New York

Welcome to the community

Child Health Plus

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United Healthcare Community Plan

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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. Just call Member Services at **1-800-493-4647**, TTY **711**, 8:00 a.m.–6:00 p.m., Monday–Friday. You can also visit our website at **myuhc.com/CommunityPlan**.

Getting started

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

1. Call your child's Primary Care Provider (PCP) and schedule a checkup

Regular checkups are important for good health. Your child's PCP name and phone number is listed on the member ID card that has been sent to you separately in the mail. If you would like help scheduling a checkup, call Member Services at **1-800-493-4647**, TTY **711**. We're here to help.
If your child requires medically necessary care, before you receive the member ID card, bring this Handbook with you to the doctor's appointment, to show that your child has coverage with UnitedHealthcare Community Plan.

2. Take your child's Health Assessment

This is a short and easy way to get a big picture of your child's current lifestyle and health. This helps us match your child with the benefits and services available to you.

You will soon receive a welcome phone call from us. We will call to explain all of your child's health plan benefits. We also will help you complete a survey about your child's health. This short survey helps us understand your child's needs so that we can serve you better. You can also visit our website and fill out the survey for your child online. See page 9.

3. Get to know your child's health plan

Start with the **Health plan highlights** section on page 7 for a quick overview of your child's 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 your child as a member. UnitedHealthcare is committed to helping our members live happier, healthier lives.

UnitedHealthcare Community Plan gives you access to many health care providers — doctors, nurses, hospitals and drugstores — 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 child's 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 **1-800-493-4647**, TTY **711**, 8:00 a.m.–6:00 p.m., Monday–Friday.

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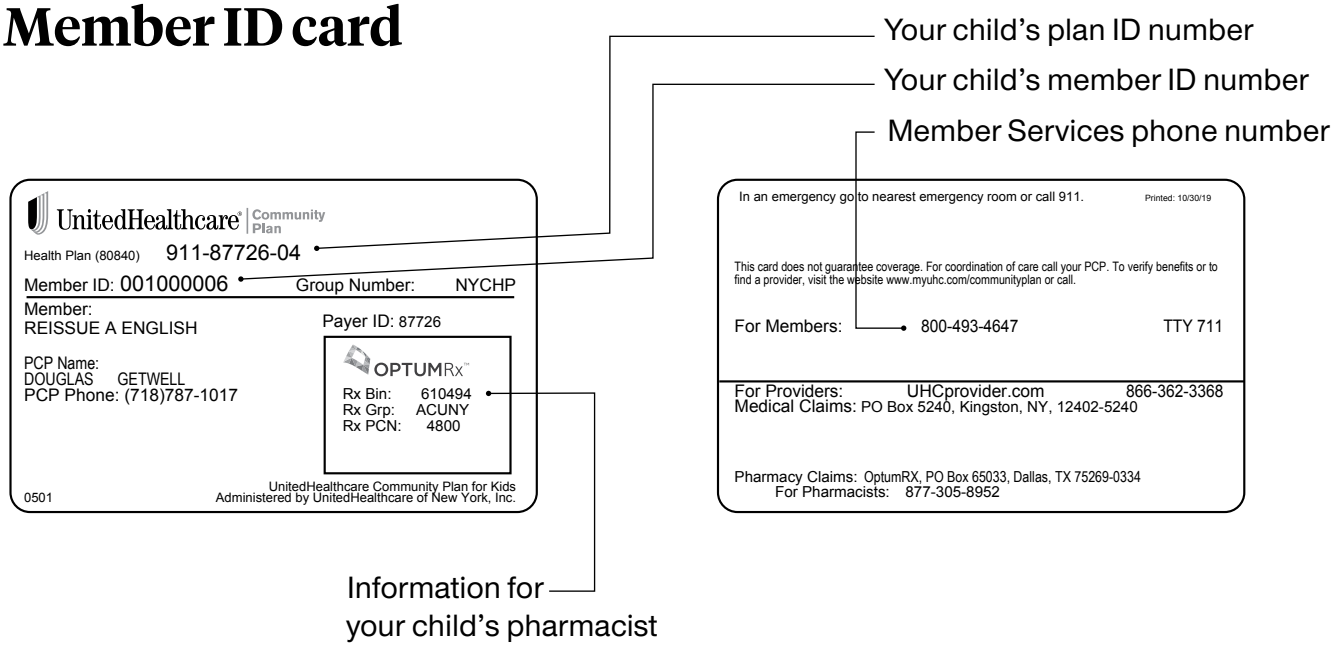
UnitedHealthcare Community Plan's Child Health Plus plan is available to members who live in Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, Wyoming and Yates Counties.

Health plan highlights

Member ID card



Your child's member ID card holds a lot of important information. It gives you access to your child's covered benefits. You should have received your child's 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 all the information is correct. If any information is wrong, call Member Services at **1-800-493-4647**, TTY **711**.

- Take your child's 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 child's card(s). It is against the law.

Show your card. Always show your child's UnitedHealthcare ID card when you get care. This helps ensure that your child gets all the benefits available. And prevents billing mistakes.

Lost your child's member ID card?

If you or a family member loses a card, contact Member Services right away and we'll send you a new one. Register online at **myuhc.com/CommunityPlan** to print a temporary card.

Benefits at a glance

As a UnitedHealthcare Community Plan member, you have a variety of health care benefits and services available to your child. Here is a brief overview. You'll find a complete listing in the Benefits section.

Primary care services

Your child is covered for all visits to his or her Primary Care Provider (PCP). Your child's PCP is the main doctor your child will see for most of his/her health care. This includes checkups, treatment for colds and flu, health concerns, immunizations and other health screenings.

Large provider network

You can choose any PCP from our large network of providers. Our network also includes specialists, hospitals and drugstores — giving you many options for your child's health care. Find a complete list of network providers at **myuhc.com/CommunityPlan** or call **1-800-493-4647**, TTY **711**.

Specialist services

Your child's 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 22.

Medicines

Your child's plan covers prescription drugs with no co-pays for members of all ages. Also covered: insulin, needles and syringes, coated aspirin for arthritis, iron pills and chewable vitamins.

Hospital services

Your child is covered for hospital stays. Your child is also covered for outpatient services. These are services you get in the hospital without spending the night.

Laboratory services

Covered services include blood 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.

Your child's 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 and fill out the Health Assessment forms.

Go online to **myuhc.com/CommunityPlan** to fill it out. Or call **1-800-493-4647**, TTY **711**.

Member support

We want to make it as easy as possible for you to get the most from your child's 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** for many of your member service needs. In addition to plan details, the site includes useful tools that can help you:

- Take your child's Health Assessment
- Find a provider or pharmacy
- Search for a medicine in the Preferred Drug List
- Get benefit details
- Download a new Member Handbook
- Keep track of your child's medical history with your child's Personal Health Record
- You may email us from our website. Select the "Contact Us" link

Member Services is available Monday–Friday, 8:00 a.m.–6:00 p.m.

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

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

Call **1-800-493-4647**, TTY **711**, 24 hours a day, 7 days a week.

Care Management program

If your child has 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. To learn more, call **1-800-493-4647**, TTY **711**.

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

Please call ahead to check for office closings.

Kings County

6402 8th Avenue, Suite 107
Brooklyn, NY 11220
Phone: **1-800-632-6311**
Monday–Friday, 9:00 a.m.–5:30 p.m.

2343 86th Street
Brooklyn, NY 11220
Phone: **1-800-632-6311**
Monday–Friday, 9:00 a.m.–5:30 p.m.

Nassau County

250 Fulton Avenue, Suite 121
Hempstead, NY 11570
Phone: **1-516-247-6352**
Monday–Friday, 9:00 a.m.–4:00 p.m.

New York County

161 Canal Street
New York, NY 10013
Phone: **1-800-632-6311**
Monday–Friday, 9:00 a.m.–5:30 p.m.

New York County (continued)

27 East Broadway, 2nd Floor
New York, NY 10002
Phone: **1-800-632-6311**
Monday–Friday, 9:00 a.m.–5:30 p.m.

558 W 181 Street
New York, NY 10033
Phone: **1-212-781-3960**
Monday–Friday, 10:00 a.m.–5:00 p.m.

Queens County

136-02 Roosevelt Avenue
Flushing, NY 11354
Phone: **1-800-632-6311**
Monday–Friday, 9:00 a.m.–5:30 p.m.

Suffolk County

46 Suffolk Avenue
Brentwood, NY 11717
Phone: **1-631-231-0180** or **1-631-231-0181**
Monday–Friday, 9:00 a.m.–4:00 p.m.

Health plan highlights

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

Emergencies

In case of emergency, call	**911**

Important numbers

UnitedHealthcare Community Plan CHP Billing Hotline	**1-877-229-3439**
Your Primary Care Physician	See Your UnitedHealthcare Community Plan ID Card
Your Nearest Emergency Room	
New York State Health Dept. (Complaints)	**1-800-206-8125**
New York State Child Health Plus Hotline	**1-800-698-4543**

Upstate County Departments of Social Services:

Albany County Department of Social Services	**1-518-447-7300**
Broome County Department of Social Services	**1-607-778-2669**
Cayuga County Department of Social Services	**1-315-253-1011**
Chautaugua County Department of Social Services	**1-716-661-8200**
Chemung County Department of Social Services	**1-607-737-5309**
Chenango County Department of Social Services	**1-607-337-1500**
Clinton County Department of Social Services	**1-518-565-3222**
Columbia County Department of Social Services	**1-518-828-9411**
Essex County Department of Social Services	**1-518-873-3450**
Fulton County Department of Social Services	**1-518-736-5640**
Genesee County Department of Social Services	**1-585-344-2580**

Upstate County Departments of Social Services (continued):

Herkimer County Department of Social Services	**1-315-867-1291**
Jefferson County Department of Social Services	**1-315-782-9030**
Lewis County Department of Social Services	**1-315-376-5105**
Madison County Department of Social Services	**1-315-366-2211**
Monroe County Department of Social Services	**1-585-753-2740**
Niagra County Department of Social Services	**1-716-439-7600**
Oneida County Department of Social Services	**1-315-798-5632**
Onondaga County Department of Social Services	**1-315-435-2928**
Ontario County Department of Social Services	**1-585-396-4060**
Orange County Department of Social Services	**1-845-291-4000**
Oswego County Department of Social Services	**1-315-963-5000**
Rensselaer County Department of Social Services	**1-518-270-3928**
Rockland County Department of Social Services	**1-845-364-2000**
Seneca County Department of Social Services	**1-315-539-1865**
St. Lawrence County Department of Social Services	**1-315-379-2276**
Tioga County Department of Social Services	**1-877-882-8313**
Ulster County Department of Social Services	**1-845-334-5000**
Warren County Department of Social Services	**1-518-761-6300**
Wayne County Department of Social Services	**1-315-946-4881**
Westchester County Department of Social Services	**1-800-549-7650**

New York City and Long Island:

Nassau County Department of Social Services	**1-516-227-8000**
New York City Human Resources Administration	**1-718-557-1399**
New York City Human Resources Administration (within the 5 boroughs)	**1-877-472-8411**
New York Medicaid CHOICE	**1-800-505-5678**
Suffolk County Department of Social Services (Hauppauge)	**1-631-853-8730**
Suffolk County Department of Social Services (Riverhead)	**1-631-852-3710**
Suffolk County Department of Social Services (Ronkonkoma)	**1-631-854-9700**

Other helpful resources

(DOH) New York State Department of Health website:
https://www.health.ny.gov/

(OMH) New York State Office of Mental Health:
https://www.omh.ny.gov/

(OASAS) New York State Office of Alcoholism and Substance Abuse Services:
https://www.ny.gov/agencies/office-alcoholism-and-substance-abuse-services

(OCFS) New York State Office of Children and Family Services:
https://ocfs.ny.gov/main/

(OPWDD) New York State Office of People with Developmental Disabilities:
https://opwdd.ny.gov/

Division of Criminal Justice Services (DCJS):
https://www.criminaljustice.ny.gov/ofpa/jj/jj-index.htm

The Child Mind Institute:
https://childmind.org/report/2016-childrens-mental-health-report/mental-health-disorders-common

First Episode Psychosis (FEP) On Track NY — NYS state funded program for people experiencing first break psychosis – website:
https://ontrackny.org/

First Episode Psychosis (FEP) On Track NY — Young Adults NYS state funded program for adolescents experiencing first break psychosis – website:
https://ontrackny.org/Young-Adults

You can start using your pharmacy benefit right away

Your child's plan covers a long list of medicines, or prescription drugs. Medicines that are covered are on the plan's Preferred Drug List. Your doctor uses this list to make sure the medicines your child needs are covered by your plan. You can find the Preferred Drug List online at **myuhc.com/CommunityPlan**. You can also search by a medicine name on the website. It's easy to start getting your prescriptions filled. Here's how:

1. Are your child's medicines included on the Preferred Drug List?

Yes

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

No

If your child's prescriptions are not on the Preferred Drug List, schedule an appointment with your doctor within the next 30 days. They may be able to help you switch to a drug that is on the Preferred Drug List. Your doctor can also help you ask for an exception if they think your child needs a medicine that is not on the list.

Not sure

View the Preferred Drug List online at **myuhc.com/CommunityPlan**. You can also call Member Services. We're here to help.

2. Does your child 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 child's 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. Does your child need to refill a drug that's not on the Preferred Drug List?

If your child needs refills of medicines that are not on the Preferred Drug List, you may be able to get a temporary 3-day supply. To do so, visit a network pharmacy and show your child's member ID card. If you don't have your child's member ID card, you can show the pharmacist the information below. Talk to your child's doctor about your prescription options.

Attention Pharmacist

Please process this UnitedHealthcare Community Plan member's claim using:

BIN: 610494
Processor Control Number: 4800
Group: ACUNY

If you receive a message that the member's medication needs a prior authorization or is not on our formulary, please call **OptumRx®** at **1-877-305-8952** for a transitional supply override.

Going to the doctor

Your child's Primary Care Provider (PCP)

We call the main doctor your child sees a Primary Care Provider, or PCP. When your child sees 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. Your child will see your PCP for:

- Routine care, including yearly checkups
- Coordinate your child's 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 child's 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 your child needs 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 child's PCP

If your child has been seeing a doctor before becoming a UnitedHealthcare member, check to see if your child's 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 your child.

1. Look through our printed Provider Directory.
2. Use the Doctor Lookup tool at **myuhc.com/CommunityPlan**.
3. Call Member Services at **1-800-493-4647**, 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 child's 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 board certifications, and languages they speak, at **myuhc.com/CommunityPlan**, or by calling Member Services. We can tell you the following information: Name, address, Professional Qualifications, Specialty, Medical School attended, Residency completion, and Board Certification status.

Changing your child's PCP

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

Federally Qualified Health Centers (FQHCs)

We also contract with several Federally Qualified Health Centers (FQHCs). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose one of our providers. Or you can sign up with a Primary Care Provider at one of the FQHCs that we work with, listed in the Provider Directory. Just call Member Services at **1-800-493-4647**, TTY **711**, for help.

Annual checkups

The importance of your child's annual checkup

Your child doesn't have to be sick to go to the doctor. In fact, yearly checkups with your PCP can help keep your child healthy. In addition to checking on your child's general health, your PCP will make sure your child gets the screenings, tests and shots he or she needs. And if there is a health problem, they're usually much easier to treat when caught early.

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

If you get a bill

If you are asked to pay for a service and you are not sure whether it is covered, call UnitedHealthcare Community Plan Member Services at **1-800-493-4647**, TTY **711** before paying for the service.

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	4 years
12 months	Once a year after age 5

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

Making an appointment with your child's PCP

Call your doctor's office directly. The number should be on your child's member ID card. When you call to make an appointment, be sure to tell the office what your child is coming in for. This will help make sure your child gets the care he/she needs, when he/she needs it. This is how quickly your child can expect to be seen:

How long it should take to see your child's PCP:	
Emergency	Immediately or sent to an emergency facility
Urgent (but not an emergency)	Within 48 hours
Routine	Within 14 days
Preventive, well-child and regular	Within 4 weeks

- First pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
- First newborn visit: within 2 weeks of hospital discharge
- First family planning visit: within 2 weeks
- Follow-up visit after mental health/substance abuse ER or inpatient visit: 5 days
- Non-urgent mental health or substance abuse visit: 2 weeks

Preparing for your child's 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 your child takes on a regular basis.

During the visit

When you are with your child's 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

If your child needs care and your provider's office is closed

Call your child's 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 your child needs 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 your child 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:

- OB/GYN
- Optometry
- Podiatry
- Dermatologist
- Behavioral Health/Substance Abuse Professionals
- Chiropractors

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

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

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

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

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

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

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

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

Getting a second opinion

A second opinion is when you want to see a second doctor for the same health concern. You are entitled to a second opinion from a network provider for any of your covered benefits.

Continued care if your child's PCP leaves the network

Sometimes PCPs leave the network. If this happens to your child's 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 child's doctor leaves the network if your child is being actively treated for a serious medical problem. For example, your child may qualify if he or she is getting chemotherapy for cancer 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 your child needs care when out of town

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

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

If you are outside of the United States and need medical care, any health care services your child receives will not be covered by UnitedHealthcare Community Plan. Child Health Plus cannot pay for any medical services your child gets outside of the United States.

Hospitals and emergencies

Emergency care

Hospital emergency rooms are there to offer emergency treatment for trauma, serious injury and life-threatening symptoms. Reasons to go to the ER include:

- Serious illness
- Broken bones
- Heart attack
- Poisoning
- Severe cuts or burns

UnitedHealthcare Community Plan covers any emergency care your child needs throughout the United States and its territories. Within 24 hours after your child's visit, call Member Services at **1-800-493-4647**, TTY **711**. You should also call your child's PCP and let them know about your child's visit so they can provide follow-up care if needed.

Don't wait

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

Urgent care

Urgent care clinics are there for you when your child needs to see a doctor for a non-life-threatening condition but your child's 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 your child has an urgent problem, call your child's 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 **1-800-493-4647**, TTY **711**.

Hospital services

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

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

Inpatient services require your child to stay overnight at the hospital. These can include serious illness, surgery or having a baby.

Inpatient services require your child to be admitted (called a hospital admission) to the hospital. The hospital will contact UnitedHealthcare Community Plan and ask for authorization for your child's care. If the doctor who admits your child to the hospital is not your child's PCP, you should call your child's PCP and let them know your child is being admitted to the hospital.

Going to the hospital

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

Emergency ambulance

Your child can get medical transportation for emergencies. Non-emergency (routine) transportation is not covered.

UnitedHealthcare covers medically necessary ambulance services when you meet the following conditions:

- Your child's sickness or injury is serious enough that he/she can only go to the hospital in an ambulance
- If your child goes in an ambulance, he/she must be taken to the closest hospital with the right equipment to help
- If your child is going from one hospital to another, to a skilled nursing facility, or to a licensed nursing home

UnitedHealthcare will not pay for the following non-emergency (routine) transportation services:

- Transportation from your home to your child's doctor office
- Transportation to the outpatient area of a hospital, unless a network provider or UnitedHealthcare decides that your child's sickness or injury requires it
- Transportation from one private home to another

No medical coverage outside of U.S.

If you are outside of the United States and need medical care, any health care services your child receives will not be covered by UnitedHealthcare Community Plan. Child Health Plus cannot pay for any medical services your child gets outside of the United States.

Pharmacy

Prescription drugs

Your benefits include prescription drugs

UnitedHealthcare Community Plan covers hundreds of prescription drugs from hundreds of pharmacies. The full list of covered 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 formulary, or online at myuhc.com/CommunityPlan.

Generic and brand name drugs

UnitedHealthcare Community Plan requires that generic drugs be used when available. 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.

Changes to the Preferred Drug List

The list of covered drugs is reviewed by the Department of Human Services on a regular basis and may change when new generic drugs are available.

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. OTCs include:

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

For a complete list of covered OTCs, go to **myuhc.com/CommunityPlan**. Or call Member Services at **1-800-493-4647**, 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 for up to two years. 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 **1-800-493-4647**, 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
Pharmacy Department
P.O. Box 41566
Philadelphia, PA 19101

Benefits

Covered and non-covered services

Please refer to your Child Health Plus Subscriber Contract for information on covered benefits and non-covered services. You can get information on covered services under Sections Three through Six of the Subscriber Contract. Non-covered services are described under Section Eight.

Eligibility for Child Health Plus

Eligibility for Child Health Plus is based on your family size and household income. Some children will qualify for free Child Health Plus coverage and others will be required to pay a monthly premium. We will let you know if you will be required to pay a monthly premium for your child(ren). In some cases, you may pay full premium if your household income exceeds the income limits set forth by the State of New York. Please refer to Section Two — Who Is Covered under your Subscriber Contract.

Renewing your Child Health Plus Coverage (Re-certification)

Your Child Health Plus coverage requires you to renew or re-certify your coverage every year. Each year, New York State of Health will ask you for information on your household income, your child's age, residency, and status of other insurance. This is required to renew or recertify your child(ren)'s coverage. New York State of Health has to collect this information to determine if your child is still eligible for the Child Health Plus program, and to determine the premium amount you must pay monthly for coverage. New York State of Health will send you a Child Health Plus Recertification form by mail two (2) to three (3) months before your recertification date. It will include a list of locations where you can get help completing your Recertification form. It is important that you complete and return your Child Health Plus Recertification form before your recertification date. If you do not complete your recertification on time, your child(ren) will lose coverage. See your Child Health Plus Subscriber Contract for more information.

Changes in eligibility

If there are changes that affect your child's eligibility or your premium payment during the year, please call New York State of Health at 1-855-355-5777 to report the change.

Here are some examples of changes in family circumstances:

- Your child(ren) move outside of the Plan's service area; or
- You get other health insurance coverage for your child(ren); and
- You have moved to a new address or changed your telephone number.

If any of the above changes occur, please notify New York State of Health at 1-855-355-5777 to report these changes. Other changes in eligibility may also change the premium amount you pay for your coverage. These include:

- A decrease in the household income from a job change, marriage or divorce, child support or other income source
- An increase or decrease in the number of people in the child's household

Premium payments for Child Health Plus

When you enrolled your child(ren) in Child Health Plus, you may be required to pay a premium for coverage. Child Health Plus is a pre-paid health plan which means you pay premiums prior to the month of coverage. This amount can vary for each family enrolled in Child Health Plus dependent upon your household income and size. Your premium payment must be received by UnitedHealthcare Community Plan on or before the last date of your grace period or your coverage will be terminated.

How the premium billing process works

UnitedHealthcare Community Plan will bill you each month for your premium amount. UnitedHealthcare Community Plan will bill you two months in advance of the month of coverage and payment is due one month prior to the month of coverage. We also provide a grace period for your payment to be received. Your payment must be received by UnitedHealthcare Community Plan on or before the last day of the grace period or coverage for your child(ren) will be terminated. You will have to re-apply to join Child Health Plus again.

Billing cycle for monthly premium amounts of $9 through $60 per child per month

If your monthly premium per child is between $9 and $60 per month, the chart below explains when we will send you a bill and when your payment is due. If you have more than three children covered with UnitedHealthcare Community Plan, you will only pay premium for up to three children. We recommend that you send your payment with enough time for us to receive it before the grace period has expired.

Month being billed	Bill issued	Payment due date	Last day of grace period
January	November 5	December 1	January 31
February	December 5	January 1	February 28/29
March	January 5	February 1	March 31
April	February 5	March 1	April 30
May	March 5	April 1	May 31
June	April 5	May 1	June 30
July	May 5	June 1	July 31
August	June 5	July 1	August 31
September	July 5	August 1	September 30
October	August 5	September 1	October 31
November	September 5	October 1	November 30
December	October 5	November 1	December 31

Billing cycle for full monthly premium payors

If you are required to pay a full monthly premium per child (generally over $150 per child per month), the below chart explains when we will send you a bill and when your payment is due. If you are paying full premium, you are required to pay a premium for each covered child in your household. Premiums are not limited to three children for full premium payors. We recommend that you send your payment with enough time for us to receive it before the grace period has expired.

Month being billed	Bill issued	Due date	Last day of grace period
January	November 5	December 1	December 31
February	December 5	January 1	January 31
March	January 5	February 1	February 28/29
April	February 5	March 1	March 31
May	March 5	April 1	April 30
June	April 5	May 1	May 31
July	May 5	June 1	June 30
August	June 5	July 1	July 31
September	July 5	August 1	August 31
October	August 5	September 1	September 30
November	September 5	October 1	October 31
December	October 5	November 1	November 30

Your premium payment must be received by us on or before the last day of the grace period or your child(ren)'s coverage will be terminated.

Do I have to pay for any services?

No. Child Health Plus enrollees do not pay for covered services from a contracted provider. All covered services are available for $0 co-payment. You may have to pay for services if:

- Your child receives services from a provider that is not part of our network; or
- Your child receives services outside of the plan's services area; or
- Your child receives non-emergency services from an emergency room.

What if I don't pay the premium for my child?

Some people have to pay a premium for their children enrolled in Child Health Plus. UnitedHealthcare Community Plan will bill you two months in advance of the month of coverage and payment is due one month prior to the month of coverage. We also provide a grace period for your payment to be received by us. Please refer to the billing cycle chart above to learn more about premium payments and due dates.

If you have to pay a premium, it is important that you pay the premium for each child enrolled with UnitedHealthcare Community Plan by the premium due date. If we do not receive your premium payment by the last day of the grace period, your child will be disenrolled from Child Health Plus.

We will send you a written notice that your child's coverage will be terminated before the end of the grace period. If you have questions regarding whether or not UnitedHealthcare Community Plan has received your premium payment or want to know when your payment is due, call toll-free 1-877-229-3439.

Important plan information – NY Child Health Plus

UnitedHealthcare is offering new ways to make it easier to pay your monthly premium. UnitedHealthcare Child Health Plus members can now pay their monthly premium online by logging on to **myuhc.com**.

Members can also pay their monthly premium by phone 24 hours a day, 7 days a week, using our automated bill payment system. Please call **1-877-229-3439**, TTY **711**.

Members can also mail in their premium payment via check or money order to the following address:

UnitedHealthcare Community Plan
P.O. Box 785462
Philadelphia, PA 19178-5462

As always, if you prefer to speak with a Customer Service Representative to make your payment, you can call **1-877-229-3439**, TTY **711** from 8:00 a.m.–5:00 p.m., Monday–Friday. We value our members and are always looking for new ways to help our members get the health care they need. Thank you for choosing UnitedHealthcare.

Members can also mail in their premium payment overnight.

Overnight mailing address:

UnitedHealthcare Community Plan
Lock Box #5462
Wells Fargo Bank Y1372-045
401 Market Street
Philadelphia, PA 19106

Can my child's coverage be terminated?

UnitedHealthcare Community Plan may, at its discretion, discontinue this benefit plan for the following reasons:

a. Your failure to pay your child(ren)'s monthly premium on time
b. Loss of eligibility for Child Health Plus (your child turns 19, becomes eligible for Medical Assistance or is enrolled in other health coverage)
c. Providing us with false information
d. Allowing other people to use your child(ren)'s ID card
e. You and your covered child(ren) have moved out of the services area
f. A written request from a member to terminate
g. Termination of the Child Health Plus agreement between UnitedHealthcare of New York, Inc. and the State of New York
h. Death

Service authorization and actions prior authorization

Prior authorization

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

- Inpatient hospital admissions, including medical, behavioral health, surgical and maternity
- Skilled Nursing Facility services
- Home health care services
- Durable Medical equipment (DME) over $500
- Prosthetic and Orthotic devices over $500
- Cosmetic and Reconstructive surgery
- Gastric Bypass Evaluations and Surgery
- Infusion Therapy
- Hospice Services, inpatient and outpatient
- Advanced Radiology Services including Nuclear Radiology and Nuclear Medicine Scans, MRI, MRA, PET Scans and CT Scans
- Experimental or investigational health care services
- Out-of-Network or Out-of-State Services
- Mental Health or Substance Abuse Services, inpatient and outpatient
- Physical, Occupational and Speech Therapy after the 20th visit. This limitation does not apply to members under 21 years of age or the developmentally disabled or members suffering from traumatic brain injury.
- Transplant evaluations
- Prescription drugs that are not on the Preferred Drug List

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

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

Written physician or health care provider requests can be sent to:

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

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

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

What happens after we get your service authorization request:

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

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

After we get your request for service, we will review it under a **standard** or **expedited** process. You or your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we received a request for home health care, we will handle the request as an expedited review.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals you will have if you don't agree with our decision.

Timeframes for prior authorization requests:

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

  We will attempt to tell you our decision by phone and send a written notice later.

Timeframes for concurrent review requests:

- **Standard review:** We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.
- With respect to requests for Home Health Care (HHC) immediately following an inpatient hospital admission, we will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request or within seventy-two (72) hours of receipt of the necessary information when the day after the request date falls on a weekend or holiday.
- **Expedited review:** We will make a decision within 1 work day of when we have all the information we need. However, if you are in the hospital or have just left the hospital, and you ask for home health care on a Friday or day before a holiday, we will make a decision no later than 72 hours of when we have all the information we need. In all cases you will hear from us no later than 3 work days after we received your request. We will tell you by the third work day if we need more information.

  We will attempt to tell you our decision by phone and send a written notice later.

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-800-493-4647**, TTY **711** or by facsimile (fax) at 1-866-950-4490.

Written physician or health care provider requests can be sent to:

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

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

We will notify you of our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

Other decisions about your care

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

Utilization review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the Utilization Review process, or need help, please call Member Services toll free at **1-800-493-4647**, TTY **711**, from 8:00 a.m.–6:00 p.m., Monday–Friday. Language help is available.

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

Wellness programs

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

- Pregnancy care and parenting classes
- Nutrition classes
- Well-care reminders

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

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** to search for a provider online. – Click on "Find a Provider."

Call Member Services at **1-800-493-4647**, 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 addresses and phone numbers of our in-network providers.

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 **1-800-493-4647**, TTY **711**, and we will mail one to you.

Member survey

Every year, UnitedHealthcare asks some of our members how they feel about UnitedHealthcare Community Plan. This survey helps us to decide which areas we should work on to make improvements and what we are doing well.

If you get a survey, please answer it. An outside firm takes the survey and we do not ever see your answers. Your privacy is guarded. Your responses will never be used to make decisions about you or your family's health care. Your answers, along with the answers of many other members, are combined to let us know how we are doing. It's your chance to "give us a grade." We want to hear from you.

Fraud and abuse

Anyone can report potential fraud and abuse. If you become aware of fraud or abuse, call Member Services at **1-800-493-4647**, TTY **711**, to report it. Some examples of fraud and abuse are:

- Receiving benefits in New York and another state at the same time
- Altering or forging prescriptions
- A person getting benefits who is not eligible for benefits
- Giving a UnitedHealthcare Community Plan ID card to someone else to use
- Excessive use or overuse of benefits
- Doctors or hospitals that bill you or UnitedHealthcare for services that were not provided to you
- Doctors or hospitals who bill UnitedHealthcare more than once for services you only had once
- Doctors who submit false documentation to UnitedHealthcare so that you may receive services that are only provided when medically needed

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 **1-800-493-4647**, TTY **711**
- Write to us at:

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

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.

Nondiscrimination policy

UnitedHealthcare members have the right to receive services from the HMO without discrimination due to age, sex, color, race, religion or national origin. We encourage any member who feels unfair discrimination has occurred to file a complaint in accordance with the UnitedHealthcare complaint and appeals procedure. We are committed to making sure our members are treated fairly.

Member rights and responsibilities

Your rights

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

- Get information about UnitedHealthcare, its services, its practitioners and providers and members rights and responsibilities
- Be cared for with respect, dignity and privacy without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation
- Be told where, when and how to get the services you need from UnitedHealthcare Community Plan
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand
- Get a second opinion about your care from an in-network provider, or from out of network at no additional cost if an in-network provider is not available
- Request a copy of the most recent individual direct pay subscriber contract
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval
- Use the UnitedHealthcare Community Plan complaint system to settle any complaints, or you can complain to the NY State Department of Health or the local Department of Social Services any time you feel you were not fairly treated
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment

- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints
- To have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage
- Make recommendations regarding the organization's member rights and responsibilities policy

If you get a bill

UnitedHealthcare Community Plan provides a full range of health care services at no cost to you. You never have to pay your PCP or any other UnitedHealthcare Community Plan participating provider anything. You should not be charged for any approved services offered through UnitedHealthcare Community Plan when you get them from a UnitedHealthcare Community Plan provider.

If you are asked to pay for services by a UnitedHealthcare Community Plan provider, remind the office that you are covered by UnitedHealthcare Community Plan and present your UnitedHealthcare Community Plan Member ID card. You can also call Member Services at **1-800-493-4647**, TTY **711**, for help. You may be asked to pay for services that are not covered by UnitedHealthcare Community Plan. You cannot be charged for any such service unless you understood and agreed before the care was given that you would pay for it.

If you get a medical bill, call UnitedHealthcare Community Plan Member Services at **1-800-493-4647**, TTY **711**, and a representative will help you straighten out the problem. Most bills should include a billing number you can call and give them your UnitedHealthcare Community Plan Member Identification number and ask them to bill UnitedHealthcare Community Plan.

If you are asked to pay for a service and you are not sure whether it is covered, call UnitedHealthcare Community Plan Member Services at 1-800-493-4647, TTY 711, before paying for the service.

If you paid a bill and you are seeking reimbursement, call UnitedHealthcare Community Plan Member Services at **1-800-493-4647**, TTY **711**, and a representative will assist you.

Your responsibilities

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

- Work with your PCP to guard and improve your health
- Find out how your health care system works
- Listen to your PCP's advice and ask questions when you are in doubt
- Call or go back to your PCP if you do not get better, or ask for a second opinion
- Treat health care staff with the respect you expect yourself
- Tell us if you have problems with any health care staff. Call Member Services

- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies
- Call your PCP when you need medical care, even if it is after-hours
- To supply true and complete information that the organization and its practitioners and providers need in order to provide care
- To follow plans and instructions for care that you have agreed to with your practitioner
- To understand health problems and participate in developing mutually agreed-upon treatment goals

Advance Directives

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out.

- First, let family, friends and your doctor know what kinds of treatment you do or don't want
- Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family or others close to you so they will know what you want.
- Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this.

You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

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

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

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

Grievances and appeals

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

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

Your provider can ask for reconsideration

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

You can file a grievance:

- If you receive a denial or we fail to pay for a referral
- If you receive a denial for a non-covered benefit
- You can do this yourself or ask someone you trust to file the grievance for you. You can call Member Services at **1-800-493-4647**, TTY **711**, if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you filed a grievance
- The grievance can be made by phone or in writing. If you make an appeal by phone it must be followed up in writing. You must sign the written grievance that you send to us.
- You can ask someone you trust (such as a legal representative, a family member, or friend) and they can request a grievance for you
- If you need our help because of a hearing or vision impairment, or if you need translation services, or help filling out the forms we can help you
- We will not make things hard for you or take any action against you for filing a grievance

What happens after we get your grievance

Within 15 days, we will send you a letter to let you know we are working on your grievance. The letter will tell you:

- That we received your grievance
- Who is working on your grievance
- How to contact someone at the Health Plan about your grievance
- If we need more information

All grievances are resolved as quickly as possible, and no more than 48 hours after we receive all the necessary information when a delay would significantly increase the risk of your health or within 30 days after receiving all the necessary information regarding referrals or decisions regarding a covered benefit.

You will be notified in writing the reasons for our decision and the process for filing a grievance appeal.

You can file an appeal:

- If you are not satisfied with what we decided about your service authorization request, you have 60 calendar days from the date of our letter/notice to you to file an appeal
- You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at **1-800-493-4647**, TTY **711**, if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you filed an appeal
- The appeal can be made by phone or in writing. If you make an appeal by phone it must be followed up in writing. You must sign the written appeal that you send to us.
- You can ask someone you trust (such as a legal representative, a family member, or friend) and they can request an appeal for you
- If you need our help because of a hearing or vision impairment, or if you need translation services, or help filling out the forms we can help you
- We will not make things hard for you or take any action against you for filing an appeal

Please send all written appeals to:

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

Your action appeal will be reviewed under the Expedited/Fast Track process if:

- If you or your doctor asks to have your action appeal reviewed under the Expedited/Fast Track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for Expedited/Fast Track is denied, we will tell you and your action appeal will be reviewed under the standard process.
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided, or
- If your request was denied when you asked for home health care after you were in the hospital.
- Expedited/Fast Track appeals can be made by phone and do not have to be followed up in writing

What happens after we get your action appeal:

Within 15 days, we will send you a letter to let you know we are working on your appeal. The letter will tell you:

- That we received your appeal
- Who is working on your appeal
- How to contact someone at the Health Plan about your appeal
- If we need more information

Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.

Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision. Before and during the appeal you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.

You can also provide information to be used in making the decision in person or in writing. Call Member Services at **1-800-493-4647**, TTY **711**, if you are not sure what information to give us. If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:

1. A written statement that the service you asked for is different from the service we have in our network; and
2. Two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you, and will not cause you more harm than the service we have in our network.

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

Timeframes for appeals

- **Standard appeals:** If we have all the information we need, we will tell you our decision in thirty (30) days from your action appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.
- **Expedited/fast track appeals:** If we have all the information we need, expedited appeal decisions will be made in 2 working days from your action appeal.
- We will tell you in 3 work days after giving us your action appeal, if we need more information. We will tell you our decision by phone and send a written notice as well.

If we need more information to make either a standard or expedited/fast track decision about your appeal we will:

- Write you and tell you what information is needed. If your request is in an expedited review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-800-493-4647**, TTY **711**, or in writing. Please send written requests to:

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

You or someone you trust can file a complaint if you don't agree with our decision to take more time to review your request. You can file this complaint with the Health Plan by calling Member Services at **1-800-493-4647** (if you have trouble hearing, call the TDD Relay Service at **711**) or with the New York State Department of Health by calling **1-800-206-8125**.

If your original denial was because we said:

- The service was not medically necessary, or
- The service was experimental, or the service was investigational, or
- The out-of-network service was not different from a service that is available in our network, and
- We do not tell you our decision about your appeal on time, the original denial of service will be reversed. This means your service authorization request will be approved.

External appeals

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

- The service is not medically necessary; or
- The service was experimental or investigational; or
- The out-of-network service was not different from a service that is available in our network;

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

Before you appeal to the State:

1. You must file an appeal with the plan and get the plan's final adverse determination; or
2. If you had an expedited appeal and are not satisfied with the plan's decision you can choose to file a standard appeal with the plan or go directly to an external appeal; or
3. You and the plan may agree to skip the plan's appeals process and go directly to external appeal.

You have 45 days after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 45 days of when you made that agreement.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the New York State Department of Financial Services within 45 days from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

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

To ask for an external appeal, fill out an application and send it to the New York State Department of Financial Services. You can call Member Services at **1-800-493-4647**, TTY **711** if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an external appeal application:

- Call the New York State Department of Financial Services at 1-800-400-8882 or its website at **www.dfs.ny.gov**
- Contact the health plan at **1-800-493-4647**, TTY **711**

Your external appeal will be decided in 30 days. More time (up to five (5) work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two (2) days after the decision is made.

If your provider has requested an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as your designee, the provider is prohibited from seeking payment, (except for any applicable co-pay) from you for services determined not to be medically necessary by the external appeal agent.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in three (3) days or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

Complaint process

Complaints

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

How to file a complaint with the plan

If you have a problem please call Member Services at so they can assist you at **1-800-493-4647**, TTY **711**. If after discussing the problem with Member Services, you want to file a complaint, Member Services can help you do so or you can write to us at:

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

You can ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to: New York State, Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Corning Tower ESP, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Insurance Department at 1-800-342-3736 if your complaint involves a billing problem.

What happens next

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

- That we received your complaint
- Who is working on your complaint
- How to contact someone at the Health Plan about your complaint
- If we need more information

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

After we review your complaint

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need
- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know

Complaint appeals

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

How to make a complaint appeal

- If you are not satisfied with what we decide, you have 60 work days from the date of our letter/ notice to you to file an appeal
- You can do this yourself or ask someone you trust to file the appeal for you
- The complaint appeal must be made in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us. Please send all written correspondence to:

  UnitedHealthcare Community Plan
  Quality Management Dept. – Complaint Appeals
  P.O. Box 1037
  New York, NY 10268-1037

What happens after we get your complaint appeal

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

- That we received your complaint
- Who is working on your complaint appeal
- How to contact someone at the Health Plan about your complaint appeal
- If we need more information

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

After we get all the information we need, we will let you know our decision within 2 work days when a delay would risk your health. For all other complaint appeals, we will let you know our decision in 30 days. We will give you the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125; or you can write to the NYS Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Corning Tower ESP, Albany, NY 12237.

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.

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. 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, call Member Services at **1-800-493-4647**, TTY **711**.

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.

United Healthcare Community Plan

Child Health Plus
New York State's Health Plan for Kids

NOTICE OF NON-DISCRIMINATION

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

UnitedHealthcare Community Plan provides the following:

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

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

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

Mail:	Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UTAH 84130
Email:	**UHC_Civil_Rights@uhc.com**

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

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

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at **1-800-493-4647**, TTY **711**, 8 a.m.–6 p.m., Monday–Friday.

LANGUAGE ASSISTANCE

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

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

We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-493-4647**, TTY **711**, 8:00 a.m.–6:00 p.m., Monday–Friday. You can also visit our website at **myuhc.com/CommunityPlan**.

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

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