Welcome to the **community.**

MississippiCAN

Mississippi Coordinated Access Network

- Welcome
- Member Handbook
- Other Information

UnitedHealthcare®
Community Plan

© 2020 United HealthCare Services, Inc. All rights reserved.
CSMS20MC4777239_000

Welcome.

Welcome to UnitedHealthcare Community Plan.

Please take a few minutes to review this Member Handbook. We're ready to answer any questions you may have. You can find answers to most questions at myuhc.com/CommunityPlan. Or, you can call Member Services at **1-877-743-8731**, TTY **711**.

UnitedHealthcare®
Community Plan

UnitedHealthcare
Community Plan

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, gender, gender identity, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, gender, gender identity, disability or national origin, you can send a complaint to:

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

UHC_Civil_Rights@uhc.com

You must submit the complaint in writing within 30 days of when you found out about it. If your complaint cannot be resolved in 1 day it will be treated as a grievance. We will send you an acknowledgement of the grievance within 5 days of receipt of the grievance. A decision will be sent to you within 30 days.

If you need help with your complaint, please call the toll-free member phone number at **1-877-743-8731**, TTY **711**, 7:30 a.m. – 5:30 p.m. CT, Monday – Friday, (and 7:30 a.m. – 8 p.m. CT on Wednesday). We are also available 8 a.m. – 5 p.m. CT the first Saturday and Sunday of each month.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone:
Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

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

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 the toll-free member phone number at **1-877-743-8731**, TTY **711**, 7:30 a.m. – 5:30 p.m. CT, Monday – Friday (and 7:30 a.m. – 8 p.m. CT on Wednesday). We are also available 8 a.m. – 5 p.m. CT the first Saturday and Sunday of each month.

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-743-8731, TTY 711.**

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-743-8731, TTY 711.**

Vietnamese
LƯU Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **1-877-743-8731, TTY 711.**

Traditional Chinese
注意：如果您說中文，您可獲得免費語言協助服務。請致電 **1-877-743-8731**，或聽障專線 **TTY 711**。

French
ATTENTION : Si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-877-743-8731, TTY 711**.

Arabic
تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم **1-877-743-8731**، الهاتف النصي **711**.

Choctaw
Pisa: Chahta anumpa ish anumpuli hokma, anumpa tohsholi yvt peh pilla ho chi apela hinla. I paya **1-877-743-8731, TTY 711**.

Tagalog
ATENSYON: Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-877-743-8731, TTY 711**.

German
HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie: **1-877-743-8731, TTY 711**.

Korean
참고: 한국어를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-877-743-8731**, **TTY 711** 로 전화하십시오.

Gujarati
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમારા માટે વિના મૂલ્યે ભાષાકીય સહાયતા સેવાઓ ઉપલબ્ધ છે. કૉલ કરો **1-877-743-8731**, **TTY 711**.

Japanese
ご注意：日本語 をお話しになる場合は、言語支援サービスを無料でご利用いただけます。電話番号**1-877-743-8731**、または**TTY 711**。

Russian
ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел **1-877-743-8731, TTY 711**.

Panjabi
ਸਾਵਧਾਨ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ, ਮੁਫ਼ਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਹੈਲਥ ਪਲਾਨ ਟੀਮ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। **1-877-743-8731, TTY 711** ਤੇ ਕਾਲ ਕਰੋ।

Italian
ATTENZIONE: se parla italiano, Le vengono messi gratuitamente a disposizione servizi di assistenza linguistica. Chiami il numero **1-877-743-8731, TTY 711**.

Hindi
ध्यान दें: यदि आप हिन्दी भाषा बोलते हैं तो भाषा सहाय ता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **1-877-743-8731, TTY 711**.

Getting started.

We want you to get the most from your health plan right away.
Start with these three easy steps:

1. **Call your Primary Care Provider (PCP) and schedule a checkup.** Regular checkups are important for good health. Your PCP's phone number should be listed on the member ID card that you recently received in the mail. If you don't know your PCP's number, or if you'd like help scheduling a checkup, call Member Services at **1-877-743-8731**, TTY **711**. We're here to help.

2. **Take your Health Assessment.** This is a short and easy way to get a big picture of your current lifestyle and health. This helps us match you with the benefits and services available to you. Go to **myuhc.com/CommunityPlan** to complete the Health Assessment today. Also, we will call you soon to welcome you to the UnitedHealthcare Community Plan. During this call, we can explain your health plan benefits. We can also help you complete the Health Assessment over the phone. See page 12.

3. **Get to know your health plan.** Start with the Health Plan Highlights section on page 10 for a quick overview of your new plan. And be sure to keep this booklet handy, for future reference.

Thank you for choosing **UnitedHealthcare Community Plan** for your health plan.

We're happy to have you as a member. You've joined the millions of members who have health insurance with UnitedHealthcare Community Plan. You've made the right choice for you and your family.

UnitedHealthcare Community Plan gives you access to many health care providers — doctors, nurses, hospitals and pharmacies — so you have access to all the health services you need. We cover preventive care, checkups and treatment services. We're dedicated to improving your health and well-being.

Remember, answers to any questions you have are just a click away at **myuhc.com/CommunityPlan**. Or, you can call Member Services at **1-877-743-8731**, TTY **711**.

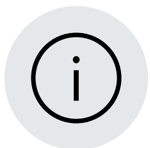
10 Health plan highlights
10 Member ID card
11 Benefits at a glance
12 Your Health Assessment
13 Member support
16 Using your pharmacy benefit

18 Going to the doctor
18 Your Primary Care Provider (PCP)
19 Annual checkups
21 Recommended health screenings
21 Making an appointment with your PCP
22 Preparing for your PCP appointment
23 NurseLine services
24 If you need care and your provider's office is closed
24 Referrals and specialists
25 Getting a second opinion
25 Prior authorizations
26 Continued care if your PCP leaves the network
26 If you need care when out of town
26 Behavioral health
27 Transportation services
27 Transition of care

28 Hospitals and emergencies
28 Emergency care
29 Urgent Care
29 Hospital services
30 Emergency dental care
30 Post-stabilization services
30 After-hours care
30 No medical coverage outside of U.S.
30 Out-of-area services
31 Prior authorization
31 Utilization review
32 In-network providers
32 Out-of-network providers

33 Pharmacy
33 Prescription drugs
33 Over-the-Counter (OTC) medicines
34 Injectable medicines
34 Pharmacy home

35 Benefits
35 Benefits covered by UnitedHealthcare Community Plan
41 Preventive health services
47 Regular Medicaid services
47 New technology
47 Disease and Care Management
48 Wellness programs
48 Quality improvement
49 For moms-to-be and children



52 Other plan details
52 Finding a network provider
52 Provider Directory
53 Interpreter services and language assistance
53 Updating your information
54 Fraud and abuse
54 If you get a bill
54 Medical advances
55 Your opinion matters
55 Advance Directives
55 Eligibility
56 Enrollment
56 Member incentives
57 If you want to leave UnitedHealthcare Community Plan
58 Disenrollment “for cause”
58 Other reasons for disenrollment
58 End of coverage
59 Other health insurance (Coordination of Benefits – COB)
59 Non-discrimination
60 Member rights and responsibilities
62 Complaints, grievances, appeals and State Fair Hearings
67 Important terms
69 Grievance and appeal form
71 Health plan notices of privacy notices

Health plan highlights

Member ID card.

Your plan ID number
Your member ID number
Member Services phone number

UnitedHealthcare | Community Plan
Health Plan (80840) 911-87726-04
Member ID: 999999930877 Group: MSCAN
Member:
REISSUE ENGLISH
Payer ID: 87726
PCP Name:
DOUGLAS GETWELL
OPTUMRx
Rx Bin: 610494
Rx Grp: ACUMS
Rx PCN: 4646
Effective Date
12/10/2014
Copay: OFFICE/ER
$0/$0
0501
UnitedHealthcare Community Plan
Administered by UnitedHealthcare of Mississippi, Inc.

In an emergency go to nearest emergency room or call 911. Printed: 08/07/18

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call. If you receive emergency services, notify Member Services within 48 hours of receiving such care.

For Member Service: 877-743-8731 TTY 711
NurseLine 24-7: 877-370-4009 TTY 711
Website: myuhc.com/communityplan
Health Plan: 795 Woodlands Parkway, Suite 301, Ridgeland, MS 39157
For Providers: UHCprovider.com 877-743-8734
Medical Claim Address: PO Box 5032, Kingston, NY, 12402-5032
For use of non-participating providers, prior authorization is required: 1-866-604-3267

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

Name of your Primary Care Provider

Information for your pharmacist

Your member ID card holds a lot of important information. It gives you access to your covered benefits. You should have received your member ID card in the mail within 10 days of joining UnitedHealthcare Community Plan. Each family member will have their own card. Check to make sure that all the information is correct. If any information is wrong, call Member Services at **1-877-743-8731**, TTY **711**.

- Take your member ID card to your appointments.
- Show it when you fill a prescription.
- Have it ready when you call Member Services; this helps us serve you better.
- Do not let someone else use your card(s). It is against the law.

Show your card. Always show your UnitedHealthcare ID card when you get care. This helps ensure that you get all the benefits available. It also prevents billing mistakes.

Lost your member ID card?

If you or a family member loses a card, you can print a new one at myuhc.com/CommunityPlan.

Benefits at a glance.

As a UnitedHealthcare Community Plan member, you have a variety of health care benefits and services available to you. Here is a brief overview. You'll find a complete listing in the Benefits section. Sometimes benefits and services may change. If this happens, we will write the member within 14 days before the change.

Primary care services.
You are covered for all visits to your Primary Care Provider (PCP). Your PCP is the main doctor you will see for most of your health care. This includes checkups, treatment for colds and flu, health concerns and health screenings.

Large provider network.
You can choose any PCP from our large network of providers. Our network also includes specialists, hospitals and pharmacies — giving you many options for your health care. Find a complete list of network providers at myuhc.com/CommunityPlan or call **1-877-743-8731**, TTY **711**.

NurseLine.
NurseLine gives you 24/7 telephone access to experienced registered nurses. They can give you information, support and education for any health-related question or concern. Call **1-877-370-4009**.

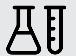
Specialist services.
Your coverage includes services from specialists. Specialists are doctors or nurses who are highly trained to treat certain conditions. You may need a referral from your PCP first. See page 24.

Medicines.
Your plan covers prescription drugs with no copays for members of all ages.
Also covered: insulin, needles and syringes, birth control, coated aspirin for arthritis, iron pills and chewable vitamins.

Hospital services.
You're covered for hospital stays. You're also covered for outpatient services. These are services you get in the hospital without spending the night.

Behavioral Health and Substance Use Disorder.
Get help with personal problems that may affect you or your family. These include stress, depression, anxiety or using drugs or alcohol.

Transportation services are available.
As a UnitedHealthcare Community Plan member, Non-Emergency Medical Transportation (NEMT) is available for some medical care for eligible members.



Laboratory services.
Covered services include tests and X-rays that help find the cause of illness.

Well-child visits.
All well-child visits and immunizations are covered by your plan.

Maternity and pregnancy care.
You are covered for doctor visits before and after your baby is born. That includes hospital stays. If needed, we also cover home visits after the baby is born.

Family planning.
You are covered for services that help you manage the timing of pregnancies. These include birth control products and procedures.

Vision care.
Your vision benefits include routine eye exams and glasses.

Your Health Assessment.

A Health Assessment is a short and easy survey that asks you simple questions about your lifestyle and your health. When you fill it out and mail it to us, we can get to know you better. And it helps us match you with the many benefits and services available to you.

Please take a few minutes to fill out the Health Assessment at myuhc.com/CommunityPlan. Click on the Health Assessment button on the right side of the page, after you register and/or log in. Or call Member Services at **1-877-743-8731**, TTY **711** to complete it by phone.

Member support.

We want to make it as easy as possible for you to get the most from your health plan. As our member, you have many services available to you, including transportation and interpreters if needed. And if you have questions, there are many places to get answers.

Website offers 24/7 access to plan details.
Go to **myuhc.com/CommunityPlan** to sign up for web access to your account. This secure website keeps all of your health information in one place. In addition to plan details, the site includes useful tools that can help you:

- Take your Health Assessment.
- Print a new member ID card.
- Find a doctor or hospital.
- Find a pharmacy.
- Search for a medicine in the Preferred Drug List.
- Look up your benefits.
- Learn how to stay healthy.
- Download a new Member Handbook.

Member Services is available on the following days and times:

Monday 7:30 a.m. – 5:30 p.m.

Tuesday 7:30 a.m. – 5:30 p.m.

Wednesday 7:30 a.m. – 8:00 p.m.

Thursday 7:30 a.m. – 5:30 p.m.

Friday 7:30 a.m. – 5:30 p.m.

First Saturday of each month 8:00 a.m. – 5:00 p.m.

First Sunday of each month 8:00 a.m. – 5.00 p.m.

Member Services can help with your questions or concerns. This includes:

- Understanding your benefits.
- Help getting a replacement member ID card.
- Finding a doctor or urgent care clinic.

Call **1-877-743-8731**, TTY **711**.

Visually and hearing impaired members.
We have this handbook in an easy to read form for people with poor eyesight. Please call us at **1-877-743-8731** for help. We have a special phone number for people with poor hearing. Members who use a Telecommunications Device for the Deaf (TDD) and American Sign Language can call **711**. These services are available to you at no cost.

Care Management program.
Care management helps members get the services and care they need and is available to all members. If you have a chronic health condition, like asthma or diabetes, you may benefit from our Care Management program. We can help with a number of things, like scheduling doctor appointments and keeping all your providers informed about the care you get. We can also help with other health, education, and social services programs; e.g., WIC, Head Start, school health and special education services, and programs for children with special health care needs from the departments of health and human services. Also, we can provide information about local free care programs and support groups. To learn more, call **1-877-743-8731**, TTY **711**.

Transportation services are available.
UnitedHealthcare Community Plan will provide transportation assistance to help eligible persons travel to and from medical appointments when they have no other way to get there. To set up a ride, call MTM at **1-877-743-8731**, 7:00 a.m. – 8:00 p.m., Monday – Friday.

We speak your language.
If you speak a language other than English, we can provide translated printed materials. Or we can provide an interpreter who can help you understand these materials. You'll find more information about Interpretive Services and Language Assistance in the section called Other Plan Details. Or call Member Services at **1-877-743-8731**, TTY **711**.

Si usted habla un idioma que no sea inglés, podemos proporcionar materiales impresos traducidos. O podemos proporcionar un intérprete que puede ayudar a entender estos materiales. Encontrará más información acerca de servicios de interpretación y asistencia lingüística en la sección Otros detalles del plan. O llame a Servicios para Miembros al **1-877-743-8731**, TTY **711**.

Emergencies.

In case of emergency, call **911**

Other important numbers.

24/7 NurseLine (available 24 hours a day, 7 days a week) . . . **1-877-370-4009**, TTY **711**

Poison Control Center **1-800-222-1222**

Division of Medicaid **1-800-421-2408**

Mental Health Crisis Line . . . . . **1-877-743-8731**, TTY **711**

Transportation (MTM) **1-877-743-8731**

You can start using your pharmacy benefit right away.

Your plan covers a long list of medicines, or prescription drugs. Preferred medicines can be found on the plan's Preferred Drug List. Your doctor uses this list to find preferred medications and to see which drugs require prior authorization by your plan. You can find the Preferred Drug List online at http://www.uhccommunityplan.com/ms/medicaid/mississippican/find-a-drug.html. Drugs that are not on this list may also be covered. These drugs may require prior authorization. Please call us at **1-877-743-8731**, TTY **711**, if you need help with your medication. Your medicine may require prior approval. Your prescriber can submit a request for it. A decision to approve or deny it is given within 24 hours.

1 Are your medicines included on the Preferred Drug List?

Yes.

If your medicines are included on the Preferred Drug List, you're all set. Be sure to show your pharmacist your latest member ID card every time you get your prescriptions filled.

No.

If your prescriptions are not on the Preferred Drug List, contact your doctor. They may be able to help switch to a drug that is on the Preferred Drug List. Your doctor can also help you ask for an exception if they think you need a medicine that is not on the list.

Not sure.

View the Preferred Drug List online at myuhc.com/CommunityPlan (click on Find A Drug on the left side of the screen). You can also call Member Services. We're here to help.

2 Do you have a prescription?

When you have a prescription from your doctor, or need to refill your prescription, go to a network pharmacy. Show the pharmacist your member ID card. You can find a list of network pharmacies in the Provider Directory online at **myuhc.com/CommunityPlan**, or you can call Member Services.

3 Do you need an emergency supply for your new prescription?

If you need a medication without delay while waiting for an exception, you can get a temporary 3-day supply. To do so, visit a network pharmacy and show your member ID card. First, always remember to talk to your doctor about your prescription options.

Going to the doctor

Your Primary Care Provider (PCP).

We call the main doctor you see a Primary Care Provider, or PCP. When you see the same PCP over time, it's easier to develop a relationship with them. Each family member can have their own PCP, or you may all choose to see the same person. You will see your PCP for:

- Routine care, including yearly checkups.
- Coordinate your care with a specialist.
- Treatment for colds and flu.
- Other health concerns.

You have options.
You can choose between many types of network providers for your PCP. Some types of PCPs include:

- Family doctor (also called a general practitioner) — cares for children and adults.
- Gynecologist (GYN) — cares for women.
- Internal medicine doctor (also called an internist) — cares for adults.
- Nurse Practitioner (NP) — cares for children and adults.
- Obstetrician (OB) — cares for pregnant women.
- Pediatrician — cares for children.
- Physician Assistant (PA) — cares for children and adults.

What is a Network Provider?

Network Providers have contracted with UnitedHealthcare Community Plan to care for our members. You don't need to call us before seeing one of these providers. There may be times when you need to get services outside of our network. Call Member Services to learn if they are covered in full. You may have to pay for those services.

Choosing your PCP.
If you've been seeing a doctor before becoming a UnitedHealthcare member, check to see if your doctor is in our network. If you're looking for a new PCP, consider choosing one who's close to your home or work. This may make it easier to get to appointments.

There are three ways to find the right PCP for you.

1. Look through our printed Provider Directory.
2. Use the Find-A-Doctor search tool at **myuhc.com/CommunityPlan**.
3. Call Member Services at **1-877-743-8731**, TTY **711**. We can answer your questions and help you find a PCP close to you.

Once you choose a PCP, call Member Services and let us know. We will make sure your records are updated. If you don't want to choose a PCP, UnitedHealthcare can choose one for you, based on your location and language spoken.

Learn more about network doctors.

You can learn information about network doctors, such as name, address, telephone numbers, professional qualifications, specialty, medical school, residency program, board certification, and languages they speak, at **myuhc.com/CommunityPlan**, or by calling Member Services.

Changing your PCP.
It's important that you like and trust your PCP. You can change PCPs at any time. Call Member Services and we can help you make the change.

Annual checkups.

The importance of your annual checkup.
You don't have to be sick to go to the doctor. In fact, yearly checkups with your PCP can help keep you healthy. In addition to checking on your general health, your PCP will make sure you get the screenings, tests and shots you need. And if there is a health problem, they're usually much easier to treat when caught early.

Here are some important screenings. How often you get a screening is based on your age and risk factors. Talk to your doctor about what's right for you.

For women.

- Pap smear — helps detect cervical cancer.
- Breast exam/Mammography — helps detect breast cancer.

For men.

- Testes exam — helps detect testicular cancer.
- Prostate exam — helps detect prostate cancer.

Well-child visits.
Well-child visits are a time for your PCP to see how your child is growing and developing. They will also give the needed screenings, like speech and hearing tests, and immunizations during these visits. These routine visits are also a great time for you to ask any questions you have about your child's behavior and overall well-being, including:

- Eating.
- Sleeping.
- Behavior.
- Social interactions.
- Physical activity.

Checkup schedule.

It's important to schedule your well-child visits for these ages:

3 to 5 days	15 months
1 month	18 months
2 months	24 months
4 months	30 months
6 months	3 years
9 months	Once a year after age 3
12 months	

Here are immunization shots the doctor will likely give, and how they protect your child:

- **Hepatitis A and Hepatitis B:** prevent two common liver infections.
- **Rotavirus:** protects against a virus that causes severe diarrhea.
- **Diphtheria:** prevents a dangerous throat infection.
- **Tetanus:** prevents a dangerous nerve disease.
- **Pertussis:** prevents whooping cough.
- **HiB:** prevents childhood meningitis.
- **Meningococcal:** prevents bacterial meningitis.
- **Polio:** prevents a virus that causes paralysis.
- **MMR:** prevents measles, mumps and rubella.
- **Varicella:** prevents chickenpox.
- **Influenza:** protects against the flu virus.
- **Pneumococcal:** prevents ear infections, blood infections, pneumonia and bacterial meningitis.
- **HPV:** protects against a sexually transmitted virus that can lead to cervical cancer in women and genital warts in men.

Recommended health screenings.

We use preventive care guidelines from the U.S. Preventive Services Task Force. Coverage and reimbursement may vary depending on state or federal law. It may vary depending on your coverage plan. Call Member Services at the number shown on your ID card if you have any questions.

Making an appointment with your PCP.

Call your doctor's office directly. The number should be on your Member ID card. When you call to make an appointment, be sure to tell the office what you're coming in for. This will help make sure you get the care you need, when you need it. This is how quickly you can expect to be seen:

How long it should take to see your PCP:	
Emergency	Immediately or sent to an emergency facility.
Urgent (but not an emergency)	Within 1 day or 24 hours.
Routine	Within 1 week or 7 days.
Preventive, Well-Child and Regular	Within 1 month.
How long it should take to get a behavioral health appointment:	
Routine (Non-Urgent)	Within twenty-one (21) calendar days.
Urgent	Within twenty-four (24) hours.
Emergent (Non-Life-Threatening) A medical situation when immediate assessment or care is needed to stabilize the condition or situation with no imminent risk of harm or loss of life to self or others.	Within 6 hours.
Emergent (Life-Threatening) A medical or psychiatric condition needing immediate assessment or care due to imminent risk or loss of life to self or others.	Immediate access to emergency services.
Inpatient Psychiatric Hospital	Within seven (7) days after discharge from an acute psychiatric hospital, when the Contractor is aware of the member's discharge.

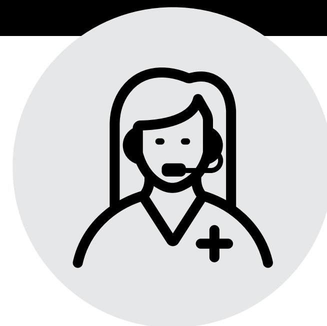
Preparing for your PCP appointment.

Before the visit.

1. Go in knowing what you want to get out of the visit (relief from symptoms, a referral to a specialist, specific information, etc.).
2. Make note of any new symptoms and when they started.
3. Make a list of any drugs or vitamins you take on a regular basis.

During the visit.
When you are with the doctor, feel free to:

- Ask questions.
- Take notes if it helps you remember.
- Ask the doctor to speak slowly or explain anything you don't understand.
- Ask for more information about any medicines, treatments or conditions.



NurseLine services – Your 24-hour health information resource.

When you're sick or injured, it can be difficult to make health care decisions. You may not know if you should go to the emergency room, visit an urgent care center, make a provider appointment or use self-care. An experienced NurseLine nurse can give you information to help you decide.

Nurses can provide information and support for many health situations and concerns, including:

- Minor injuries.
- Common illnesses.
- Self-care tips and treatment options.
- Recent diagnoses and chronic conditions.
- Choosing appropriate medical care.
- Illness prevention.
- Nutrition and fitness.
- Questions to ask your provider.
- How to take medication safely.
- Men's, women's and children's health.

You may just be curious about a health issue and want to learn more. Experienced registered nurses can provide you with information, support and education for any health-related question or concern.

Simply call the toll-free number **1-877-370-4009** or TTY **711** for the hearing impaired. You can call the toll-free NurseLine number anytime, 24 hours a day, 7 days a week. And, there's no limit to the number of times you can call.

If you need care and your provider's office is closed.

Call your PCP if you need care that is not an emergency. Your provider's phone is answered 24 hours a day, 7 days a week. Your provider or someone from the office will help you make the right choice for your care.

You may be told to:

- Go to an after-hours clinic or urgent care center.
- Go to the office in the morning.
- Go to the emergency room (ER).
- Get medicine from your pharmacy.

Referrals and specialists.

A referral is when your PCP says you need to go to another doctor who focuses on caring for a certain part of the body or treating a specific condition. This other doctor is called a specialist. You must see your PCP before you see a specialist. If your doctor wants you to see a specialist that you do not want to see, you can ask your PCP to give you another name. A couple of examples of specialists include:

- Cardiologist — for problems with the heart.
- Pulmonologist — for problems with the lungs and breathing.

You do not need a referral from your PCP for:

- Emergency services.
- OB/GYN.
- Optometry.
- Podiatry.
- Dermatologist.
- Behavioral.
- Health/substance abuse professionals.
- Chiropractors.

Getting a second opinion.

A second opinion is when you want to see a second doctor for the same health concern. You can get a second opinion from a network provider for any of your covered benefits. You are not required to get a second opinion. If you cannot find a second network provider, you can get a second opinion from an out-of-network provider with prior authorization. Call Member Services for help. There is no charge to you for a second opinion.

Prior authorizations.

In some cases your provider must get permission from the health plan before giving you a certain service. This is called prior authorization. This is your provider's responsibility. If they do not get prior authorization, you will not be able to get those services.

You do not need prior authorization for advanced imaging services that take place in an emergency room, observation unit, urgent care facility or during an inpatient stay. You do not need a prior authorization for emergencies. You also do not need prior authorization to see a women's health care provider for women's health services or if you are pregnant.

UnitedHealthcare will make routine prior approval decisions. Notice will be given by three (3) calendar days or by two (2) business days. We will make emergency prior approval decisions. Notice will be given by twenty-four (24) hours after it is requested.

A prior authorization may be needed.

Some services that need prior authorization include:

- Hospital admissions.
- Home health care services.
- Certain outpatient imaging procedures, including MRIs, MRAs, CT scans and PET scans.
- Sleep studies.

Continued care if your PCP leaves the network.

Sometimes PCPs leave the network. If this happens to your PCP, you will receive a letter from us letting you know. Sometimes UnitedHealthcare Community Plan will pay for you to get covered services from doctors for a short time after they leave the network. You may be able to get continued care and treatment when your doctor leaves the network if you are being actively treated for a serious medical problem. For example, you may qualify if you are getting chemotherapy for cancer or are at least six months pregnant when your doctor leaves the network. To ask for this, please call your doctor. Ask them to request an authorization for continued care and treatment from UnitedHealthcare.

If you need care when out of town.

UnitedHealthcare Community Plan will pay for routine care out-of-area only if:

- You call your PCP first and he or she says that it is important that you get care before you return home.

Behavioral health.

Behavioral health services are provided to members who have emotional problems or mental illness. You can get help by calling Member Services at **1-877-743-8731**, TTY **711**. Your covered care includes:

- Outpatient services when provided by a doctor, licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed counselor, psychiatric advanced practice nurse, home health psychiatric nurse or state-certified mental health program.
- Crisis intervention/access, including a 24-hour hotline staffed by qualified mental health professionals. Counselors provide intake, evaluation and referral services, including alternatives to out-of-home placements and mobile crisis teams for on-site interventions.
- Reasonable and cost-effective alternate services related to your treatment plan. Inpatient psychiatric care is available for children, adolescents and adults. Please contact member services for more information.

If you received care from an out-of-network doctor before joining UnitedHealthcare Community Plan, your doctor can call us for help in joining our network. He or she can also move you to an in-network doctor. We will authorize out-of-network providers to continue ongoing mental health care until we can arrange for in-network care.

Transportation services.

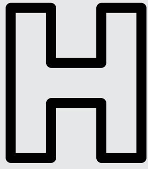
UnitedHealthcare Community Plan will provide non-emergency transportation assistance to help eligible persons travel to and from medical appointments when they have no other way to get there. Member requests for Non-Emergency Transportation (NET) services must be made at least three (3) business days before the NET services are needed.

To set up a ride, call MTM at **1-877-743-8731**, 7:00 a.m. – 8:00 p.m., Monday – Friday.

Transition of care.

If you are new to our plan, your medical services may go on for up to 90 days with your same doctor. If we find a new doctor for you, it may be less than 90 days. Services can go on for 30 days with no prior approval. After 30 days, your doctor must follow the prior approval process.

If you are more than four months pregnant, you may continue services with your same doctor until after your baby is born.



Hospitals and Emergencies

Emergency care.

Hospital emergency rooms are there to offer emergency treatment for trauma, serious injury and life-threatening symptoms.

Examples of emergencies:

- Severe pain.
- Convulsions.
- Unconsciousness.
- Severe or unusual bleeding.
- A serious accident.
- A suspected heart attack or stroke.
- Mental Health and Substance Use Disorder Services — A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.

Don't wait.

If you need emergency care, call **911** or go to the nearest hospital.

Examples of what is not generally an emergency:

- Colds and flu.
- Headaches.
- Sore throats.
- Bruises or minor cuts.
- Rashes.

UnitedHealthcare Community Plan covers any emergency care you need throughout the United States and its territories. Within 24 hours after your visit, call Member Services at **1-877-743-8731**, TTY **711**. You should also call your PCP and let them know about your visit so they can provide follow-up care if needed.

Urgent care.

Urgent care clinics are there for you when you need to see a doctor for a non-life-threatening condition but your PCP isn't available or it's after clinic hours. Common health issues ideal for urgent care include:

- Sore throat.
- Ear infection.
- Minor cuts or burns.
- Flu.
- Low-grade fever.
- Sprains.

If you or your children have an urgent problem, call your PCP first. Your doctor can help you get the right kind of care. Your doctor may tell you to go to urgent care or the emergency room.

Planning ahead.

It's good to know what urgent care clinic is nearest to you. You can find a list of urgent care clinics in your Provider Directory. Or you can call Member Services at **1-877-743-8731**, TTY **711**.

Hospital services.

There are times when your health may require you to go to the hospital. There are both inpatient and outpatient hospital services.

Outpatient services include X-rays, lab tests and minor surgeries. Your PCP will tell you if you need outpatient services. Your doctor's office can help you schedule them.

Inpatient services require you to stay at the hospital overnight. You may be required to stay overnight because of illness, surgery or having a baby. The hospital will call UnitedHealthcare Community Plan and ask for permission to take care of you. If the doctor who admits you to the hospital is not your Primary Care Provider (PCP), you should call your PCP as soon as possible and let them know you are being admitted into the hospital.

Going to the hospital.

You should go to the hospital only if you need emergency care or if your doctor told you to go.

Prior approval.
Doctors may need to get UnitedHealthcare Community Plan approval before giving you certain care. This is called prior authorization. Inpatient services at the hospital will need prior approval.

Emergency dental care.

Emergency dental care services to control pain, bleeding or infection are covered by your plan.

Post-stabilization services.

Post-stabilization services are covered and provided without prior authorization. These are services that are medically necessary after an emergency medical condition has been stabilized.

After-hours care.

Sometimes you may need your PCP when the office is closed. If you need urgent care, call your PCP's office. They will give you directions on how to reach your doctor. You may also contact our 24/7 NurseLine at 1-877-370-4009. In emergency cases, go to the nearest emergency room.

No medical coverage outside of U.S.

If you are outside of the United States and need medical care, any health care services you receive will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services you get outside of the United States.

Out-of-area services.

UnitedHealthcare Community Plan will cover out-of-area services if the provider is an MS Medicaid provider. If he or she is not an MS Medicaid provider, you may be responsible for the costs of those services.

Prior authorization is not needed for emergency room visits out-of-area.

Non-emergency visits need prior authorization. If you are out-of-area and need non-emergency services, call your doctor.

Prior authorization.

Doctors may need to get our approval before giving you certain care. This is called prior authorization. If services need prior authorization and your doctor does not get one, UnitedHealthcare Community Plan may not pay for these services. Your doctor should call Provider Services at 1-877-743-8734 to get prior authorizations.

Here are some types of care that need a prior authorization:

- Inpatient hospital to inpatient hospital transfers.
- Non-emergency services from an out-of-network provider.
- Some dental treatments.
- Some prescription drugs.

You do not need a prior authorization for:

- Emergency and urgent care.
- Hospital admissions for normal newborn deliveries.
- Some dental treatments.

Utilization review.

UnitedHealthcare Community Plan follows steps to decide if we will approve care. Our goal is to make sure the care is medically necessary, a covered benefit and done in the right setting at the right time. We also make sure you get quality care. No UnitedHealthcare employee, provider, or utilization decision maker is rewarded, penalized or given financial incentive for not giving you the care or services you need or for saying that you should not get them.

You can ask for a copy of the criteria we use. Call Member Services at **1-877-743-8731**. Staff, interpreters and TTD/TTY **711** services are available to assist members who have Utilization Management questions.

In-network providers.

In-network providers have contracted with UnitedHealthcare Community Plan. They include hospitals, pharmacies, dentists, optometrists, chiropractors and nurse practitioners. We have a relationship with these providers. We trust them to offer services to our members.

Our members can visit these providers just by making an appointment. You don't need to call us first. If you want information about a network doctor, such as his/her schooling, residency, or if he/she will see new patients, call Member Services.

Sometimes a provider that has previously participated in our network may change status and no longer be available as a participating provider. If such a change results in a provider no longer participating in our network, we will notify impacted members within 14 days of receiving notice.

Out-of-network providers.

A provider who is not in our network is an out-of-network provider. Usually, we will not pay for out-of-network care. If you go to an out-of-network provider, you may have to pay for those services.

If your PCP wants you to see a doctor who is not in our network, your PCP has to call us to get approval. Have your doctor call the number on the back of your ID card. If approved, these services will be paid for as if the provider was an in-network provider, at no cost to you.

Our network has doctors and hospitals to provide most requested services. If services are available in our network, you must use one of these providers. If you need help finding a provider, call Member Services.

If your PCP's request for out-of-network services is denied, you may file an appeal with UnitedHealthcare Community Plan within 60 days of denial, or file a fair hearing request with the Mississippi Division of Medicaid within 120 calendar days from the date of UnitedHealthcare Community Plan's adverse benefit determination. See the *Complaints, Grievances, Appeals and State Fair Hearings* section of this handbook for more information.

Pharmacy

Prescription drugs.

Your benefits include prescription drugs.
UnitedHealthcare Community Plan covers hundreds of prescription drugs from hundreds of pharmacies. The full list of preferred drugs is included in the Preferred Drug List. You can fill your prescription at any in-network pharmacy. All you have to do is show your member ID card.

What is the Preferred Drug List?

This is a list of drugs covered under your plan. You can find the complete list in your Preferred Drug List, or online at http://www.uhccommunityplan.com/ms/medicaid/mississippican/find-a-drug.html.

Over-the-Counter (OTC) medicines.

UnitedHealthcare Community Plan also covers many over-the-counter (OTC) medications. An in-network provider must write you a prescription for the OTC medication you need. The supply is limited to 30 days. Then all you have to do is take your prescription and member ID card into any network pharmacy to fill the prescription at no cost to you. OTC medications may include:

- Pain relievers.
- Cough medicine.
- First-aid cream.
- Cold medicine.
- Contraceptives.

For a complete list of covered OTC medicines, go to http://www.uhccommunityplan.com/ms/medicaid/mississippican/find-a-drug.html. Or call Member Services at **1-877-743-8731**, TTY **711**.

Injectable medicines.

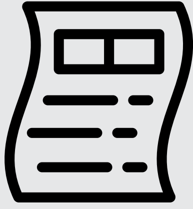
Injectable medications are medicines given by a shot, and they are a covered benefit. Your PCP can have the injectable medication delivered either to the doctor's office or to your home. In some cases, your doctor will write you a prescription for an injectable medication (like insulin) that you can fill at a pharmacy.

Pharmacy home.

Some UnitedHealthcare Community Plan members will be assigned a pharmacy home. In this case, members must fill prescriptions at a single pharmacy location for up to two years. This is based on prior medication use, including overuse of the pharmacy benefit, narcotics, pharmacy locations and other information.

Members of this program will be sent a letter with the name of the pharmacy they are required to use. If you get this letter, you have 30 days from the date of the letter to request a change of pharmacy. To change pharmacies during this time, call Member Services at **1-877-743-8731**, TTY **711**. After 30 days from the date of the letter, you will need to make your request in writing. Send your request to:

UnitedHealthcare Community Plan
795 Woodland Parkway, Suite 301
Ridgeland, MS 39157



Benefits

Your MississippiCAN benefits.

The following are services covered by UnitedHealthcare Community Plan for MississippiCAN members.

There are no copayments (copays), deductibles or cost-sharing for any service covered by UnitedHealthcare Community Plan.

Benefit	Limitation	Prior Authorization
Ambulatory Surgical Center Services		No.
Ambulance Services	Prior authorization required for Urgent Air Ambulance (fixed wing) only.	*No prior authorization required for emergency services. *Prior authorization required for non-emergency transportation, fixed wing or otherwise.
Chiropractic Services	$700 maximum per calendar year.	No.
Christian Science Sanatoria Services		No.

Benefit	Limitation	Prior Authorization
Cosmetic and Reconstructive Surgery – Outpatient		Yes.
Dental Services **Children** • Emergency pain relief. • Preventive. • Diagnostic. • Restorative. • Orthodontia. **Adults** • Emergency pain relief. • Diagnostic.	**Dental** $2,500 maximum per calendar year — adults and children; additional benefits if prior authorized. **Orthodontia** $4,200 maximum per lifetime per child. *Orthodontics are not covered for adults.	Yes, certain dental procedures such as crowns, root canals, dentures and orthodontics require prior authorization. *Orthodontics are not covered for adults.
Dialysis Outpatient Center Services		No.
Durable Medical Equipment	All Medicaid policy restrictions apply.	Prior authorization needed for items over $500.
Emergency Room Visits • Outpatient ER visits.	Unlimited.	No.
EPSDT	Limited to beneficiaries under 21 years of age.	No.
Expanded EPSDT Services	Prior authorization required for services not covered, or any service that exceeds service limits. Limited to beneficiaries under 21 years of age.	No.

Benefit	Limitation	Prior Authorization
Eye Care (Eye exams and glasses)	2 eye exams per year/2 pair of glasses per year for children (prior authorization required after the first pair). 1 eye exam per year/ 1 pair of glasses every 3 years for adults.	Yes, for children after 1st pair per calendar year.
Family Planning Services		No.
Federally Qualified Health Center Services		No.
Genetic Testing		Yes.
Health Department Services		No.
Hearing Services	Hearing aids and implants limited to beneficiaries under 21 years of age (EPSDT).	Prior authorization required for any services beyond EPSDT-covered services.
Home Health Services	Adults – 36 visits per calendar year. Children – no limitation.	Yes. Yes.
Home Infusion		No. Injectables may require a prior authorization depending on the Preferred Drug List.
Hospice • Inpatient. • Outpatient.		No.

Benefit	Limitation	Prior Authorization
Hospital Care • Inpatient services.		Yes.
Imaging: nuclear studies, computed tomography (CT and SPECT scans), magnetic resonance studies (MRI, MRA), and PET scans		Yes.
Laboratory and X-Ray Services		No.
Medical Supplies	Covered.	No.
Mental Health Services 1. Outpatient services. 2. Crisis intervention. 3. Inpatient psychiatric care. See page 26 for more information.	 1. Covered. 2. Covered. 3. Available for children, adolescents and adults. Call Member Services at **1-877-743-8731** for more information.	 1. No. 2. No. 3. Yes.
Newborn Circumcision	Not covered.	
Non-Contracted Provider Services (outpatient facility and professional)		Yes.
Non-Emergency Transportation Services	Covered.	Call MTM at **1-877-743-8731**, 7:00 a.m. – 8:00 p.m., Monday – Friday to arrange.

Benefit	Limitation	Prior Authorization
Nurse Practitioner Services		No.
Orthotics and Prosthetics	Limited to beneficiaries under 21 years of age.	Yes, over $500.
Outpatient PT/OT/ST		Yes.
Perinatal High Risk Management Services		No.
Physician Assistant Services		No.
Physician Services – Office (PCP and Specialists) • Office.	Unlimited.	No.
Physician Services – ER • ER visits.		No.
Podiatrist Services		No.
Private Duty Nursing (PDN)	Limited to beneficiaries under 21 years of age.	Yes.
Prescribed Pediatric Extended Care (PPEC)	PPEC is only covered for those members who are ages 20 and younger. PPEC are services for medically or device dependent children who need such services. For a member to get basic nonresidential services at a PPEC center, the member must have an illness or disability that needs constant care.	Yes.

Benefit	Limitation	Prior Authorization
Prescription Drugs	6 per month with no more than 2 of the 6 being brand-name non-preferred drugs; beneficiaries under age 21 can receive more than the monthly limits with a medical necessity prior authorization.	Yes — for beneficiaries under 21 that require more than 6 prescriptions per month. Some medications on our PDL need prior authorization. If the prior authorization is not obtained, you will not receive the drug.
Psychiatric Care • Inpatient.	Available for children, adolescents and adults.	Yes.
Rural Health Clinic Services		No.
Sleep Studies		Yes.
Transplant Services	Human solid organ (heart, lung, liver, kidney, and cornea) or bone marrow and stem cell transplants are covered with prior approval. If both the person receiving the organ and person donating the organ are members, regular benefits are provided to the member donating the organ. Charges related to covered organ transplants are also covered. This includes: • The search for matching tissue, bone marrow or organs. • The donor's transportation and hospital stay. • The removal, withdrawal and preservation of tissue, bone marrow and organs.	Yes.

Preventive health services.

Regular visits to your doctor are important. The following are preventive health guidelines for men, women and children. Talk to your PCP about any services that may be needed. You may need other services if you are at risk for any health problems.

Preventive Health Care for Men*					
Services	**Ages:**	**18 to 30 Years**	**31 to 50 Years**	**51 to 64 Years**	**65 Years and Older**
Annual Exam					
Should include: Medical history; Height and weight; Discuss how well you eat; Behavioral health screening; Hearing screens; Blood pressure checks; Screening for alcohol or substance abuse; Any referrals to special services you may need.		Every year.	Every year.	Every year.	Every year.
Immunizations					
Shots are important. Ask your doctor what shots are needed.		Ask your doctor at every visit about your shots.	Ask your doctor at every visit about your shots.	Ask your doctor at every visit about your shots.	Ask your doctor at every visit about your shots.

* *These are guidelines for routine services. Talk to your doctor about any additional services you may need. You may need other services if you are at risk for certain health problems. This information is from the U.S. Preventive Services Task Force.*

Preventive Health Care for Men* *(continued)*					
Services	**Ages:**	**18 to 30 Years**	**31 to 50 Years**	**51 to 64 Years**	**65 Years and Older**
Cancer Screenings					
Colorectal cancer: 1. Fecal Occult Blood Test. 2. Sigmoidoscopy or Colonoscopy.			1. Every year starting at age 50. 2. Every 5 years starting at age 50.	1. Every year. 2. Every 5 years.	1. Every year. 2. Every 5 years.
Prostate cancer.			If you are age 50 or older, talk to your doctor about being tested for prostate cancer.	Talk to your doctor about being tested for prostate cancer.	Talk to your doctor about being tested for prostate cancer.
Testicular cancer.		Talk to your doctor about being tested for testicular cancer.	Talk to your doctor about being tested for testicular cancer.	Talk to your doctor about being tested for testicular cancer.	Talk to your doctor about being tested for testicular cancer.
Screening Tests					
Tuberculosis screen; Diabetes screen; Screening for sexually transmitted diseases; Serum cholesterol tests.		Ask your doctor about any screening tests you may need.	Ask your doctor about any screening tests you may need.	Ask your doctor about any screening tests you may need.	Ask your doctor about any screening tests you may need.

** These are guidelines for routine services. Talk to your doctor about any additional services you may need. You may need other services if you are at risk for certain health problems. This information is from the U.S. Preventive Services Task Force.*

Preventive Health Care for Women*					
Services	**Ages:**	**18 to 30 Years**	**31 to 50 Years**	**51 to 64 Years**	**65 Years and Older**
Annual Exam					
Should include: Medical history; Height and weight; Discuss how well you eat; Behavioral health screening; Hearing screens; Blood pressure checks; Screening for alcohol or substance abuse; Any referrals to special services you may need.		Every year.	Every year.	Every year.	Every year.
Immunizations					
Shots are important. Ask your doctor what shots are needed.		Ask your doctor at every visit about your shots.	Ask your doctor at every visit about your shots.	Ask your doctor at every visit about your shots.	Ask your doctor at every visit about your shots.
Cancer Screenings					
Cervical cancer screen.		At least once by age 21. Then every 3 years.	Every 3 years.	Every 3 years.	Every 3 years.
Breast cancer screen.			Mammogram every 1 to 2 years starting at age 40.	Mammogram every 1 to 2 years starting at age 40.	Mammogram every 1 to 2 years starting at age 40.
Colorectal cancer screens 1. Fecal Occult Blood Test. 2. Sigmoidoscopy or Colonoscopy.			1. Every year starting at age 50. 2. Every 5 years starting at age 50.	1. Every year. 2. Every 5 years.	1. Every year. 2. Every 5 years.

* *These are guidelines for routine services. Talk to your doctor about any additional services you may need. You may need other services if you are at risk for certain health problems. This information is from the U.S. Preventive Services Task Force.*

Preventive Health Care for Women* *(continued)*				
Services **Ages:**	**18 to 30 Years**	**31 to 50 Years**	**51 to 64 Years**	**65 Years and Older**
Other Screening Tests				
Tuberculosis screen; Rubella screen; Diabetes screen; Serum cholesterol tests.	Ask your doctor about any screening tests you may need.	Ask your doctor about any screening tests you may need.	Ask your doctor about any screening tests you may need.	Ask your doctor about any screening tests you may need.

Services **Ages:**	**All Women of Childbearing Age**
Gynecology/Family Planning	
Pap smear; Pelvic exam; Clinical breast exam; Chlamydia screen; Rubella screen; Screening and counseling for HIV testing; Sexually transmitted disease testing; Sexual health education; Information about contraception; Pregnancy testing.	See your doctor, nurse practitioner, or certified midwife when you become sexually active or by age 21. Then, see your doctor, nurse practitioner, or certified midwife every year. See any Medicaid approved doctor, nurse practitioner, or midwife for family planning services and supplies, even if they are not a part of the network.

* *These are guidelines for routine services. Talk to your doctor about any additional services you may need. You may need other services if you are at risk for certain health problems. This information is from the U.S. Preventive Services Task Force.*

Preventive Health Care for Women* *(continued)*		
Services	**Ages:**	**All Women of Childbearing Age**
Prenatal Care		
Prenatal screen; Medical history; Behavioral health history; Screening for alcohol or substance abuse; Case management if needed.		See your doctor or midwife as soon as you think you are pregnant. Then, follow the visit schedule your doctor or midwife gives you.
Postpartum Care		
Follow-up visit; Case management if needed.		See your doctor or midwife six (6) weeks from delivery of your baby.

* *These are guidelines for routine services. Talk to your doctor about any additional services you may need. You may need other services if you are at risk for certain health problems. This information is from the U.S. Preventive Services Task Force.*

Preventive Health Care for Children*					
Services	**Ages:**	**Birth to 2 Years**	**3 to 6 Years**	**7 to 12 Years**	**13 to 20 Years**
Tot to Teen Health Check or Well Child Exam					
Should include: Exam of child; Medical history of child; Weigh and measure child; Discuss how well your child eats; Developmental and behavioral screening; Vision and hearing screens at the right age; The doctor will talk to you about what to expect from your child; Any referrals to special services for your child.		Exams at ages: **3 – 5 days, 1, 2, 4, 6, 9, 12, 15, 18, 24,** and **30** months.	Every year.	Every year.	Every year.

* *These are guidelines for routine services. Talk to your child's doctor about any additional services they may need. They may need other services if they are at risk for certain health problems. This information is from the AAP – American Academy of Pediatrics.*

Preventive Health Care for Children* *(continued)*				
Services **Ages:**	**Birth to 2 Years**	**3 to 6 Years**	**7 to 12 Years**	**13 to 20 Years**
Dental Exams				
Starting at **6 months**, your child should be seen by the dentist every 6 months.		Take your child to the dentist every **6** months.	Take your child to the dentist every **6** months.	Take your child to the dentist every **6** months.
Immunizations				
Shots are important. Ask your child's doctor at every visit what shots are needed.	Ask your child's doctor at every visit what shots are needed.	Ask your child's doctor at every visit what shots are needed.	Ask your child's doctor at every visit what shots are needed.	Ask your child's doctor at every visit what shots are needed.
Screening Tests				
Anemia; Lead testing. **Other screening tests:** TB; Cholesterol; STD (Sexually Transmitted Disease).	Test for anemia at **9** or **12** months. Lead testing at **12** and **24** months.	Ask your child's doctor about any screening tests your child may need.	Ask your child's doctor about any screening tests your child may need.	Ask your child's doctor about any screening tests your child may need.

* *These are guidelines for routine services. Talk to your child's doctor about any additional services they may need. They may need other services if they are at risk for certain health problems.*
This information is from the AAP – American Academy of Pediatrics.

Regular Medicaid services.

There are some Medicaid services that are NOT covered by UnitedHealthcare Community Plan, but you may be able to get from Medicaid. This could include counseling or referral of a service not covered because of moral or religious objections. Call your local Medicaid office for information on these services and any cost sharing required. (See the *Important phone numbers* page for the Medicaid Office phone number.)

New technology.

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

Disease and Care Management.

If you have a chronic health condition like asthma or diabetes, UnitedHealthcare Community Plan has a program to help you live with your condition and improve the quality of your life. These programs are voluntary and available at no cost to you. The programs give you important information about your health condition, medications, treatments and the importance of follow-up visits with your physician.

A team of registered nurses and social workers will work with you, your family, your PCP, other health care providers and community resources to design a plan of care to meet your needs in the most appropriate setting. They can also help you with other things like weight loss, stopping smoking, making appointments with your doctor and reminding you about special tests that you might need.

You or your doctor can call us to ask if our care management or disease management programs could help you. If you or your doctor thinks a Care Manager could help you, or if you want more information about our care management or disease management programs, call us at **1-877-743-8731**, TTY **711**.

Wellness programs.

UnitedHealthcare Community Plan has many tools to help keep you and your family healthy, including:

- Information to help you quit smoking.
- Pregnancy care and parenting information.
- Nutrition information.
- Well-care reminders.

To quit smoking, you can also call **1-800-227-2345** or visit **quitnow.net**.

Your provider may suggest one of these programs for you. If you want to know more, or to find a program near you, talk to your PCP or call Member Services at **1-877-743-8731**, TTY **711**.

Quality improvement.

UnitedHealthcare Community Plan wants you to get quality health care. We study the care you get from your providers. We look for ways to make our services better and fix any problems.

For information on our Quality Improvement program, how we are meeting our goals, or practice guidelines, write to:

UnitedHealthcare Community Plan
Quality Improvement
795 Woodlands Parkway, Suite 301
Ridgeland, Mississippi 39157

For moms-to-be and children.

Healthy First Steps™.

UnitedHealthcare Community Plan has a Healthy First Steps program available to expectant mothers, at no cost to you. This program is there to help keep you and your baby healthy during and after pregnancy. When you enroll in this program, you'll get a personal care manager who will work closely with you. He or she can:

- Help you find a doctor.
- Set up transportation to appointments.
- Offer helpful information on caring for your baby.
- Support you after your baby is born.

Having a baby?

When you think you are pregnant, call your local Medicaid Office and Member Services at **1-877-743-8731**, TTY **711**. This will help ensure you get all the services available to you.

The sooner you enroll, the sooner you and your baby benefit. To enroll, simply call **1-800-599-5985**, TTY **711**, 8:30 a.m. – 5:30 p.m., Monday – Friday.

WIC is a nutrition education program. It provides healthy foods such as milk, cereal and juice if you're pregnant or breastfeeding. It may also provide food for your baby and children up to 5 years of age. Visit www.nwica.org for the phone number to your local WIC office if you aren't already signed up.

Prenatal care.

Prenatal care is when a pregnant woman visits the doctor during her pregnancy. Prenatal care lets your child's doctor see how well the pregnancy is going and if there are any problems. Even if a woman has been pregnant before, she should visit her doctor regularly.

It is best if your child gets all of her prenatal care from the same doctor. We recommend that your child see the doctor at least ten times during her pregnancy. She will also need to go back to her doctor after delivery. This is called postpartum care. It is to make sure both she and her baby are healthy.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) well child program.

These EPSDT doctor visits are for all MississippiCAN members under 21 years of age.

EPSDT visits.
EPSDT visits are a time for your PCP to see how your child is growing and developing. They will also give the needed screenings, like speech and hearing tests, and immunizations during these visits. These routine visits are also a great time for you to ask any questions you have about your child's behavior and overall well-being, including:

- Eating.
- Sleeping.
- Behavior.
- Social interactions.
- Physical activity.
- Adolescent counseling and guidance.

All EPSDT visits and procedures are covered. For information, call Member Services at **1-877-743-8731**, TTY **711**.

Checkup schedule.

It's important to schedule your child's EPSDT visits for these ages:

- 3 to 5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Once a year after age 3

Here are shots the doctor will likely give, and how they protect your child:

- **Hepatitis A and Hepatitis B:** prevent two common liver infections.
- **Rotavirus:** protects against a virus that causes severe diarrhea.
- **Diphtheria:** prevents a dangerous throat infection.
- **Tetanus:** prevents a dangerous nerve disease.
- **Pertussis:** prevents whooping cough.
- **HiB:** prevents childhood meningitis.
- **Meningococcal:** prevents bacterial meningitis.
- **Polio:** prevents a virus that causes paralysis.
- **MMR:** prevents measles, mumps and rubella.
- **Varicella:** prevents chickenpox.
- **Influenza:** protects against the flu virus.
- **Pneumococcal:** prevents ear infections, blood infections, pneumonia and bacterial meningitis.
- **HPV:** protects against a sexually transmitted virus that can lead to cervical cancer in women and genital warts in men.

Dr. Health E. Hound® program.

We are proud of our mascot — Dr. Health E. Hound. His goal is to teach your kids about fun ways to stay fit and healthy.

Dr. Health E. Hound loves to travel around the state and meet kids of all ages. He hands out flyers, posters, stickers and coloring books about healthy foods and exercise. He helps kids understand that going to the doctor is an important way to stay healthy. You and your family can meet Dr. Health E. Hound at some of our events. Come to an event and learn about healthy eating and exercise.

Other plan details

Finding a network provider.

We make finding a network provider easy. To find a network provider or a pharmacy close to you:

Visit myuhc.com/CommunityPlan for the most up-do-date information.
Click on "Find a Provider."

Call Member Services at **1-877-743-8731**, TTY **711**. We can look up network providers for you. Or, if you'd like, we can send you a Provider Directory in the mail.

Provider Directory.

You have a directory of providers available to you in your area. The directory lists names, addresses, phone numbers and hour of operation including non-traditional hours of operation of our in-network providers including, PCP and PCP Group specialists, hospital, facilities, FQHCs and RHC. In addition, the directory provides whether a provider will accept new patients and whether the office/facility has accommodations for people with physical disabilities including offices, exam rooms and equipment.

Your directory will inform you of any restrictions of choice among network providers and closed panels (webbased version only).

Finally, the directory identifies the cultural and linguistic capabilities including languages and sign language offered by the provider or interpreter at their office, as well as the provider's completion of training.

Provider information changes often. Visit our website for the most up-to-date listing at myuhc.com/CommunityPlan. You can view or print the provider directory from the website, or click on "Find a Provider" to use our online searchable directory.

If you would like a printed copy of our directory, please call Member Services at **1-877-743-8731**, TTY **711**, and we will mail one to you.

Interpreter services and language assistance.

Many of our Member Services employees speak more than one language. If you can't connect with one who speaks your language, you can use an interpreter to help you speak with Member Services free of charge.

Many of our network providers also speak more than one language. If you see one who doesn't speak your language, you can use our interpreter or sign language services to help you during your appointment free of charge. Arrange for your translation services at least 72 hours before your appointment. Sign language services require two weeks' notice.

You can also have any printed materials we send you either sent in a different language or translated for you. To arrange for interpreter, translation services or audio format free of charge, call Member Services at **1-877-743-8731**, TTY **711**.

Updating your information.

To ensure that the personal information we have for you is correct, please tell us if any of the following changes:

- Marital status.
- Address.
- Member name.
- Phone number.
- You become pregnant.
- Family size (new baby, death, etc.).
- Other health insurance.

Please call Member Services at **1-877-743-8731**, TTY **711**, if any of this information changes. UnitedHealthcare Community Plan needs up-to-date records to tell you about new programs, to send you reminders about healthy checkups, and to mail you member newsletters, ID cards and other important information. You should also tell Medicaid if you have any changes. They need updated address information every time you move.

Other insurance.

If you have any other insurance, call Member Services and let us know.

- If you are a member, your other health insurance will have to pay your health care bills first.
- When you get care, always show both member ID cards (for UnitedHealthcare Community Plan and your other insurance).

Fraud and abuse.

Committing fraud or abuse is against the law. Fraud is a dishonest act done on purpose. Examples of member fraud are:

- Letting someone else use your MississippiCAN health plan card(s) or your Medicaid ID card.
- Getting prescriptions with the intent of abusing or selling drugs.

An example of provider fraud is:

- Billing for services not provided.

Abuse is an act that does not follow good practices. An example of member abuse is:

- Going to the emergency room for a condition that is not an emergency.

An example of provider abuse is:

- Prescribing a more expensive item than is necessary.

Any intentional false statement or claim to receive or increase benefits may result in criminal charges, and may lead to prosecution for fraud. It may also cause you to lose your MississippiCAN benefits. **If you suspect anyone of fraud, call 1-866-242-7727**. You do not have to give or leave your name.

If you get a bill.

Before you get any health care services that are not covered, talk to your doctor about how you can pay for them. Remember, if you ask for a service that is not covered by UnitedHealthcare Community Plan, you will have to pay the bill.

We will pay for all covered care from in-network providers. In-network providers should not charge you any fees or copays for any care offered as part of your health plan. If you are ever asked to pay for a covered service, call your doctor right away and give him or her your insurance information and UnitedHealthcare's address. Do not pay the bill yourself. If you still get bills, please call Member Services at **1-877-743-8731**, TTY **711** for help.

Medical advances.

Our Technology Assessment Committee reviews requests to cover newly developed equipment or procedures. This committee includes doctors and other health professionals. The Committee uses national guidelines and scientific evidence to decide if we should approve them.

Your opinion matters.

Do you have any ideas about how to make UnitedHealthcare Community Plan better? There are many ways you can tell us what you think.

- Call Member Services at **1-877-743-8731**, TTY **711**.
- Write to us at:

  UnitedHealthcare Community Plan
  Member Advocate
  795 Woodland Parkway, Suite 301
  Ridgeland, MS 39157

Member Advisory Committee.

We also have a Member Advisory Committee that meets every three months. If you'd like to join us, call Member Services.

Advance Directives.

The patient's right to decide.
You have a right to file an "Advance Directive." This document says, in advance, what kind of treatment you want or do not want if you have a serious medical condition that prevents you from telling your provider how you want to be treated. For example, if you were taken to a health care facility in a coma, an Advance Directive would let the facility's staff know how you want your health care to be handled.

There are two types of an Advance Directive: 1) a Living Will; and, 2) a Medical Power of Attorney (which may also be called a "durable power of attorney for health care or health care agent"). An "agent" is the person you trust to speak for you when you are not able to do so for yourself. You should think carefully about the person you choose to be your health care agent. You should have a long talk with your agent about your Advance Directive so they are able to make the decision the way you would. Two examples of Advance Directives can be found on our website at myuhc.com/CommunityPlan. Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health.

Eligibility.

UnitedHealthcare Community Plan does not decide if you qualify for MississippiCAN. The Mississippi Division of Medicaid (DOM) makes the decision.

If you have questions, call the Division of Medicaid (DOM) at 1-800-884-3222 or 1-800-421-2408 or 1-601-359-6050.

Enrollment.

Your enrollment in MississippiCAN is for 12 months or until you lose eligibility, whichever comes first. DOM will tell UnitedHealthcare Community Plan the date you are enrolled. Your eligibility continues until DOM tells UnitedHealthcare the date you will be disenrolled.

Contact your source of eligibility where you enrolled, such as Social Security Administration or Medicare or Medicaid:

- If your family size changes.
- If you move.
- If your income goes up or down.
- If you get health care coverage under another policy or there are changes to that coverage.

To report changes, call, write or visit your source of eligibility — the place where you first enrolled.

Member incentives.

UnitedHealthcare Community Plan of Mississippi offers member incentives on select measures to encourage members to complete annual wellness screenings. Some measures eligible for incentives may include:

- Breast cancer screenings.
- Adolescent EPSDT/Well child exams.
- Diabetic eye exams.

Members who are eligible for incentives will receive communication about current programs via calls and/or mailings. Members can also contact Member Services at **1-877-743-8731**, TTY **711** to get a list of current incentives.

Each year, UHC reviews the incentive program. Member incentives usually range from $25 to $50 and are offered in the form of a prepaid Mastercard reward card.

If you want to leave UnitedHealthcare Community Plan.

The Mississippi Division of Medicaid (DOM) has mandated that members in specific categories of eligibility be enrolled with a Coordinated Care Organization (CCO) under the MississippiCAN program. You will receive a letter from the Division of Medicaid informing you of your status upon initial enrollment. You can also contact DOM at any time to determine if you are a mandatory or optional enrollee.

For mandatory enrollees.
If you are in one of these categories of eligibility, then you can change CCOs within 90 days of enrollment by returning the MississippiCAN Mandatory Change Form, but you must be enrolled with a CCO:

- SSI.
- Working Disabled.
- Breast & Cervical Cancer.
- Pregnant Women.
- Parent/Caretakers.
- Medical Assistance Children.
- Populations other than SSI, Disabled Child Living at Home, DHS – Foster Care Children (Adoption Assistance) and American Indians.

For optional enrollees.
Once you enroll in UnitedHealthcare Community Plan, you have 90 days to submit your MississippiCAN Optional Change Form which you received in the mail to stop your enrollment. After that you will be a member of our plan for the next year or until the next open enrollment period. You can change for any reason in the first 90 days of your membership. Call the DOM to stop your membership during this period.

After your first 90 days, there may be a reason you need to end your UnitedHealthcare Community Plan membership. Some reasons may be:

- You move outside our service area.
- We do not cover the service you are requesting.

You must contact the DOM in writing or by phone to disenroll or change plan.

Disenrollment "for cause."

Any member may ask for Disenrollment "for cause." The request must be sent to the Division of Medicaid for approval. You may ask for disenrollment by mouth or in writing. You may ask for Disenrollment "for cause" if:

- The services you want are not covered because of moral or religious reasons.
- You are not able to get all related services within the Plan's network.
- Your doctor determines receiving the services separately could cause risk and poor quality care.
- Your ability to get health care services covered under the Plan is limited.
- Your ability to get health care services from providers experienced in treating your health care needs is limited.

Other reasons for disenrollment.

A member may also be disenrolled for the following reasons:

- You are deceased.
- You no longer qualify for medical assistance.
- You become a resident of a nursing home, intermediate care facility, or any facility that is not a psychiatric residential treatment facility.
- You are in a wavier program.
- You become eligible for Medicare coverage.
- You are diagnosed with hemophilia.
- You no longer reside in the State.

End of coverage.

If you are disenrolled, your coverage will end on the last day of that month.

Other health insurance (Coordination of Benefits – COB).

If you or anyone in your family has other health insurance, you must call Member Services and tell us about it. For example, if you have a health plan at work or if your children have insurance with their other parent, call Member Services.

If you have other insurance:

- Call Member Services at **1-877-743-8731**, TTY **711**.
- Call the Division of Medicaid (DOM) at 1-800-884-3222 or 1-800-421-2408 or 601-359-6050.

If you have other insurance, UnitedHealthcare Community Plan and your other plan will share the cost of your care. This is called **Coordination of Benefits**. Together, both plans will pay no more than 100% of the bill.

If we pay the full bill and another party should pay part, we will contact the other plan. For example, if you are hurt in a car accident, auto insurance may pay some of your bills. You will not get a bill for covered services. We get the bill. If you get the bill by mistake, call **Member Services at 1-877-743-8731**, TTY **711**.

Non-discrimination.

UnitedHealthcare Community Plan will not discriminate based on race, ethnicity, gender identity, sexual orientation, age, religion, creed, color, national origin, ancestry, disability, health status or need for health services.

Member rights and responsibilities.

Uphold customer "Bill of Rights."
As a UnitedHealthcare Community Plan member, you have certain rights and responsibilities when you enroll. It is important that you fully understand both your rights and your responsibilities. The following statement of rights and responsibilities is presented here for your information. The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

You have a right to:

- Get information about UnitedHealthcare Community Plan, its services, the doctors giving care, and member rights and responsibilities.
- Be told by your doctor what is wrong, what can be done and what the result may be in language you understand.
- Learn about options for treatment, regardless of cost or coverage, in a way that you can understand.
- Voice complaints or appeals about us and your care.
- Suggest changes to our member rights and responsibilities.
- Be cared for with respect and dignity and with regard to your privacy, without regard for health status, physical or mental handicap, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need.
- Get a second opinion.
- Give your OK to any treatment or care plan after it has been explained to you.
- Refuse care and be told what you may risk if you do.
- Be free from any restraint or seclusion as a means of coercion, discipline, convenience or retaliation.
- Get a copy of your medical record. Talk about it with your doctor and ask, if needed, that it be amended or corrected.
- Have your medical record kept private, shared only when required by law or contract or with your approval.
- Get respectful care in a clean and safe environment free of unnecessary restraints.
- Get information about doctor incentives.
- Exercise your rights and not have this affect the way you are treated.
- Make an advance directive.
- Make a decision on organ donation.

- Have services that are not denied or reduced. These services should not be denied or reduced due to diagnosis, type of illness, or medical problem.
- Access oral interpretation services free of charge.

You have a responsibility to:

- Give information that UnitedHealthcare Community Plan and your doctor need to care for you.
- Listen to the doctor's advice, follow instructions and ask questions.
- Understand your health problems and work with your doctor to set treatment goals.
- Work with your doctor to guard and improve your health.
- Find out how your health care system works.
- Go back to your doctor or ask for a second opinion if you do not get better.
- Treat health care staff with respect.
- Tell us if you have problems with any health care staff.
- Follow the appointment scheduling process.
- Keep your appointments. If you must cancel, call as soon as you can.
- Call your doctor when you need medical care, even after office hours.
- Use the emergency room only for real emergencies.
- Inform the plan of changes in address, family size, or other health care coverage.
- Pay for services not approved and received from non-network providers when:
  - You know the service is not covered.
  - You have agreed in writing to be financially responsible for the service.
- Know how to get services approved.

Complaints, grievances, appeals and State Fair Hearings.

What Is a complaint?
A complaint is an expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) calendar day. A complaint might be about, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.

You must submit the complaint in writing or over the phone within thirty (30) calendar days of the date of the event causing the dissatisfaction. If someone else is going to file a complaint for you, we must have your written permission for that person to file your complaint. Any complaint not resolved within one (1) calendar day shall be treated as a grievance.

What is a grievance?
A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

A grievance might be about:

- Transportation.
- Access to service/providers.
- Provider care and treatment.
- Coordinated care organization customer service.
- Payment and reimbursement Issues.
- Administrative Issues.

Examples of grievances include but are not limited to:

- You are unhappy with the quality of care or services you are getting.
- The doctor you want to see is not a UnitedHealthcare Community Plan doctor.

What should I do if I have a grievance?
You or someone acting on your behalf (provider, family member, etc.) can file a grievance by calling or writing to UnitedHealthcare Community Plan. Call **1-877-743-8731**, TTY **711** or write to:

Grievance and Appeals
P.O. Box 5032
Kingston, NY 12402-5032

If you need help with your grievance, please call the toll-free member phone number at **1-877-743-8731**, TTY **711**, 7:30 a.m. – 5:30 p.m. CT Monday – Friday, (and 7:30 a.m. – 8:00 p.m. CT on Wednesday). We are also available 8:00 a.m. – 5:00 p.m. CT the first Saturday and Sunday of each month.

If someone else is going to file a grievance for you, we must have your written permission for that person to file your grievance. There is a form you can use at the end of this Handbook.

You can file a grievance by calling or writing to UnitedHealthcare Community Plan. When you call we will let you know at the time of your call we've received your grievance unless you ask us to confirm receipt in writing. If you write to us we will send you a letter within five (5) calendar days telling you we received your grievance. We will review your grievance and send notice of our decision within thirty (30) calendar days of receiving your grievance or expeditiously as your health condition requires.

If you ask for more time or we show there is a need for more information and the delay is in your interest, the time frame may be extended by up to 14 days. If we ask for more time, we make a reasonable attempt to call you and we send you a letter to let you know why we need more time.

What is the time period a member can file a grievance?
A member may file a grievance at any time.

What can I do if I need a fast decision?
If you or someone acting on your behalf (provider, family member, etc.) wants a fast decision because your health is at risk, call Member Services at **1-877-743-8731**, TTY **711**. You may file an Expedited Grievance. UnitedHealthcare Community Plan will call you with our decision within 72 hours of you asking for a fast decision. This time frame may be extended up to 14 days. If you ask for more time or we show that there is need for additional information and the delay is in your interest, the time frame may be extended. If we ask for an extension, we will give you written notice of the reason. You will receive a letter in writing. The letter will let you know the reason for our decision and what to do if you don't like the decision.

If we decide that your grievance does not need a fast decision based on the rules, we will call you to let you know. Your grievance will be handled within 30 calendar days. We will also send you a letter telling you this within two days of calling you.

After your grievance is reviewed, we will send you a letter letting you know our decision.

What is an Adverse Benefit Determination?
An adverse benefit determination is the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. An adverse benefit determination includes:

- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner as defined in the appointment standards.
- The failure of the health plan to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

For a resident of a rural area with only one Managed Care Organization, the denial of a member's request to exercise his or her right, under § 42 C.F. R. 438.52(b)(2)(ii) to obtain services outside of the network:

- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities; and
- Determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

What is an appeal?
An appeal means a review by UnitedHealthcare Community Plan of an Adverse Benefit Determination.

If any of the above occurs, UnitedHealthcare Community Plan will send you a Adverse Benefit Determination. An appeal is when you tell us you believe our Adverse Benefit Determination was made in error.

How do I file an appeal with UnitedHealthcare Community Plan?
Members have a right to request appeal of a grievance decision. You or someone acting on your behalf (provider, family member, etc.) with your written permission can file an appeal by calling or writing to UnitedHealthcare Community Plan. Call **1-877-743-8731**, TTY **711** or write to:

Grievance and Appeals
P.O. Box 5032
Kingston, NY 12402-5032

You must file your appeal within 60 calendar days of receiving UnitedHealthcare's Notice of Adverse Benefit Determination. If you need help writing or filing an appeal, call Member Services at **1-877-743-8731**, TTY **711**.

If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal. Members have the right to present additional information or review the appeal case file for an appeal.

If someone else is going to file an appeal for you, we must have your written permission for that person to file your appeal.

You will receive a letter telling the reason for our decision and what to do if you don't like the decision. When you file an appeal, we will send you a letter within ten (10) calendar days telling you we received your appeal. We will review your appeal and send you our decision within thirty (30)calendar days. If you ask for more time or we show there is a need for more information and the delay is in your interest, the time frame may be extended up to 14 days. If we ask for more time, we make a reasonable attempt to call you and we send you a letter to let you know why we need more time.

If you have been getting medical care and your health plan reduces, suspends, or ends the service, you can appeal. In order for medical care not to stop while you appeal the decision you must appeal within ten (10) calendar days from the date of the Notice of Adverse Benefit Determination and tell us not to stop the service while you appeal. If you do not win your appeal you may have to pay for the medical care you got during this time. Your benefits will continue until one of the following occurs:

- You withdraw the appeal request.
- You do not request an appeal within 10 calendar days from the date of the notice of adverse benefit determination.
- The authorization for services has expired or service authorization limits are met.
- An appeal decision is issued that is adverse to you.

UnitedHealthcare will resolve an appeal and provide written notice of the resolution within 30 calendar days. UnitedHealthcare may extend this time frame by up to 14 calendar days upon a member's request or if UnitedHealthcare demonstrates the need for more information and that a delay in rendering the decision is in the member's best interest. For any extension not requested by the member, UnitedHealthcare will give the member written notice of the reason for delay.

What can I do if I need immediate care?
If you or your doctor wants a fast decision because your health is at risk, call Member Services at **1-877-743-8731**, TTY **711** for an expedited review of a Notice of Adverse Benefit Determination.You do not have to send a letter for a fast decision once you call Member Services. UnitedHealthcare Community Plan will call you with our decision within 72 hours of getting your request for an expedited review. This time frame may be extended up to 14 days if you ask for the extension or we show that there is need for additional information and the delay is in your interest. If we ask for an extension, we will make a reasonable attempt to call you and we send you a letter to let you know why we need more time.

If we decide that your appeal does not need a fast decision based on the rules, we will call you. Your appeal will be handled within 30 calendar days. We will also send you a letter telling you this within two days of calling you.

You will receive a letter telling the reason for our decision and what to do if you don't like the decision.

How do I file a State Fair Hearing request?

If you disagree with an adverse benefit determination by UnitedHealthcare Community Plan, you or someone acting on your behalf (provider, family member, etc.) can also appeal directly to the Mississippi Division of Medicaid (DOM) by filing a request for a State Fair Hearing. You can appeal to DOM:

- After you have exhausted your appeal rights with UnitedHealthcare Community Plan.

You must file for a State Fair Hearing within one hundred and twenty (120) calendar days of your receipt of the final decision from UnitedHealthcare Community Plan. For information on requesting a State Fair Hearing, call 601-359-6050 or 1-800-421-0488 or write to:

Division of Medicaid Office of the Governor
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, Mississippi 39201

Continuation of benefits.

If you have been getting an ongoing service or item that is being reduced, changed or stopped, you may continue with it if:

1. Your appeal is received within 10 days from the date you receive UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination.
2. You request that the service be continued.

The service may be continued through the appeal and State Fair Hearing process unless you discontinue your appeal, fail to request a State Fair Hearing and continuation of benefits, or the prescription for your service ends. If you request a State Fair Hearing and want your benefits to continue, you must file your request within 10 days from the date you receive our decision. If the State Fair Hearing finds that UnitedHealthcare Community Plan's decision was right, you may be responsible for the cost of the continued benefits.

Additional protections for Mississippi Medicaid beneficiaries.

Pursuant to federal law, state law and agency policy, the Mississippi Division of Medicaid further protects PHI that pertains to alcohol and drug abuse, HIV/AIDS, sexually transmitted diseases (STDs), mental health, genetic test results and family planning. Information in these categories requires written authorization before disclosure to someone outside Medicaid unless it is:

- For treatment for medical emergency.
- Deidentified or the disclosure does not identify the beneficiary as possessing a sensitive data category.
- For scientific research in certain circumstances.
- For management and financial audits in certain circumstances.
- For program evaluations in certain circumstances.
- By court order, if appropriate.

- If otherwise required by law.
- To a personal representative (except in cases of minors — consent must be obtained from the minor before disclosing to parent, guardian or other legal representative).
- Internal agency communications for the purpose of the provision of diagnosis, treatment or referral for treatment.
- To law enforcement regarding crimes or threats to commit crimes on premises or against personnel.
- To entities that provide services to the agency (e.g., contractors and business associates).

Important terms.

Abuse: Harming someone on purpose. (Includes yelling, ignoring a person's need and inappropriate touching).

Adverse Benefit Determination: An adverse benefit determination is the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

An adverse benefit determination includes:

- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner as defined in the appointment standards.
- The failure of the health plan to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

For a resident of a rural area with only one Managed Care Organization, the denial of a member's request to exercise his or her right, under § 42 C.F. R. 438.52(b)(2)(ii) to obtain services outside the network:

- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

Appeal: A formal request for UnitedHealthcare to review an adverse benefit determination.

Durable Medical Equipment (DME): Things such as wheelchairs, walkers, glucose meter, IV poles. Also disposable supplies such as bandages, catheters and needles.

Emergency: A sudden and unexpected change in physical or mental health which, if not treated right away, could result in (1) loss of life or limb, (2) harm to a bodily function, or (3) permanent damage to a body part.

FQHC: Federally Qualified Health Care Center.

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination.

Health Information: Facts about your health and care. This may come from UnitedHealthcare or a provider. It includes physical and mental health and payments for care.

Immunization: A shot that protects from a disease. Children should get a variety at specific ages. Shots are often given during regular doctor visits.

In-Network: Doctors, specialists, hospitals, pharmacies and other providers who have an arrangement with UnitedHealthcare to offer services to members.

Medical Home: A doctor or medical practice that you go to all the time.

Medically Necessary: (1) a service that prevents, diagnoses or treats a physical or mental illness or injury; ensures age-appropriate growth and development; minimizes the worsening of a disability; or attains, maintains, or regains functional capacity per accepted standards of practice. (2) It cannot be omitted without affecting the member's condition or quality of care. (3) It is given in the best setting.

Member: A person enrolled in UnitedHealthcare through MississippiCAN.

Out-of-Network: Doctors, specialists, hospitals, pharmacies and other providers who do not have an arrangement with UnitedHealthcare to offer services to members.

Prescription: A doctor's written instructions that authorizes drugs or treatment.

Prior Authorization: Approval for services not normally covered by UnitedHealthcare.

Provider or **Practitioner:** A person or facility that provides health care (doctors, pharmacies, dentists, clinics, hospitals, etc.).

RHC: Rural Health Care Center

Specialist: Any doctor who has special training for a specific condition or illness.

SSI: Social Security Insurance

Grievance and appeal form.

Member's name ______________________________ ID #______________________________

Address ____

Telephone number (Home) ______________________ (Work) ______________________

Describe your concern in detail using names, dates, places of services, time of day and issues. If applicable, also say why UnitedHealthcare should consider payment for requested services that are not normally covered. Mail this form to the address at the bottom.

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Mail to:

Grievance and Appeals
P.O. Box 5032
Kingston, NY 12402-5032

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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

Effective January 1, 2019.

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

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

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

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

How We Use or Share Your Information.
We must use and share your HI with:

- You or your legal representative.
- Government agencies.

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

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

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

We may use or share your HI as follows.

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

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

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

Your Rights.
You have the following rights.

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

- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons: (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website **(www.uhccommunityplan.com)**.

Using Your Rights.

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or TTY **711**.
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare Privacy Office
  MN017-E300
  P.O. Box 1459
  Minneapolis, MN 55440

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

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

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

Financial Information Privacy Notice.

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

Effective January 1, 2019.

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

Information We Collect.

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

Sharing of FI.
We will only share FI as permitted by law.

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

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

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

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

[2] For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; Lifeprint East, Inc.; Lifeprint Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women’s and Children’s Health, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services LLC; and UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. This list of health plans is completed as of the effective date of this notice. For a current list of health plans subject to this notice, go to **www.uhc.com/privacy/entities-fn-v2-en** or call the number on your health plan ID card.

We’re here for you.

Remember, we’re always ready to answer any questions you may have. Just call Member Services at **1-877-743-8731**, TTY **711**. You can also visit our website at **myuhc.com/CommunityPlan**.

UnitedHealthcare Community Plan
795 Woodland Parkway, Suite 301
Ridgeland, MS 39157

myuhc.com/CommunityPlan

1-877-743-8731, TTY **711**

UnitedHealthcare®
Community Plan