



Welcome to the  
**community.**

**New York**

Medicaid Managed Care Member Handbook  
Revised July 2017



## 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**

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 1-800-868-1019, 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**, Monday – Friday 8:00 a.m. to 6:00 p.m.

**Member Services 1-800-493-4647 (For a Mental Health or Substance Abuse Crisis press 8)**

## LANGUAGE ASSISTANCE

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 TTY/711.	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: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-493-4647 TTY/711.	Albanian/ Shqip
ΠΡΟΣΟΧΗ: Στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-493-4647 TTY/711.	Greek/ Ελληνικά
توجه دیں: 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

**Member Services 1-800-493-4647 (For a Mental Health or Substance Abuse Crisis press 8)**



# Important Phone Numbers

<b>Member Services Department</b> (Monday – Friday 8:00 a.m. to 6:00 p.m.)	<b>1-800-493-4647</b>
TDD/TTY (for the hearing impaired)	<b>711</b>
<b>Your Primary Care Physician:</b>	See Your UnitedHealthcare Community Plan ID Card
<b>NurseLine</b>	<b>1-877-597-7801</b>
<b>Prior Authorization Department</b>	<b>1-866-604-3267</b>
<b>Pharmacy Department</b>	<b>1-800-310-6826</b>
<b>Behavioral Health Services</b>	<b>1-888-291-2506</b>
<b>New York State Department of Health</b> (Complaints)	<b>1-800-206-8125</b>
<b>New York Medicaid CHOICE</b>	<b>1-800-505-5678</b>
<b>New York State Growing Up Healthy Hotline</b>	<b>1-800-522-5006</b>
<b>New York State Fair Hearing</b>	<b>1-800-342-3334</b>
<b>New York State Department of Financial Services</b>	<b>1-800-342-3736</b>
<b>Upstate County Departments of Social Services:</b>	
Albany County Department of Social Services	<b>1-518-447-7300</b>
Broome County Department of Social Services	<b>1-607-778-2669</b>
Cayuga County Department of Social Services	<b>1-315-253-1011</b>
Chautauqua County Department of Social Services	<b>1-716-661-8200</b>
Chemung County Department of Social Services	<b>1-607-737-5309</b>
Chenango County Department of Social Services	<b>1-607-337-1500</b>
Clinton County Department of Social Services	<b>1-518-565-3222</b>
Columbia County Department of Social Services	<b>1-518-828-9411</b>
Dutchess County Department of Social Services	<b>1-845-486-3000</b>
Erie County Department of Social Services	<b>1-716-858-8000</b>
Essex County Department of Social Services	<b>1-518-873-3450</b>
Franklin County Department of Social Services	<b>1-518-483-6770</b>
Fulton County Department of Social Services	<b>1-518-736-5640</b>
Genesee County Department of Social Services	<b>1-585-344-2580</b>
Greene County Department of Social Services	<b>1-518-943-3200</b>
Herkimer County Department of Social Services	<b>1-315-867-1291</b>
Jefferson County Department of Social Services	<b>1-315-782-9030</b>
Lewis County Department of Social Services	<b>1-315-376-5105</b>
Livingston County Department of Social Services	<b>1-585-243-7300</b>
Madison County Department of Social Services	<b>1-315-366-2211</b>
Monroe County Department of Social Services	<b>1-585-753-2740</b>
Niagara County Department of Social Services	<b>1-716-439-7600</b>

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

Oneida County Department of Social Services . . . . .	<b>1-315-798-5632</b>
Onondaga County Department of Social Services . . . . .	<b>1-315-435-2928</b>
Ontario County Department of Social Services . . . . .	<b>1-585-396-4060</b>
Orange County Department of Social Services . . . . .	<b>1-845-291-4000</b>
Orleans County Department of Social Services . . . . .	<b>1-585-589-7000</b>
Oswego County Department of Social Services . . . . .	<b>1-315-963-5000</b>
Rensselaer County Department of Social Services . . . . .	<b>1-518-270-3928</b>
Rockland County Department of Social Services . . . . .	<b>1-845-364-2000</b>
Seneca County Department of Social Services . . . . .	<b>1-315-539-1865</b>
Schenectady County Department of Social Services . . . . .	<b>1-518-388-4470</b>
St. Lawrence County Department of Social Services . . . . .	<b>1-315-379-2276</b>
Tioga County Department of Social Services . . . . .	<b>1-877-882-8313</b>
Ulster County Department of Social Services . . . . .	<b>1-845-334-5000</b>
Warren County Department of Social Services . . . . .	<b>1-518-761-6300</b>
Wayne County Department of Social Services . . . . .	<b>1-315-946-4881</b>
Westchester County Department of Social Services . . . . .	<b>1-800-549-7650</b>
Wyoming County Department of Social Services . . . . .	<b>1-585-786-8900</b>
Yates County Department of Social Services . . . . .	<b>1-315-536-5183</b>

**New York City and Long Island:**

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

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

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**Other Health Provider(s)**

Your PCP: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Nearest Emergency Room: \_\_\_\_\_ Phone: \_\_\_\_\_

Local Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_



**8 Welcome to UnitedHealthcare Community Plan's  
Medicaid Managed Care Program**

- 8 How Managed Care Works
  - 9 Confidentiality
  - 9 How to Use This Handbook
  - 10 Help From Member Services
  - 12 Your Health Plan ID Card
- 



**13 PART I – First Things You Should Know**

- 13 How to Choose Your Primary Care Provider (PCP)
  - 15 How to Get Regular Health Care
  - 16 Appointment Standards
  - 16 How to Get Specialty Care – Referrals
  - 18 Get These Services From UnitedHealthcare Community Plan  
*Without* a Referral
  - 21 Emergencies
  - 22 Urgent Care
  - 22 Care Outside of the United States
  - 23 We Want to Keep You Healthy
- 



**24 PART II – Your Benefits and Plan Procedures**

- 24 Benefits
- 24 New Technology
- 25 Services Covered by UnitedHealthcare Community Plan
- 41 Benefits That Only Apply to Members Age 21 Years and Older
- 42 Behavioral Health
- 43 Health Home Care Management – Age 21 and Over
- 45 Benefits That Only Apply to Members Age 20 Years and Under
- 46 Behavioral Health Care
- 49 Non-Emergency Transportation
- 51 Emergency Transportation

52	Additional Covered Services by UnitedHealthcare Community Plan
52	myMoneyConnect™
53	Services NOT Covered
53	If You Get a Bill
54	Service Authorization and Actions
54	Prior Authorization and Time Frames
57	Retrospective Review and Time Frames
58	How Our Providers Are Paid
58	You Can Help With Plan Policies
58	Information From Member Services
59	Keep Us Informed
60	Disenrollment Options
60	If YOU Want to Leave the Plan
61	You Could Become Ineligible for Medicaid Managed Care
62	We Can Ask You to Leave UnitedHealthcare Community Plan
62	Action Appeals
65	External Appeals
67	Fair Hearings
69	Complaint Process
69	How to File a Complaint
70	What Happens Next
71	Appeals
72	Member Rights and Responsibilities
73	Advance Directives
74	Notice of Privacy Practices

# 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**.

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## **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](https://myuhc.com/CommunityPlan)**.

When you join UnitedHealthcare Community Plan, one of our providers will take care of you. Most of the time that person will be your Primary Care Provider (PCP). 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 18 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.

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## 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.

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## 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

## Welcome

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. to 6:00 p.m. at **1-800-493-4647**. If you have trouble hearing, call AT&T TDD Relay Service at **711**.

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## Help From Member Services

There is someone to help you at Member Services. Just call toll-free **1-800-493-4647**, Monday – Friday 8:00 a.m. to 6:00 p.m. 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.

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

### **New York County**

168 Centre Street, 4th Floor

New York, NY 10013

Phone: Call Member Services at

**1-800-493-4647** to make an appointment

Location hours:

- Monday – Friday 9:00 a.m. to 5:30 p.m.
- Saturday, 9:00 a.m. to 4:00 p.m.

### **Queens County**

136-02 Roosevelt Ave., Main Floor

Flushing, NY 11354

Phone: Call Member Services at

**1-800-493-4647** to make an appointment

Location hours:

- Monday – Friday, 9:00 a.m. to 5:30 p.m.
- Saturday – Sunday, 9:00 a.m. to 4:00 p.m.

### **Kings County**

30 Flatbush Ave., Main Floor

Brooklyn, NY 11217

Phone: 347-464-5142

Location hours:

- Monday – Friday 9:00 a.m. to 7:00 p.m.
- Saturday, 10:00 a.m. to 6:00 p.m.

### **Nassau County**

250 Fulton Ave., Suite 121

Hempstead, NY 11570

Phone: 516-247-6352

Location hours:

- Monday – Friday, 9:00 a.m. to 6:00 p.m.
- Saturday, 9:00 a.m. to 5:00 p.m.

**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.



# Welcome

## 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.


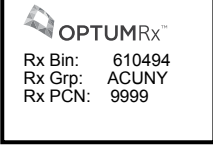
Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need the card to get services that UnitedHealthcare Community Plan does not cover.

### Medicaid Only

	
Health Plan (80840) 911-87726-04	
Member ID: 000000000	Group Number: NYCDFHP
Member: SUBSCRIBER BROWN	Payer ID: 87726
CIN#: 00000000	
PCP Name: PROVIDER BROWN	
PCP Phone: (000) 000-0000	
0501	
UnitedHealthcare Community Plan for Families Administered by UnitedHealthcare of New York, Inc.	

In an emergency go to nearest emergency room or call 911. <span style="float: right;">Printed: 04/08/15</span>	
<small>This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website <a href="http://www.myuhc.com/communityplan">www.myuhc.com/communityplan</a> or call.</small>	
For Members: 800-493-4647	TDD 800-662-1220
Mental Health: 888-291-2506	TDD 800-486-7914
For Providers: <a href="http://www.uhcommunityplan.com">www.uhcommunityplan.com</a>	866-362-3368
Medical Claims: PO Box 5240, Kingston, NY, 12402-5240	
Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903 For Pharmacists: 877-305-8952	

### Medicaid With Behavioral Health

	
Health Plan (80840) 911-87726-04	
Member ID: 000000233	Group Number: NYCDFHP
Member: NEW ENGLISH	Payer ID: 87726
CIN#: 9999999233	
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. <span style="float: right;">Printed: 06/10/15</span>	
<small>This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website <a href="http://www.myuhc.com/communityplan">www.myuhc.com/communityplan</a> or call.</small>	
For Members: 800-493-4647	TTY 711
NurseLine: 877-597-7801	TTY 711
Mental Health: 888-291-2506	TTY 711
For Providers: <a href="http://uhcommunityplan.com">uhcommunityplan.com</a>	866-362-3368
Medical Claims: PO Box 5240, Kingston, NY, 12402-5240	
Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903 For Pharmacists: 877-305-8952	

## How to Choose Your Primary Care Provider (PCP)

You may have already picked your Primary Care Provider (PCP) to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP for you and your family, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you.

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](https://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/community plan](https://myuhc.com/community plan), or by calling Member Services.

We can tell you the following information:

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion, and;
- 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.

### 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.

## Part I – First Things You Should Know

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.

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 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.

## 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 abuse ER or inpatient visit	5 days
Non-urgent mental health or substance abuse visit	2 weeks

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## 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.

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 and Actions” section for more information on what documentation your request to see a provider who is not in the UnitedHealthcare network should include. If UnitedHealthcare Community Plan approves the use of a provider who is not in the UnitedHealthcare network, you are not responsible for any of the costs, except any copayments as described in this handbook.

Sometimes we may not approve an out-of-network referral because we have a provider in UnitedHealthcare Community Plan that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for an **action appeal**. See page 62 to find out how.

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

1. A statement in writing that says UnitedHealthcare Community Plan’s provider does not have the right training and experience to meet your needs, and
2. That recommends an out-of-network provider with the right training and experience who is able to treat you.
3. Two medical or scientific documents that prove the treatment you are asking for is more helpful to you and will not cause you more harm than the treatment you can get from UnitedHealthcare Community Plan.

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

If your doctor does not send this information, we will still review your action appeal. However, you may not be eligible for an external appeal. See page 65 for more information about external appeals.

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.

# **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.

### **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.

## Part I – First Things You Should Know

### **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 abuse 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.

### **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.

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**.

## Part I – First Things You Should Know

### **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.

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## 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.

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## 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.

## 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](http://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.

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### 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.

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### 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.
- Smoking cessation counseling.
- Access to free needles and syringes.
- HIV education and risk reduction.

## **Maternity care.**

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

## Part II – Your Benefits and Plan Procedures

### **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.

### **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.

## 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**.

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## 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.

## Part II – Your Benefits and Plan Procedures

If you need to find a dentist or change your dentist, visit our website at [myuhc.com/CommunityPlan](http://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.

### **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.

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## **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.
- 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) and tuberculosis.

Prescription Item	Copayment	Copayment Details
<b>Brand-Name Prescription Drugs</b>	\$3.00	1 copay charge for each new prescription and each refill
<b>Preferred Brand-Name Prescription Drugs</b>	\$1.00	1 copay for each prescription refill

- There is a copayment for each new prescription and each refill.
- If you have a copay, you are responsible for a maximum of \$200 per calendar 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.
- 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.

## Part II – Your Benefits and Plan Procedures

### **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](http://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 \$200 per calendar 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](http://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 5-day emergency supply**, until we process the request. If we do not approve the request, we will tell you how you can appeal.

### **Step therapy.**

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

### **Brand-name drugs instead of generic equivalents.**

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

### **Specialty medications.**

A specialty pharmacy drug is typically a high-cost medication (taken by mouth or injected) that treats rare, complex or chronic diseases. (These include, for example, medications for rheumatoid arthritis, growth hormone, and oral cancer medications.) These drugs usually require frequent monitoring (to make sure they are working and to avoid side effects) and the patients taking them may need extra support or help to manage their treatment. Certain specialty medications require prior authorization. Once approved, a specialty pharmacy calls the member to arrange delivery. The pharmacy will call the member before each refill is due. If preferred, members can get their specialty medications through their local network pharmacy. If you need assistance, please call Member Services at **1-800-493-4647**.

### **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](http://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.

## Part II – Your Benefits and Plan Procedures

### These items are not covered:

- Anabolic steroids.
- Anorectics (drugs used for weight loss).
- Anti-wrinkle agents.
- Fees for the administration of any drug.
- 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.

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## 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 21.



## Specialty Care

Includes the services of other practitioners, including:

- Occupational, physical and speech therapists – Limited to twenty (20) visits per 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.
- Audiologists.
- Midwives.
- Cardiac rehabilitation.
- Podiatrists, if you are diabetic.
- Psychiatrists.
- Psychologists.
- Licensed social workers.
- Psychotherapists.

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## 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.

## Part II – Your Benefits and Plan Procedures

### **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.

### **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. Durable Medical Equipment that costs more than \$500 requires prior authorization by calling 1-866-604-3267.

- Hearing Aids.
- Prosthetics.
- Orthotics.

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## Physical Therapy, Occupational Therapy and Speech Therapy

Physical, occupational and speech therapy do not require Prior Authorization. There is a benefit limitation of 20 visits, per therapy type, per calendar year. Limits do not apply to Enrollees under age 21, are developmentally disabled, or who have traumatic brain injury.

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## Foot Care

Includes routine foot care provided by qualified provider types other than podiatrists 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.

## **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.

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## **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.

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## **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: <http://www.cdc.gov/zika/geo/united-states.html>.

For a full list of covered products, please go to [uhccommunityplan.com/health-professionals/ny/pharmacy-program.html](http://uhccommunityplan.com/health-professionals/ny/pharmacy-program.html). A quantity limit of 2 cans per month will be applied to all these products.

Zika is a serious illness. The CDC does not currently list any locally transmitted cases of Zika in New York. To stop the spread of the Zika virus, NYS Medicaid Fee-for-Service will pay for repellent until the CDC states that Zika is no longer a risk.

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## 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.

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.

## **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.

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## **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).

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## **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.

UnitedHealthcare wants to make sure that you get the medical care that you need. That means making sure you are able to get to your doctor appointments. We offer non-emergent transportation to doctor appointments for our members living in Nassau and Suffolk counties.

If you have questions about transportation, Member Services is available to assist you with transportation needs Monday – Friday 8:00 a.m. to 6:00 p.m. If you have questions about transportation, please call Member Services at **1-800-493-4647**.

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## Other Covered Services

- Durable medical equipment (DME)/hearing aids/prosthetics/orthotics.
- Court-ordered services.
- Help getting social support services.
- FQHC.
- Family planning.
- Services of a podiatrist for children under 21 years old.



**Benefits  
in this section  
only apply to  
members age  
21 years and older.**



### Covered Services for Members Age 21 and Older

Benefits in this section are covered using your UnitedHealthcare Community Plan member ID card. **Members must be 21 years old and older to obtain services under UnitedHealthcare Community Plan for Adults.** You do not need a referral from your PCP to get these services. Call us if you have questions at **1-800-493-4647**. You may also call our NurseLine after normal business hours at 1-877-597-7801 to speak with someone about your clinical health needs.

## Behavioral Health

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

#### **Mental health care.**

- Intensive psychiatric rehab treatment.
- Day treatment.
- Clinic continuing day treatment.
- Inpatient and outpatient mental health treatment.
- Partial hospital care.
- Rehab services if you are in a community home or in family-based treatment.
- Continuing day treatment.
- Personalized recovery-oriented services.
- Assertive community treatment services.
- Individual and group counseling.
- Crisis intervention services.

#### **Substance use disorder services.**

- Inpatient and outpatient substance use disorder (alcohol and drug) treatment.
- Inpatient detoxification services.
- Opioid, including methadone maintenance treatment.
- Residential substance use disorder treatment.
- Outpatient alcohol and drug treatment services.
- Detox services.

## Mental Health/Substance Use Disorder

Addiction can happen to anyone, any family, at any time according to the New York State Office of Alcoholism and Substance Abuse Services (OASAS). UnitedHealthcare is here to assist you in all your health care needs. We have trained professionals who are experienced in understanding substance use disorder and able to help you get treatment or give you information that will help you make decisions about your health care. You or your provider can call Optum Behavioral Health anytime for help at 1-888-291-2506.

Covered services include:

- All inpatient mental health and substance use disorder services (including alcohol and substance use disorder).
- Most outpatient mental health services (contact plan for specifics).
- Medicaid recipients who receive SSI or who are certified blind or disabled get mental health and substance use disorder services from any Medicaid provider by using their Medicaid Benefit Card.
- Detoxification services are covered by UnitedHealthcare Community Plan as a benefit.

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## Health Home Care Management – Age 21 and Over

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.

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 ongoing medical issues like diabetes, asthma, and high blood pressure.

To learn more about Health Homes, contact Member Services at **1-800-493-4647**.

***End of Section:  
Covered Services for Members Age 21 and Older.***



**Benefits  
in this section  
only apply to  
members age 20  
and under.**

### Benefits You Can Get From Your State Medicaid Card for Members Under 21 Years Old

For some services, you can choose where to get the care. If you are under 21 years old, you can get these services by using your New York State Medicaid benefit card. You do not need a referral from your PCP to get these services. Call us if you have questions at **1-800-493-4647**. You may also call our Behavioral Health Team after normal business hours at 1-888-291-2506 to speak with someone about your clinical health needs.

### Behavioral Health Care

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

#### Mental health care:

- Intensive psychiatric rehab treatment.
- Day treatment.
- Clinic continuing day treatment.
- Inpatient and outpatient mental health treatment.
- Partial hospital care.
- Rehab services if you are in a community home or in family-based treatment.
- Continuing day treatment.
- Personalized recovery-oriented services.
- Assertive community treatment services.
- Individual and group counseling.
- Crisis intervention services.

**Substance use disorder services:**

Inpatient and outpatient substance use disorder (alcohol and drug) treatment.

- Inpatient detoxification services.
- Opioid, including methadone maintenance treatment.
- Residential substance use disorder treatment.
- Outpatient alcohol and drug treatment services.
- Detox services.

**Family planning.**

You can go to any Medicaid doctor or clinic that provides family planning.

**Developmental disabilities.**

These services are covered using the Medicaid Card for members under 21 years old.

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

***End of Section:******Benefits You Can Get From Your State Medicaid Card for Members Under 21 Years Old.***

## 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

## Part II – Your Benefits and Plan Procedures

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

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.
- Services received under the Home and Community Based Services Waiver.
- Medical Model (Care-at-Home) Waiver Services.

### Alcohol and substance abuse services.

- Methadone treatment.
- Outpatient substance abuse treatment at substance use disorder clinics.
- Outpatient alcohol rehab at substance use disorder clinics.
- Outpatient alcohol clinic services.
- Outpatient substance use disorder for youth programs.
- Substance use disorder services ordered by the LDSS.
- All covered alcohol and substance use disorder services (except detox) are available for people who receive SSI or who are certified blind or disabled by using their Medicaid benefit card. Detoxification services are available using your UnitedHealthcare Community Plan ID card.

### Other Medicaid services.

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

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## myMoneyConnect™

With the UnitedHealthcare myMoney Connect™ program, you can get rewarded for doing health-related activities. The program provides a reloadable prepaid debit MasterCard® with wellness rewards to enable you to earn incentives. myMoney Connect has **no credit check, no fund minimums and no start-up or monthly fees.**

To learn more about myMoney Connect and how it can help you use your money the way you want to, visit [UHCmyMoneyConnect.com](http://UHCmyMoneyConnect.com).

## 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.
- Services of a podiatrist (for those 21 years and older unless you are a diabetic).
- 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.
- Infertility treatments.
- 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.

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## 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.

## Part II – Your Benefits and Plan Procedures

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.**

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## Service Authorization and Actions

### **Prior authorization.**

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

- Admissions to inpatient facilities (example: hospital, except for maternity).
- Home health care services.
- Personal Care Services.
- Durable medical equipment (DME) over \$500.
- All power wheelchairs regardless of cost.
- Topical Oxygen requests.
- Prosthetic and orthotic devices over \$500.
- Cosmetic and reconstructive surgery.
- Gastric bypass evaluations and surgery.
- Advanced radiology services including MRI, MRA and PET scans.
- Accidental dental services.
- Experimental or investigational health care services.
- Out-of-network or out-of-state services.
- Requests to use a non-participating provider.

- Transplant evaluations and listing.
- Treatment of erectile dysfunction, drug therapies, devices and/or surgery.
- Medical injectables including IVIG, Botox, Acthar HP and Makena.
- Private duty nursing on an outpatient basis.
- Sleep studies for members over age 6, inpatient and/or outpatient.
- Cross-sex hormone therapy.
- Gender reassignment surgery.
- Gender reassignment post-transitional therapy.

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

UnitedHealthcare Community Plan of New York  
14141 SW Freeway, 6th Floor  
Sugar Land, TX 77478

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**.

Home health care (HHC) services that follow an inpatient hospital admission are evaluated and determined in the same manner as if you are already getting the service now, but need to continue or get more of the care (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. 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.

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

After we get your request, we will review it under 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. If you are in the hospital or have just left the hospital and we receive a request for home health care,

## Part II – Your Benefits and Plan Procedures

we will handle the request as a fast track review. 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.

### **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 3 work days. We will tell you by the third work day 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.
- 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 no later than 72 hours 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 no later than 24 hours.

In all cases, you will hear from us no later than 3 work days after we received your request. We will tell you by the third work day if we need more information.

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

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

You, 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  
14141 SW Freeway, 6th Floor  
Sugar Land, TX 77478

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review 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 you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

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## 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 these other actions.

### Time frames for notice of other actions:

- 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 necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by the plan or 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.

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### 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.

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### 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.
- 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  
77 Water Street, 14th Floor  
New York, NY 10005

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## 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. If YOU Want to Leave the Plan

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

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.

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## 2. You Could Become Ineligible for Medicaid Managed 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.

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## Action 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. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**.

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.

#### **You can file an action appeal:**

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 work days from the date of our letter/notice to you to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services at **1-800-493-4647** if you need help filing an action appeal.
- We will not treat you any differently or act badly toward you because you file an action appeal.
- The action appeal can be made by phone or in writing. If you make an action appeal by phone, it must be followed up in writing. You must sign the written action appeal that you send to us. You or your designee must sign the written action appeal.

If you need our help because of a hearing or vision impairment, or if you need translation services, or help filling out the forms we can help you.

Please send all written appeals to:

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

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

- If you or your doctor asks to have your action 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 action appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- If your request was denied when you asked for home health care after you were in the hospital; **or**
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

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

**What happens after we get your action appeal.**

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.
- Action 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.
- Before and during the action appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.
- 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.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained, or you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

## Part II – Your Benefits and Plan Procedures

### Time frames for action appeals:

- **Standard action appeals:** If we have all the information we need, we will tell you our decision in thirty days from your action appeal. A written notice of our decision will be sent within 2 working days from when we make the decision.
- **Fast track action appeals:** If we have all the information we need, fast track action appeal decisions will be made in 2 working days from your action appeal.
  - We will tell you in 3 working days after giving us your action appeal, 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.

If we need more information to make either a standard or fast track decision about your action 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.

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 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 someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your action 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 your original denial was because we said:

- The service was not medically necessary; **or**
- The service was experimental or investigational; **or**
- The out-of-network service was not different from a service that is available in our network; **or**
- The out-of-network service was available from a plan provider who has the training and experience to meet your needs; **or**
- We do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

**Aid to continue while appealing a decision about your care.**

In some cases you may be able to continue the services while you wait for your action appeal to be decided. **You may be able to continue the services that are scheduled to end or be reduced if you ask for a fair hearing:**

- 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.

If your fair hearing results in another denial, you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

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## External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because:

- The service was not medically necessary; **or**
- The service was experimental or investigational; **or**
- The out-of-network service was not different from a service that is available in our network; **or**
- The out-of-network service was available from a plan provider who has the training and experience to meet your needs.

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

Before you ask for an external appeal:

- You must file an action 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 action 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 action 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.

## Part II – Your Benefits and Plan Procedures

If you had a fast track action appeal and are not satisfied with the plan's decision, you can choose to file a standard action appeal with the plan or ask for an external appeal. If you choose to file a standard action appeal with the plan, and the plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the New York State Department of Financial Services within 4 months from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

**You will lose your right to an external appeal if you do not file an application for an external appeal on time.**

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, the plan will continue to pay for your stay if:

- You ask for a fast track Internal Appeal within 24 hours, AND
- You ask for a fast track External Appeal at the same time.

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 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.

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

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## 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 that we made about medical care you were getting. You feel the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Medicaid benefits.
- You are not happy about a decision we made to deny payment for care you received. You feel the decision limits your Medicaid benefits.
- 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 state fair hearing.
- The decision you receive from the fair hearing officer will be final.



## Part II – Your Benefits and Plan Procedures

**If the services you are now getting are going to be reduced, stopped, or restricted, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided.** You must ask for a fair hearing **within 10 days** from the date of the notice that says your care will change or by the time the action takes effect. However, if you choose to ask for services to be continued, and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

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](http://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.

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 ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing the forms, we can help you. 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:

NYS Department of Health  
Division of Managed Care  
Bureau of Consumer Services  
ESP Corning Tower, Room 2019  
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.

## How to file a complaint with our plan.

To file by phone, call Member Services toll-free at **1-800-493-4647**, Monday – Friday 8:00 a.m. to 6:00 p.m. 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

## Part II – Your Benefits and Plan Procedures

### **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.

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 business days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone, it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us. 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, 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.

## **Your responsibilities.**

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

- Work with your PCP to guard and improve your health.
- To supply 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.

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## 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.

# 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, 2017.

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

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

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

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

### **How We Use or Share Your Information**

**We must use and share your HI with:**

- You or your legal representative.
- Government agencies.

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

- **For Payment.** We may use or share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.

- **For Underwriting Purposes.** We may use your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may use your HI to send you appointment reminders and information about your health benefits.

#### We may use or share your HI as follows.

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



## Part II – Your Benefits and Plan Procedures

- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below.
  1. HIV/AIDS
  2. Mental health
  3. Genetic tests
  4. Alcohol and drug abuse
  5. Sexually transmitted diseases and reproductive health
  6. Child or adult abuse or neglect or sexual assault

We will follow stricter laws that apply. The attached “Federal and State Amendments” document describes those laws.

We will only use your HI as described here or with your written consent. We will get your written consent to share psychotherapy notes about you. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain promotional mailings. If you let us share your HI, the recipient may further share it. You may take back your consent. To find out how, call the phone number on your ID card.

### Your Rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. You can have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete, you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons: (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website ([www.uhccommunityplan.com](http://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.

<sup>1</sup> This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Health Plan of Nevada, Inc.; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; 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.

## Part II – Your Benefits and Plan Procedures

### Financial Information Privacy Notice

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

Effective January 1, 2017.

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

#### Information We Collect

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

#### Sharing of FI

We will only share FI as permitted by law.

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

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

#### Confidentiality and Security

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

## 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**.

<sup>2</sup> 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: Alere Women’s and Children’s Health, LLC; AmeriChoice Health Services, Inc.; Connexions HCl, LLC; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services LLC; 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.

## Part II – Your Benefits and Plan Procedures

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

Revised: January 1, 2017.

The first part of this Notice (pages 74 – 77) says how we may use and share your health information (“HI”) under federal privacy rules. Other laws may limit these rights. The charts below:

1. Show the categories subject to stricter laws.
2. Give you a summary of when we can use and share your HI without your consent.

Your written consent, if needed, must meet the rules of the federal or state law that applies.

#### SUMMARY OF FEDERAL LAWS

##### Alcohol and Drug Abuse Information

We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.

##### Genetic Information

We are not allowed to use genetic information for underwriting purposes.

#### SUMMARY OF STATE LAWS

##### General Health Information

We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

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

## Part II – Your Benefits and Plan Procedures

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

