc.), and does not automatically make a child eligible for Health Home. In addition, the Medicaid member must be appropriate for the intensive level of care management services provided by the Health Home (i.e., satisfy the appropriateness criteria).

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 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 **1-800-493-4647**, TTY **711**. Language help is available.

Family planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning providers as well. 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.

Transportation

Emergency transportation

If you need emergency transportation, call 911.

Non-emergency transportation

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. Please see page 53 for additional information.

Other covered services

- Durable medical equipment (DME)/hearing aids/prosthetics/orthotics
- Court-ordered services
- Help getting social support services
- Federally Qualified Health Center (FQHC)
- Family planning
- Services of a podiatrist for medically needed conditions

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:

Adult 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 18 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 18 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)

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- 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

Mental health care for individuals under age 21

All eligible children under age 21:

- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation bed
- Partial hospitalization
- Inpatient psychiatric services
- Individual and group counseling through OMH clinics
- Children and Family Treatment and Support Services (CFTSS), including:
 - Other Licensed Practitioner (OLP)
 - Psychosocial Rehabilitation (PSR)
 - Community Psychiatric Supports and Treatment (CPST)
 - Family Peer Support Services (FPSS)
 - Crisis Intervention
 - Youth Peer Support and Training (YPST)
- Psychiatric services
- Psychological services
- Injections for behavioral health related conditions

Children’s crisis residence

This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

Eligible children under age 21 (minimum age of 18-20):

- Assertive Community Treatment (ACT)
- Continuing day treatment
- Personalized Recovery Oriented Services (PROS)

Substance Use Disorder Services for individuals under age 21

- Crisis services
 - Medically managed withdrawal management
 - Medically supervised withdrawal management (inpatient/outpatient* *)
- Inpatient addiction treatment services (hospital or community based)
- Residential addiction treatment services
 - Stabilization in residential setting
 - Rehabilitation in residential setting
- Outpatient addiction treatment services
 - Intensive outpatient treatment
 - Outpatient rehabilitation services
 - **Outpatient withdrawal management
 - Medication assisted treatment
- Opioid Treatment Programs (OTP)

Part II – Your benefits and plan procedures

Children’s Home and Community Based Services

New York State covers Children’s Home and Community Based Services (HCBS) under the children’s waiver. UnitedHealthcare Community Plan covers children’s HCBS for members participating in the children’s waiver and provide care management for these services.

Children’s HCBS offer personal, flexible services to meet the needs of each child/youth. HCBS is provided where children/youth and families are most comfortable and supports them as they work towards goals and achievements.

Who is eligible to get Children’s HCBS?

Children’s HCBS are for children and youth who:

- Need extra care and support to remain at home/in the community
- Have complex health, developmental and/or behavioral health needs
- Want to avoid going to the hospital or a long-term care facility
- Are eligible for HCBS and participate in the children’s waiver

Members under age 21 will be able to get these services from their health plan:

- Community habilitation
- Day habilitation
- Caregiver/family support and services
- Community self-advocacy training and support
- Prevocational services – must be age 14 and older
- Supported employment – must be age 14 and older
- Respite services (planned respite and crisis respite)
- Palliative care
- Environmental modifications
- Vehicle modifications
- Adaptive and assistive equipment

Children/youth participating in the children’s waiver must receive care management. Care management provides a person who can help you find and get the services that are right for you.

- If you are getting care management from a Health Home Care Management Agency (CMA), you can stay with your CMA. UnitedHealthcare Community Plan will work with your CMA to help you get the services you need.
- If you are getting care management from the Children and Youth Evaluation Service (C-YES), UnitedHealthcare Community Plan will work with C-YES and provide your care management.

To learn more about these services, call Member Services at **1-800-493-4647**, TTY **711**.

52 **Questions?** Call Member Services **1-800-493-4647**, TTY **711**
(For a mental health or substance use crisis, press 8)

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

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Contact number	County	Who provides transportation
716-858-8000	Erie County	Medical Answering Service – MAS
866-753-4442	Essex County	Medical Answering Service – MAS
888-262-3975	Franklin 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
866-666-8653	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
866-260-2305	Orleans County	Medical Answering Service – MAS
855-733-9395	Oswego County	Medical Answering Service – MAS

54 **Questions?** Call Member Services **1-800-493-4647**, TTY **711**
 (For a mental health or substance use crisis, press 8)

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Contact number	County	Who provides transportation
844-666-6270	Queens County	Medical Answering Service – MAS
866-666-8653	Rensselaer County	Medical Answering Service – MAS
844-666-6270	Richmond County (Staten Island)	Medical Answering Service – MAS
855-360-3542	Rockland County	Medical Answering Service – MAS
855-852-3291	Schenectady 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
866-753-4467	Yates 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.

Additional covered services by UnitedHealthcare Community Plan

Developmental disabilities

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Medical Model (Care-at-Home) Waiver Services

Other Medicaid services

- Pre-school and school services programs (early intervention)
- Early start programs

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
- Except for medical emergencies as defined under Part II in this handbook, we do not cover services received outside of the plan’s service area
- 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 sent you to that provider
- Services for which you need a referral (approval) in advance and you did not get it

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

Note: It is the policy of the New York State Department of Health that Medicaid recipients receive breast cancer surgery services at high volume facilities — those performing 30 or more all-payer mastectomy and lumpectomy procedures associated with a breast cancer diagnosis on average over a three-year period. Low-volume facilities, identified in the listing below, will not be reimbursed for breast cancer surgeries provided to Medicaid recipients. This policy does not affect a facility’s ability to provide diagnostic or excisional biopsies, and post-surgical care (chemotherapy, radiation, reconstruction, etc.) for Medicaid patients. Visit https://www.health.ny.gov/health_care/medicaid/quality/surgery/cancer/breast/ for a list of facilities NOT COVERED by Medicaid.

Part II – Your benefits and plan procedures

If you get a bill

UnitedHealthcare provides a full range of health care services at no cost to you. You never have to pay your PCP or any other UnitedHealthcare participating provider anything. You should not be charged for any approved services offered through UnitedHealthcare when you get them from a UnitedHealthcare Community Plan provider. Starting July 1, 2016, the Health Plan must further ensure the risk for accidental release of confidential health information is reduced for all minor members (0–17 years of age). To do so, the Health Plan will not be sending notices to members about claim payment denials including dental and behavioral health claims.

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 **1-800-493-4647** 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.

The health plan is required to protect minor confidentiality (age 0–17) and therefore, will not be sending notices to members of claim payment denials. If you receive a bill for health care services, and you did not receive a notice from the health plan, you may contact Member Services at **1-800-493-4647**, 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 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 Hearing** section later in this handbook.

If you have any questions, call Member Services at **1-800-493-4647**.

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 **1-800-493-4647** 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.

Part II – Your benefits and plan procedures

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.

60 **Questions?** Call Member Services **1-800-493-4647**, TTY **711**
(For a mental health or substance use crisis, press 8)

Service authorization

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
- Certain 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
- 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 (excludes oral medications)
- 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 reassignment post-transitional therapy

Part II – Your benefits and plan procedures

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 of the 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 care. 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 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**, we use to make decisions about medical necessity.

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

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 of a service than 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 **Plan Appeals** and **Fair Hearing** sections later in this handbook.)

62 **Questions?** Call Member Services **1-800-493-4647**, TTY **711**
(For a mental health or substance use crisis, press 8)

Time frames 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.

Time frames 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 you need more information.

Special time-frames for other requests:

- If you are in the hospital or have just left the hospital, and you ask for home health care on a Friday or day before a holiday, we will make a decision within 72 hours of your request of when we have all the information we need
- 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.

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

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

Part II – Your benefits and plan procedures

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-800-493-4647**, 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 your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your 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 Appeal** section later in this handbook.

Other decisions about your care

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

Time frames 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, adult day health care, and permanent 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 all information we need 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 by Medicaid even if we later deny payment to the provider.**

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 **1-800-493-4647** 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 **1-800-493-4647** to find out how you can help.

Information from Member Services

Here is information you can get by calling Member Services at **1-800-493-4647**.

- 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 UnitedHealthcare Community Plan checks on the quality of care to our members

Questions? Call Member Services **1-800-493-4647**, TTY 711 65
(For a mental health or substance use crisis, press 8)

Part II – Your benefits and plan procedures

- 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 in writing, we will tell you the qualifications needed and how health care providers can apply to be part of UnitedHealthcare Community Plan
- If you ask, we will tell you: 1) whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so, 2) information on the type of incentive arrangements used; and 3) whether stop loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works

Please send all written requests to:

Member Services Department
UnitedHealthcare Community Plan
P.O. Box 1037
New York, NY 10268-1037

Keep us informed

Call Member Services at **1-800-493-4647** 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 or your children

If you have a change in address, telephone number or you have moved outside of New York State, you must notify your local Department of Social Services or New York City Human Resources Administration of these changes. You may be required to present proof of your new address by visiting your Local DSS or NYC HRA office. Medicaid maintains your demographic information and it is important that you report these changes immediately to ensure that you receive important information like changes in benefits, and/or your renewal form.

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. When benefits end or 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) to disenroll from our plan.

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
- You are a child that has entered foster care at the LDSS and need to transfer to a new plan to see the appropriate providers
- We do not have a contract with the nursing home you are living in or are going to live in, and you need to transfer to a plan that does

To change plans

If you live in Broome, Chautauqua, Herkimer, Niagara, Oneida, Rensselaer, Seneca or Wyoming county, call your managed care staff at your local Department of Social Services. Tell them you want to transfer to another Medicaid Managed Care plan, and they will send the necessary forms to transfer to you. Fill out the forms and either mail or take them to the local Department of Social Services office. You will get a notice that the change will take place by a certain date. We will provide the care you need until then. The phone numbers for the local Departments of Social Services are listed in the front of this handbook.

Part II – Your benefits and plan procedures

In New York City, Albany, Cayuga, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Fulton, Genesee, Greene, Jefferson, Lewis, Livingston, Madison, Monroe, Nassau, Onondaga, Ontario, Orange, Oswego, Rockland, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, or Westchester counties, call New York Medicaid Choice at 1-800-505-5678, to change health plans or disenroll. The New York Medicaid-Choice counselors can help you change health plans.

You may be able to 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

During transition from pediatric to adult care, you or your child may have to leave UnitedHealthcare Community Plan if you or the child:

- 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
- Otherwise lose eligibility

Your child may have to leave UnitedHealthcare Community Plan or * change plans if he or she:

- Joins a Physically Handicapped Children's Program; or
- Is placed in foster care by an agency that has a contract to provide that service for the local Department of Social Services, including all children in foster care in New York City, or
- * Is placed in foster care by the local Department of Social Services in an area that is not served by your child's current plan.

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);
- Cause abuse or harm to plan members, providers or staff; or
- 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.

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 work day.

Part II – Your benefits and plan procedures

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 to ask for a Plan Appeal
- You can call Member Services at **1-800-493-4647** 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 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.

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 your 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.

You can call, 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

Part II – Your benefits and plan procedures

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 **1-800-493-4647**. Give us your information and materials by phone or mail:

Phone **1-800-493-4647**

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 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 Appeal** section later in this handbook.

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 Appeal** section later in this handbook.

Part II – Your benefits and plan procedures

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 Community Plan at **1-800-493-4647** 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
- 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:
 - You can ask for a Fair Hearing. See the **Fair Hearing** section of this handbook.
 - For some decisions, you may be able to ask for an External Appeal. See the **External Appeal** section of this handbook.
 - File a complaint with the New York State Department of Health at 1-800-206-8125

Time frames 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 ask for your Plan Appeal. A written notice of our decision will be sent within 2 working days from when we make the decision.
- **Fast track Plan 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 ask for your Plan Appeal.
 - We will tell you within 72 hours, if we need more information
 - 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
 - We will tell you our decision by phone and send a written notice later

Part II – Your benefits and plan procedures

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 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

Your 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 decide your case. This can be done by calling toll-free **1-800-493-4647** 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 file this complaint with the health plan by calling Member Services at **1-800-493-4647** (if you have trouble hearing, call the TDD Relay Service at **711**) or 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 Hearing** section of this handbook.

Part II – Your benefits and plan procedures

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

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

the original denial 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 a Plan Appeal:**

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

If your Plan Appeal results in another denial, ask for a Fair Hearing. See the **Fair Hearing** section later in this handbook. If you lose your plan appeal and Fair Hearing, 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; or
- Experimental or investigational; or
- Not different from a service that is available in our network; or
- Available from a plan provider who has the 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.

Part II – Your benefits and plan procedures

Before you ask for an external appeal:

- You must file a Plan Appeal with the plan 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 with the plan, 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 **1-800-493-4647** 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 **1-800-493-4647**

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.

Part II – Your benefits and plan procedures

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your fast track Internal 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 or stops your service, you can ask for a Fair Hearing. You may ask for a fair hearing and ask for an External Appeal. 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

In some cases 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 with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
 - reduce, suspend or stop care you were getting; or
 - deny care you wanted;
 - deny payment for care you received; or
 - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.

Part II – Your benefits and plan procedures

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 will be final.

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

1. By phone, call toll-free 1-800-342-3334
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 **1-800-493-4647** to ask for it.

The health plan is required to protect minor confidentiality (age 0–17) and therefore, will not be sending notices to members of claim payment denials.

Starting July 1, 2016, the Health Plan must further ensure the risk for accidental release of confidential health information is reduced for all minor members (0–17 years of age). To do so, the Health Plan will not be sending notices to members about claim payment denials including dental and behavioral health claims.

Part II – Your benefits and plan procedures

If you receive a bill for health care services, you may contact Member Services at **1-800-493-4647**, 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.

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

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 at **1-800-493-4647**, TTY **711** 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 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 DHP CO 1CP-1609
New York Department of Health
Albany, NY 12237

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

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(For a mental health or substance use crisis, press 8)

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 by phone, call Member Services toll-free at **1-800-493-4647**, 8:00 a.m.–6:00 p.m., Monday–Friday. If we need more information to make a decision, we will tell you.

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

Member 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 work days. The letter will tell you:

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

You can also provide information to be used reviewing your complaint in person or in writing. Call the plan at **1-800-493-4647**, TTY **711** 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 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need
- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know

Complaint appeals

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

How to make a complaint appeal

- If you are not satisfied with what we decide, you have at least 60 work 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 a complaint 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 complaint 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. Please send all written correspondence to:

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

What happens after we get your complaint appeal

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

- Who is working on your complaint appeal
- How to contact someone at UnitedHealthcare about your complaint appeal
- 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 work days. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the 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.

Member rights and responsibilities

Your rights

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

- Get information about UnitedHealthcare, its services, its practitioners and providers and member rights and responsibilities
- 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
- Be told where, when and how to get the services you need from UnitedHealthcare Community Plan
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand
- Get a second opinion about your care from an in-network provider, or from OON at no additional cost if an in-network provider is not available
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval
- Use the UnitedHealthcare 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 anytime you feel you were not fairly treated
- Make recommendations regarding the organization's member rights and responsibilities policy
- 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
- To have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage

Part II – Your benefits and plan procedures

Your responsibilities

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

- Work with your PCP to guard and improve your health
- To supply true and complete information that the organization and its practitioners and providers need in order to provide care
- To follow plans and instructions for care that you have agreed to with your practitioner
- To understand health problems and participate in developing mutually agreed-upon treatment goals
- Find out how your health care system works
- Listen to your PCP's advice and ask questions when you are in doubt
- Call or go back to your PCP if you do not get better, or ask for a second opinion
- Treat health care staff with the respect you expect yourself
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies
- Call your PCP when you need medical care, even if it is after-hours

Advance Directives

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

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

- **CPR and DNR** – You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.
- **Organ Donor Card** – This wallet-sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver’s license to let others know if and how you want to donate your organs.

Definitions

Advocacy: The spirit of this work is one that promotes effective parent/caregiver-professional-systems partnerships. Advocacy in this role does not include legal consultation or representation. It is defined as constructive, collaborative work with and on behalf of families to assist them to obtain needed services and supports to promote positive outcomes for their children.

Behavioral Health (BH): Refers to mental health and/or SUD benefits and/or conditions.

Behavioral Health Service (BH Service): Any or all of the services identified in Table 2 (Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Populations under 21) of this document.

Behavioral Health Professional (BHP):¹² An individual with an advanced degree in the mental health or addictions field who holds an active, unrestricted license to practice independently or an individual with an associate’s degree or higher in nursing who is a registered nurse with three years of experience in a mental health or addictions setting. BHPs, as described in Section 3.2 (Personnel) of this document, will be specified as either a NYS or United States (U.S.) BHP. When specified as a NYS BHP, the individual must hold an active, unrestricted license to practice independently in NYS or be a registered nurse in NYS. When specified as a U.S. BHP, the individual may meet the licensure requirement with an active, unrestricted license to practice independently or be a registered nurse in any state in the U.S.

Caregiver/Legal Guardian: The adult or adults that have the legal decision making and consent authority for the child or youth in care/services. This may include the parent(s), OCFS, LDSS, etc.

Part II – Your benefits and plan procedures

Community First Choice Option (CFCO): Enhanced services and supports for eligible individuals who need assistance with everyday activities due to a physical, developmental or behavioral disability. These services and supports address activities of daily living, instrumental activities of daily living and health-related tasks through hands-on assistance, supervision and/or cueing. Medicaid recipients must meet HCBS setting requirements and institutional LOC criteria, as well as other eligibility criteria, to be eligible for CFCO services. CFCO services must be provided pursuant to a Person-Centered Service Plan. More information is available at https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm.

Credentialed Alcoholism and Substance Abuse Counselor (CASAC): Credentialed Alcoholism and Substance Abuse Counselor as defined by OASAS in 14 NYCRR Part 853.

Certified Recovery Peer Advocate – Family: OASAS-certified peer support specialist with special “Family” training and designation.

Certified Recovery Peer Advocate – Youth: OASAS-certified peer support specialist with special “Youth” training and designation.

Child and Adolescent Needs and Strengths Assessment – New York (CANS-NY): Validated, structured, child/youth assessment tool comprised of domains relevant to determining a child/youth’s and family’s strengths and needs. This tool is used to assist with care coordination for members enrolled in Health Homes. The CANS-NY will also be used to determine certain child/youth populations’ HCBS eligibility. For more detailed information on eligibility, refer to Attachments A and B.

Child/Adolescent/Youth: Individuals under age 21.

Children’s Medicaid Redesign Team: A subcommittee of the MRT commissioned by Governor Andrew Cuomo in an effort to restructure the Medicaid program. The Children’s subcommittee participated in the development and design of the children’s MRT initiatives. For more information visit: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/child_mrt.htm.

Children’s Continuous Episode of Care: A course of ambulatory health or behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the Children’s Expanded Benefit Inclusion in which a service under the NY OMH Serious Emotional Disturbance Waiver (0296.R03.00), NY Bridges to Health for Children w/Serious Emotional Disturbance Waiver (0469.R01.00), NY Bridges to Health for Children w/Developmental Disabilities Waiver (0470.R01.00), NY Bridges to Health for Children who are Medically Fragile (0471.R01.00), or NY Care at Home I/II (4125.R04.00) Waivers had been provided at least twice during the six months preceding the Children’s Expanded Benefit Inclusion date by the same provider to an Enrollee under the age of 21 for the treatment of the same or related health or behavioral health condition.

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(For a mental health or substance use crisis, press 8)

Part II – Your benefits and plan procedures

Children’s Specialty Services: Services to address mental health, physical health and/or substance use disorders, including: Early Periodic Screening, Diagnostic, and Treatment Services and health and behavioral health; services as defined in 18 NYCRR Part 507 and authorized by the State to be provided by designated treatment providers pursuant to rules and regulations of the State for individuals under the age of 21; and Children’s Home and Community Based Services.

Collateral: A person who is a member of the child/youth’s family or household, or other individual who regularly interacts with the child/youth and is directly affected by or has the capability of affecting his or her condition, and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the child/youth.

Complex Trauma: Complex Trauma is a single qualifying eligibility condition for Health Home and is part of the LON target criteria for HCBS for the Abuse, Neglect and Maltreatment or Health Home complex trauma population. The definition of Complex Trauma was developed in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Child Traumatic Stress Network (NCTSN), www.nctsn.org. The definition of complex trauma is as follows:

- A. The term complex trauma incorporates at least:
 - i. infants/children/adolescents’ with exposure to multiple traumatic events, often of an invasive, interpersonal nature,[1] and ii) the wideranging, longterm impact of this exposure.
- B. The nature of the traumatic events:
 - i. Often is severe and pervasive, such as abuse or profound neglect;
 - ii. Usually begins early in life;
 - iii. Can be disruptive of the child’s development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
 - iv. Often occur in the context of the child’s relationship with a caregiver; and
 - v. Can interfere with the child’s ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.
- C. Many aspects of a child’s healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.
- D. Wide-ranging, long-term adverse effects can include impairments in:
 - i. Physiological responses and related neurodevelopment,
 - ii. Emotional responses,
 - iii. Cognitive processes including the ability to think, learn, and concentrate,
 - iv. Impulse control and other self-regulating behavior,
 - v. Self-image,
 - vi. Relationships with others, and
 - vii. Dissociation.

Part II – Your benefits and plan procedures

Complex trauma information, tools, and forms (including Complex Trauma Exposure, Assessments and Eligibility Determination forms) can be found at the Department of Health’s website.

Court-Ordered Services: Services the Plan is required to provide to enrollees pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the Plan’s benefit package and reimbursable under Title XIX of the Federal Social Security Act, SSL 364-j(4)(r).

Crisis Plan: A tool utilized by providers for children/youth in order to assist in: reducing or managing crisis related symptoms; promoting healthy behaviors; addressing safety measures; and/or preventing or reducing the risk of harm or diffusion of dangerous situations. The child/youth/family will be an active participant in the development of the crisis plan. With the family’s consent, the crisis plan may be shared with collateral contacts also working with that child/youth/family who might provide crisis support or intervention in the future. Sharing the crisis plan helps to promote future providers’ awareness of and ability to support the strategies being implemented by the child/youth/family.

Cultural Competency: An awareness and acceptance of cultural differences, an awareness of individual cultural values, an understanding of how individual differences affect those participating in the helping process, a basic knowledge about the client’s culture, knowledge of the client’s environment, and the ability to adapt practice skills to fit the individual or family cultural context.

Days: Refers to calendar days except as otherwise stated.

Demonstration: The four BH Demonstration services already included under the 1115 demonstration in managed care and will be expanded to children enrolled in managed care:

- Outpatient addiction services,
- Residential addiction services,
- Licensed Behavioral Health Practitioners, and
- Crisis Intervention.

Department of Health (DOH): http://www.health.ny.gov/health_care/managed_care/

Developmental Disability: A child having a DD as defined by OPWDD which: is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism; is attributable to any other condition found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such children; is attributable to dyslexia resulting from a disability described above; originated before the child turns 22 years old; has continued or can be expected to continue indefinitely; and constitutes a substantial handicap to such child’s ability to function normally in society.

Part II – Your benefits and plan procedures

Developmental Milestones: Markers across lifespan that are typically assessed throughout childhood. Milestones include physical, emotional, cognitive, social and communication skills.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

Essential Community Behavioral Health Providers: Essential Community Behavioral Health Providers include the following:

- A. State-operated providers of ambulatory mental health services, service providers;
- B. State-operated providers of Behavioral Health Home and Community Based Services; and
- C. Opioid Treatment Programs;
- D. OMH licensed outpatient clinics licensed to treat children ages 0–5 years;
- E. Comprehensive Psychiatric Emergency Programs that serve children;
- F. OMH licensed inpatient psychiatric services for children located within hospitals licensed under Article 28 of the New York State Public Health Law; and
- G. Hospitals designated under Mental Hygiene Law § 9.39 serving children.

Evidence-Based Practice (EBP): The Institute of Medicine (IOM) defines “evidence-based practice” as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values.* These factors are also relevant for child welfare. The State has adopted the IOM’s definition for EBP with a slight variation that incorporates child welfare language: best research evidence, best clinical experience, and consistent with family/client values. This definition builds on a foundation of scientific research while honoring the clinical experience of child welfare practitioners, and being fully cognizant of the values of the families served.

* Institute of Medicine, 2001. **Crossing the quality chasm: A new health system for the 21st century.** Washington, DC: National Academy Press

Family: Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Family Member: Parent, grandparent, sibling, aunt, uncles, etc. that is biological, foster/adoptive or invested in the care of the child/youth.

Part II – Your benefits and plan procedures

Family of One: A commonly used phrase to describe a child that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow a budgeting methodology for children to meet Medicaid financial eligibility criteria as a “family of one,” using the child’s own income and disregarding parental income.

Family Peer Advocate: OMH certified peer support specialist.

First Episode Psychosis (FEP): Members with FEP are individuals who have displayed psychotic symptoms suggestive of recently-emerged schizophrenia. FEP generally occurs in individuals age 16–35. FEP includes individuals whose emergence of psychotic symptoms occurred within the previous two years, who remain in need of mental health services, and who have a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, psychotic disorder not otherwise specified (DSM-IV), or other specified/unspecified schizophrenia spectrum and other psychotic disorder (DSM-5). The definition of FEP excludes individuals whose psychotic symptoms are due primarily to a mood disorder or substance use.

Healthcare Effectiveness Data and Information Set (HEDIS): The set of performance measures used in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

Health Home Care Management: Health Home is a care management service model for individuals enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Health Home care managers provide person-centered, integrated physical and behavioral health care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high need Medicaid members with chronic conditions.

In April 2016 New York State received CMS approval to expand and tailor the Health Home model to serve children under 21 beginning in the Fall of 2016. As defined and implemented by the Medicaid State Plan, Health Home care management includes the six core functions, and the provision of required care plans for HCBS. The six core functions include:

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Enrollee and Family Support
- Referral to Community and Social Supports
- Use of Health Information Technology to Link Services

Part II – Your benefits and plan procedures

All children receiving HCBS are eligible for Health Home care management under the children's 1115 MRT waiver amendment in addition to children eligible for Health Home under the Medicaid State Plan. For children who opt-out of Health Homes, the Plan or a State Designated Entity for FFS enrolled children will conduct the HCBS assessment, plan of care (POC) development and on-going monitoring of the POC.

Home Setting or Community Setting: The setting in which a child primarily resides or spends time, as long as it is not a hospital nursing facility, Intermediate Care Facility (ICF), or psychiatric nursing facility. Note: this is distinguished from a HCBS. State Plan services, including the new EPSDT OLP and Rehabilitation services as well as Clinic Services, do not have to comply with the HCBS settings rule, 42 CFR 441.301 and 530.

Inpatient Classified Settings: Medicaid compensable 24 hour levels of care that NYS has classified as inpatient, including but not limited to acute psychiatric inpatient facilities, psychiatric RTFs, and Chemical Dependence RRSY.

Level of Care for Alcohol and Drug Treatment Referral (LOCADTR): LOCADTR is developed and updated, as appropriate, by OASAS and is the clinical LOC tool that assesses the intensity and need of services for an individual with a SUD. It is to be used in making all initial and ongoing LOC decisions in NYS. For more information please visit: <https://oasas.ny.gov/treatment>.

Licensed Practitioner of the Healing Arts (LPHA): An individual professional who is licensed practicing within the scope of their State license including: Physician, Psychiatrist, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, Licensed Psychologist, Licensed Master Social Worker (LMSW), Clinical Nurse Specialist, and Physician Assistants. The licensed professional is responsible for ensuring that the diagnosis, recommendation, referral, supervision, and/or care provided is within their scope of practice under current state law.

Local Department of Social Services (LDSS): Each County has an LDSS that provides or administers the full range of publicly funded social services and cash assistance programs. In NYC, these departments are named the Human Resources Administration and Administration for Children's Services.

Medicaid Managed Care Organization (MMCO): MCOs certified by NYS to manage health and BH services for Medicaid beneficiaries who are not also eligible for Medicare. MMCOs also include HIV Special Needs Plans (HIV SNPs).

Part II – Your benefits and plan procedures

Medically Fragile Children: The NYS Office of Health Insurance Programs (OHIP) has historically defined Medically Fragile as children who have a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meet one or more of the following criteria: is technologically dependent for life or health sustaining functions; requires complex medication regimen or medical interventions to maintain or to improve their health status; or is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at-risk.

Chronic debilitating conditions include, but are not limited to: bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy. All health plans must comply with MFC requirements for any MFC child.

Medically Fragile Level of Care (LOC) Population: A child under age 21 with a documented physical disability following state demonstration protocols. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at risk of institutionalization. The LPHA has submitted written clinical documentation to support the determination. The child has received a face-to-face assessment and been found to meet hospital or nursing facility admission criteria. The child is eligible to receive LOC HCBS services including CFCO services if CFCO requirements are met.

Medical Necessity: New York law defines “medically necessary medical, dental, and remedial care, services, and supplies” in the Medicaid program as those “necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law” (N.Y. Soc. Serv. Law, § 365-a).

Mental Health Parity and Addiction Equity Act (MHPAEA):* The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or SUD benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. In March 2016, the CMS published the final rule addressing the application of certain requirements set forth in MHPAEA to coverage offered by MMCOs, Medicaid Alternative Benefit Plans, and Children’s Health Insurance Programs. <https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf>

* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

Natural Supports: Natural supports are individuals and informal resources that a family/caregiver can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child and family/caregiver after formal services have ended. Natural supports can include, but are not limited to family members, friends, neighbors, clergy, and other acquaintances.

90 **Questions?** Call Member Services **1-800-493-4647**, TTY **711**
(For a mental health or substance use crisis, press 8)

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Non-Physician Licensed Behavioral Health Professional (NP-LBHP): NP-LBHPs include individuals licensed and able to practice independently for which reimbursement is authorized under the Other Licensed Practitioner section of the Medicaid State Plan. Non-physician NP-LBHP include: Licensed Psychoanalysts, LCSW, Licensed Marriage & Family Therapists and Licensed Mental Health Counselors. NP-LBHPs also include the following individuals who are licensed to practice under supervision or direction of a LCSW, a Licensed Psychologist, or a Psychiatrist: LMSW. Note: Psychiatrists, Licensed Physician Assistants, Licensed Physicians, Psychologists, and Licensed Nurse Practitioners are licensed practitioners, but not referred to as NP-LBHPs.

Office of Alcoholism and Substance Abuse Services (OASAS): <https://oasas.ny.gov/>

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

Office of Mental Health (OMH): <https://www.omh.ny.gov/omhweb/about/>

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

Person-Centered Care: Services that are family-driven, youth-guided and reflect a child and family’s goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services must be designed to optimally treat illness, improve clinical and psychosocial outcomes, and emphasize wellness and attention to the family’s overall well-being and the child’s full community inclusion.

Plan: the MMCO.

Plan of Care (POC): The written plan that describes the type, level and duration of services and care necessary to treat the assessed needs for Children/Youth.

Preventive Care: The care or services rendered to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term “preventive care” is used to designate prevention and early detection programs rather than treatment programs.

Provider Agreement: Any written contract between the Plan and a participating service provider to provide medical care and/or services to Plan enrollees.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or SUDs. Specifically, services support the acquisition of living, vocational, and social skills and are offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

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Regional Planning Consortium (RPC): A Regional Behavioral Health planning Consortium, which is comprised of the Local Government Unit(s) in each region, representatives of mental health and Substance Use Disorder service providers, child welfare system, peers, families, Health Homes, and MCOs. The RPC works closely with State agencies to guide policy as it relates to Medicaid Managed Care in the region, problem solve regional service delivery challenges, and recommend provider training topics.

Resilience: The principle that children/youth have qualities that equip them and/or can be strengthened to help them manage through the effects of adversity or trauma and help them to cope, survive and even thrive.

Serious Emotional Disturbance (SED): A designated mental illness diagnosis according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a child or adolescent who has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- A. Ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- B. Family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- C. Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- D. Self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- E. Ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

To be eligible for Health Home due to SED, SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following DSM categories¹⁵ as defined by the most recent version of the DSM of Mental Disorders AND has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis.

DSM Qualifying Mental Health Categories:

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders

Functional limitations requirements for SED definition of Health Home – To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents; or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/4_29_2015_children_webinar.pdf (pages 16 and 17)

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Single Case Agreement (SCA): An agreement between a non-contracted provider and the MMCO with in which the provider is reimbursed for the care for one specific child’s case.

Start-Up Date: The date the Plan will begin providing health services described in this document.

Substance Use Disorder (SUD): A diagnosis of a SUD is a pathological pattern of behaviors related to the use of a substance. The diagnosis of SUD is based on criteria defined in the DSM and can be applied to all ten classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, anxiolytics; stimulants; tobacco; and other (or unknown) substances.

Teaching Family Home: A home which provides specially trained teaching parents who provide individualized care for up to four children/adolescents with SEDs at a time in a family setting.

Transition Aged Youth (TAY): Individuals under age 23 transitioning into the adult system from any OMH, OASAS or OCFS licensed, certified, or funded children’s program. This also includes individuals under age 23 transitioning from State Education 853 schools (These are operated by private agencies and provide day and/or residential programs for students with disabilities).

Trauma: Affects a child’s sense of safety, ability to regulate emotions and capacity to relate well to others. Trauma is defined as exposure to a single severely distressing event or multiple, chronic, or prolonged traumatic events as a child or adolescent which is often invasive and interpersonal in nature.

Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be modified to be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

Treatment Plan: A treatment plan describes the child’s condition and services that will be needed for that Episode of Care, detailing the practices to be provided, expected outcome, and expected duration of the treatment for each provider. The treatment plan should be culturally relevant, trauma informed, and person-centered.

Voluntary Foster Care Agency (VFCA): A foster care agency responsible for the temporary custody and care of children/youth placed in foster care either by order of a court (involuntary) or because their parents are willing to have them cared for temporarily outside the home (voluntary). As of December 2016, there were 93 VFCAs operating in NYS.

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, we¹ 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.uhcommunityplan.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.

Part II – Your benefits and plan procedures

- **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.

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- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
 1. Alcohol and Substance Use
 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.

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- **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.; UnitedHealthcare 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.

We² 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.

Part II – Your benefits and plan procedures

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.; Lifepoint East, Inc.; Lifepoint 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.

