



Welcome to the
community.

Rhode Island Medicaid Member Handbook

Here's Where to Find Information You Want

Important Phone Numbers.

HealthSource RI	1-855-840-4774
RI Department of Human Services	1-855-697-4347
UnitedHealthcare Dental/RIte Smiles	1-866-375-3257
RI Public Transit Authority (RIPTA)	401-784-9500, ext. 2012
Non-Emergency Transportation Broker	1-855-330-9131
RI Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH)	1-855-747-3224
RI Legal Services	401-274-2652

UnitedHealthcare Community Plan Member Services: 1-800-587-5187, TTY 711
8:00 a.m. – 6:00 p.m., Monday – Friday

My Primary Care Provider.

Name: _____

Telephone: _____

Address: _____

If we have any significant change to the information found in this Member Handbook, we will let you know at least 30 days before we make the change. Things included would be changes in your benefits and how you get them.



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Health Plan Highlights

Welcome to UnitedHealthcare Community Plan

We are glad that you enrolled in UnitedHealthcare Community Plan. This handbook will be your guide to the full range of health care services that you may get. We want to be sure you get off to a good start as a new member. To get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at **1-800-587-5187, TTY 711**.

How Managed Care Works

The plan, our providers, and you.

- You may have heard about the changes in health care. Many consumers get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, many of those services are now available through UnitedHealthcare Community Plan.
- UnitedHealthcare Community Plan has a contract with the Rhode Island Executive Office of Health and Human Services to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs, and other health care facilities make up our provider network. You will find a list in our Provider Directory. If you do not have a Provider Directory, call **1-800-587-5187, TTY 711** to get a copy or visit our website at UHCCommunityPlan.com.
- When you join UnitedHealthcare Community Plan, one of our providers will take care of you. Most of the time, that person will be your Primary Care Provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.
- If you need to talk to your PCP after hours or weekends, leave a message and how you can be reached. Your PCP, or the provider covering for him/her, will get back to you as soon as they are able.

Confidentiality

We respect your right to privacy. UnitedHealthcare Community Plan understands the trust needed between you, your family, your doctors, and other care providers. UnitedHealthcare Community Plan will never give out your medical or behavioral health information without your written approval. The only persons that will have your health information will be UnitedHealthcare Community Plan, your Primary Care Provider, other providers who give you care, and anyone who you have asked to talk about your care for you. Your PCP will always talk to you about referrals to other providers. UnitedHealthcare Community Plan staff has been trained in keeping your information private.

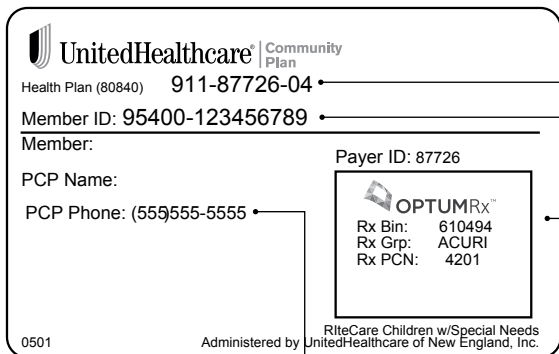
Transition of Care

UnitedHealthcare Community Plan is responsible for making sure that all its members can keep getting the care that they need. You can keep getting care from your provider for 180 days after joining UnitedHealthcare Community Plan. You can see that provider even if that provider is not in our network. After that time UnitedHealthcare Community Plan will work with you so you are referred to the right providers that are in the network.

Member ID Cards

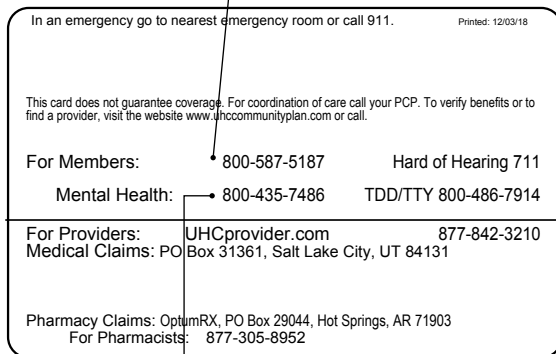
When you join UnitedHealthcare Community Plan, you will get a member ID card in the mail about 10 days after your effective date. Check to make sure the information on your ID card or your family member's ID card is right. If any information is wrong, please call Member Services at **1-800-587-5187, TTY 711**.

Front of card.



0501 Administered by RiteCare Children w/Special Needs UnitedHealthcare of New England, Inc.

Back of card.



Printed: 12/03/18

Your plan ID number

Your member ID number

Member Services

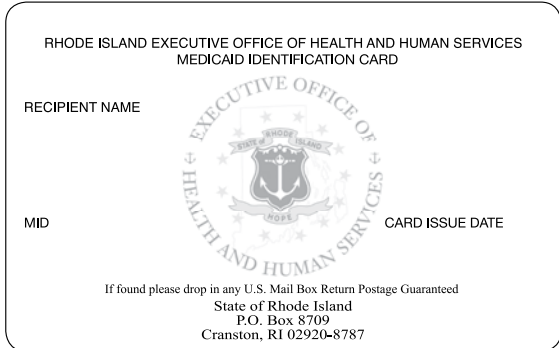
Information for your pharmacist

Mental Health Services

Name of your Primary Care Provider

You will also get a RI Medicaid (anchor) card in a separate mailing from the State of Rhode Island. Each family member who is enrolled will have their own card.

Rhode Island Medicaid card.



RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAID IDENTIFICATION CARD

RECIPIENT NAME

MID

CARD ISSUE DATE

If found please drop in any U.S. Mail Box Return Postage Guaranteed
State of Rhode Island
P.O. Box 8709
Cranston, RI 02920-8787

For assistance in English and Spanish, call: **1-855-MYRIDHS**
1-855-697-4347

For TDY, dial: **711**

If you are a doctor or hospital, dial: (401) 784-8100 In-State
or 1-800-964-6211 for Toll or Long Distance

This card does not guarantee eligibility.

**MISUSE OR ABUSE OF THIS CARD MAY MAKE YOU
LIABLE FOR CIVIL ACTION OR CRIMINAL PROSECUTION**

Always show both ID cards when you go to the doctor, hospital, pharmacy or other provider.

Update Your Information

It's very important that we have your correct address, so you can receive mail from UnitedHealthcare Community Plan and the RI Medicaid Program. Be sure to have your full name on your mailbox (and other family members' last name if it is different than your own). The post office will not deliver mail if the last names on the mailbox do not match the last name on the letter/envelope.

It's very important to tell us if you have a change, in any of these:

- Name, address, phone number.
- If you move out of state.
- If you get married; if you change your last name.
- If you become pregnant.
- Family size (adding a new baby or adopting a child, death of a family member who is enrolled, etc.).
- Change in income that could affect eligibility for Medicaid.
- If you have other health insurance.

You are required to report changes to Healthsource RI or the RI Department of Human Services (DHS) within 10 days of the change.

How to Tell Us About Changes

Contact **Healthsource RI** to report any of these changes. If you have an account at Healthsource RI, you can go online at www.healthsourceri.com or call 1-855-840-4774 to make a change. You can also visit the Healthsource RI walk-in center at 401 Wampanoag Trail, East Providence, RI 02915. Business hours are 8:00 a.m. – 6:00 p.m., Monday – Friday.

If you, your child, or another family member has SSI or became eligible for Medicaid due to a disability, please call the **RI Department of Human Services (DHS)** at 1-855-697-4347. You can also contact your local DHS Office to report changes. Business hours are 8:30 a.m. – 4:00 p.m., Monday – Friday.

Renew Your Medicaid Eligibility

RI Medicaid will send you a notice about renewing your eligibility. If you receive this notice, please answer promptly so your health coverage is not stopped. Be sure to answer all notices. If you have questions about your notice, please call Healthsource RI or DHS.

Member Services

We want to make it as easy as possible for you to get the information and services you need from UnitedHealthcare Community Plan. Check our website or call Member Services for more information. We're here for you!

Phone:

1-800-587-5187, TTY 711

8:00 a.m. – 6:00 p.m., Monday – Friday.

After business hours, please leave a message and we will get back to you soon.

Member Services can help you:

- Understand your benefits.
- Get a member ID card, if lost.
- Find a provider or urgent care clinic.
- Make a complaint or file a grievance or appeal.

Website:

Go to [UHCCommunityPlan.com](https://www.uhc.com/communityplan) to view plan details and helpful tools.

- Find a provider or pharmacy.
- Search for a drug on the Preferred Drug List.
- Get benefit details.
- View or download a Member Handbook.

Call Member Services at **1-800-587-5187, TTY 711** if you would like us to look up network physicians/providers for you.

If you would like a printed copy of our Provider Directory or Member Handbook, please call Member Services at **1-800-587-5187, TTY 711** and we will send you a printed copy in the mail.

We Speak Your Language

If you speak a language other than English, we can provide an interpreter or print materials in your language. If you call Member Services we can connect you with a representative who speaks your language or an interpreter. If you need an interpreter for a medical, behavioral health or dental appointment, we can arrange for one. Please call Member Services **1-800-587-5187, TTY 711** at least 72 hours before your appointment. If you need an American sign language interpreter, please call at least 2 weeks prior to your appointment.

UnitedHealthcare Community Plan Provider Directory indicates if a provider speaks other languages in addition to English. To check the Provider Directory, visit [UHCCommunityPlan.com](https://www.uhc.com/communityplan).

Need Print Material in Other Formats?

If needed, we can provide printed material in other formats, including print materials in a larger font, audio or Braille. Please contact Member Services **1-800-587-5187, TTY 711** to request materials in other formats.



Going to the Doctor

Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is the health care professional who knows you best. He/she works with you to keep you and your family healthy.

You have options.

You can choose your PCP from the following types of providers:

- Family doctor or general practitioner.
- Internal medicine doctor (internist, geriatrician).
- Pediatrician.
- Obstetrician/gynecologist (OB/GYN).
- Nurse practitioner (NP).
- Physician's assistant (PA).

Choosing Your PCP

Check to see if your doctor is in UnitedHealthcare Community Plan's network. If you don't already have a PCP when you join UnitedHealthcare Community Plan, you can choose one from our network. Each member of your family can have his or her own PCP.

Our Provider Directory lists all the primary care providers in our network. It also tells you where the provider's office is, the phone number, the languages spoken, the hours the office is open, if they are accepting new patients and if their office is handicap accessible. To see the directory, go to our website at: UHCCommunityPlan.com or call Member Services to ask for a copy or for help picking a PCP. We also have a printed Provider Directory available upon request that lists all UnitedHealthcare Community Plan providers by specialty and location.

After you select a PCP, please call Member Services to let us know. If you do not choose a PCP, we will choose one for you.

Going to the Doctor

What your PCP can do for you.

- Give you regular checkups and screenings.
- Arrange tests.
- Keep your medical records.
- Recommend and refer you to specialists.
- Write prescriptions.
- Help you get behavioral health services.
- Answer questions about your health care.

Changing Your PCP

You can change your PCP or your child's PCP at any time, however, there's value in staying with the same PCP. As you get to know one another and develop trust, you can work through your health issues with your PCP. If you need to change your PCP, call Member Services **1-800-587-5187, TTY 711**.

If your PCP leaves the UnitedHealthcare Community Plan network, we will send you a letter to let you know. You can choose another PCP from our network. There are times when UnitedHealthcare Community Plan will let you continue to get care from your PCP or specialist for some time after he/she has left our network. This is called "continuity of care." If you are pregnant or being treated for an ongoing medical condition, we can work with your provider, so he/she can continue to treat you longer. We will work with you and your provider to make sure you safely change to another provider.

Learn more about network physicians/providers.

You can learn information about network physicians/providers, such as board certifications, and languages they speak, at myuhc.com/CommunityPlan, or by calling Member Services.

We can tell you the following information:

- Name, address, telephone numbers.
- Languages they speak.
- Professional qualifications.
- Specialty.
- Medical school attended (phone only).
- Residency completion (phone only).
- Board certification status.

Getting Care

Take Charge — Prepare to see your provider.

Preparing for your provider's visit can help you get the most out of it. So can making sure your provider knows about all the care you have. Here's how you can take charge of your health care:

1. Think about what you want to get out of the visit before you go. Try to focus on the top three things that you need help with.
2. Tell your provider about any drugs or vitamins you take on a regular basis. Bring a written list. Or bring the medicine itself with you.
3. Tell your provider about other providers you may be seeing. Include behavioral health providers. Mention any medications or treatment they have prescribed for you. Also bring copies of results of any tests you have had.

Making an Appointment with Your PCP

Call your Primary Care Provider's office to schedule an appointment.

Annual Checkups

You don't have to be sick to go to your PCP (doctor). Yearly checkups with your PCP are important to keep you healthy. Plus, your PCP will make sure you get the necessary screenings, tests and shots you need. If you have a health problem, it's easier to treat when found early. Talk to your PCP about what is right for you and your family.

Specialty Care and Referrals

Your doctor (PCP) may refer you to a specialist, a referral is require for some specialty services.

Your primary care provider (PCP) will need to send us a referral before you make an appointment to see a specialist. This will help make sure you're getting the best health care possible.

Please check your member ID card to make sure that the PCP listed is the PCP you are currently are seeing.

If the PCP on your card is not the one you are seeing please call Member Services at **1-800-587-5187, TTY 711**, 8:00 a.m. – 6:00 p.m., Monday – Friday, to correct this to avoid any delay in processing your referrals.

Going to the Doctor

How do I get a referral?

Talk with your PCP to see if you need a referral for a specialist. If you do need one your PCP will send us a referral and give you a copy or the referral number. You'll need the referral number to make an appointment. If you need to see a specialist more than once, your PCP can make sure the referral will cover other visits.

Do I need a referral for all specialists?

You need a referral to see most of our network specialists, but there are some exceptions. You do not need a referral for any of the following when provided from a network provider or specialist:

- OB/GYN.
- Behavioral health or substance use services.
- Physical, Occupational or Speech Therapy.
- Family planning services.
- Sexually transmitted disease services.
- Early intervention services.
- Post-operative care.
- Laboratory services.
- Radiology Services.
- Kidney dialysis.
- Routine eye exams, eyeglasses, contacts and services from an Optometrist or Ophthalmologist.
- Urgent care and emergency at an emergency room or hospital.

We transitioned to a specialist referral requirement for its Community Plan members on November 19, 2018. As a result, members who need specialty care must be referred to in-network specialists by their primary care provider (PCP) or claims may not be paid. Any PCP within the same tax ID (TIN) can issue a referral on behalf of a member assigned to a PCP within that TIN.

You do not need a referral to see a women's health care provider for women's health services or if you are pregnant.

Specialists are doctors with special training and work in a particular field of medicine. Specialists include: cardiologist (heart doctor); obstetricians/gynecologists who treat women's health needs including family planning and pregnancy; ophthalmologist (eye doctor); podiatrist (foot doctor); and dermatologist (skin doctor).

You do not have to see the specialist your PCP suggests. You can ask your PCP for the name of another specialist. Or you are free to pick any network provider for specialty care. Not seeing the specialist will not affect your future treatment by your PCP. You have a right to refuse the treatment a specialist recommends. If that happens, contact your PCP to talk about other options.

Urgent Care

Urgent care centers are available when you need to see a provider for a non-life-threatening condition, but your PCP isn't available or it is after clinic/office hours. Common health issues that may be treated in an urgent care center include:

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

If you or a family member has an urgent problem, call your PCP first. Your PCP can help you get the right kind of care. Your PCP may tell you to go to an urgent care center (or the emergency room).

Emergency Services

An emergency is a life-threatening illness or injury. It can cause serious pain or harm to your health if you do not receive treatment right away. Some examples of emergency conditions include:

- Serious illness or trauma.
- Broken bones.
- Bleeding that will not stop.
- Heart attack.
- Poisoning.
- Severe cuts or burns.
- Behavioral health emergency such as drug overdose or threat of harm to self or others.

You can go to any hospital for emergency care. UnitedHealthcare Community Plan covers any emergency care you need throughout the United States and its territories. Within 24 hours after your visit, you should call your PCP and let them know about your visit. You may need follow-up care.

If you need emergency care, **call 911** or go to the nearest hospital. Emergency care does not require a referral from your PCP or a prior authorization from us.

Early Periodic Screening Diagnostic Treatment (EPSDT)

EPSDT stresses preventive and complete care. As they grow, infants, children and younger people should see their PCP often. It is important that they receive all suggested preventive services and any medical treatment needed to help healthy growth.

Children up to age 21 should receive regular well-child check-ups of their physical and mental health, growth, development, and dietary status. A well-child check-up includes:

- A complete health and growing history, including both physical and mental health development assessments;
- Physical exam;
- Age-appropriate shots;
- Vision and hearing tests;
- Dental exam;
- Laboratory tests, including blood lead level assessments at certain ages; and
- Health education.

Your child's PCP will let you know how often you will need to bring your child in for a visit.

Behavioral Health Services

Behavioral health services include mental health and treatment for substance use problems. UnitedHealthcare Community Plan is contracted with Optum Behavioral Health to provide these services. To find a behavioral health provider, call Optum at 1-800-435-7486. This number is also on your UnitedHealthcare Community Plan member ID card. Member Services representatives are available 24 hours a day, seven days a week to help you. Your call is confidential. Check the Provider Directory for a list of behavioral health providers. If you are not sure what type of help you need or the type of provider, our Member Services representative can help you.

If UnitedHealthcare Community Plan does not cover a counseling or referral services because of moral or religious objections, we will let you know that the service is not covered by us. We will also tell you how you can obtain information from the Executive Office of Health and Human Services (EOHHS) about how to get these services.

Dental

Dental services for children are provided through Rlte Smiles. Rlte Smiles is a dental plan for children who are eligible for RI Medicaid born after May 1, 2000. To find a dentist who participates with the Rlte Smiles program, check the website for UnitedHealthcare Dental/Rlte Smiles (<https://www.uhc.com/ritesmiles>) or call United Healthcare Dental Member Services at 1-866-375-3257. All other members should use their Rhode Island Medicaid card (Anchor card) when going to a Medicaid Dental provider.

Appointment Availability

Appointment	Access Standard
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within twenty-four (24) hours
Routine Care Appointment	Within thirty (30) calendar days
Physical Exam	180 calendar days
EPSDT Appointment	Within 6 weeks
New Member Appointment	Thirty (30) calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within ten (10) calendar days

Special Programs to Keep You Healthy

If you have health condition for a long time, like diabetes or heart disease, you may benefit from our care management programs. Our nurse care managers can help you understand your options, how to stay healthy and keep a better quality of life. Care management helps members with special needs get the services and care they need. Care managers work with the health plan, providers and outside agencies. Call our Medical Management Department at 1-800-672-2156, TTY 711 or 401-732-7373.

- Health Risk Assessments.
- Healthy First Steps.
- Health and Wellness.
- Physical disabilities.
- Serious mental illness.
- Complex health problems.
- A more complete description of care management and disease management.

Take a Health Risk Assessment at myuhc.com/CommunityPlan. You may also complete the Health Risk Assessment over the telephone by calling Member Services toll-free at **1-800-587-5187, TTY 711**. This short survey will help find programs that are right for you.

Getting a Second Opinion

A second opinion is when you want to see another provider to get his or her opinion or recommendation for your health concern or problem. You can get a second opinion from a network provider for any of your covered benefits. This is your choice. You are not required to get a second opinion. A second opinion from an out-of-network provider is available with a prior authorization.

Out of Network/Out of Area Care

Other than emergency services and urgently needed care, all covered benefits, care, and services provided out of area need to be approved by UnitedHealthcare Community Plan first. Sometimes you may need care from a provider who is not in our network. This provider is out-of-network. To see an out-of-network provider you will need prior authorization from UnitedHealthcare Community Plan before you make an appointment. Your PCP should submit the request for review. Call Member Services to learn more and if it will be covered in full. You may have to pay for those services.

Prior Authorizations

Sometimes your provider must get permission from UnitedHealthcare Community Plan before giving you a certain service. This is called prior authorization or prior approval. This is the provider's responsibility. If providers do not get prior authorization, you will not be able to get the service.

You do not need a prior authorization to see a women's health care provider for women's health services or if you are pregnant.

Non-Emergency Medical Transportation

Transportation may be available for medical, dental or other health-related appointments. If family, friends or neighbors cannot drive you to appointments, you have several options.

✓ **Rhode Island Public Transit Authority (RIPTA).**

RIPTA has fixed-route bus services to most communities in Rhode Island. Routes are available online at www.ripta.com or by calling Customer Support at 401-781-9400. RIPTA also offers flex services and the ADA Disabled Program.

✓ **Non-Emergency Medical Transportation Broker.**

Non-Emergency Medical Transportation is a covered benefit in RI Medicaid. The contracted vendor for these services is MTM, Inc. Please contact MTM at 1-855-330-9131, TTY 711, 8:00 a.m. – 5:00 p.m., Monday – Friday, to arrange for rides to medical, dental or other health-related appointments. Bus tickets for appointments need to be requested seven (7) business days prior to the appointment.

Van or taxi rides to medical appointments may be available for members who qualify. Please allow 48 hours prior to your appointment. For example:

- Call Monday for a ride on Wednesday.
- Call Tuesday for a ride on Thursday.
- Call Wednesday for a ride on Friday, Saturday or Sunday.
- Call Thursday for a ride on Monday.
- Call for Friday for a ride on Tuesday.

✓ **Mileage Reimbursement.**

If you qualify for transportation and you or someone else can drive you, you may get money for gas. There are several rules and requirements.

Please contact MTM for more information. UnitedHealthcare Community Plan Member Services can also help with setting up or coordinating transportation if you need it.



Pharmacy

Your Benefits Include Prescription Drugs

UnitedHealthcare Community Plan covers hundreds of prescription drugs from hundreds of pharmacies. The Preferred Drug List (PDL) is a list of drugs covered under your plan. You can fill your prescription at any in-network pharmacy. All you have to do is show your member ID card. If you have not received your Member ID card, call Member Services at **1-800-587-5187, TTY 711**.

Generic and brand name drugs.

The Rhode Island General Assembly passed a law that requires all members to use generic drugs first. Generic drugs have the same ingredients as brand name drugs they often cost less, but they work the same.

In some cases, a limited number of brand name drugs are covered. These are limited to certain classes (or types) of drugs. Some of these may require prior authorization by UnitedHealthcare Community Plan.

Over-the-Counter (OTC) Medicines

UnitedHealthcare Community Plan also covers many over-the-counter (OTC) medications. You must have a written 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. Your pharmacy may dispense the store-brand or the generic version of the OTC medication. Both OTC store brands and generic substitutions are covered. OTCs include:

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

For a complete list of covered OTCs, go to myuhc.com/CommunityPlan. Click on “Find a Drug” to use the searchable tool or to view the Over the Counter Medication List. Or call Member Services at **1-800-587-5187, TTY 711**.

Injectable Medicines

Injectable medications are medicines given by 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. This is based on prior medication use, including overuse of 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 **1-800-587-5187, TTY 711**. After 30 days from the date of the letter or if you have moved, you can call Member Services to change pharmacies.

90-Day Benefit

With a 90-day supply, you won't need to get a refill every month. You'll have 3 months between refills. This helps with making sure that you always have your most important medications on hand.

What are the benefits of filling my maintenance medication with a 90-day supply?

- **Save time.**
Make less trips to the pharmacy. Instead of filling your prescription monthly, you will only have to refill your medication every 3 months.
- **Same pharmacy.**
You can fill a 90-day supply from your current pharmacy or at any of the covered pharmacies in the network.
- **No additional cost.**
No copay for a 90-day supply of your medication.

What do I need to do if I want a 90-day supply?

- **Talk with your pharmacist.**
Your pharmacist can call your doctor to get a new prescription for a 90-day supply.
- **Talk with your doctor.**
Your doctor can write you a new 90-day supply prescription for your maintenance medication.



Benefits

Covered Benefits

You are eligible to receive these benefits with your UnitedHealthcare Community Plan ID card. You do not have any cost sharing responsibilities. However, if a provider tells you a service is not covered by UnitedHealthcare Community Plan, and you still get the service, you will have to pay for it. There are some services that are not covered.

You should not be balanced billed by your provider for a covered service. Call UnitedHealthcare Community Plan Member Services if you receive a bill.

Description of Benefits from UnitedHealthcare Community Plan For more detail on what is covered, call Member Services at 1-800-587-5187, TTY 711.

Covered Service/Benefit	Coverage
Provider Services	Includes the services of primary care physicians, specialists, obstetrician-gynecologists (OB/GYN) and other MCO network providers.
Services of Other Practitioners	Includes the services of practitioners certified or licensed by the State of Rhode Island, i.e., nurse practitioners, physician's assistants, social workers, registered dietitian nutritionists, psychologists, and certified nurse midwives in the MCO network.
Annual Wellness Check-Ups and Preventive Screenings, Immunizations	Covered when provided by primary care providers (PCPs) in the MCO network.

Benefits

Covered Service/Benefit	Coverage
Eye Care	<p>Includes medically necessary treatment for illness and injury to the eye.</p> <p>For adults: Routine eye exams and one pair of glasses are covered once every 24 months.</p> <p>For children under age 21: routine eye exam and glasses are covered as needed.</p> <p>For members with diabetes, annual eye exams are covered every 12 months.</p>
Foot Care	Covered with a referral by the member's PCP.
Group/Individual Education Classes	The following group classes are covered: childbirth education, parenting, smoking cessation, diabetes, asthma, nutrition, lactation consultation etc.
Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	Screening, diagnosis and treatment services for children and young adults up to age 21. Includes the initial and follow-up visits. Includes inter-periodic screens as <i>medically</i> indicated.
Special Education	Services Covered for children with special needs or developmental delays as stated in the child's Individual Education Plan (IEP) are covered but not provided by UnitedHealthcare Community Plan.
Lead Program	Covered – includes home assessment and non-medical case management. Services are provided by the state Department of Health or lead centers for lead-poisoned children and not UnitedHealthcare Community Plan.
School-Based Clinic Services	Covered if Medically Necessary at all designated sites.
Family Planning Services	Includes over-the-counter (OTC) family planning supplies including foam, condoms, spermicidal jelly or cream, and sponges. Screenings for sexually transmitted infections (STIs) and HIV are covered. You can go to any provider, including out-of-network providers, for these services.
Prenatal and Post-Partum Care	Covered by MCO physician/provider.

Benefits

Covered Service/Benefit	Coverage
Nutrition Services	Covered by licensed Registered Dietitian Nutritionists (RDNs) for certain medical conditions. Referral by member's PCP is required.
Therapies	Covered as medically necessary. Includes physical therapy, occupational therapy, speech and language therapy, hearing therapy, respiratory therapy.
Lab Tests, Diagnostic Services, Radiology Services	Covered when ordered by a MCO physician/provider.
Prescription Drugs	<p>Covered when ordered by a MCO physician/provider. Must use generic drugs first. There are a limited number of brand drugs that are approved; most require prior authorization. Some drugs may have step therapy. This means that you will have to try drugs in a certain order for your medical condition. You may need to try one drug before we will cover another drug. To view the Preferred Drug List or check the drug formulary at UHCommunityPlan.com.</p> <p>Click on "Search for Drugs covered by United Healthcare" and enter the drug name in the box to search the list of FDA approved drugs and coverage.</p>
Non-Prescription Drugs (OTC)	Covered when your MCO physician/provider writes a prescription. Also referred to as "over-the-counter" drugs. Includes family planning supplies, nicotine cessation supplies and certain vitamins and minerals.
Durable Medical Equipment	Covered when ordered by a MCO physician/provider. Includes surgical appliances, prosthetic devices, orthotic devices, assistive technology and other medical supplies.

Covered Service/Benefit	Coverage
Hospital Care, Inpatient	Covered as medically necessary. Includes Medicaid covered services delivered in an inpatient hospital setting.
Hospital Care, Outpatient	Covered as medically necessary. Includes Medicaid covered services delivered in an outpatient hospital setting. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
Emergency Room Services	Emergency room services are covered both in and out of state for emergency situations. Prior authorization is not needed for emergency care.
Emergency Transportation	Covered as medically necessary.
Behavioral Health Services	Includes community-based mental health and substance use counseling and treatment services.
Behavioral Health Services, Intensive	Covered as needed. Behavioral Health and Substance Use Disorder treatment includes but is not limited to the following: community-based narcotic treatment, methadone, detoxification, emergency services intervention, observation/crisis stabilization, acute inpatient services, acute residential treatment, partial hospital programs, mental health psychiatric rehabilitation residences (MHPRR), day programs, intensive outpatient treatment programs, assertive community treatment (ACT), integrated health homes (IHH), community mental health center services, home-based treatment services (HBTS), applied behavior analysis (ABA), personal assistance services and supports (PASS) and respite. Residential treatment does not include room and board. Services also include administratively necessary days ordered by the Department of Children, Youth and Families.

Benefits

Covered Service/Benefit	Coverage
Court-Ordered Mental Health and Substance Use Services	Services are provided in-plan; includes transitional care management services after court-order services end.
Preventive Home Health Services	Covered when ordered by a MCO physician/provider. Prior authorization may be required. Services include homemaker services, minor environmental modifications, physical therapy home assessment, and personal care services.
Home Care Services	Covered services provided under a home care plan authorized by a physician including full-time, part-time, or intermittent care by a licensed nurse or home health aide (certified nursing assistant) for patient care and including, as authorized by a physician, physical therapy, occupational therapy, respiratory therapy, and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living area, such as bedroom and bathroom, and doing the client's laundry and shopping. Homemaking services are only covered when the member also needs personal care services. Home care services do not include respite care, relief care, or day care.
Home Health Services	Home health care is supportive care provided in the home. Care may be provided by licensed healthcare professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the activities of daily living (ADLs) are met. For patients recovering from surgery or illness, home care may include rehabilitative therapies.

Covered Service/Benefit	Coverage
Rehabilitation Services	Physical, occupational, and speech/language therapy provided in licensed outpatient rehabilitation centers and ordered by a MCO physician.
Adult Day Health	Covered for frail seniors and other adults who need supervision and health services during the daytime when medically necessary. Prior authorization is required.
Nursing Home Care, Skilled Nursing Facility Care	Covered for Rhody Health Partners and Rhody Health Expansion members for 30 consecutive days. All skilled and custodial care covered.
Hospice Services	Covered when ordered by a network provider. Services are limited to those services covered by Medicare.
Services for Members with HIV/AIDS or at High-Risk for HIV	Medical and non-medical case management services. Benefits/entitlement counseling and referral activities to help member to obtain get to public and private programs.
Transplant Services	Covered when ordered by a Health Plan physician.
Cedar Family Services	Family centered care management for children with special health needs.
Gender Dysphoria Treatment	Some services may require Prior Approval.

Benefits from RI Medicaid

Covered Service/Benefit	Coverage
Dental Services	<p>Includes routine dental check-ups and treatment for adults and children.</p> <p>Children born before May 1, 2000 receive dental benefits through UnitedHealthcare Dental and the RIte Smiles program. Emergency dental services are covered in-plan by UnitedHealthcare Community Plan.</p> <p>For older children and adults, dental services are provided using the Medicaid (anchor) card.</p>
Non-Emergency Medical Transportation	<p>Includes coverage for bus tickets, van or taxi ride to Medicaid covered or health plan prior approved medical, dental, or other health care provider appointments if no other transportation is available. Must be scheduled in advanced.</p>

Extended Family Planning Benefits

This benefit is for women who have:

- Qualified for RIte Care.
- Were pregnant and are now sixty days postpartum or sixty days post loss of pregnancy.
- Are subject to losing eligibility for Medicaid.

Eligible women may receive for *up to twenty four months* of the following schedule of family planning related benefits:

Covered Service/Benefit	Coverage
Prescription and Non-Prescription Family Planning Methods	Covered, including these drugs: emergency contraceptive pills, specific oral contraceptives, contraceptive patches, Depo-Provera, cervical caps, and diaphragms. Over-the-counter (OTC) family planning supplies, including foam, condoms, spermicidal jelly or cream and sponges, are covered with a prescription from your doctor.
Outpatient Hospital Services and Surgery-Related Services	Tubal ligation (sterilization). IUD insertion and removal.
Outpatient Procedures (in the office or clinic) – Office Visit	One comprehensive GYN visit and up to 5 additional family-planning method related office visits. Tubal ligation (sterilization). IUD insertion and removal.
Referrals to Free Clinics for Other Medical Services	Referral for other services as needed. For example, referrals to the state's:
Contact the Rhode Island Department of Health at 401-222-2320 for a list of clinics and counseling locations that can provide these services to you.	<ul style="list-style-type: none"> • Sexually transmitted disease clinic for treatment. • Confidential HIV testing and counseling sites.
Gynecological Services (Well Woman Care)	Includes annual GYN exam, one comprehensive visit and up to 5 family-planning visits annually.
Laboratory	Includes pregnancy testing, annual pap smear, sexually transmitted disease testing, anemia testing, dipstick urinalysis, and urine culture.

Extended Family Planning Program

Eligibility Requirements.

Family planning and family planning-related services and supplies are provided to individuals that are redetermined eligible for the program on an annual basis. The state must enroll only women, meeting the eligibility criteria below into the demonstration who have a family income at or below 253 percent of the FPL and who are not otherwise enrolled in Medicaid or Children's Health Insurance Plan (CHIP). Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum and who have a family income at or below 253 percent of the FPL at the time of annual redetermination are auto enrolled in the Extended Family Planning group.

Disenrollment from the Extended Family Planning Program.

If a woman becomes pregnant while enrolled in the Extended Family Planning Program, she may be determined eligible for Medicaid under the State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Extended Family Planning Program.

Extended Family Planning Program Benefits.

Benefits for the family planning expansion group are limited to family planning and family planning-related services. Family planning services and supplies described in section 1905(a)(4)(C) of the Act and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable:

- a. Approved methods of contraception;
- b. Sexually transmitted infection (STI) testing, Pap smears and pelvic exams;
Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
- c. Members covered to receive three hundred sixty-five (365) days of prescription contraception of F.D.A. approved drugs and devices which will require a prescription dispensed as a single prescription.
- d. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements).
- e. Contraceptive management, patient education, and counseling.

Family Planning-Related Benefits.

Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit. Such services are provided because a “family planning-related” problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

- a. Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
- b. Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- c. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/ disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.
- d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
- e. Treatment of major complications (including anesthesia) arising from a family planning procedure such as:
 - Treatment of a perforated uterus due to an intrauterine device insertion;
 - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
 - Treatment of surgical or anesthesia-related complications during a sterilization procedure.

Out-of-Network Services

Covered Service/Benefit	Coverage
Emergency Care	Covered in the United States and its territories. No prior authorization needed.
Family Planning Services	Members can see UnitedHealthcare Community Plan's providers or out-of-network providers for family planning services. No referral is needed.
All Other Services	Require prior authorization from UnitedHealthcare Community Plan. Call Member Services at 1-800-587-5187, TTY 711.

Non-Covered Services

- Experimental procedures.
- Abortion, except to preserve the life of the woman or in cases of rape or incest.
- Private rooms in hospitals, unless medically necessary.
- Cosmetic surgery.
- Infertility treatment services.
- Medications for sexual or erectile dysfunction.
- Services received outside of the United States or its territories.



Other Plan Details

Member Rights and Responsibilities

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

- To receive information about UnitedHealthcare Community Plan, its services, providers and members' rights and responsibilities.
- To be treated with respect and dignity and right to privacy.
- To participate with your providers in decision-making about your health care, including the right to refuse treatment.
- To privacy of all records and communications as required by law. UnitedHealthcare Community Plan employees follow a strict confidentiality policy regarding all member information.
- To respectful, personal attention without regard to your race, national origin, gender, gender identity, age, sexual orientation, religious affiliation, or preexisting conditions.
- To an open discussion of appropriate home and community services or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To get a second medical opinion for medical and surgical concerns.
- To voice grievances, complaints or appeals about UnitedHealthcare Community Plan or the care provided by its providers and/or agencies.
- To make recommendations about UnitedHealthcare Community Plan's Member Rights and Responsibilities policies.
- To refuse treatment, and if you do, it will not affect your future treatment.
- To receive information on available treatment options and alternatives.
- To be free from any form of coercion, discipline, or retaliation.
- To request and receive a copy of your medical records, and request that they be amended or corrected.
- To be given health care services.
- To exercise your rights, and that the exercise of those rights does not negatively affect the way UnitedHealthcare Community Plan and its providers treat you.

Other Plan Details

You have a responsibility to:

- To report changes such as, address, income, family size, etc. to the State (Healthsource RI or the Department of Human Services) within 10 days of the change.
- To choose a PCP and primary care site. Your PCP will coordinate all of your medical care. You may change your PCP at any time by calling UnitedHealthcare Community Plan Member Services.
- To have all of your medical care provided by, or arranged by, a provider in the UnitedHealthcare Community Plan network.
- To carry your UnitedHealthcare Community Plan member ID and your Rhode Island Medicaid card with you.
- To provide, to the extent possible, information that UnitedHealthcare Community Plan and its practitioners and providers need to care for you.
- To learn about your health problems and understand the plan treatment you and your provider agree on.
- To follow the plans and instructions for care that you have agreed on with your providers.
- To talk with your PCP about all specialty care. If you need a specialist, your PCP will work with you to make sure you get quality care.
- To call your PCP first for help if you have an urgent medical condition. If an emergency is life threatening, call 911 right away or go to the nearest emergency room.

Call UnitedHealthcare Community Plan Member Services if you have any questions about your rights and responsibilities.

Advance Directives

When you can no longer make health care decisions for yourself, there are documents that will help make your wishes known. These are called living wills and durable power of attorney.

- A living will is a set of instructions. It says what should happen if you become seriously ill and are unable to communicate.
- Durable power of attorney lets another person make health care decisions for you. You choose who this person will be. It could be your spouse, a family member, or a friend.

Advance directives explain the treatment you want if you become seriously ill or injured. Advance directives can be written or spoken. Ask your primary care provider about these options. You also can find more information and related forms at the Rhode Island Department of Health website, www.health.ri.gov/lifestages/death/about/endoflifedecisions/.

Complaints, Grievances, and Appeals

You have a right to make a complaint, file a grievance or an appeal. If you are unhappy about the care or services you receive, we want to know about it, so we can help fix the problem.

Can someone else complain or file a grievance or appeal for me?

Yes. Your doctor, another provider, friend, family member or anyone you want, can ask for you. First you must let us know in writing that you are allowing that person to work with us. Members can complete an *Authorized Representative Form* that gives the person permission to help with your complaint, grievance or appeal. UnitedHealthcare Community Plan **must** get the completed form before we can talk to the person you've identified. Keep a copy of your Authorized Representative form. The form is valid for one year from the date you sign it unless you tell us you no longer want to allow someone to act on your behalf. To get an Authorized Representative form, call Member Services.

Complaints

You or your authorized representative have the right to file a complaint at any time. Please call your UnitedHealthcare Community Plan Member Services. We can address your questions or concerns about benefits, services, access to appointments, wrong bills you receive or other issues. If possible, we will resolve your problem at the time of your call. If that is not possible, we will ask for more information and get back to you within the timeframes specified in the grievance section of this handbook. At any time, we may ask you for more information.

If you file your complaint in writing, it will be processed as a grievance. Please see grievance section of this handbook for more information.

Send written complaints to:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt lake City, UT 84131

Grievances

A grievance is a dissatisfaction about any matter other than a service not being covered. Examples of a grievance include:

- You are not satisfied with the way we responded to your complaint.
- You disagree with us asking for more time to make an authorization decision.
- You have concerns of quality of care or services provided.
- You feel a provider or their employee was rude.
- You feel a provider did not respect your member rights.

You may file a grievance at any time. We will respond to your grievance within 90 calendar days. Sometimes we need more information or time to decide. If we need more time, we will contact you to let you know.

You or your authorized representative can file a grievance in writing or over the phone at any time. Filing a grievance will not affect your health coverage.

Civil Rights Grievance.

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a grievance to:

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

You must send the grievance within 60 calendar days of when you found out about it. A decision will be sent to you within 30 calendar days.

Appeals

An appeal is a request to change a decision made by UnitedHealthcare Community Plan for medical care, services, or drugs that you or your provider believe you should receive. It could also be a request for services or supplies that are not included in your covered benefits that you or your provider believe you should receive. You or an authorized representative can file an appeal in writing, in person, or by calling UnitedHealthcare Community Plan Member Services. Requests to review services that were denied by us must be made within 60 calendar days of our decision to deny a service or supply. We will review the care or services that were denied or the coverage decision that was made.

Grievance and Appeals
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

Qualified UnitedHealthcare Community Plan staff decide on appeals that are not about medical issues. Qualified health care professionals decide on appeals about medical issues. We will give you a decision about your appeal within 30 calendar days of our receiving it. We may ask you for an additional 14 calendar days if we need more to look into your appeal.

You have a right.

- You have a right to ask for and get copies of all documents related to your appeal. You may add information about the appeal to your file in writing or in person.
- You have a right to continue to have Medicaid covered services while your appeal is under review. To have these Medicaid covered services continue, you must call or tell us within 10 calendar days of the denial. If your appeal is denied, you may have to pay for the cost of any continued benefits you received. If your appeal is approved and you did not request that your services be continued while your appeal was being decided, we will authorize or provide services within 72 hours.
- You have a right to a fast (expedited) appeal if your provider feels a delay in your care or treatment might be a risk to your life or cause you severe pain. You or your provider should call UnitedHealthcare Community Plan Member Services to request a fast appeal.

Urgent (fast) appeals.

You can ask us for an urgent or “fast” appeal if waiting up to 30 calendar days for a decision would cause severe pain or could be a risk to your life without immediate medical attention. When your provider feels a delay in your care or treatment might be a medical emergency, you or your provider should call **1-800-587-5187, TTY 711** to request a fast appeal. We will respond to your fast appeal within 72 hours of receiving it. We will respond to your fast appeal within 72 hours of receiving it. We may need to extend our review time for up to 14 days. If we need to extend our timeframe, we will notify you within 2 calendar days of our decision to extend the timeframe.

If you disagree with our decision to take more time, you may file a **[grievance](#)** with us.

If we deny your request for a fast appeal, we will decide on your appeal within 30 calendar days of receiving your appeal. If you disagree with our decision to deny your request for a fast appeal, you may file a **[grievance](#)** with us.

External appeals.

After you complete the appeal process with your MCO, and you are still not satisfied, you can request that an Independent Review Organization (IRO) review your appeal for medical services. Requests for external appeals must be received within four months from the date of your appeal decision. Call **1-800-587-5187, TTY 711** for help or for written directions on how to file an external appeal.

State Fair Hearing

If you are not satisfied with the outcome of the MCO's appeal decision, you may request a State Fair Hearing. Your request must be within one hundred and twenty (120) calendar days from the date of your appeal decision. The State Fair Hearing is facilitated by the Executive Office of Health and Human Services (EOHHS). You have a right to have Medicaid covered services continue while you are going through a State Fair Hearing. If the State Fair Hearing appeal is denied, you may be responsible for the cost of any continued benefits you received. To request a State Fair Hearing, you can either:

- Call 401-462-2132 (TDD 401-462-3363), after you have finished the MCO's internal appeal process, or
- Fax your request to 401-462-0458, or
- Email your request to: OHHS.AppealsOffice@ohhs.ri.gov, or
- Mail your request to:
EOHHS Appeals Office
Virks Building
3 West Road
Cranston, RI 02920

Complaints About the Appeal Process

You can file a complaint at any time during the appeal process with the Office of the Health Insurance Commissioner (OHIC) through the consumer helpline:

RI Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH)
1210 Pontiac Avenue
Cranston, RI 02920
Telephone: 1-855-747-3224
Website: www.rireach.org
Email: rireach@ripin.org

For help with your complaint, grievance or appeal, you may also call RI Legal Services at 401-274-2652.

Quality Program

Our Quality program can help you stay healthy by working with your doctor. The quality program helps you remember to get preventive tests and shots that prevent sickness. We send you and your providers reminders about lead tests, Pap tests, mammograms and shots that prevent diseases like polio, mumps, measles and chickenpox.

UnitedHealthcare Community Plan uses HEDIS® standards to help measure how we are doing with our quality program. HEDIS is a set of standard performance measures and scores to help people compare the performance of managed care plans. HEDIS studies many areas, such as prenatal care and disease prevention programs.

UnitedHealthcare Community Plan wants to make sure you are happy with the services you get from your doctor and from us. To do this, we look at CAHPS® data. CAHPS stands for Consumer Assessment of Healthcare Providers and Systems. This survey asks questions to see how happy you are with the care you receive. If you get a member survey in the mail, please fill it out and return it to us.

UnitedHealthcare Community Plan looks at the results of HEDIS and CAHPS. Then we share the results with our providers. We work with providers to make sure the services they give you and the services we give you add to your health care in a positive way.

If you would like to know more about the quality program, call Member Services at **1-800-587-5187**, **TTY 711**.

Other Health Plan Information

How to Disenroll from UnitedHealthcare Community Plan

You may change your health plan during the state’s annual open enrollment period or within 90 calendar days of joining UnitedHealthcare Community Plan. If you wish to disenroll at any other time, you may do so for any of the following reasons: poor quality of care, poor continuity of care (such as lack of access to your PCP or necessary specialty services), discrimination, lack of access to transportation, moving out of state, or for other good reasons. Visit www.eohhs.ri.gov to get a Request to Change Health Plans form. The Rhode Island Executive Office of Health and Human Services (EOHHS) will decide if you can change plans.

Coordination of Benefits (COB)

If you or any member of your family have another health plan, that plan is your primary insurance. UnitedHealthcare Community Plan would be your secondary health plan. Call Member Services if you have other insurance or if that coverage has ended

Utilization Management

UnitedHealthcare Community Plan does not want you to get too little care or care you don’t really need. We also have to make sure that the care you get is a covered benefit. We use utilization management (UM) to make sure you are getting the right care at the right time and in the right place.

Only doctors and pharmacists perform UM. Approval or denial decisions are based on care and service as well as your benefits. The decisions are not made because of financial or other rewards. If you have any questions, you can talk to our UM staff directly at 1-800-672-2156, TTY 711 or 1-401-732-7373. They are available 8 hours a day during normal business hours. If you need to leave a message, someone will call you back. Language assistance is also available.

If You Get a Bill for Services

Participating hospitals and doctors cannot bill members for covered services. If you get a bill, call Member Services at **1-800-587-5187, TTY 711**. A representative will work with you to find out if you need to pay the bill or if you should send it to us at:

UnitedHealthcare Community Plan
Attention: Member Appeals
P.O. Box 31364
Salt lake City, UT 84131

Keep a copy of the bill for yourself. We will review these bills to make sure the services are covered benefits. If they are covered, we will pay the health care provider right away. Call Member Services at **1-800-587-5187, TTY 711**, with any questions.

If you receive a service covered under UnitedHealthcare Community Plan, you should not receive a bill. If you do, call your provider (doctor or hospital) right away. Tell them you have insurance with UnitedHealthcare Community Plan and make sure they have your ID number. Tell the provider to stop billing you and to send a claim to UnitedHealthcare Community Plan.

New Technology Assessment

Some medical practices and treatments are not yet proven to be effective. New practices, treatments, tests and technologies are reviewed nationally by UnitedHealthcare Community Plan to make decisions about new medical practices and treatments and what conditions they can be used for. This information is reviewed by a committee of UnitedHealthcare Community Plan doctors, nurses, pharmacists and guest experts who make the final decision about coverage. If you would like more information about how we make decisions about new medical practices and treatments, call us at **1-800-587-5187, TTY 711**.

CurrentCare[®]

The more information your providers have about your medical history, the better they can care for you. You may see more than one provider. You may have had visits to a hospital, provider's office, or community clinic. Each of these providers can do a better job caring for you if they have access to all of your medical records in one place. CurrentCare[®] is a database that can give them those records. It is Rhode Island's electronic health network. If you sign up, you give permission to your providers to see your health information in the database. This keeps all of your providers informed and allows them to easily coordinate your health care. If you want to sign up for CurrentCare, call 1-888-858-4815. There is no cost to join.

Rhode Island All-Payer Claims Database

UnitedHealthcare Community Plan is required by law to report data about its members' health care use and costs. This information will be put in the Rhode Island All-Payer Claims Database. It will be used by policy makers to make better health care decisions. You have the choice:

1. If you want your family's data in the records, you do not have to do anything.
2. If you want to have your data left out, please go to www.riapcd-optout.com. If you cannot get online, please call Rhode Island's Health Insurance Consumer Support at 1-855-747-3224. If you have a question or want to learn more, email riapcd@ohic.ri.gov.

Fraud, Waste and Abuse

If you suspect or know that fraud, waste, or abuse is occurring, report it immediately. Fraud happens when a member or provider does something that is not honest so that he/she or another person experiences positive results or some type of benefit or incentive. Waste happens when there is an overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system. Abuse happens when appropriate business and medical practices are not followed, and the result is an unnecessary cost to the Medicaid program. Reporting fraud, waste, and abuse will not affect how you will be treated by UnitedHealthcare Community Plan. You have the choice to remain anonymous when you make the report. Provide as much information as possible; this will assist those investigating the report.

Some examples of fraud, waste or abuse are:

- Sharing, loaning, changing or selling a health plan or Rhode Island Medicaid ID card so someone else can get health care services.
- Using someone else's health plan or Rhode Island Medicaid ID card to get health care services.
- Using a provider's prescription pad to alter or forge a provider's prescription to receive drugs.
- Receiving benefits in both Rhode Island and another state.
- Lying about how much money you make or where you live to become eligible for benefits.
- Selling or giving prescriptions to others that were prescribed to you.
- Providers or hospitals that bill you or your health plan for services that were never provided.

There are many ways to report fraud, waste, and abuse:

- Call UnitedHealthcare Community Plan Member Services **1-800-587-5187, TTY 711** or write UnitedHealthcare Community Plan a letter at 475 Kilvert Street, Warwick, RI 02886.
- Contact the:
 - RI Office of Program Integrity at 401-462-6503.
 - RI Department of Human Services Fraud hotline for reports on CCAP, SNAP, RI Works and GPA at 401-415-8300.
 - Department of RI Attorney General for reports on Medicaid fraud, Patient Abuse or Neglect, or Drug Diversion at 401-222-2556 or 401-274-4400 ext. 2269.

Parity

Behavioral health and substance use disorder services are considered essential health benefits. UnitedHealthcare Community Plan ensures that financial requirements (such as co-pays and deductibles) and treatment limitations (such as limits on visits) that apply to mental-health or substance use disorder benefits are no stricter than the limits that insurance plans place on medical or surgical benefits. If you think that your ability to get behavior health services is different than getting medical services, call UnitedHealthcare Community Plan Member Services **1-800-587-5187, TTY 711** and tell them you have a parity complaint.

Definitions

Appeal: An appeal is a special kind of complaint you make if you don't agree with a decision to deny a request for health care services. You may also file an appeal if you disagree with a decision to stop or reduce services that you are receiving. For example, you may ask for an appeal if UnitedHealthcare Community Plan does not pay for an item or service you think you should be able to get. There is a specific process that we must use when you ask for an appeal.

Complaint: a concern about benefits, services, access to appointments, wrong bills you receive or other issues. If possible, we will resolve your problem at the time of your call.

Coordination of Benefits (COB): If you have another health plan, that plan is your primary insurance. UnitedHealthcare Community Plan would be your secondary health plan. Call Member Services if you have other insurance or if that coverage has ended.

Copayment: a payment made by a member for health services in addition to that made by an insurer.

Durable Medical Equipment (DME): Bought or rented items such as hospital beds, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment ordered by a health care provider to be used in a patient's home.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a lay person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Also known as ambulance services or paramedic services, are emergency services which treat illnesses and injuries that require an urgent medical response and transport to acute care facility.

Emergency Room Care: Care given for a medical emergency when you believe that your health is in danger.

Emergency Services: An emergency is a potential life-threatening illness or injury. It can cause serious pain or harm to you if you do not receive treatment right away.

EPSDT: Early, Periodic, Screening, Diagnostic and Treatment.

Excluded Services: Items or services that UnitedHealthcare Community Plan does not cover.

Grievance: A complaint about the way your health plan is giving care or dissatisfaction about anything other than a service not being covered. Examples of a grievance include: dissatisfied with the way your health plan responded to your complaint; your health plan asking for more time to make an authorization decision; you have concerns about quality of care or services you got; you feel a provider, or their employee was rude, or you feel a provider did not respect your member rights. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see *Appeal*).

Habilitation Services and Devices: Health care services that help you keep, learn, or improve skills needed for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all your health care costs in exchange for a premium.

Home Health Care: Skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services supplied in the home.

Medically Necessary: Direct care, services or supplies that are needed for the diagnosis or treatment of your medical condition, behavioral health, or prevention of worsening of your condition. They must meet the standards of good medical practice and aren't for the convenience of you or your doctor.

Network: A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

Non-Participating Provider: A health care provider or supplier who is not contracted with your health plan.

Physician Services: Services provided by an individual licensed under state law to practice medicine or osteopathy.

Plan: Managed care entity that manages the delivery of health care services.

Preauthorization (Prior Authorization): Health plan approval necessary before you get care.

Participating Provider: A healthcare provider or supplier who is contracted with the Plan and agrees to accept health plan members. Also known as network or in-network provider.

Premium: The amount paid for health insurance every month.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that, by law, require a prescription.

Primary Care Physician/Provider: A doctor (MD or DO), nurse practitioner, physician assistant who is trained to give you basic care. Your primary care provider (PCP) is the person you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy.

Referral: Request from your PCP to your health plan to approve appointment and/or treatment to a specialist.

Other Plan Details

Rehabilitation Services and Devices: Services ordered by your PCP to help you recover from an illness or injury. These services are given by nurses and physical, occupational, and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

Skilled Nursing Care: A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Specialist: A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

Urgent Care: Care that you get for a sudden illness or injury that needs medical care right away but is not life threatening. Your primary care doctor generally provides urgently needed care.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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

Effective January 1, 2019.

By law, we¹ must protect the privacy of your health information (“HI”). We must send you this notice. It tells you:

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

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

HI is information about your health or health care services. We have the right to change our privacy practices for handling HI. If we change them, we will notify you by mail or email. We will also post the new notice at this website (www.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.

Other Plan Details

- **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.

Other Plan Details

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

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or **TTY 711**.
- **To Submit a Written Request.** Mail to:
UnitedHealthcare Privacy Office
MN017-E300
P.O. Box 1459
Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

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

Financial Information Privacy Notice

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

Effective January 1, 2019.

We² protect your “personal financial information” (“FI”). FI is non-health information. FI identifies you and is generally not public.

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

Other Plan Details

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.; Life Print 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; y 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.



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

If you think you were treated unfairly because of your sex, age, race, color, 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 send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 6:00 p.m.

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

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

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 listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 6:00 p.m.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-587-5187, TTY 711.

Spanish

ATENCIÓN: Los servicios de asistencia de idiomas están a su disposición sin cargo. Llame al 1-800-587-5187, TTY 711.

Portuguese

ATENÇÃO: Encontram-se disponíveis serviços de assistência de idioma. Contacte 1-800-587-5187, TTY 711.

Chinese

注意：我們提供免費的語言協助服務。請致電 1-800-587-5187 或聽障專線 (TTY) 711。

French Creole (Haitian Creole)

ATANSYON: Gen sèvis èd pou lang, gratis, ki disponib pou ou. Rele 1-800-587-5187, TTY 711.

Mon-Khmer, Cambodian

សូមយកចិត្តទុកដាក់៖ សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក ។ សូមទូរស័ព្ទទៅលេខ 1-800-587-5187, TTY 711 ។

French

ATTENTION : vous pouvez profiter d'une assistance linguistique sans frais en appelant le 1-800-587-5187, TTY 711.

Italian

ATTENZIONE: È disponibile un servizio gratuito di assistenza linguistica. Chiamare il numero 1-800-587-5187, TTY 711.

Laotian

ໝາຍເຫດ: ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າແມ່ນມີໃຫ້ແກ່ທ່ານ. ໂທຫາ 1-800-587-5187, TTY 711.

Arabic

تنبيه: تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-800-587-5187، الهاتف النصي: 711.

Russian

ВНИМАНИЕ! Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-800-587-5187, TTY 711.

Vietnamese

LƯU Ý: Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho bạn. Hãy gọi 1-800-587-5187, TTY 711.

Kru (Bassa)

TÒ ĐÙŨ NÒMÒ DYÍIN CÁO: À bédé gbo-kpá-kpá bó wuḍu-dù kò-kò po-nyò bě bìi nō à gbo bó pídyi. M̄ dyi gbo-kpá-kpá m̄wín, dá nòbà nià ke: 1-800-587-5187, TTY 711.

Igbo

NRỤBAMA: Ọrụ enyemaka asụsụ, n'efu, dijirị gị. Kpọọ 1-800-587-5187, TTY 711.

Yoruba

AKIYESI: Iranlowo siso ede, o wa ni ofe fun o. Pe 1-800-587-5187, TTY 711.

Polish

UWAGA: Zapewniamy bezpłatne wsparcie tłumaczeniowe. Prosimy o kontakt telefoniczny: 1-800-587-5187, TTY 711.

We're here for you.

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-587-5187, TTY 711**, 8:00 a.m. – 6:00 p.m., Monday – Friday. You can also visit our website at [UHCCommunityPlan.com](https://www.uhc.com/communityplan).

UnitedHealthcare Community Plan
475 Kilvert Street, Suite 310
Warwick, RI 02886

[UHCCommunityPlan.com](https://www.uhc.com/communityplan)

1-800-587-5187, TTY 711



