Virginia

Welcome to the community

Commonwealth of Virginia

Department of Medical Assistance Services

Commonwealth Coordinated Care Plus Program

Effective December 1, 2021

United Healthcare Community Plan

Plus Commonwealth Coordinated Care Plus

CSVA21MC4924583_000

Where to find information

Important phone numbers

Your Care Coordinator . . . . . **1-866-622-7982**, TTY **711**

UnitedHealthcare Community Plan
Member Services . . . . . **1-866-622-7982**, TTY **711**

UnitedHealthcare Community Plan
24/7 Medical/Behavioral Health Advice Line . . . . . **1-866-622-7982**, TTY **711**

UnitedHealthcare Community Plan
24/7 Behavioral Health Crisis Line . . . . . **1-866-622-7982**, TTY **711**

UnitedHealthcare Community Plan
Adult Dental . . . . . **1-866-622-7982**, TTY **711**

UnitedHealthcare Community Plan
NurseLine **1-888-547-3674**

DMAS Dental Benefits Administrator
For questions or to find a dentist in your area,
call the DMAS Dental Benefits Administrator at **1-888-912-3456**
Information is also available on the DMAS website
at **https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/**
or the DentaQuest website at . . . . . **http://www.dentaquestgov.com/**

UnitedHealthcare Community Plan Transportation . . . . . **1-866-622-7982**, TTY **711**

DMAS Transportation Contractor for transportation
to and from DD Waiver Services **1-866-386-8331**
TTY **1-866-288-3133**
Or dial **711** to reach a relay operator

CCC Plus Helpline **1-844-374-9159**
TDD **1-800-817-6608**
or visit the website at . . . . . **cccplusva.com**

CoverVA **1-855-242-8282**
www.coverva.org

Department of Health and Human Services' Office for Civil Rights **1-800-368-1019**
or visit the website at . . . . . **www.hhs.gov/ocr**

Office of the State Long-Term Care Ombudsman **1-800-552-5019**
TTY **1-800-464-9950**

Help in other languages or alternate formats

This handbook is available for free in other languages and formats including online, in large print, Braille or Audio CD. To request the handbook in an alternate format and or language, please call our Member Services staff at **1-866-622-7982**, TTY **711**.

If you have any problems reading or understanding this information, please contact our Member Services staff at **1-866-622-7982**, TTY **711** for help at no cost to you.

We provide reasonable accommodations and communications access to persons with disabilities. Individuals who are deaf or hard of hearing or who are speech-impaired, who want to speak to a Member Services representative, and who have a TTY or other assistive device can dial **711** to reach a relay operator. They will help you reach our Member Services staff.

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Please call **1-866-622-7982, TTY 711.**

Spanish
ATENCIÓN: si habla **español (Spanish)**, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-622-7982, TTY 711.**

Korean
참고: **한국어(Korean)**를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다.
1-866-622-7982, TTY 711 로 전화하십시오.

Vietnamese
LƯU Ý: Nếu quý vị nói Tiếng **Việt (Vietnamese)**, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **1-866-622-7982, TTY 711.**

Chinese
注意：如果您說**中文 (Chinese)**，您可獲得免費語言協助服務。請致電 **1-866-622-7982**，或聽障專線 **(TTY) 711**。

Arabic
تنبيه: إذا كنت تتحدث **العربية (Arabic)**، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم **1-866-622-7982**، الهاتف النصي **711**.

Tagalog
ATENSYON: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-866-622-7982, TTY 711.**

Persian (Farsi)
توجه: اگر به **فارسی (Farsi)** صحبت می کنید، خدمات ترجمه به صورت رایگان در اختیارتان قرار می گیرد. با **1-866-622-7982** (**TTY 711**) تماس بگیرید.

Amharic
አማሪኛ (Amharic) ቋዋንቋ የሚናገሩ ከሆነ የቋንቋ ርዳታ ኣገልግሎት ከክፍያ ነጻ ይገኝሎታል። **1-866-622-7982, TTY 711** ይደዉሉ።

Urdu
اگر آپ **اردو (Urdu)** بولتے/بولتی ہیں، تو آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ کال کریں **1-866-622-7982**، ٹی ٹی وائی **711**.

French
ATTENTION : Si vous parlez **français (French)**, vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-866-622-7982, TTY 711.**

Russian
ВНИМАНИЕ: Если вы говорите по-**русски (Russian)**, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел **1-866-622-7982, TTY 711.**

Hindi
ध्यान दें: यदि आप **हिन्दी (Hindi)** भाषा बोलते हैं तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **1-866-622-7982, TTY 711.**

German
HINWEIS: Wenn Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie: **1-866-622-7982, TTY 711.**

Bengali
আপনি যদি **বাংলায় কথা (Bengali)** বলেন, তাহলে ভাষা সহায়তা পরিষেবাগুলি, আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-866-622-7982, TTY 711** নম্বরে ফোন করুন।

Kru (Bassa)
TÒ ĐÙŬ NƆ̀ MƆ̀ DYÍIN CÁO: À ɓéɖé gbo-kpá-kpá **ɓó wuɖu (Kru (Bassa))**-dù kò-kò po-nyɔ̀ ɓě bìì nɔ̄ à gbo ɓó pídyi. M̀ dyi gbo-kpá-kpá mɔ́ ín, ɖá nɔ̀ ɓà nìà kɛ: **1-866-622-7982, TTY 711**.

Igbo
Ọ bụrụ na ị na asụ **Igbo (Igbo)**, ọrụ enyemaka asụsụ, n'efu dịịrị gị. Kpọọ **1-866-622-7982, TTY 711**.

Yoruba
Tí ó bá ń sọ **Yorùbá (Yoruba)**, ìrànlọ́wọ́ ìtumò èdè, wá fún ọ ní ọ̀fẹ́. Pe **1-866-622-7982, TTY 711**.

1. Commonwealth Coordinated Care Plus (CCC Plus)

Welcome to UnitedHealthcare Community Plan

Thank you for being a Member of UnitedHealthcare Community Plan, a Commonwealth Coordinated Care Plus (CCC Plus) plan. If you are a new Member, we will get in touch with you in the next few weeks to go over some very important information with you. You can ask us any questions you have, or get help making appointments. If you need to speak with us right away or before we contact you, call us at the number listed below.

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

We're ready to answer any questions you may have. Just call Member Services at **1-866-622-7982**, TTY **711**.You can also visit our website at **myuhc.com/CommunityPlan**.

How to use this handbook

This handbook will help you understand your Commonwealth Coordinated Care Plus (CCC Plus) benefits and how you can get help from UnitedHealthcare Community Plan. This handbook is your guide to health services. It explains your health care, behavioral health, prescription drug, and long-term services and supports coverage under the CCC Plus program. It tells you the steps you can take to make your health plan work for you.

Feel free to share this handbook with a family member or someone who knows your health care needs. When you have a question, check this handbook and call Member Services at **1-866-622-7982**, TTY **711**.

Member Services, our website and your Care Coordinator can also provide the latest information related to COVID-19.

Getting started

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

1. **Call your doctor and schedule a checkup**

   Regular checkups are important for good health. If you don't know your Primary Care Provider (PCP) number, or if you need help finding a network doctor near you, call Member Services at **1-866-622-7982**, TTY **711**. We're here to help.

2. **Take your Health Assessment**

   You will soon receive a welcome phone call from us to help you complete a survey about your health. This is also called the initial health screening for new Members. This survey helps us understand your needs so that we can serve you better. You can also fill out the survey online. See page 30 for details.

3. **Get to know your health plan**

   This Member handbook gives you general information about your health care coverage, special programs, and rights and responsibilities. And be sure to keep this booklet handy, for future reference.

4. **Discover your plan online**

   Go to **myuhc.com/CommunityPlan** to sign up for web access to your account. This secure website keeps all of your health information in one place. Take your Health Assessment, find answers to your questions about plan benefits, network doctors and more. In addition to plan details, the site includes useful tools that can help you. You can even print a copy of your Member ID card. Register today.

5. Check your Member ID card

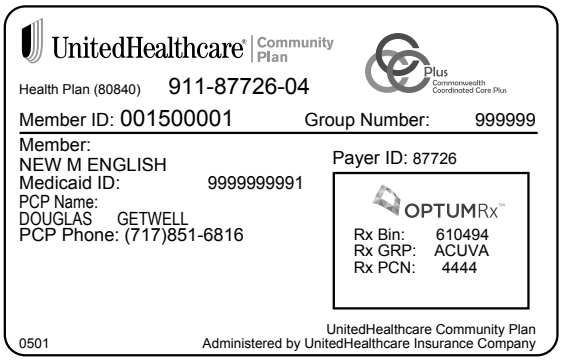
You should have received a Member ID card in the mail. The card has the UnitedHealthcare Community Plan logo on it. You should have a separate ID card for each member of your family who is enrolled with us. If you did not get an ID card, or if the information on it is not correct, call Member Services.

Other information we will send to you

You should have already received your UnitedHealthcare Community Plan Member ID Card, and information on how to access a Provider and Pharmacy Directory, and a List of Covered Drugs.

UnitedHealthcare Community Plan Member ID card

Show your UnitedHealthcare Community Plan ID card when you receive Medicaid services, including when you get long-term services and supports, at doctor visits, and when you pick up prescriptions. You must show this card when you get any services or prescriptions. If you have Medicare and Medicaid, show your Medicare and UnitedHealthcare Community Plan ID card when you receive services. Below is a sample card to show you what yours will look like:


UnitedHealthcare Community Plan

Health Plan (80840) 911-87726-04

Member ID: 001500001 Group Number: 999999

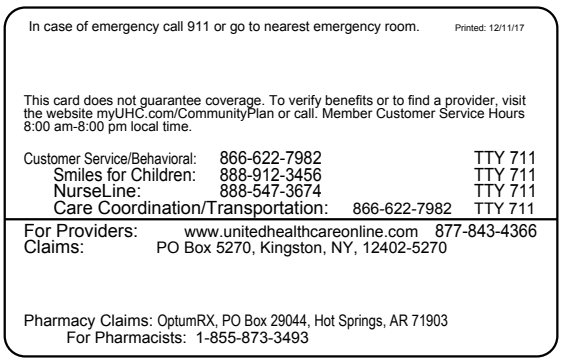
Member:
NEW M ENGLISH
Medicaid ID: 9999999991
PCP Name:
DOUGLAS GETWELL
PCP Phone: (717)851-6816

Payer ID: 87726

OPTUMRx
Rx Bin: 610494
Rx GRP: ACUVA
Rx PCN: 4444

0501

UnitedHealthcare Community Plan
Administered by UnitedHealthcare Insurance Company


In case of emergency call 911 or go to nearest emergency room. Printed: 12/11/17

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myUHC.com/CommunityPlan or call. Member Customer Service Hours 8:00 am-8:00 pm local time.

Customer Service/Behavioral:	866-622-7982	TTY 711
Smiles for Children:	888-912-3456	TTY 711
NurseLine:	888-547-3674	TTY 711
Care Coordination/Transportation:	866-622-7982	TTY 711

For Providers: www.unitedhealthcareonline.com 877-843-4366
Claims: PO Box 5270, Kingston, NY, 12402-5270

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-855-873-3493

If you haven't received your card, or if your card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away, and we will send you a new card.

In addition to your UnitedHealthcare Community Plan ID card, keep your Commonwealth of Virginia Medicaid ID card to access services that are covered by the State, under the Medicaid Fee-for-Service program. These services are described in **Services covered through Medicaid Fee-for-Service**, in Section 11 of this handbook.

Provider and Pharmacy Directory

You can ask for an annual Provider and Pharmacy Directory by calling Member Services at **1-866-622-7982**, TTY **711**. You can also see the Provider and Pharmacy Directory at **myuhc.com/CommunityPlan**.

The **Provider and Pharmacy Directory** provides information on health care professionals (such as doctors, nurse practitioners, psychologists, etc.), facilities (hospitals, clinics, nursing facilities, etc.), support providers (such as adult day health, home health providers, etc.), and pharmacies in the UnitedHealthcare Community Plan network. While you are a Member of our plan, you generally must use one of our network providers and pharmacies to get covered services. There are some exceptions, however, including:

- When you first join our plan (see **Continuity of care period** in Section 3 of this handbook),
- If you have Medicare (see **How to get care from your Primary Care Physician** in Section 6 of this handbook), and
- In several other circumstances (see **How to get care from out-of-network providers** in Section 6 of this handbook).

You can ask for a paper copy of the Provider and **Pharmacy Directory or List of Covered Drugs** by calling Member Services at **1-866-622-7982**, TTY **711**. You can also see the **Provider and Pharmacy Directory and List of Covered Drugs** at **myuhc.com/CommunityPlan** or download it from this website. Refer to **List of covered drugs** in Section 9 of this handbook.

2. What is Commonwealth Coordinated Care Plus

The Commonwealth Coordinated Care Plus (CCC Plus) program is a Medicaid managed care program through the Department of Medical Assistance Services (DMAS). UnitedHealthcare Community Plan was approved by DMAS to provide care coordination and health care services. Our goal is to help you improve your quality of care and quality of life.

What makes you eligible to be a CCC Plus member

You are eligible for CCC Plus when you have full Medicaid benefits, and meet one of the following categories:

- You are age 65 and older
- You are an adult or child with a disability
- You reside in a nursing facility (NF)
- You receive services through the CCC Plus home and community based services waiver (formerly referred to as the Technology Assisted and Elderly or Disabled with Consumer Direction [EDCD] Waivers)
- You receive services through any of the three waivers serving people with developmental disabilities (Building Independence, Family and Individual Supports, and Community Living Waivers), also known as the DD Waivers

Medicaid expansion populations, which includes individuals that meet the following criteria:

- Adults ages nineteen (19) through sixty-four (64),
- Who are not already eligible for Medicare coverage,
- Who are not already eligible for a mandatory coverage group (such as pregnant women or disabled),
- Whose income does not exceed 138% of the Federal Poverty Level (FPL), and

- Who have been identified as Medically Complex through the MCO Member Health Screening as described in Section 5.3.1. (Non-medically complex individuals are covered under the Medallion 4.0 program).

CCC Plus enrollment

Eligible individuals must enroll in the CCC Plus program. DMAS and the CCC Plus Helpline manage the enrollment for the CCC Plus program. To participate in CCC Plus, you must be eligible for Medicaid.

Reasons you would not be eligible to participate in CCC Plus

You would not be able to participate in CCC Plus if any of the following apply to you:

- You lose/lost Medicaid eligibility
- You do not meet one of the eligible categories listed above
- You are enrolled in hospice under the regular Fee-for-Service Medicaid program prior to any CCC Plus benefit assignment
- You enroll in the Medicaid Health Insurance Premium Payment (HIPP) program
- You enroll in PACE (Program of All-Inclusive Care for the Elderly). **For more information about PACE, talk to your Care Coordinator or visit: http://www.pace4you.org/**.
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID)
- You are receiving care in a Psychiatric Residential Treatment Facility (children under age 21)
- You reside in a Veteran's Nursing Facility
- You reside in one of these State long-term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock
- You live on Tangier Island

What if I am pregnant?

If you are within your first ninety (90) days of initial enrollment, and in your 3rd trimester of pregnancy, and your provider is not participating with UnitedHealthcare Community Plan, you may request to move to another MCO where your provider participates.
If your provider does not participate with any of the CCC Plus health plans, you may request to receive coverage through Fee-for-Service Medicaid until after delivery of your baby. Contact the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608** to make this request.

Coverage for newborns born to moms covered under CCC Plus

If you have a baby, you will need to report the birth of your child as quickly as possible to enroll your baby in Medicaid. You can do this by:

- Calling the Cover Virginia Call Center at **833-5CALLVA** (TDD: **1-888-221-1590**) to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child.

You will be asked to provide your information and your baby's:

- Name
- Date of Birth
- Race
- Gender
- The baby's mother's name and Medicaid ID number

When first enrolled in Medicaid, your baby will be able to access health care through the Medicaid Fee-for-Service program. This means that you can take your baby to any provider in the Medicaid Fee-for-Service network for covered services. Look for additional information in the mail about how your baby will receive Medicaid coverage from DMAS.

Medicaid eligibility

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at **833-5CALLVA** (TDD: **1-888-221-1590**) about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at **www.coverva.org**.

Choosing or changing your health plan

Health plan assignment

You received a notice from DMAS that included your initial health plan assignment. With that notice, DMAS included a comparison chart of health plans in your area. The assignment notice provided you with instructions on how to make your health plan selection.

You may have chosen us to be your health plan. If not, DMAS may have assigned you to our health plan based upon your history with us as your managed care plan. For example, you may have been enrolled with us before either through Medicare or Medicaid. You may also have been assigned to us if certain providers you see are in our network. These include nursing facilities, adult day health care, and private duty nursing providers.

You can change your health plan through the CCC Plus Helpline

The CCC Plus Helpline can help you choose the health plan that is best for you. For assistance, call the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608**, or visit the website at **cccplusva.com**. The CCC Plus Helpline is available from 8:30 a.m.–6:00 p.m., Monday–Friday (except on State Holidays). The CCC Plus Helpline can help you understand your health plan choices and answer your questions about which doctors and other providers participate with each health plan. The CCC Plus Helpline services are free and are not connected to any CCC Plus health plan.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between October and December. You will get a letter from DMAS during open enrollment with more information. You may also ask to change your health plan at any time for "good cause," which can include:

- You move out of the health plan's service area,
- You need multiple services provided at the same time but cannot access them within the health plan's network,
- Your residency or employment would be disrupted as a result of your residential, institutional, or employment supports provider changing from an in-network to an out-of-network provider, and
- Other reasons determined by DMAS, including poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care.

The CCC Plus Helpline handles "good cause" requests and can answer any questions you may have. Contact the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608**, or visit the website at **cccplusva.com**.

Automatic re-enrollment

If your enrollment ends with us and you regain eligibility for the CCC Plus program within 60 days or less, you will automatically be reenrolled with UnitedHealthcare Community Plan. You will also be sent a re-enrollment letter from DMAS.

UnitedHealthcare Community Plan's service area

Our service area is statewide. Only people who live in our service area can enroll with UnitedHealthcare Community Plan. If you move outside of our service area, you cannot stay in this plan. If this happens, you will receive a letter from DMAS asking you to choose a new plan. You can also call the CCC Plus Helpline if you have any questions about your health plan enrollment. Contact the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608** or visit the website at **cccplusva.com**.

If you have Medicare and Medicaid

If you have Medicare and Medicaid, some of your services will be covered by your Medicare plan and some will be covered by UnitedHealthcare Community Plan. We are your CCC Plus Medicaid Plan.

Types of services under Medicare	Types of services under CCC Plus (Medicaid)
• Inpatient Hospital Care (Medical and Psychiatric) • Outpatient Care (Medical and Psychiatric) • Physician and Specialists Services • X-Ray, Lab Work and Diagnostic Tests • Skilled Nursing Facility Care • Home Health Care • Hospice Care • Prescription Drugs • Durable Medical Equipment • **For more information, contact your Medicare Plan, visit Medicare.gov, or call Medicare at 1-800-633-4227**	• Medicare Copayments • Hospital and Skilled Nursing when Medicare Benefits are Exhausted • Long-Term Nursing Facility Care (Custodial) • Home and Community Based Waiver Services, like personal care and respite care, environmental modifications, and assistive technology services • Community-Based Behavioral Health Services • Medicare Non-Covered Services, like some over-the-counter medicines, medical equipment and supplies, and incontinence products

You can choose the same health plan for Medicare and Medicaid

You have the option to choose the same health plan for your Medicare and CCC Plus Medicaid coverage. The Medicare plan is referred to as a **Dual Special Needs Plan (D-SNP)**. Having the same health plan for Medicare and Medicaid will enhance and simplify the coordination of your Medicare and Medicaid benefits. There are benefits to you if you are covered by the same health plan for Medicare and Medicaid. Some of these benefits include:

- You receive better coordination of care through the same health plan
- You have one health plan and one number to call for questions about all of your benefits
- You work with the same Care Coordinator for Medicare and Medicaid. This person will work with you and your providers to make sure you get the care you need.

If you choose Medicare Fee-for-Service or a Medicare plan other than our Medicare D-SNP plan, we will work with your Medicare plan to coordinate your benefits.

How to contact the Medicare State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP). You can contact the Virginia Insurance Counseling Assistance Program if you need assistance with your **Medicare health insurance options**. VICAP can help you understand your Medicare plan choices and answer your questions about changing to a new Medicare plan. VICAP is an independent program that is free and not connected to any CCC Plus health plans.

Call	**1-800-552-3402**. This call is free.
TTY	TTY users dial **711**.
Write	Virginia Insurance Counseling and Assistance Program 1610 Forest Avenue, Suite 100 Henrico, Virginia 23229
Email	aging@dars.virginia.gov
Website	https://www.vda.virginia.gov/vicap.htm

3. How CCC Plus works

UnitedHealthcare Community Plan contracts with doctors, specialists, hospitals, pharmacies, providers of long-term services and supports, and other providers. These providers make up our provider network. You will also have a Care Coordinator. Your Care Coordinator will work closely with you and your providers to understand and meet your needs. Your Care Coordinator will also provide you with information about your covered services and the choices that are available to you. Refer to **Your Care Coordinator** in Section 4 of this handbook.

What are the advantages of CCC Plus

CCC Plus provides person-centered supports and coordination to meet your individual needs. Some of the advantages of CCC Plus include:

- You will have a care team that you help put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a Care Coordinator. Your Care Coordinator will work with you and with your providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and Care Coordinator
- Your care team and Care Coordinator will work with you to come up with a care plan specifically designed to meet your health and/or long-term support needs. Your care team will be in charge of coordinating the services you need. This means, for example:
  - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects
  - Your care team will make sure your test results are shared with all your doctors and other providers so they can be kept informed of your health status and needs

- Treatment choices that include preventive, rehabilitative, and community-based care
- An on-call nurse or other licensed staff is available 24 hours per day, 7 days per week to answer your questions. We are here to help you. You can reach us by calling the number at the bottom of this page. Also refer to **Medical Advice Line available 24 hours a day, 7 days a week** in Section 5 of this handbook.

What are the advantages of choosing UnitedHealthcare Community Plan

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

For additional benefits and services offered by UnitedHealthcare Community Plan, please see page 71 of this handbook.

Remember, answers to any questions you have are just a click away at **myuhc.com/CommunityPlan**.

Or, you can call Member Services at **1-866-622-7982**, TTY **711**.

Our Member Services staff can:

- Explain your covered services
- Assist you with claims and billing issues
- Replace identification cards
- Make changes in your address or telephone number
- Listen and help you with a problem
- Describe our quality benefit enhancements
- Provide our quality performance ratings (including pay incentives, if applicable), quality enhancements, Member satisfaction survey results, structure and operation of the Health Plan

Transition of care policy: Continuity of care period

The continuity of care period is 30 days. If UnitedHealthcare Community Plan is new for you, you can keep seeing the doctors you go to now for the first 30 days. You can also keep getting your authorized services for the duration of the authorization or for 30 days after you first enroll, whichever is sooner. After 30 days in our plan, you will need to see doctors and other providers in the UnitedHealthcare Community Plan network. A network provider is a provider who contracts and works with our health plan. You can call your Care Coordinator or Member Services for help finding a network provider. Your new provider can get a copy of your medical records from your previous provider, if needed.

If you are in a nursing facility at the start of the CCC Plus Program, you may choose to:

- Remain in the facility as long as you continue to meet the Virginia DMAS' criteria for nursing facility care,
- Move to a different nursing facility, or
- Receive services in your home or other community based setting.

The continuity of care period may be longer than 30 days. UnitedHealthcare Community Plan may extend this time frame until the health risk assessment is completed. UnitedHealthcare Community Plan will also extend this time frame for you to have a safe and effective transition to a qualified provider within our network. Talk to your Care Coordinator if you want to learn more about these options.

If you have other coverage

Medicaid is the payer of last resort. This means that if you have another insurance, are in a car accident, or if you are injured at work, your other insurance or Workers' Compensation has to pay first.

We have the right and responsibility to collect payment for covered Medicaid services when Medicaid is not the first payer. We will not attempt to collect any payment directly from you. Contact Member Services if you have other insurance so that we can best coordinate your benefits. Your Care Coordinator will also work with you and your other health plan to coordinate your services.

4. Your Care Coordinator

You have a dedicated Care Coordinator who can help you to understand your covered services and how to access these services when needed. Your Care Coordinator will also help you to work with your doctor and other health care professionals (such as nurses and physical therapists), to provide a health risk assessment, and develop a care plan that considers your needs and preferences. We provide more information about the **health risk assessment** and the **care plan** below.

How your Care Coordinator can help

Your Care Coordinator can:

- Answer questions about your health care
- Provide assistance with appointment scheduling
- Answer questions about getting any of the services you need. For example: mental health services, transportation, and long-term services and supports (LTSS).
  - Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and facilitate maximum independence. Examples include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as meal preparation, laundry, and shopping. LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities.
- Help with arranging transportation to your appointments when necessary. If you need a ride to receive a Medicaid covered service and cannot get there, non-emergency transportation is covered. Just call ModivCare at **1-844-604-2078** (toll-free) or call your Care Coordinator for assistance.

Transportation contacts

Name	Contact information	Details
Transportation	**ModivCare: 844-604-2078**	Call to schedule transportation or for transportation assistance. For non-urgent appointments, members must call for transportation at least five (5) business days before their appointment. Urgent Trips can be scheduled the same day. Urgent Trips are defined as an unscheduled, same day transportation request in which there is no immediate threat to life or limb but the member must be seen on the day of the request and treatment cannot be delayed until the next day, e.g., hospital or ED discharges, follow-up appointments scheduled less than 5 days after the last appointment; unexpected pre-operative appointments; hospital discharges; appointments for new medical conditions or tests when the member must be seen; and, dialysis.

- Answer questions you may have about your daily health care and living needs including these services:
  - Skilled nursing care
  - Physical therapy
  - Occupational therapy
  - Speech therapy
  - Home health care
  - Personal care services
  - Mental health services
  - Services to treat addiction
  - Other services that you need

What is a Health Screening

Within three months after you enroll with UnitedHealthcare Community Plan, an UnitedHealthcare Community Plan representative will contact you or your authorized representative via telephone, mail or in person to ask you some questions about your health and social needs. These questions will make up what is called the "Health Screening." The representative will ask about any medical conditions you currently have or have had in the past, your ability to do everyday things, and your living conditions.

Your answers will help UnitedHealthcare Community Plan understand your needs, identify whether or not you have medically complex needs, and to determine when your Health Risk Assessment is required. UnitedHealthcare Community Plan will use your answers to develop your Care Plan (for more information on your Care Plan, see below).

Please contact UnitedHealthcare Community Plan if you need accommodations to participate in the health screening.

If you have questions about the health screening, please contact Member Services at **1-866-622-7982**, TTY **711**. This call is free.

What is a Health Risk Assessment

After you enroll with UnitedHealthcare Community Plan, your Care Coordinator will meet with you to ask you some questions about your health, needs and choices. Your Care Coordinator will talk with you about any medical, behavioral, physical, and social service needs that you may have. This meeting may be in-person or by phone and is known as a health risk assessment (HRA). A HRA is a complete, detailed assessment of your medical, behavioral, social, emotional, and functional status. The HRA is typically completed by your Care Coordinator. This health risk assessment will enable your Care Coordinator to understand your needs and help you get the care that you need.

What is a care plan

A care plan includes the types of health services that are needed and how you will get them. It is based on your health risk assessment. After you and your Care Coordinator complete your health risk assessment, your care team will meet with you to talk about what health and/or long-term services and supports you need and want as well as your goals and preferences. Together, you and your care team will make a personalized care plan, specific to your needs. **(This is also referred to as a person-centered care plan.)** Your care team will work with you to update your care plan when the health services you need or choose change, and at least once per year.

How to contact your Care Coordinator

Call	**1-866-622-7982**. This call is free. 8:00 a.m.–8:00 p.m., daily. We have free interpreter services for people who do not speak English.
TTY	TTY **711**. This call is free. 8:00 a.m.–8:00 p.m., daily. We have free interpreter services for people who do not speak English.

5. Help from Member Services

Our Member Services Staff are available to help you if you have any questions about your benefits, services or procedures or have a concern about UnitedHealthcare Community Plan. When you call Member Services, you will be connected with a trained Advocate. They will help you get the most from your health plan. For example, your Advocate will answer your questions, resolve issues, help set up doctor appointments, and directly connect you with services available to you.

Call **1-866-622-7982**, TTY **711**, 8:00 a.m.–8:00 p.m., daily.

How to contact UnitedHealthcare Community Plan Member Services

Call	**1-866-622-7982**. This call is free. 8:00 a.m.–8:00 p.m., daily. We have free interpreter services for people who do not speak English.
TTY	TTY **711**. This call is free.
Write	UnitedHealthcare Community Plan 9020 Stony Point Parkway, Suite 400 Richmond, VA 23235
Website	myuhc.com/CommunityPlan

How Member Services can help

Member Services can:

- Answer questions you have about UnitedHealthcare Community Plan
- Answer questions you have about claims, billing or your Member ID Card
- Help you find a doctor or see if a doctor is in UnitedHealthcare Community Plan's network
- Help you change your Primary Care Physician (PCP)
- Provide information on coverage decisions about your health care services (including medications)
- A coverage decision about your health care is a decision about:
  - Your benefits and covered services, or
  - The amount we will pay for your health services.
- Provide information on how you can submit an appeal about a coverage decision on your health care services (including medications). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake. (See **Your right to appeal** in Section 15 of this handbook.)
- Grievances about your health care services (including medications). You can file a grievance about us or any provider (including a non-network or network provider). A network provider is a provider who contracts and works with the health plan. You can also file a grievance about the quality of the care you received to us or to the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608**. (See **Your right to file a grievance** in Section 15 of this handbook.)

Medical advice line available 24 hours a day, 7 days a week

If you are unable reach your Care Coordinator, you can reach a nurse or behavioral health professional 24 hours a day, 7 days a week to answer your questions toll-free at **1-888-547-3674**, TTY **711**.

When you are sick or injured, it can be hard to make health care decisions. You may not know if you should go to the emergency room, visit an urgent care center, make a doctor appointment or use self-care.

A NurseLine nurse can give you information to help you decide. Nurses can provide information and support for many health situations and concerns, including:

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

You may just be curious about a health issue and want to learn more. Experienced registered nurses can provide you with information, support and education for any health-related question or concern. Simply call the toll-free number **1-888-547-3674** or TTY **711** for the hearing impaired.

You can call the toll-free number anytime, 24 hours a day, 7 days a week. And, there's no limit to the number of times you can call.

Please remember the NurseLine does not take the place of your PCP. Always follow up with your PCP if you have questions about your health care.

Call	**1-888-547-3674**. This call is free. Available 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	TTY **711**. This call is free.

Behavioral health crisis line available 24 hours a day, 7 days a week

Contact UnitedHealthcare Community Plan if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call **1-866-622-7982**, TTY **711**. If you have thoughts about harming yourself or someone else, you should:

- Get help right away by calling **911**
- Go to the closest hospital for emergency care

Call	**1-866-622-7982**. This call is free. Available 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	TTY **711**. This call is free.

Addiction and Recovery Treatment Services (ARTS) advice line available 24 hours a day, 7 days a week

If you are unable reach your Care Coordinator, you can reach an ARTS health professional 24 hours a day, 7 days a week to answer your questions at: **1-866-622-7982**, TTY **711**. The call is free.

Call	**1-866-622-7982**. This call is free. Available 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	TTY **711**. This call is free.

If you do not speak English

We can provide you with translation services. UnitedHealthcare Community Plan Member Services has employees who speak your language and we are able to access interpreter services. We also have written information in many languages for our Members. Currently, written materials are available in English and Spanish. If you need interpretation, please call Member Services (at no charge) at **1-866-622-7982**, TTY **711**, and request to speak to an interpreter or request written materials in your language.

If you have a disability and need assistance in understanding information or working with your Care Coordinator

We provide reasonable accommodations to people with disabilities in compliance with the Americans with Disabilities Act. This includes but is not limited to accessible communications (such as a qualified sign language interpreter), braille or large print materials, etc. If you need a reasonable accommodation, please call Member Services (at no charge) at **1-866-622-7982**, TTY **711**, to ask for the help you need.

If you have questions about your Medicaid eligibility

If you have questions about your Medicaid eligibility, contact your Medicaid eligibility worker at the Department of Social Services in the city or county where you live. If you have questions about the services you get under UnitedHealthcare Community Plan, call Member Services at **1-866-622-7982**, TTY **711**.

6. How to get care and services

How to get care from your Primary Care Physician

Your Primary Care Physician

A Primary Care Physician (PCP) is a doctor selected by you who meets state requirements and is trained to give you basic medical care. You will usually see your PCP for most of your routine health care needs. Your PCP will work with you and your Care Coordinator to coordinate most of the services you get as a Member of our plan. Coordinating your services or supplies includes checking or consulting with other plan providers about your care. If you need to see a doctor other than your PCP, you may need a referral (authorization) from your PCP. You may also need to get approval in advance from your PCP before receiving certain types of covered services or supplies. In some cases, your PCP will need to get authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Contact Member Services or your Care Coordinator with any questions you have about getting your medical records transferred to your PCP or about your care and services.

Choosing your PCP

New Members have the right to choose a PCP in our network soon after joining UnitedHealthcare Community Plan by calling Member Services at **1-866-622-7982**, TTY **711**. If you do not already have a PCP you must request one prior to the 25th day of the month before your effective enrollment date, or else UnitedHealthcare Community Plan may assign you a PCP. You have the right to change your PCP at any time by calling Member Services at the number listed at the bottom of this page.

If you do not have a PCP in our network, we can help you find a highly-qualified PCP in your community. For help locating a provider, you can use our online provider directory at **myuhc.com/CommunityPlan**. The provider directory includes a list of all of the doctors, clinics, hospitals, labs, specialists, long-term services and supports providers, and other providers who work with UnitedHealthcare Community Plan. The directory also includes information on the accommodations each provider has for individuals who have disabilities or who do not speak English. We can also provide you with a paper copy of the provider directory. You can also call Member Services at the number on the bottom of this page or call your Care Coordinator for assistance.

You may want to find a doctor:

- Who knows you and understands your health condition,
- Who is taking new patients,
- Who can speak your language, or
- Who has appropriate accommodations for people with physical or other disabilities.

If you have a disability or a chronic illness, you can ask us if your specialist can be your PCP. We also contract with Federally Qualified Health Centers (FQHCs) that provide primary and specialty care. Another clinic can also act as your PCP if the clinic is a network provider.

Women can also choose an OB/GYN for women's health issues. These include routine checkups, follow-up care if there is a problem, and regular care during a pregnancy. Women do not need a PCP referral to see an OB/GYN provider in our network.

If you have Medicare, tell us about your PCP

If you have Medicare, you do not have to choose a PCP in UnitedHealthcare Community Plan's network. Simply call Member Services or your Care Coordinator to let us know the name and contact information for your PCP. We will coordinate your care with your Medicare assigned PCP.

If your current PCP is not in our network

If you do not have Medicare, you need to choose a PCP that is in UnitedHealthcare Community Plan's network. You can continue to see your current PCP during the continuity of care period even if they are not in the UnitedHealthcare Community Plan's network. The continuity of care period is 30 days. Your Care Coordinator can help you find a PCP in our network. At the end of the continuity of care period, if you do not choose a PCP in the UnitedHealthcare Community Plan network, we will assign a PCP to you.

Changing your PCP

You may call Member Services to change your PCP at any time to another PCP in our network. When you change your PCP, we will send you a new Member ID Card. The PCP is effective immediately. Also, it is possible that your PCP might leave our network. We will tell you within 15 days from when we know about this. We can help you find a new PCP. Call Member Services at **1-866-622-7982**, TTY **711**.

Getting an appointment with your PCP

Your PCP will take care of most of your health care needs. Call your PCP to make an appointment. If you need care before your first appointment, call your PCP's office to ask for an earlier appointment. If you need help making an appointment, call Member Services at the number below.

Appointment standards

You should be able to get an appointment with your PCP within the same amount of time as any other patient seen by the PCP. Expect the following times to see a provider:

- For an emergency — Immediately
- For urgent care and office visits with symptoms — Within 24 hours of request
- For routine primary care visit — Within 30 calendar days

If you are pregnant, you should be able to make an appointment to see an OB/GYN as follows:

- First trimester (first 3 months) — Within fourteen (14) calendar days of request
- Second trimester (3 to 6 months) — Within seven (7) calendar days of request
- Third trimester (6 to 9 months) — Within five (5) business days of request
- High Risk Pregnancy — Within three (3) business days or immediately if an emergency exists

If you are unable to receive an appointment within the times listed above, call Member Services at the number below and they will help you get the appointment.

How to get care from network providers

Our provider network includes access to care 24 hours a day, 7 days per week and includes hospitals, doctors, specialists, urgent care facilities, nursing facilities, home and community based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health and hospice providers, durable medical equipment providers, and other types of providers. UnitedHealthcare Community Plan provides you with a choice of providers and they are located so that you do not have to travel very far to see them. There may be special circumstances where longer travel time is required; however, that should be only on rare occasions.

Travel time and distance standards

UnitedHealthcare Community Plan will provide you with the services you need within the travel time and distance standards described in the table below. These standards apply for services that you travel to in order to receive care from network providers. These standards do not apply to providers who provide services to you at home. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, in the Roanoke/Alleghany Region, or the Southwest Region, you should not have to travel more than 60 miles or 75 minutes to receive services.

Member travel time and distance standards		
Standard	**Distance**	**Time**
Urban • PCPs • Specialists and other providers	 15 miles 30 miles	 30 minutes 45 minutes
Rural • PCPs • Specialists and other providers	 30 miles 60 miles	 45 minutes 75 minutes
Roanoke/Alleghany and Southwest Regions		
Urban and Rural • PCPs • Specialists and other providers	 30 miles 60 miles	 45 minutes 75 minutes

Accessibility

UnitedHealthcare Community Plan wants to make sure that all providers and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. If you have difficulty getting an appointment with a provider, or accessing services because of a disability, contact Member Services at **1-866-622-7982**, TTY **711** for assistance.

Telehealth visits

UnitedHealthcare offers members options for telehealth visits with local providers or by using UnitedHealthcare's preferred telehealth partners. For benefits coverage information, please sign in to your health plan account. Let's go over some of the basics about telehealth and how it works.

Telehealth visits

Talk to a health care provider by phone or video.

What does telehealth mean exactly? It may be a term you're hearing more often lately. That's because telehealth services have expanded recently, to offer more people ways to connect with a health care provider from home or at work. With telehealth, you use digital technologies, like your smartphone or computer, to talk with a provider. You can get treatment options and even prescriptions for medications, if needed.

How do telehealth visits work?

Telehealth doesn't require special equipment, and it can be easy to get started. If connecting with a local provider, you can talk to your provider by phone first and ask questions before you start your visit, so you're prepared when it's time to start your appointment. Want to get a picture of how a visit might go?

Telehealth for COVID-19 testing-related visits

For COVID-19 testing-related visits, a telehealth visit may be a preferred way to connect with your provider. UnitedHealthcare is committed to helping you get the care you need from home or work through telehealth visits during this time.

Telehealth visits for mental health

If you need care for mental health issues, local healthcare providers may be able provide a telehealth visit. Coverage may depend on your health plan benefits, so sign in to your health plan account or call the number on your member ID card first to learn what benefits may be available to you.

Emotional support by phone or mobile app

Some emotional support programs may be included with certain health plans. Sign in to your health plan account to learn if the following benefits may be available with your health plan.

An on-demand emotional support mobile app may be available to help you cope with stress, anxiety and depression. With online therapy, you can regularly communicate with a therapist, safely and securely from your phone or desktop. No office visit required. This method is convenient, safe and secure.

The following are 3 steps to help with getting the most out of your telehealth visit:

1. Get yourself ready

Take a few minutes before your telehealth visit to prepare.

Quiet space: Choose a quiet area to avoid interruptions from family and pets.

Good lighting: Position yourself in a well-lit room and try to avoid windows in the background that can cause glare.

Comfortable spot: Find a place to settle in for your visit, like sitting at the kitchen table or in a comfy living room chair.

2. Get your information ready

It's a good idea to have your questions and information on hand.

Questions: Jot down questions about symptoms, procedures or prescriptions.

Medications: List your prescriptions, over-the-counter medications, plus vitamins and supplements, along with your pharmacy name and address.

Insurance: Keep your UnitedHealthcare member ID card handy for easy access.

3. Get your tech ready

To ensure a smooth experience, take a few minutes to check your tech.

Connect: Test your internet signal to ensure it's strong.

Charge: Plug in or charge up your selected device — smartphone, laptop or tablet.

Position: Steady your camera by propping it up in front of you instead of holding the device.

Access: Follow any special instructions from your provider, like downloading an app or setting up an account.

Provider incentive plan

You are entitled to ask if we have special financial arrangements with our providers that can affect the use of referrals and other services you might need. To get this information, call Member Services at **1-866-622-7982** or TTY **711** for the hearing impaired and request information about our provider payment arrangements.

What are "network providers"?

UnitedHealthcare Community Plan's network providers include:

- Doctors, nurses, and other health care professionals that you can go to as a Member of our plan
- Clinics, hospitals, nursing facilities, and other places that provide health services in our plan
- Early intervention providers, home health agencies and durable medical equipment suppliers
- Long-term services and supports (LTSS) providers including nursing facilities, hospice, adult day health care, personal care, respite care, and other LTSS providers

Network providers have agreed to accept payment from our plan for covered services as payment in full.

Learn more about network doctors

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

What are "network pharmacies"?

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our Members. Use the Provider and Pharmacy Directory to find the network pharmacy you want to use.

Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them. Call Member Services at the number at the bottom of the page for more information. Both Member Services and UnitedHealthcare Community Plan's website can give you the most up-to-date information about changes in our network pharmacies and providers.

You can find a list of network pharmacies in the Provider Directory online at **myuhc.com/CommunityPlan**, or you can call Member Services at **1-866-622-7982**, TTY **711**.

What are specialists?

If you need care that your PCP cannot provide, your PCP may refer you to a specialist. Most of the specialists are in UnitedHealthcare Community Plan's network. A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- **Oncologists** care for patients with cancer
- **Cardiologists** care for patients with heart problems
- **Orthopedists** care for patients with bone, joint, or muscle problems

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 (known as a standing referral). If you have a standing referral, you will not need a new referral each time you need care. If you have a disabling condition or chronic illnesses, you can ask us if your specialist can be your PCP.

If your provider leaves our plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers
- When possible, we will give you at least 15 days' notice so that you have time to select a new provider
- We will help you select a new qualified provider to continue managing your health care needs
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a grievance or request a new provider
- If you find out one of your providers is leaving our plan, please contact your Care Coordinator so we can assist you in finding a new provider and managing your care

How to get care from out-of-network providers

If we do not have a specialist in the UnitedHealthcare Community Plan network to provide the care you need, we will get you the care you need from a specialist outside of the UnitedHealthcare Community Plan network. We will also get you care outside of the UnitedHealthcare Community Plan network in any of the following circumstances:

- When UnitedHealthcare Community Plan has approved a doctor out of its established network;
- When emergency and family planning services are rendered to you by an out-of-network provider or facility;
- When you receive emergency treatment by providers not in the network;
- When the needed medical services are not available in UnitedHealthcare Community Plan's network;
- When UnitedHealthcare Community Plan cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas;
- When the type of provider needed and available in UnitedHealthcare Community Plan's network does not, because of moral or religious objections, furnish the service you need;
- Within the first 30 days of your enrollment, when your provider is not part of UnitedHealthcare Community Plan network but has treated you in the past; and
- If you are in a nursing facility when you enroll with UnitedHealthcare Community Plan, and the nursing facility is not in UnitedHealthcare Community Plan's network.

If your PCP or UnitedHealthcare Community Plan refer you to a provider outside of our network, you are not responsible for any of the costs, except for your **patient pay** towards long-term services and supports. See Section 13 of this handbook for information about what a **patient pay** is and how to know if you have one.

Care from out-of-state providers

UnitedHealthcare Community Plan is not responsible for services you obtain outside Virginia except under the following circumstances:

- Necessary emergency or post-stabilization services;
- Where it is a general practice for those living in your locality to use medical resources in another State; and
- The required services are medically necessary and not available in-network and within the Commonwealth of Virginia.

Network providers cannot bill you directly

Network providers must always bill UnitedHealthcare Community Plan. Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us; this is known as "balanced billing." This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.

If you receive a bill for covered services

If you are billed for any of the services covered by our plan, you should not pay the bill. If you do pay the bill, UnitedHealthcare Community Plan may not be able to pay you back.

Whenever you get a bill from a network provider or for services that are covered outside of the network (example emergency or family planning services), send us the bill. We will contact the provider directly and take care of the bill for covered services.

If you receive care from providers outside of the United States

Our plan does not cover any care that you get outside the United States.

7. How to get care for emergencies

What is an emergency

You are always covered for emergencies. An emergency is a sudden or unexpected illness, severe pain, accident or injury that could cause serious injury or death if it is not treated immediately.

What to do in an emergency

Call 911 at once! You do not need an authorization or a referral for emergency services. You do not need to call UnitedHealthcare Community Plan first. Go to the closest hospital. Calling **911** will help you get to a hospital. You can use any hospital for emergency care, even if you are in another city or state. If you are helping someone else, try to stay calm.

Tell the hospital that you are a UnitedHealthcare Community Plan Member. Ask them to call UnitedHealthcare Community Plan at the number on the back of your CCC Plus ID Card.

What is a medical emergency

This is when a person thinks he or she must act quickly to prevent serious health problems. It includes symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you believe that it could cause:

- Serious risk to your health; or
- Serious harm to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

- In the case of a pregnant woman in active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer you to another hospital before delivery, or
  - The transfer may pose a threat to your health or safety or to that of your unborn child.

What is a behavioral health emergency

A behavioral health emergency is when a person thinks about or fears they might hurt themselves or hurt someone else.

Examples of non-emergencies

Examples of non-emergencies are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. If you are not sure, call your PCP or the UnitedHealthcare Community Plan 24/7 medical advice line at **1-866-622-7982**, TTY **711**.

If you have an emergency when away from home

You or a family member may have a medical or a behavioral health emergency away from home. You may be visiting someone outside Virginia. While traveling, your symptoms may suddenly get worse. If this happens, go to the closest hospital emergency room. You can use any hospital for emergency care. Show them your UnitedHealthcare Community Plan card. Tell them you are in UnitedHealthcare Community Plan's program.

What is covered if you have an emergency

You may receive covered emergency care whenever you need it, anywhere in the United States. If you need an ambulance to get to the emergency room, our plan covers the ambulance transportation. If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is complete.

Notifying UnitedHealthcare Community Plan about your emergency

Notify your doctor and UnitedHealthcare Community Plan as soon as possible about the emergency within 48 hours if you can. However, you will not have to pay for emergency services because of a delay in telling us. We need to follow up on your emergency care. Your Care Coordinator will assist you in getting the correct services in place before you are dis-charged to ensure that you get the best care possible. Please call **1-866-622-7982**, TTY **711**.

This number is also listed on the back of your UnitedHealthcare Community Plan Member ID Card.

After an emergency

UnitedHealthcare Community Plan will provide necessary follow-up care, including through out-of-network providers if necessary, until your physician says that your condition is stable enough for you to transfer to an in-network provider, or for you to be discharged. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible after your physician says you are stable. You may also need follow-up care to be sure you get better. Your follow-up care will be covered by our plan.

Hospital services

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

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

Inpatient services require you to stay overnight at the hospital. These can include serious illness, surgery or having a baby. Inpatient services require you to be admitted (called a hospital admission) to the hospital. The hospital will contact UnitedHealthcare Community Plan and ask for authorization for your care. If the doctor who admits you to the hospital is not your PCP, you should call your PCP and let them know you are being admitted to the hospital.

If you are hospitalized

If you are hospitalized, a family member or a friend should contact UnitedHealthcare Community Plan as soon as possible. By keeping UnitedHealthcare Community Plan informed, your Care Coordinator can work with the hospital team to organize the right care and services for you before you are discharged. Your Care Coordinator will also keep your medical team, including your home care services providers, informed of your hospital and discharge plans.

If it wasn't a medical emergency

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care, and the doctor may say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care. However, after the doctor says it was not an emergency, we will cover your additional care only if you follow the **General coverage rules** described in Section 10 of this handbook.

8. How to get urgently needed care

What is urgently needed care

Urgently needed care is care you get for a non-life-threatening, sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have an existing condition that worsens and you need to have it treated right away. Other examples of urgently needed care include sprains, strains, skin rashes, infection, fever, flu, etc. In most situations, we will cover urgently needed care only if you get this care from a network provider. However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

You can find a list of urgent care centers we work with in our Provider and Pharmacy Directory, available on our website at **myuhc.com/CommunityPlan**.

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

9. How to get your prescription drugs

This Section explains rules for getting your **outpatient prescription drugs**. These are drugs that your provider orders for you that you get from a pharmacy or drug store.

Rules for UnitedHealthcare Community Plan's outpatient drug coverage

UnitedHealthcare Community Plan will usually cover your drugs as long as you follow the rules in this Section.

1. You must have a doctor or other authorized provider write your prescription. This person often is your primary care physician (PCP). It could also be another provider if your primary care physician has referred you for care. Prescriptions for controlled substances must be written by an in network doctor or provider.
2. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on UnitedHealthcare Community Plan's List of Covered Drugs. If it is not on the List of Covered Drugs, we may be able to cover it by giving you a service authorization.
4. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical reference books.
5. If you have Medicare, most of your drugs are covered through your Medicare carrier. We cannot pay for any drugs that are covered under Medicare Part D, including copayments.
6. UnitedHealthcare Community Plan can provide coverage for coinsurance and deductibles on Medicare Part A and B drugs. These include some drugs given to you while you are in a hospital or nursing facility.

Getting your prescriptions filled

In most cases, UnitedHealthcare Community Plan will pay for prescriptions only if they are filled at UnitedHealthcare Community Plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our Members. You may go to any of our network pharmacies.

To find a network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services at the number at the bottom of the page or your Care Coordinator.

To fill your prescription, show your Member ID Card at your network pharmacy. If you have Medicare, show your Medicare Part D and UnitedHealthcare Community Plan ID cards. The network pharmacy will bill UnitedHealthcare Community Plan for the cost of your covered prescription drug. If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call UnitedHealthcare Community Plan to get the necessary information.

If you need help getting a prescription filled, you can contact Member Services at **1-866-622-7982**, TTY **711** or call your Care Coordinator.

Preferred Drug List (PDL)

Your 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 you need 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.

You can start using your pharmacy benefit right away

Your 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 you need 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 medicines included on the Preferred Drug List?

Yes

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

No

If your prescriptions are not on the Preferred Drug List, 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 you need a brand-name medicine that is not on the list and is medically necessary.

Not sure

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

2. Do you have a prescription?

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

3. Do you need to refill a drug that's not on the Preferred Drug List?

If you need refills of medicines that are not on the Preferred Drug List, you can get a temporary 5-day supply. To do so, visit a network pharmacy and show your Member ID card. If you don't have your Member ID card, you can show the pharmacist the information below. Talk to your doctor about your prescription options.

Attention Pharmacist

Please process this UnitedHealthcare Member's claim using:

BIN: 610494

Processor Control Number: 4444

Group: ACUVA

Copays

There are no copays for drugs.

List of covered drugs

UnitedHealthcare Community Plan has a List of Covered Drugs that are selected by UnitedHealthcare Community Plan with the help of a team of doctors and pharmacists. The UnitedHealthcare Community Plan List of Covered Drugs also includes all of the drugs on the DMAS Preferred Drug List (PDL). The List of Covered Drugs can be found at **myuhc.com/CommunityPlan**. The List of Covered Drugs tells you which drugs are covered by UnitedHealthcare Community Plan and also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get.

You can call Member Services to find out if your drugs are on the List of Covered Drugs or check online at myuhc.com/CommunityPlan. **If you would like a printed copy mailed to you, please call Member Services.**

The List of Covered Drugs may change during the year. To get the most up-to-date List of Covered Drugs, visit myuhc.com/CommunityPlan or call **1-866-622-7982**, TTY **711**, 8:00 a.m.–8:00 p.m., daily.

We will generally cover a drug on UnitedHealthcare Community Plan's List of Covered Drugs as long as you follow the rules explained in this Section. You can also get drugs that are not on the list when medically necessary. Your physician may have to obtain a service authorization from us in order for you to receive some drugs.

Limits for coverage of some drugs

For certain prescription drugs, special rules limit how and when we cover them. In general, our rules encourage you to get a drug that works for your medical condition and that is safe and effective, and cost-effective.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may need to request a service authorization for you to receive the drug. We may or may not agree to approve the request without taking extra steps. Refer to **Service authorization and benefit determination** and **Service authorizations and continuity of care** in Section 14 of this handbook.

If UnitedHealthcare Community Plan is new for you, you can keep getting your authorized drugs for the duration of the authorization or or during the continuity of care period after you first enroll, whichever is sooner. The continuity of care period is 30 days. Refer to **Continuity of care period** in Section 3 of this handbook.

If we deny or limit coverage for a drug, and you disagree with our decision, you have the right to appeal our decision. Refer to **Your right to appeal** in Section 15 of this handbook. If you have any concerns, contact your Care Coordinator. Your Care Coordinator will work with you and your PCP to make sure that you receive the drugs that work best for you.

Getting approval in advance

For some drugs, you or your doctor must get a service authorization approval from UnitedHealthcare Community Plan before you fill your prescription. If you don't get approval, UnitedHealthcare Community Plan may not cover the drug.

Prior authorization

Certain medications may require that your doctor get prior authorization from us before writing your prescription. This means they must be approved before you can get them. When a drug needs prior authorization, your doctor must contact our Pharmacy Department. They will review your doctor's request and you and your doctor will be told the outcome. If the drug you are prescribed needs prior authorization and your doctor does not get it, you will not be able to get your prescription. Your doctor needs to call our Pharmacy Department at **1-800-310-6826**. Your pharmacist may be able to give you a 3-day emergency supply until we process the request. Pharmacy prior authorizations are processed within 24 hours. If we do not approve the request, we will tell you how you can appeal.

Trying a different drug first

We may require that you first try one (usually less-expensive) drug (before we will cover another (usually more-expensive) drug for the same medical condition. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, then we will cover Drug B. This is called step therapy.

If the required drug has not been tried, your doctor must get prior authorization. We will ask your doctor to explain why you can't use the required drug first. If we do not approve the request, we will tell you how you can appeal.

Quantity limits

For some drugs, we may limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug your physician has prescribed, check the List of Covered Drugs. For the most up-to-date information, call Member Services at **1-866-622-7982**, TTY **711** or check our website at **myuhc.com/CommunityPlan**.

Emergency supply

There may be an instance where your medication requires a service authorization, and your prescribing provider cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 3-day emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit a service authorization request for the prescribed medication.

Non-covered drugs

By law the types of drugs listed below are not covered by Medicare or Medicaid:

- Drugs used to promote fertility;
- Drugs used for cosmetic purposes or to promote hair growth;
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
- Drugs used for treatment of anorexia, weight loss, or weight gain;
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective, including prescriptions that include a DESI drug;
- Drugs that have been recalled;
- Experimental drugs or non-FDA-approved drugs; and
- Any drugs marketed by a manufacturer who does not participate in the Virginia Medicaid Drug Rebate program.

Changing pharmacies

If you need to change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy. If you need help changing your network pharmacy, you can contact Member Services at the number at the bottom of the page or your Care Coordinator.

If the pharmacy you use leaves UnitedHealthcare Community Plan's network, you will have to find a new network pharmacy. To find a new network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website at **myuhc.com/CommunityPlan**, or contact Member Services at **1-866-622-7982**, TTY **711** or your Care Coordinator. Member Services can tell you if there is a network pharmacy nearby.

What if you need a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialty drugs are used for treatment of complex diseases and when prescribed the medications required special handling or clinical care support prior to dispensing. Only a limited number of pharmacies are contracted by each MCO to provide these drugs. These medications will be shipped directly to the member's home or the prescriber office and cannot be picked up at all retail outlets. Also these drugs usually require a service authorization prior to dispensing. Be sure to check with the formulary of your plan regarding coverage of these specialty drugs and allow time for shipment deliveries.

Usually, nursing facilities have their own pharmacies. If you are a resident of a nursing facility, we must make sure you can get the drugs you need at the nursing facility's pharmacy. If you have any problems getting your drug benefits in a nursing facility, please contact your Care Coordinator or Member Services at **1-866-622-7982**, TTY **711**.

Can you use mail-order services to get your drugs

You may use mail-order services to get up to a 31-day supply. Contact Member Services at the number listed below for more information.

Can you get a long-term supply of drugs

Members may receive up to a one-month supply (31 days) of medication per prescription order or prescription refill. Members may reorder or refill a medication after using 85 percent of the medication.

If you have a long-term supply need for a specific prescription, contact Member Services at **1-866-622-7982**, TTY **711** or call your Care Coordinator.

Can you use a pharmacy that is not in UnitedHealthcare Community Plan's network

Most chain pharmacies and independent pharmacies fill prescriptions for UnitedHealthcare Community Plan Members.

To locate a pharmacy convenient for a Member, please visit our website at **UHCCommunityPlan.com/VA/PharmacyProgram** or contact Member Services at **1-866-622-7982**, TTY **711**.

What is the Patient Utilization Management and Safety (PUMS) program

Some Members who require additional monitoring may be enrolled in the Patient Utilization Management and Safety (PUMS) program. The PUMS program is required by DMAS and helps make sure your drugs and health services work together in a way that won't harm your health. As part of this program, we may check the Prescription Monitoring Program (PMP) tool that the Virginia Department of Health Professions maintains to review your drugs. This tool uses an electronic system to monitor the dispensing of controlled substance prescription drugs.

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works. The lock-in period is for 12 months. At the end of the lock in period, we'll check in with you to see if you should continue the program. If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to **Appeals, State Fair Hearings, and grievances** in Section 15 of this handbook.

If you're in the PUMS program, you can get prescriptions after-hours if your selected pharmacy doesn't have 24-hour access. You'll also be able to pick a PCP, pharmacy or other provider where you want to be locked in. If you don't select providers for lock-in within 15 days, we'll choose them for you.

Members who are enrolled in PUMS will receive a letter from UnitedHealthcare Community Plan that provides additional information on PUMS including all of the following information:

- A brief explanation of the PUMS program;
- A statement explaining the reason for placement in the PUMS program;
- Information on how to appeal to UnitedHealthcare Community Plan if placed in the PUMS program;

- Information regarding how to request a State Fair Hearing after first exhausting UnitedHealthcare Community Plan's appeals process;
- Information on any special rules to follow for obtaining services, including for emergency or after-hours services; and
- Information on how to choose a PUMS provider.

Contact Member Services at **1-866-622-7982**, TTY **711** or your Care Coordinator if you have any questions on PUMS.

Language assistance services, free of charge, are available to you. Please call Member Services at **1-866-622-7982**, TTY **711**.

Over-the-Counter (OTC) medicines

UnitedHealthcare 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 31 days. Then all you have to do is take your prescription and Member ID card into any network pharmacy to fill the prescription at no cost to you. OTC medications include:

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

For a complete list of covered OTC medicines, go to **myuhc.com/CommunityPlan**. Or call Member Services at **1-866-622-7982**, TTY **711**.

10. How to access your CCC Plus benefits

CCC Plus benefits

As a UnitedHealthcare Community Plan Member, you have a variety of health care benefits and services available to you. You will receive most of your services through the UnitedHealthcare Community Plan, but may receive some through DMAS or a DMAS Contractor.

- Services provided through UnitedHealthcare Community Plan are described in this Section 10 of the handbook
- Services covered by DMAS or a DMAS Contractor are described in Section 11 of this handbook
- Services that are not covered through UnitedHealthcare Community Plan or DMAS are described in Section 12 of this handbook

Services you receive through UnitedHealthcare Community Plan or through DMAS will not require you to pay any costs other than your "patient pay" towards long-term services and supports. Section 13 of this handbook provides information on what a "patient pay" is and how you know if you have one.

General coverage rules

To receive coverage for services you must meet the general coverage requirements described below.

1. Your services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means you need the service or supplies to prevent, diagnose, or treat a medical condition or its symptoms based on accepted standards of medical practice.

2. In most cases, you must get your care from a network provider. A network provider is a provider who works with UnitedHealthcare Community Plan. In most cases, UnitedHealthcare Community Plan will not pay for care you get from an out-of-network provider unless the service is authorized by UnitedHealthcare Community Plan. Section 6 has more information about using network and out-of-network providers, including **Services you can get without first getting approval from your PCP**.
3. Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called a service authorization. Section 14 includes more information about service authorizations.
4. If UnitedHealthcare Community Plan is new for you, you can keep seeing the doctors you go to now during the 30 day continuity of care period. You can also keep getting your authorized services for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. Also see **Continuity of care period** in Section 3 of this handbook.

Benefits covered through UnitedHealthcare Community Plan

UnitedHealthcare Community Plan covers all of the following services for you when they are medically necessary. If you have Medicare or another insurance plan, we will coordinate these services with your Medicare or other insurance plan. Refer to Section 11 of this handbook for **Services covered through the DMAS Medicaid Fee-for-Service program**.

- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. **See Section 6 of this handbook for more information about PCP services.**
- Preventive care, including regular checkups, adult wellness screenings, and well-baby/child visits. **See Section 6 of this handbook for more information about PCP services.**
- Addiction and Recovery Treatment Services (ARTS), including inpatient, outpatient, community-based, medication-assisted treatment, peer services, and case management. Services may require authorization. **Additional information about ARTS services is provided below in this Section of the handbook.**

- Adult day health care services (see **CCC Plus waiver**)
- Care coordination services, including assistance connecting to CCC Plus covered services and to housing, food, and community resources. **See Section 4 of this handbook for more information about your Care Coordinator.**
- Clinic services, including renal dialysis
- CCC Plus Home and Community Based Waiver services (formerly known as the EDCD and Technology Assisted Waivers), including: adult day health care, assistive technology, environmental modifications, personal care services, personal emergency response systems (PERS), private duty nursing services, respite services, services facilitation, transition services. **Additional information about CCC Plus waiver services is provided later in this Section. Section 11 of this handbook provides information about DD waiver services.**
- Colorectal cancer screening
- Court ordered services
- Dental services, including preventive and diagnostic care services for ages 21 and over
- Durable medical equipment (DME) and supplies including medically necessary respiratory, oxygen, and ventilator equipment and supplies, wheelchairs and accessories, hospital beds, diabetic equipment and supplies, incontinence products, assistive technology, communication devices, and rehabilitative equipment and devices and other necessary equipment and supplies
- Early and Periodic Screening Diagnostic and Treatment services (EPSDT) for children under age 21. **Additional information about EPSDT services is provided later in this Section of the handbook.**
- Early Intervention services for children from birth to age 3. **Additional information about early intervention services is provided later in this Section of the handbook.**
- Electroconvulsive therapy (ECT)
- Emergency custody orders (ECO)
- Emergency services including emergency transportation services (ambulance, etc.)

- Emergency and post-stabilization services. **Additional information about emergency and post-stabilization services is provided in Section 7 of this handbook.**
- End-stage renal disease services
- Eye examinations
- Family planning services, including services, devices, drugs (including long-acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of UnitedHealthcare Community Plan's network. UnitedHealthcare Community Plan does not require you to obtain a service authorization or a PCP referral for family planning services.
- Gender Dysphoria treatment services
- Glucose test strips
- Hearing (audiology) services
- Home health services
- Hospice services
- Hospital care — Inpatient/outpatient
- Human Immunodeficiency Virus (HIV) testing and treatment counseling
- Immunizations, including adult immunizations
- Inpatient psychiatric hospital services
- Laboratory, Radiology and Anesthesia Services
- Lead investigations
- Mammograms
- Maternity care — Includes: pregnancy care, lactation support, doctors/certified nurse-midwife services. **Additional information about maternity care is provided in Section 6 of this handbook.**
- Mental health services, including, outpatient psychotherapy services, community-based, crisis and inpatient services. Community and facility based services include:
  - Mental Health Case Management
  - Therapeutic Day Treatment (TDT) for Children

  - Mental Health Skill-building Services (MHSS)
  - Intensive In-Home
  - Psychosocial Rehabilitation
  - Applied Behavior Analysis
  - Mental Health Peer Recovery Supports Services
  - Mental Health Partial Hospitalization Program
  - Mental Health Intensive Outpatient
  - Assertive Community Treatment
  - Multisystemic Therapy (MST)
  - Functional Family Therapy (FFT)
  - Mobile Crisis
  - Community Stabilization
  - 23-Hour Observation
  - Residential Crisis Stabilization
- Nursing facility — Includes skilled, specialized care, long stay hospital, and custodial care. **Additional information about nursing facility services is provided later in this Section of the handbook.**
- Nurse Midwife Services through a Certified Nurse Midwife provider
- Nutritional counseling
- Organ transplants
- Orthotics, including braces, splints and supports — For children under 21, or adults through an intensive rehabilitation program
- Outpatient hospital services
- Pap smears
- Personal care or personal assistance services (through EPSDT or through the CCC Plus Waiver)
- Physician's services or provider services, including doctor's office visits
- Physical, occupational, and speech therapies
- Podiatry services (foot care)

- Prenatal and maternal services
- Prescription drugs. **See Section 9 of this handbook for more information on pharmacy services.**
- Private duty nursing services (through EPSDT and through the CCC Plus HCBS Waiver)
- Prostate specific antigen (PSA) and digital rectal exams
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses)
- Psychiatric or psychological services
- Radiology services
- Reconstructive breast surgery
- Renal (kidney) dialysis services
- Rehabilitation services — Inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services)
- Second opinion services from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out-of-network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.
- Surgery services when medically necessary and approved by UnitedHealthcare Community Plan
- Telemedicine services
- Temporary detention orders (TDO)
- Tobacco Cessation Services, education and pharmocotherapy for all members
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). UnitedHealthcare Community Plan will also provide transportation to/from most "carved-out" and enhanced services. **Additional information about transportation services is provided later in this Section of the handbook. Transportation services for DD waiver services are covered through DMAS, as described in Section 11 of this handbook.**

- Vision services, including one routine eye exam per year and one pair of prescription eyeglasses every two years
- Well Visits, including regular check ups and immunizations
- Abortion services — Coverage is only available in cases where there would be a substantial danger to the life of the mother

Extra benefits we provide that are not covered by Medicaid

As a Member of UnitedHealthcare Community Plan, you have access to services that are not generally covered through Medicaid Fee-for-Service. These are known as "enhanced benefits." We provide the following enhanced benefits:

- **Acute Home-Delivered Meals:** Members who are discharged from an acute inpatient hospital stay or from a nursing facility back into the community setting can receive nutritious prepared meals chosen from menus that support the management of many chronic conditions such as diabetes. After discharge, 14 meals will be conveniently delivered to your home; enough to provide two meals per day for seven days. Requests are coordinated through your care coordinator and require approval.
- **Adult Vision:** Good vision is related directly to a higher quality of life and independence, and provides early detection of diseases like diabetes, multiple sclerosis and high blood pressure. We will provide adult vision coverage to eligible Members over the age of 21. Our vision coverage includes an annual eye exam and frames/lenses every two years, if necessary. This benefit is limited to in-network providers.
- **Environmental Home Modifications:** Environmental home modifications such as ramps and grab bars in homes can help you live safely in the least restrictive environment. We will provide environmental and home modifications to all Members who are not currently eligible for coverage through a waiver. Limits include $5,000 each calendar year or $10,000 per lifetime. Requests for modifications are coordinated through your Care Coordinator and require approval.

- **Free Cellphone Program:** Being able to connect directly with you is essential to supporting your health improvement goals. To support open communication, we will provide help with applying for free cell phone program, MyHealthLine, to all eligible Members. The Free Cellphone program provides a smart phone with 350 free minutes, 3GB of data each month and unlimited texts. By providing a cellphone pre-programmed with UnitedHealthcare contacts, Members can quickly and easily reach us to discuss benefit questions or for NurseLine support. To access the Free Cellphone Program members can either contact Member Services at **866-622-7982** or the member can apply online at **www.lifelinesupport.org**.
- **Healthy First Steps Prenatal Care Program:** Prenatal care is foundational to a healthy pregnancy and improved health and early childhood outcomes. Healthy First Steps reminds and rewards Members for attending prenatal appointments and appointments into their baby's first 15 months. The program includes an easy enrollment process, appointment reminders and health tips. We will provide Healthy First Steps to all pregnant Members or Members who are new mothers.
- **Kids for Grades:** $50 gift card to Footlocker for 9th-12th graders with a 3.5 Semester GPA
- **Non-emergency Medical Transportation (NEMT):** NEMT provides crucial support for helping individuals take personal responsibility and improving overall health. This benefit will improve your access to care, particularly in rural areas where transportation needs affect a Member's ability to pursue a healthier lifestyle. Our enhanced benefit includes up to 6 trips per 6 months to destinations that were not otherwise covered by Medicaid. This includes round trips to places of worship, Department of Motor Vehicles, grocery store, and Medicaid eligibility offices. No limits on rides to food banks, farmer's markets or Women Infants and Children appointments.
- **Sanvello:** Sanvello is an interactive phone application that helps to manage symptoms of stress, anxiety and depression. For enrollment information please visit **Sanvello.com**.
- **Transitional Support Funds:** Transitional support funds will be made available when other resources are not available to remove barriers preventing eligible Members from being discharged from psychiatric hospitals. Requests are coordinated through your care coordinator and require approval.

- **Weight Watchers:** We will provide 13 Weight Watchers meeting vouchers annually to qualified Members who are 10 years of age and older. Members will learn valuable skills about healthy eating and weight loss. Reviews are coordinated through the individual's Care Coordinator and require approval.
- **Wellness Rewards:** UHC will provide rewards for meeting certain health goals. Limits up to $25 per goal. For more information please contact your Care Coordinator or member services at **1-866-622-7982**, TTY **711**.

Clinical practice guidelines and new technology

UnitedHealthcare Community Plan gives our providers clinical guidelines. These have information on the best way to provide care for some conditions. Each guideline is a standard of care in the medical profession. This means other doctors agree with that approach.

If you have any questions about UnitedHealthcare Community Plan's clinical guidelines or would like a copy of a guideline, call Member Services at **1-866-622-7982**, TTY **711**. You can also find the clinical guidelines on our website at **myuhc.com/CommunityPlan**.

New technology assessment

Some medical practices and treatments are not yet proven to be effective. New practices, treatments, tests and technologies are reviewed nationally by UnitedHealthcare Community Plan to decide on coverage.

They are reviewed by a committee of UnitedHealthcare Community Plan doctors, nurses, pharmacists and guest experts. They make the final decision about coverage. If you want more information, call us at **1-866-622-7982**, TTY **711**.

How to access Early and Periodic Screening, Diagnostic, and Treatment services

What is EPSDT

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federally mandated Medicaid benefit that provides comprehensive and preventive health care services for children under age 21. If you have a child that is under age 21, EPSDT provides appropriate preventive, dental, behavioral health, developmental, and specialty services. It includes coverage for immunizations, well child visits, lead investigations, private duty nursing, personal care, and other services and therapies that treat or make a condition better. It will also cover services that keep your child's condition from getting worse. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid.

Getting EPSDT services

UnitedHealthcare Community Plan provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by UnitedHealthcare Community Plan. For any services not covered by UnitedHealthcare Community Plan, you can get these through the Medicaid Fee-for-Service program. **Additional information about services provided through Medicaid Fee-for-Service is provided in Section 11 of this handbook.**

Getting early intervention services

If you have a baby under the age of three, and you believe that he or she is not learning or developing like other babies and toddlers, your child may qualify for early intervention services. Early intervention includes services such as speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to help families support their child's learning and development during everyday activities and routines. Services are generally provided in your home.

The first step is meeting with the local **Infant and Toddler Connection** program in your community to see if your child is eligible. A child from birth to age three is eligible if he or she has (i) a 25% developmental delay in one or more areas of development; (ii) atypical development; or, (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

For more information, call your Care Coordinator. Your Care Coordinator can help. Or call Member Services at **1-866-622-7982**, TTY **711**. If your child is enrolled in UnitedHealthcare Community Plan, we provide coverage for early intervention services. Your Care Coordinator will work closely with you and the **Infant and Toddler Connection** program to help you access these services and any other services that your child may need. Information is also available at **www.infantva.org** or by calling **1-800-234-1448**.

How to access behavioral health services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues as well as using substances at some time in their lives. These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in your home or in the community, for a short or long timeframe, and all are performed by qualified individuals and organizations. You may need to get approval ahead of time for some of these services. Your Care Coordinator can help.

Contact your Care Coordinator if you are having trouble coping with thoughts and feelings. Your Care Coordinator will help you make an appointment to speak with a behavioral health care professional.

Some Behavioral Health services are covered for you through Magellan, the DMAS Behavioral Health Services Administrator (BHSA). Your Care Coordinator will work closely with the BHSA to coordinate the services you need, including those that are provided through the BHSA.

How to access Addiction and Recovery Treatment Services (ARTS)

UnitedHealthcare Community Plan offers a variety of services that help individuals who are struggling with using substances, including drugs and alcohol. Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment no matter how bad the problem may seem. If you need treatment for addiction, we provide coverage for services that can help you. These services include settings in inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options, counseling services, and behavioral therapy options are also available if you are dealing with using prescription or non-prescription drugs. Other options that are helpful include peer recovery services (someone who has experience similar issues and in recovery), as well as case management services. Talk to your PCP or call your Care Coordinator to determine the best option for you and how to get help in addiction and recovery treatment services. To find an ARTS provider, you can look in the Provider and Pharmacy Directory, visit our website, call your Care Coordinator, or contact Member Services at one of the numbers below.

How to access Long-Term Services and Supports (LTSS)

UnitedHealthcare Community Plan provides coverage for long-term services and supports (LTSS) including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. LTSS can provide assistance that helps you live in your own home or other setting of your choice and improves your quality life. Example services include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities (through a home and community based waiver), but also in nursing facilities. If you need help with these services, please call your Care Coordinator who will help you in the process to find out if you meet the Virginia eligibility requirements for these services. Also see the Sections: **Commonwealth Coordinated Care Plus waiver**, **Nursing facility services**, and **How to get services if you are in a DD waiver** described later in this Section of the handbook.

Commonwealth Coordinated Care Plus Waiver

Some Members may qualify for home and community based care waiver services through the Commonwealth Coordinated Care Plus Waiver (formerly known as the Elderly or Disabled with Consumer Direction and Technology Assistance Waivers).

The Commonwealth Coordinated Care Plus (CCC Plus) Waiver is meant to allow a Member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus Waiver services, you may choose how to receive personal assistance services. You have the option to receive services through an agency (known as agency directed) or you may choose to serve as the employer for a personal assistance attendant (known as self-directed). Information on self-directed care is described in more detail below, in this Section of the handbook.

CCC Plus Waiver Services may include:

- Private duty nursing services (agency directed)
- Personal care (agency or self-directed)
- Respite care (agency or self-directed)
- Adult day health care
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for Members transitioning to the community from a nursing facility or long stay hospital
- Assistive technology
- Environmental modifications

Note: Individuals enrolled in a DD Waiver should see How to get services if you are in a DD waiver described later in this Section.

How to self-direct your care

Self-directed care refers to personal care and respite care services provided under the CCC Plus Waiver. These are services in which the Member or their family / caregiver is responsible for hiring, training, supervising, and firing of their attendant. You will receive financial management support in your role as the employer to assist with enrolling your providers, conducting provider background checks, and paying your providers.

If you have been approved to receive CCC Plus Waiver services and would like more information on the self-directed model of care, please contact your Care Coordinator who will assist you with these services.

Your Care Coordinator will also monitor your care as long as you are receiving CCC Plus Waiver services to make sure the care provided is meeting your daily needs.

Nursing facility services

If you are determined to meet the coverage criteria for nursing facility care, and choose to receive your long-term services and supports in a nursing facility, UnitedHealthcare Community Plan will provide coverage for nursing facility care. If you have Medicare, UnitedHealthcare Community Plan will provide coverage for nursing facility care after you exhaust your Medicare covered days in the nursing facility, typically referred to as skilled nursing care.

If you are in a nursing facility, you may be able to move from your nursing facility to your own home and receive home and community based services if you want to. If you are interested in moving out of the nursing facility into the community, talk with your Care Coordinator. Your Care Coordinator is available to work with you, your family, and the discharge planner at the nursing facility if you are interested in moving from the nursing facility to a home or community setting.

If you choose not to leave the nursing facility, you can remain in the nursing facility for as long as you are determined to meet the coverage criteria for nursing facility care.

Screening for long-term services and supports

Before you can receive long-term services and supports (LTSS), you must be screened by a community based or hospital screening team. A screening is used to determine if you meet the level of care criteria for LTSS. Contact your Care Coordinator to find out more about the screening process in order to receive LTSS.

Freedom of choice

If you are approved to receive long-term services and supports, you have the right to receive care in the setting of your choice:

- In your home, or
- In another place in the community, or
- In a nursing facility.

You can choose the doctors and health professionals for your care from our network. If you prefer to receive services in your home under the CCC Plus Waiver, for example, you can choose to directly hire your own personal care attendant(s), known as self-directed care. Another option you have is to choose a personal care agency in our network, where the agency will hire, train, and supervise personal assistance workers on your behalf, known as agency direction. You also have the option to receive services in a nursing facility from our network of nursing facility providers.

How to get services if you are in a Developmental Disability Waiver

If you are enrolled in one of the DD waivers, you will be enrolled in CCC Plus for your non-waiver services. The DD waivers include:

- The Building Independence (BI) Waiver,
- The Community Living (CL) Waiver, and
- The Family and Individual Supports (FIS) Waiver.

UnitedHealthcare Community Plan will only provide coverage for your non-waiver services. Non-waiver services include all of the services listed in Section 10, **Benefits covered through UnitedHealthcare Community Plan**. Exception: If you are enrolled in one of the DD Waivers, you would not also be eligible to receive services through the CCC Plus Waiver.

DD Waiver services, DD and ID targeted case management services, and transportation to/from DD waiver services, will be paid through Medicaid Fee-for-Service as "carved-out" services. The carve-out also includes any DD waiver services that are covered through EPSDT for DD waiver enrolled individuals under the age of 21.

If you have a developmental disability and need DD waiver services, you will need to have a diagnostic and functional eligibility assessment completed by your local Community Services Board (CSB). All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in your person-centered individualized service plan.

The DD waivers have a wait list. Individuals who are on the DD waiver waiting list may qualify to be enrolled in the CCC Plus Waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in your community. For more information on the DD Waivers and the services that are covered under each DD Waiver, visit the Department of Behavioral Health and Developmental Services (DBHDS) website at: **http://www.mylifemycommunityvirginia.org/** or call **1-844-603-9248**. Your Care Coordinator will work closely with you and your DD or ID case manager to help you get all of your covered services. Contact your Care Coordinator if you have any questions or concerns.

How to get non-emergency transportation services

Non-emergency transportation services covered by UnitedHealthcare Community Plan

Non-Emergency transportation services are covered by UnitedHealthcare Community Plan for covered services, carved out services, and enhanced benefits. Exception: If you are enrolled in a DD Waiver, UnitedHealthcare Community Plan provides coverage for your transportation to/from your non-waiver services. (Refer to **Transportation to/from DD waiver services** below.)

Transportation may be provided if you have no other means of transportation and need to go to a physician or a health care facility for a covered service. For urgent or non-emergency medical appointments, call the reservation line at **1-866-622-7982**, TTY **711**. If you are having problems getting transportation to your appointments, call the Transportation number listed below, or call Member Services at **1-866-622-7982**, TTY **711**. Member Services is here to help.

In case of a life-threatening emergency, call **911**. Refer to **How to get care for emergencies** in Chapter 7 of this handbook.

Name	Contact information	Details
Transportation	**ModivCare: 844-604-2078**	For non-urgent appointments, members must call for transportation at least five (5) business days before their appointment.

Urgent Trips can be scheduled the same day. Urgent Trips are defined as an unscheduled, same day transportation request in which there is no immediate threat to life or limb but the member must be seen on the day of the request and treatment cannot be delayed until the next day, e.g., hospital or ED discharges, follow-up appointments scheduled less than 5 days after the last appointment; unexpected pre-operative appointments; hospital discharges; appointments for new medical conditions or tests when the member must be seen; and, dialysis.

Transportation to and from DD Waiver services.

If you are enrolled in a DD Waiver, UnitedHealthcare Community Plan provides coverage for your transportation to and from your non-waiver services. (Call the number **above** for transportation to your **non-waiver services**.)

Transportation to your DD Waiver services is covered by the DMAS Transportation Contractor. You can find out more about how to access transportation services through the DMAS Transportation Contractor on the website at: **http://transportation.dmas.virginia.gov/** or by calling the Transportation Contractor. Transportation for routine appointments are taken between the hours of 6:00 a.m.–8:00 p.m., Monday–Friday. The DMAS Transportation Contractor is available 24 hours a day, 7 days a week to schedule urgent reservations, at: **1-866-386-8331** or TTY **1-866-288-3133** or **711** to reach a relay operator.

If you have problems getting transportation to your DD waiver services, you may call your DD or ID Waiver case manager or the DMAS Transportation Contractor at the number above. You can also call your Care Coordinator. Your Care Coordinator will work closely with you and your DD or ID Waiver case manager to help get the services that you need. Member Services is also available to help at **1-866-622-7982**, TTY **711**.

11. Services covered through the DMAS Medicaid Fee-for-Service program

Carved-out services

The Department of Medical Assistance Services will provide you with coverage for the services listed below. These services are known as "carved-out services." Your provider bills Fee-for-Service Medicaid (or a DMAS Contractor) for these services.

Your Care Coordinator can also help you to access these services if you need them.

- **Dental Services** are provided through the DMAS Dental Benefits Administrator. DMAS has contracted with its Dental Benefits Administrator to coordinate the delivery of all Medicaid dental services. The dental program provides coverage for the following populations and services:
  - For children under age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services
  - For pregnant women: X-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, partials, and dentures, tooth extractions and other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. The dental coverage ends 60 days after the baby is born.
  - For adults age 21 and over, coverage will include cleanings, x-rays, exams, fillings, dentures, root canals, gum-related treatment, oral surgery and more
  - We provide coverage for oral services such as hospitalizations, surgeries or services billed by a medical doctor not a dentist

- If you have any questions about your dental coverage through the DMAS Dental Benefits Administrator, you can reach DentaQuest Member Services at **1-888-912-3456**, 8:00 a.m.–6:00 p.m. EST, Monday–Friday. The TTY/TDD number is **1-800-466-7566**. Additional information is provided at: **https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/**.
- UnitedHealthcare Community Plan provides coverage for non-emergency transportation for any dental services covered through the DMAS Dental Benefits Administrator, as described above. Contact Member Services at the number below if you need assistance.
- **Developmental Disability (DD) Waiver Services**, including Case Management for DD Waiver Services, are covered through DBHDS. The carve-out includes any DD Waiver services that are covered through EPSDT for DD waiver enrolled individuals and transportation to/from DD Waiver services. Also see **How to get services if you are in a developmental disability waiver** in Section 10 of this handbook.
- **School Health Services** including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's **Individualized Education Program (IEP)**. While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.
- **Treatment Foster Care Case Management** is managed by Magellan of Virginia and more information is available at: **http://www.magellanofvirginia.com** or by calling: **1-800-424-4046**, TDD **1-800-424-4048** or TTY **711**. You can also call your Care Coordinator for assistance.

- **Therapeutic Group Home Services** for children and adolescents younger than the age of 21. This is a place where children and adolescents live while they get treatment. Children under this level of care have serious mental health concerns. These services provide supervision and behavioral health care toward therapeutic goals. These services also help the Member and their family work towards discharge to the Member's home. Additional information about Therapeutic Group Home Services is available on the Magellan website at: **www.magellanofvirginia.com** or by calling: **1-800-424-4046**, TDD **1-800-424-4048** or TTY **711**. You can also call your Care Coordinator for assistance.
- For Members age twenty-one (21) through sixty-four (64), where the Member goes into private freestanding Institution for Mental Disease (IMD) or a State freestanding IMD for a Temporary Detention Order (TDO), the state TDO program will pay for the service

Services that will end your CCC Plus enrollment

If you receive any of the services below, your enrollment with UnitedHealthcare Community Plan will end. You will receive these services through DMAS or a DMAS Contractor.

- PACE (Program of All Inclusive Care for the Elderly). **For more information about PACE, talk to your Care Coordinator or visit: http://www.pace4you.org/**.
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID)
- You are receiving care in a Psychiatric Residential Treatment Facility (children under 21). Additional information about Psychiatric Residential Treatment Facility Services is available on the Magellan website at: **www.magellanofvirginia.com** or by calling: **1-800-424-4046**, TDD **1-800-424-4048** or TTY **711**. You can also call your Care Coordinator for assistance.
- You reside in a Veteran's Nursing Facility
- You reside in one of these State long-term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock

12. Services not covered by CCC Plus

The following services are not covered by Medicaid or UnitedHealthcare Community Plan. If you receive any of the following non-covered services, you will be responsible for the cost of these services.

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Cosmetic treatment or surgery
- Daycare, including companion services for the elderly (except in some home and community-based service waivers)
- Drugs prescribed to treat hair loss or to bleach skin
- Eyeglasses repair for Members age 21 or older
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by UnitedHealthcare Community Plan)
- Medical care other than emergency services, urgent services, or family planning services, received from providers outside of the network unless authorized by UnitedHealthcare Community Plan
- Personal care services (except through some home and community-based service waivers or under EPSDT)
- Prescription drugs, including the Medicare copayment
- Private duty nursing (except through some home and community-based service waivers or under EPSDT)
- Care outside of the United States

If you receive non-covered services

We cover your services when you are enrolled with our plan and:

- Services are medically necessary, and
- Services are listed as **Benefits covered through UnitedHealthcare Community Plan** in Section 10 of this handbook, and
- You receive services by following plan rules.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we will pay for any medical service or care, you have the right to ask us. You can call Member Services or your Care Coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Section 15 provides instructions for how to appeal UnitedHealthcare Community Plan's coverage decisions. You may also call Member Services to learn more about your appeal rights or to obtain assistance in filing an appeal.

13. Member cost sharing

There are no copayments for services covered through the CCC Plus Program. This includes services that are covered through UnitedHealthcare Community Plan or services that are carved-out of the CCC Plus contract. The services provided through UnitedHealthcare Community Plan or through DMAS will not require you to pay any costs other than your patient pay towards long-term services and supports. See the **Member patient pay** Section below.

CCC Plus does not allow providers to charge you for covered services. UnitedHealthcare Community Plan pays providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. If you receive a bill for a covered service, contact Member Services and they will help you.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we will pay for any medical service or care, you have the right to ask us. You can call Member Services or your Care Coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision. See Section 12 of this handbook for a list of non-covered services.

Member patient pay toward long-term services and supports

You may have a **patient pay** responsibility toward the cost of nursing facility care and home and community-based waiver services. A patient pay is required to be calculated for all Members who get nursing facility or home and community-based waiver services. When your income exceeds a certain amount, you must contribute toward the cost of your long-term services and supports. If you have a patient pay amount, you will receive notice from your local Department of Social Services (DSS) of your patient pay responsibility. DMAS also shares your patient pay amount with UnitedHealthcare Community Plan if you are required to pay towards the cost of your long-term services and supports. If you have questions about your patient pay amount, contact your Medicaid eligibility worker at the local Department of Social Services.

Medicare members and Part D drugs

If you have Medicare, you get your prescription medicines from Medicare Part D; not from the CCC Plus Medicaid program. CCC Plus does not pay the copayment for the medicines that Medicare Part D covers.

14. Service authorization and benefit determination

Service authorization

There are some treatments, services, and drugs that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called a service authorization. You, your doctor, or someone you trust can ask for a service authorization.

If the services you require are covered through Medicare, then a service authorization from UnitedHealthcare Community Plan is not required. If you have questions regarding what services are covered under Medicare, please contact your Medicare health plan. You can also contact your UnitedHealthcare Community Plan Care Coordinator.

A service authorization helps to determine if certain services or procedures are medically needed and covered by the plan. Decisions are based on what is right for each Member and on the type of care and services that are needed.

We look at standards of care based on:

- Medical policies
- National clinical guidelines
- Medicaid guidelines
- Your health benefits

UnitedHealthcare Community Plan does not reward employees, consultants, or other providers to:

- Deny care or services that you need
- Support decisions that approve less than what you need
- Say you don't have coverage

Service authorizations are not required for early intervention services, emergency care, family planning services (including long-acting reversible contraceptives), preventive services, and basic prenatal care.

The following treatments and services must be authorized before you get them:

- Adult Day Health Care
- Assistive Technology
- Bariatric Surgery
- Bone Growth Stimulator
- Breast Reconstruction (Non-Mastectomy)
- Cardiology
- Cochlear Implants and Other Auditory Implants
- Cosmetic and Reconstructive Surgery
- DME Greater than $500
- Enteral Services
- Environmental Modifications
- Experimental and Investigational
- Femoroacetabular Impingement Syndrome (FAI)
- Functional Endoscopic Sinus Surgery (FESS)
- Gender Dysphoria Treatment
- Home Health Care
- Injectable Medications
- Joint Replacement
- Medical Day Care Services
- Medication Monitoring Monitor
- Non-Emergent Air Ambulance Transport
- Orthognathic Surgery
- Orthotics/Prosthetic Greater than $500
- Personal Care Attendent – Attendent Care
- Personal Emergency Response (PERS) Installation
- Private Duty Nursing
- Proton Beam Therapy
- Psychological Testing
- Radiology
- Respite Care
- Rhinoplasty
- Service Facilitation Visits
- Sinuplasty
- Skilled Nursing Facility
- Sleep Apnea Procedures and Surgeries
- Spinal Stimulator for Pain Management
- Spinal Surgery
- Transition Assistance Service
- Transplants
- Vagus Nerve Stimulation
- Vein Procedures
- Ventricular Assist Device (VAD)
- Wound Vac

To find out more about how to request approval for these treatments or services, you can contact Member Services at the number below or call your Care Coordinator.

Service authorizations and continuity of care

If you are new to UnitedHealthcare Community Plan, we will honor any service authorization approvals made by DMAS or issued by another CCC Plus plan during the continuity of care period or until the authorization ends if that is sooner. The continuity of care period is 30 days. Refer to **Continuity of care period** in Section 3 of this handbook.

How to submit a service authorization request

To submit a Service Authorization Request, please call **1-877-843-4366**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week. Or call Member Services. Your Care Coordinator is also available to help you contact a provider or doctor to request service authorizations.

What happens after we get your service authorization request

UnitedHealthcare Community Plan has a review team to be sure you receive medically necessary services. Doctors, nurses and licensed clinicians 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. The standards we use to determine what is medically necessary are not allowed to be more restrictive than those that are used by DMAS.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination (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 medical or behavioral health professional, who may be a doctor or other health care

professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

Timeframes for service authorization review

UnitedHealthcare Community Plan follows National Committee for Quality Assurance service authorization standards and timeframes.

UnitedHealthcare Community Plan is responsible for deciding how quickly the authorization is needed depending on the urgency and type of service requested. For standard authorization decisions, UnitedHealthcare Community Plan will provide written notice as quickly as needed, and within fourteen (14) calendar days. For urgent decisions, UnitedHealthcare Community Plan will provide written notice within three (3) calendar days.

Urgent requests include requests for medical or behavioral health care or services where waiting 14 days could seriously harm your health or ability to function in the future. Care or services to help with transitions from inpatient hospital or institutional setting to home are also urgent requests. You or your doctor can ask for an urgent request if you believe that a delay will cause serious harm to your health.

For standard or urgent decisions, if UnitedHealthcare Community Plan, you or your provider request an extension, or more information is needed, an extension of up to fourteen (14) additional calendar days is allowed.

For pharmacy services, we must provide decisions by telephone or other telecommunication device within 24 hours.

There may be an instance where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit an authorization request for the prescribed medication.

If we need more information to make a decision about your service request, we will:

- Write and tell you and your provider what information is needed. If your request is in an urgent request, we will call you or your provider 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 UnitedHealthcare Community Plan to help decide your case. This can be done by calling **1-866-622-7982**, TTY **711**.

You or someone you trust can file a grievance with UnitedHealthcare Community Plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a grievance about the way UnitedHealthcare Community Plan handled your service authorization request to the State through the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608**. Also see **Your right to file a grievance**, in Section 15 of this handbook.

Benefit determination

We will notify you with 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 disagree with our decision, you have the right to file an appeal with us. Also see **Your right to appeal**, in Section 15 in this handbook.

We will tell you and your provider in writing if your request is denied. A denial includes when the request is approved for an amount that is less than the amount requested. We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain what options for appeals you have if you do not agree with our decision. Also see **Your right to appeal**, in Section 15 of this handbook.

Advance notice

In most cases, if we make a benefit determination to reduce, suspend or end a service we have already approved and that you are now getting, we must tell you at least 10 days before we make any changes to the service. Also see **Continuation of benefits** in Section 15 of this handbook.

Post payment review

If we are checking on care or services that you received in the past, we perform a provider post payment review. If we deny payment to a provider for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by UnitedHealthcare Community Plan even if we later deny payment to the provider.

15. Appeals, State Fair Hearings, and grievances

Your right to appeal

You have the right to appeal any adverse benefit determination (decision) by UnitedHealthcare Community Plan that you disagree with that relates to coverage or payment of services.

For example, you can appeal if UnitedHealthcare Community Plan denies:

- A request for a health care service, supply, item or drug that you think you should be able to get, or
- A request for payment of a health care service, supply, item, or drug that UnitedHealthcare Community Plan denied.

You can also appeal if UnitedHealthcare Community Plan stops providing or paying for all or a part of a service or drug you receive through CCC Plus that you think you still need.

Adverse benefit determination

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. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision we make to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. Refer to **Service authorization and benefit determinations** in Section 14 of this handbook.

Authorized representative

You can give someone like your PCP, provider, or friend or family member written permission to help you with your appeal. This person is known as your authorized representative. You must inform UnitedHealthcare Community Plan of the name of your authorized representative. You can do this by calling our Member Services Department at one of the phone numbers below. We will provide you with a form that you can fill out and sign stating who your representative will be.

How to submit your appeal

If you are not satisfied with a decision we made about your service authorization request, you have 60 calendar days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at one of the numbers below if you need help filing an appeal or if you need assistance in another language or require an alternate format. We will not treat you unfairly because you file an appeal.

You can file your appeal by phone or in writing. Unless you need an expedited review, you must complete a written request even if you filed orally. If a signed written appeal is not received within 30 days of your Standard appeal phone request, your appeal will be closed. You can send the appeal as a standard appeal or your provider may send an expedited (fast) appeal request.

Your doctor can ask to have your appeal reviewed under the expedited process if he or she believes your health condition or your need for the service requires an expedited review. **In order to meet for Expedited processing**, your doctor will have to explain how a delay will cause harm to your physical or behavioral health. If your request for an expedited appeal is denied, we will tell you and your appeal will be reviewed under the standard process.

Send your Appeal request to:

UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

Continuation of benefits

In some cases you may be able to continue receiving services that were denied by us while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from when we sent you a notice telling you that your request was denied or care was changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received if the services were provided solely because of the requirements described in this Section.

What happens after we get your appeal

We will send you a letter to let you know we have received and are working on your appeal.

Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to make a decision on your case. This information is available at no cost to you.

You can also provide information that you want to be used in making the appeal decision in person or in writing.

Mailing Address:

UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

In-Person Address:

UnitedHealthcare Community Plan
9020 Stony Point Parkway, Suite 400
Richmond, VA 23235

You can also call Member Services at one of the numbers below if you are not sure what information to give us.

Timeframes for appeals

Standard appeals

If we have all the information we need, we will give written notice of our decision within 30 calendar days.

Expedited appeals

If we have all the information we need, expedited appeal decisions will be made within 72 hours of receipt of your appeal. We will tell you our decision by phone and send a written notice within 3 calendar days from when we orally tell you the decision.

If we need more information

If we can't make the decision within the needed timeframes because we need more information, 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; and
- Make a decision no later than 14 **additional days** from the timeframes described above.

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 UnitedHealthcare Community Plan to help decide your case. This can be done by calling or writing to:

Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

You or someone you trust can file a grievance with UnitedHealthcare Community Plan if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a grievance about the way UnitedHealthcare Community Plan handled your appeal to the State through the CCC Plus Help Line at **1-844-374-9159** or TDD **1-800-817-6608**.

If we do not tell you our decision about your appeal on time, you have the right to appeal to the State through the State Fair Hearing process. An untimely response by us is considered a valid reason for you to appeal further through the State Fair Hearing process.

Written notice of appeal decision

We will tell you and your provider in writing if your request is denied or approved in an amount less than requested. We will also tell you the reason for the decision and the titles, and qualifications, including specialties of individuals responsible for making the adverse determination. We will explain your right to appeal through the State Fair Hearing Process if you do not agree with our decision.

Your right to a State Fair Hearing

If you disagree with our decision on your appeal request, you can appeal directly to DMAS. This process is known as a State Fair Hearing. You may also submit a request for a State Fair Hearing if we do not respond to an appeal request for services within the times described in this handbook. The State requires that you first exhaust (complete) the UnitedHealthcare Community Plan appeals process before you can file a State Fair Hearing request through the State Fair Hearing process.

State fair hearings can be requested for an adverse benefit decision related to Medicaid covered services. You cannot appeal to DMAS for an adverse benefit decision related to extra benefits we provide that are not covered by Medicaid (see Section 10 for a list of extra benefits).

Standard or expedited review requests

For standard requests, appeals will be heard and DMAS will give you an answer generally within 90 days from the date you filed your appeal. If you want your State Fair Hearing to be handled quickly, you must write "Expedited Request" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited appeal within 72 hours of receiving the letter from your doctor.

Authorized representative

You can give someone like your PCP, provider, or friend or family member written permission to help you with your State Fair Hearing request. This person is known as your authorized representative.

Where to send the State Fair Hearing request

There are a few ways to ask for an appeal with DMAS. Your deadline to ask for an appeal with DMAS is 120 calendar days from when we issue our final MCO internal appeal decision.

1. **Electronically.** Online at **www.dmas.virginia.gov/#/appealsresources** or email to **appeals@dmas.virginia.gov**.
2. **By fax.** Fax your appeal request to DMAS at 804-452-5454.
3. **By mail or in person.** Send or bring your appeal request to:
   Appeals Division
   Department of Medical Assistance Services
   600 E. Broad Street
   Richmond, VA 23219
4. **By phone.** Call DMAS at 804-371-8488 (TTY: 1-800-828-1120)

To help you, an appeal request form is available from DMAS at **www.dmas.virginia.gov/#/appealsresources**. You can also write your own letter. Include a full copy of our final denial letter when you file your appeal with DMAS. Also include any documents you would like DMAS to review during your appeal. All information submitted during the initial request and during the DMAS appeal process will be considered to determine if the individual meets the criteria for approval of the requested eligibility/service(s).

After you file your State Fair Hearing appeal

DMAS will notify you of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

State Fair Hearing timeframes

Expedited appeal

If you qualify for an expedited appeal, 3 business days. Hearings for expedited decisions are usually held within 3 business days of DMAS receiving the letter from your doctor.

Standard appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will generally give you an answer within 90 days from the date you filed your appeal. You will have an opportunity to participate in a hearing to present your position before a decision is made.

Continuation of benefits

In some cases you may be able to continue receiving services that were denied by us while you wait for your State Fair Hearing appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from the notice telling you that your request was denied or care was changing
- By the date the change in services is scheduled to occur

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. **You may, however, have to repay UnitedHealthcare Community Plan for any services you receive during the continued coverage period if UnitedHealthcare Community Plan's adverse benefit determination is upheld and the services were provided solely because of the requirements described in this Section.**

If the State Fair Hearing reverses the denial

If services were not continued while the State Fair Hearing was pending
If the State Fair Hearing decision is to reverse the denial, UnitedHealthcare Community Plan must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date UnitedHealthcare Community Plan receives notice from the State reversing the denial.

If services were provided while the State Fair Hearing was pending
If the State Fair hearing decision is to reverse the denial and services were provided while the appeal is pending, UnitedHealthcare Community Plan must pay for those services, in accordance with State policy and regulations.

If you disagree with the State Fair Hearing decision
The State Fair Hearing decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision, you may appeal it to your local circuit court.

Your right to file a grievance

UnitedHealthcare Community Plan will try its best to deal with your concerns as quickly as possible to your satisfaction. Depending on what type of concern you have, it will be handled as a grievance or as an appeal.

Timeframe for grievances

You can file a grievance with us at any time.

What kinds of problems should be grievances

The grievance process is used for concerns related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by UnitedHealthcare Community Plan's grievance process.

Grievances about quality

- You are unhappy with the quality of care, such as the care you got in the hospital

Grievances about privacy

- You think that someone did not respect your right to privacy or shared information about you that is confidential or private

Grievances about poor customer service

- A health care provider or staff was rude or disrespectful to you
- UnitedHealthcare Community Plan staff treated you poorly
- UnitedHealthcare Community Plan is not responding to your questions
- You are not happy with the assistance you are getting from your Care Coordinator

Grievances about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office
- You were not provided requested reasonable accommodations that you needed in order to participate meaningfully in your care

Grievances about communication access

- Your doctor or provider does not provide you with a qualified interpreter for the deaf or hard of hearing or an interpreter for another language during your appointment

Grievances about waiting times

- You are having trouble getting an appointment, or waiting too long to get it
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other UnitedHealthcare Community Plan staff

Grievances about cleanliness

- You think the clinic, hospital or doctor's office is not clean

Grievances about communications from us

- You think we failed to give you a notice or letter that you should have received
- You think the written information we sent you is too difficult to understand
- You asked for help in understanding information and did not receive it

Grievances

To file a grievance, call Member Services at the number below. You can also write your grievance and send it to us. If you put your grievance in writing, we will respond to your grievance in writing. You can file a grievance in writing, by mailing or faxing it to us at:

Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

So that we can best help you, include details on who or what the grievance is about and any information about your grievance. UnitedHealthcare Community Plan will review your grievance and request any additional information. You can call Member Services at the number below if you need help filing a grievance or if you need assistance in another language or format.

We will notify you of the outcome of your grievance within a reasonable time, but no later than 90 calendar days after we receive your grievance.

If your grievance is related to our refusal to expedite your appeal, or you don't agree with our decision to extend the appeal resolution timeframe, we will respond within 24 hours after the receipt of the grievance.

External grievances

You can file a grievance with the CCC Plus Helpline.

You can file a grievance about UnitedHealthcare Community Plan to the CCC Plus Helpline. Contact the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608**.

You can file a complaint with the Office for Civil Rights.

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. You can also visit **http://www.hhs.gov/ocr** for more information.

You may contact the local Office for Civil Rights at:

Office of Civil Rights – Region III
Department of Health and Human Services
150 S Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106

1-800-368-1019

Fax: **215-861-4431**

TDD: **1-800-537-7697**

You can file a grievance with the Office of the State Long-Term Care Ombudsman.

The State Long-Term Care Ombudsman serves as an advocate for older persons receiving long-term care services. Local Ombudsmen provide older Virginians and their families with information, advocacy, grievance counseling, and assistance in resolving care problems.

The State's Long-Term Care Ombudsman program offers assistance to persons receiving long-term care services, whether the care is provided in a nursing facility or assisted living facility, or through community-based services to assist persons still living at home. A Long-Term Care Ombudsman does not work for the facility, the State, or UnitedHealthcare Community Plan. This helps them to be fair and objective in resolving problems and concerns.

The program also represents the interests of long-term care consumers before state and federal government agencies and the General Assembly.

The State Long-Term Care Ombudsman can help you if you are having a problem with UnitedHealthcare Community Plan or a nursing facility. The State Long-Term Care Ombudsman is not connected with us or with any insurance company or health plan. The services are free.

Office of the State Long-Term Care Ombudsman
1-800-552-5019 This call is free.
1-800-464-9950

This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Virginia Office of the State Long-Term Care Ombudsman
Virginia Department for Aging and Rehabilitative Services
8004 Franklin Farms Drive
Henrico, Virginia 23229

804-662-9140

http://www.ElderRightsVA.org

16. Member rights

Your rights

It is the policy of UnitedHealthcare Community Plan to treat you with respect. We also care about keeping a high level of confidentiality with respect for your dignity and privacy. As a CCC Plus Member, you have certain rights. You have the right to:

- Receive timely access to care and services
- Decline participation in care coordination. When you are contacted by a care coordinator, let them know you do not wish to participate.
- Take part in decisions about your health care, including your right to choose your providers from UnitedHealthcare Community Plan network providers and your right to refuse treatment
- To participate in candid discussions with your physicians about appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- Choose to receive long-term services and supports in your home or community or in a nursing facility
- Confidentiality and privacy about your medical records and when you get treatment
- Receive information and to discuss available treatment options and alternatives presented in a manner and language you understand
- Get information in a language you understand — you can get oral translation services free of charge
- Receive reasonable accommodations to ensure you can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services
- Receive information necessary for you to give informed consent before the start of treatment
- Be treated with respect and dignity

- Get a copy of your medical records and ask that the records be amended or corrected
- Participate in decisions regarding your health care, including the right to refuse treatment
- Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to you or others or when there is a specific medical necessity. Seclusion and restraint will never be used as a means of coercion, discipline, retaliation, or convenience.
- Get care in a culturally competent manner including without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status or religion
- Be informed of where, when and how to obtain the services you need from UnitedHealthcare Community Plan, including how you can receive benefits from out-of-network providers if the services are not available in UnitedHealthcare Community Plan's network
- Complain about UnitedHealthcare Community Plan to the State. You can call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 to file a grievance about us.
- Appoint someone to speak for you about your care and treatment and to represent you in an Appeal
- Make advance directives and plans about your care in the instance that you are not able to make your own health care decisions. See Section 17 of this handbook for information about Advance Directives.
- Change your CCC Plus health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference Section 2 of this handbook or call the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608** or visit the website at **cccplusva.com** for more information.
- Appeal any adverse benefit determination (decision) by UnitedHealthcare Community Plan that you disagree with that relates to coverage or payment of services. See **Your right to appeal** in Section 15 of this handbook.

- File a grievance about any concerns you have with our customer service, the services you have received, or the care and treatment you have received from one of our network providers. See **Your right to file a grievance** in Section 15 of this handbook.
- To receive information from us about our plan, your covered services, providers in our network, and about your rights and responsibilities
- To make recommendations regarding our Member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this Section of the handbook)
- Exercise your rights and to know that you will not have any retaliation against you by UnitedHealthcare, any of our doctors/providers or state agencies

Your right to be safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If you, or someone you know, is being abused, physically, is being neglected, or is being taken advantage of financially by a family member or someone else, you should call your local department of social services or the Virginia Department of Social Services' 24-hour, toll-free hotline at: **1-888-832-3858**. You can make this call anonymously; you do not have to provide your name. The call is free.

They can also provide a trained local worker who can assist you and help you get the types of services you need to assure that you are safe.

Your right to confidentiality

UnitedHealthcare Community Plan will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse.

UnitedHealthcare Community Plan staff will ask questions to confirm your identity before we discuss or provide any information regarding your health information.

Confidentiality of Enrollee Information

Privacy of Member information and records is important to UnitedHealthcare Community Plan. There are several ways we protect your records.

- Members sign a release of medical records. This means you allow us to get your health care records when looking into a quality matter or health care inquiry.
- UnitedHealthcare has written and implemented policies and procedures that protect the privacy of your data. This type of data can be released to a person or organization that has provided your written consent. This data can be released to enrollees age eighteen (18) and older.
- Contracts between the Plan and its health care providers include terms concerning the privacy of your records

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.

How to join the Member Advisory Committee

UnitedHealthcare Community Plan would like you to help us improve our health plan. We invite you to join our Member Advisory Committee. On the committee, you can let us know how we can better serve you. Going to these meetings will give you and your caregiver or family member the chance to help plan meetings and meet other Members in the community. These educational meetings are held once every three months. If you would like to attend or would like more information, please contact UnitedHealthcare Community Plan Member Services using one of the numbers below.

We follow non-discrimination policies

UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. In other words, 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 free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact UnitedHealthcare Community Plan at the toll-free Member phone number listed on your health plan Member ID card, TTY **711**.

If you feel that UnitedHealthcare Community Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or email:

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

UHC_Civil_Rights@uhc.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/porta/lobby.jsf** or by mail at:

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)

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

UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. In other words, UnitedHealthcare Community Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY **711**, 8 a.m. to 8 p.m., 7 days a week.

If you feel that UnitedHealthcare Community Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or email:

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

UHC_Civil_Rights@uhc.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail at:

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)

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

English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Please call **1-866-622-7982, TTY 711.**

Spanish

ATENCIÓN: si habla **español (Spanish)**, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-622-7982, TTY 711.**

Korean

참고: **한국어(Korean)**를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-866-622-7982, TTY 711** 로 전화하십시오.

Vietnamese

LƯU Ý: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **1-866-622-7982, TTY 711.**

Chinese

注意:如果您說**中文(Chinese)**，您可獲得免費語言協助服務。請致電 **1-866-622-7982，或聽障專線(TTY)711**。

Arabic

تنبيه: إذا كنت تتحدث اللغة **العربية (Arabic)** ، تتوفر لك خدمات المساعدة اللغوية مجانًا.
اتصل بالرقم **1-866-622-7982، الهاتف النصي 711.**

Tagalog

ATENSYON: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-866-622-7982, TTY 711**.

Persian (Farsi)

توجه: اگر به **فارسی (Farsi)** صحبت می کنید، خدمات ترجمه به صورت رایگان در اختیارتان قرار می گیرد. با **1-866-622-7982 (TTY 711)** تماس بگیرید.

Amharic

የሚናገሩት ቋንቋ **አማርኛ** (Amharic) ከሆነ የቋንቋ እርዳታ አገልግሎት ከክፍያ ነጻ አለልዎት። ወደ **1-866-622-7982,TTY 711** ይደውሉ።

Urdu

توجہ فرمائیں: اگر آپ کی زبان **اردو (Urdu)** ہے تو آپ کے لیے لسانی خدمات مفت دستیاب ہیں۔ **1-866-622-7982 (TTY 711)** پر کال کریں۔

French

ATTENTION: Si vous parlez **français (French)**, vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-866-622-7982,TTY 711**.

Russian

ВНИМАНИЕ: Если вы говорите по-**русски (Russian)**, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел **1-866-622-7982, TTY 711.**

Hindi

ध्यान दें: यदि आप **हिंदी (Hindi)** भाषा बोलते हैं तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **1-866-622-7982**, TTY 711.

German

HINWEIS: Wenn Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Wählen Sie: **1-866-622-7982, TTY 711.**

Bengali

আপনি যদি **বাংলায় কথা (Bengali)** বলেন, তাহলে ভাষা সহায়তা পরিষেবাগুলি, আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-866-622-7982, TTY 711** নম্বরে ফোন করুন।

Kru (Bassa)

TÒ ĐÙŬ NƆ̀ MƆ̀ DYÍIN CÁO: À ɓéɖé gbo-kpá-kpá **ɓó wuɖu (Kru (Bassa))**-dù kò-kò po-nyɔ̀ ɓě bìì nɔ̄ à gbo ɓó pídyi. M̀ dyi gbo-kpá-kpá mɔ́ ín, ɖá nɔ̀ ɓà nìà kɛ: **1-866-622-7982, TTY 711.**

Igbo

Ọ bụrụ na ị na asụ **Igbo (Igbo),** ọrụ enyemaka asụsụ, n'efu dịịrị gị. Kpọọ **1-866-622-7982, TTY 711.**

Yoruba

Tí ó bá ń s **Yorùbá (Yoruba)**, ìrànlọ́wọ́ ìtum èdè, wà fún ní ọ̀fẹ́. Pe **1-866-622-7982, TTY 711.**

17. Member responsibilities

Your responsibilities

As a Member, you also have some responsibilities. These include:

- Present your UnitedHealthcare Community Plan Membership card whenever you seek medical care
- Provide complete and accurate information to the best of your ability on your health and medical history
- To participate in understanding your health problems and developing mutually agreed-upon treatment goals
- Participate in your care team meetings, develop an understanding of your health condition, and provide input in developing mutually agreed upon treatment goals to the best of your ability
- Keep your appointments. If you must cancel, call as soon as you can.
- Receive all of your covered services from UnitedHealthcare Community Plan's network
- Obtain authorization from UnitedHealthcare Community Plan prior to receiving services that require a service authorization review (see Section 14)
- Call UnitedHealthcare Community Plan whenever you have a question regarding your Membership or if you need assistance toll-free at one of the numbers below
- Tell UnitedHealthcare Community Plan when you plan to be out of town so we can help you arrange your services
- Use the emergency room only for real emergencies
- Call your PCP when you need medical care, even if it is after-hours
- Tell UnitedHealthcare Community Plan when you believe there is a need to change your plan of care
- Tell us if you have problems with any health care staff. Call Member Services at one of the numbers below

- Call Member Services at one of the phone numbers below about any of the following:
  - If you have any changes to your name, your address, or your phone number. Report these also to your case worker at your local Department of Social Services.
  - If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
  - If you have any liability claims, such as claims from an automobile accident
  - If you are admitted to a nursing facility or hospital
  - If you get care in an out-of-area or out-of-network hospital or emergency room
  - If your caregiver or anyone responsible for you changes
  - If you are part of a clinical research study

Advance Directives

You have the right to say what you want to happen if you are unable to make health care decisions for yourself. There may be a time when you are unable to make health care decisions for yourself. Before that happens to you, you can:

- Fill out a written form to give someone the right to make health care decisions for you if you become unable to make decisions for yourself
- Give your doctors written instructions about how you want them to handle your health care if you become unable to make decisions for yourself

The legal document that you can use to give your directions is called an advance directive. An advance directive goes into effect only if you are unable to make health care decisions for yourself. Any person age 18 or over can complete an advance directive. There are different types of advance directives and different names for them. Examples are a living will, a durable power of attorney for health care, and advance care directive for health care decisions.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

Where to get the Advance Directives form

You can get the Virginia Advance Directives form at: **http://www.virginiaadvancedirectives.org/the-virginia-hospital—healthcares-association–vhha–form.html**.

Additional resources:

- Caring Connections (NHPCO) at **1-800-658-8898** or on the Internet at: **http://www.caringinfo.org**
- Our website at **myuhc.com/CommunityPlan**

You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicaid may also have advance directive forms. If you have any questions about this information, please contact Customer Service at **1-888-622-7982**, TTY **711**.

Contact Caring Connections (NHPCO) at **1-800-658-8898** or on the Internet at: **http://www.caringinfo.org**.

Completing the Advance Directives form

Fill it out and sign the form. The form is a legal document. You may want to consider having a lawyer help you prepare it. There may be free legal resources available to assist you.

Share the information with people you want to know about it

Give copies to people who need to know about it. You should give a copy of the Living Will, Advance Care Directive, or Power of Attorney form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, take a copy of it to the hospital. The hospital will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

We can help you get or understand Advance Directives documents

Your Care Coordinator 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.

Remember, it is your choice to fill out an advance directive or not. You can revoke or change your advance care directive or power of attorney if your wishes about your health care decisions or authorized representative change.

Other resources

You may also find information about advance directives in Virginia at: **www.virginiaadvancedirectives.org**.

You can store your advance directive at the Virginia Department of Health Advance Healthcare Directive Registry: **https://connectvirginia.org/adr/**.

If your Advance Directives are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the following organizations.

For complaints about doctors and other providers, contact the Enforcement Division at the Virginia Department of Health Professions:

Call	Virginia Department of Health Professions: Toll-free phone: **1-800-533-1560** Local phone: **804-367-4691**
Write	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
Fax	**804-527-4424**
Email	**enfcomplaints@dhp.virginia.gov**
Website	**http://www.dhp.virginia.gov/Enforcement/complaints.htm**

For complaints about nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and health plans (also known as managed care organizations), contact the Office of Licensure and Certification at the Virginia Department of Health:

Call	Toll-Free Phone: **1-800-955-1819** Local Phone: **804-367-2106**
Write	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1463
Fax	**804-527-4503**
Email	**OLC-Complaints@vdh.virginia.gov**
Website	**http://www.vdh.virginia.gov/licensure-and-certification/**

18. Fraud, waste, and abuse

What is fraud, waste, and abuse

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste includes overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act, but does result in spending that should not have occurred. As a result, waste should be reported so that improper payments can be identified and corrected.

Abuse includes practices that are inconsistent with sound fiscal, business, or medical practice, and result in unnecessary cost to the Medicaid program, payment for services that are not medically necessary, or fail to meet professionally recognized health care standards.

Common types of health care fraud, waste, and abuse include:

- Medical identity theft
- Billing for unnecessary items or services
- Billing for items or services not provided
- Billing a code for a more expensive service or procedure than was performed (known as up-coding)
- Charging for services separately that are generally grouped into one rate (Unbundling)
- Items or services not covered
- When one doctor receives a form of payment in return for referring a patient to another doctor. These payments are called “kickbacks.”

How do I report fraud, waste, or abuse?

If you suspect anyone is committing fraud and abuse, including providers, call UnitedHealthcare Community Plan's Member Services line at **1-866-622-7982**, TTY **711**. You can remain anonymous. If you do give your name, the provider will not be told you called. If you would prefer to refer your fraud, waste, or abuse concerns directly to the State, you can report to the contacts listed below.

Department of Medical Assistance Services Fraud Hotline:

Phone: **1-800-371-0824** or
1-866-486-1971 or
804-786-1066

Virginia Medicaid Fraud Control Unit (Office of the Attorney General):

Email: **MFCU_mail@oag.state.va.us**

Fax: **804-786-3509**

Mail: Office of the Attorney General
Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, VA 23219

Virginia Office of the State Inspector General.
Fraud, Waste, and Abuse Hotline:

Phone: **1-800-723-1615**

Fax: **804-371-0165**

Email: **covhotline@osig.virginia.gov**

Mail: State FWA Hotline
101 N. 14th Street
The James Monroe Building, 7th Floor
Richmond, VA 23219

19. Other important resources

The Virginia Department for the Deaf and Hard of Hearing (VDDHH)

The Technology Assistance Program (TAP) provides telecommunication equipment to qualified applicants whose disabilities prevent them from using a standard telephone. VDDHH outreach specialists can also provide information and referral for assistive technology devices.

804-662-9502 (Voice/TTY)

1-800-552-7917 (Voice/TTY)

804-662-9718 (Fax)

1602 Rolling Hills Drive, Suite 203
Richmond, VA 23229-5012

http://www.vddhh.org

20. Information for Medicaid Expansion members

What makes you eligible to be a Medicaid Expansion member

You are eligible for Medicaid Expansion if you are 19 years of age to 64 years of age and you meet all of the following categories:

- You are not already eligible for Medicare coverage,
- You are not already eligible for Medicaid coverage through a mandatory coverage group (you are pregnant or disabled, for example),
- Your income does not exceed 138% of the Federal Poverty Limit (FPL), and
- You indicated in your application that you have complex medical needs.

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at **833-5CALLVA** or TDD: **1-888-221-1590** about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at **http://www.coverva.org**.

Enrollment for a Medicaid Expansion member

Within three months after you enroll with UnitedHealthcare Community Plan, a health plan representative will contact you or your authorized representative via telephone, mail or in person to ask you some questions about your health and social needs.

If you do not meet the medically complex criteria, you may transfer from CCC Plus to the Medicaid Managed Care Medallion 4.0 program. If UnitedHealthcare Community Plan is unable to contact you, or you refuse to participate in the entire health screening, you may be transferred to the Medallion program. You will stay with UnitedHealthcare Community Plan no matter which program you are in. If you prefer to change health plans, you can change within the first 90 days of enrolling into the Medallion 4.0 program. For more information on the Health Screening, see section 4.

If you do not meet medically complex criteria and do not agree, you have a right to submit a grievance to UnitedHealthcare Community Plan. See the **Your right to file a grievance** section for details.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between November and December 31, with a January 1st coverage begin date. You will get a letter from DMAS during open enrollment with more information.

You may also ask to change your health plan at any time for "good cause," which can include:

- You move out of the health plan's service area,
- You need multiple services provided at the same time but cannot access them within the health plan's network,
- Your residency or employment would be disrupted as a result of your residential, institutional, or employment supports provider changing from an in-network to an out-of-network provider, and

- Other reasons determined by DMAS, including poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care.
- You do not meet medically complex criteria and transfer to the Medallion 4.0 Medicaid Managed Care program

The CCC Plus Helpline handles "good cause" requests and can answer any questions you may have. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at **cccplusva.com**.

Medicaid Expansion benefits and services

As a Medicaid expansion Member, you have a variety of health care benefits and services available to you. You will receive most of your services through UnitedHealthcare Community Plan, but may receive some through DMAS or a DMAS Contractor.

Services provided through UnitedHealthcare Community Plan are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 10.

Services covered by DMAS or a DMAS Contractor are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 11.

Services that are not covered through UnitedHealthcare Community Plan or DMAS are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 12.

If you are an eligible Medicaid expansion Member, in addition to the services listed above (in the same amount, duration, and scope of services as other CCC Plus Program Members) you will also receive the following four additional health benefits:

- Annual adult wellness exams
- Nutritional counseling if you are diagnosed with obesity or chronic medical diseases
- Recommended adult vaccines or immunizations

20. Information for Medicaid Expansion members

UnitedHealthcare Community Plan will also encourage you to take an active role in your health. This may mean taking part in disease management programs, getting a flu shot, quitting smoking or using tobacco/nicotine products, or accessing services that are not typically covered by traditional medical practices like gym memberships or vision services.

If you frequently visit the emergency room, UnitedHealthcare Community Plan will reach out to you to help you address your needs. There may be opportunities to address your needs outside of the emergency room, like in physician offices and clinics.

UnitedHealthcare Community Plan may also discuss with you several opportunities to take advantage of job training, education, and job placement assistance to help you find the work situation that is right for you.

21. Important words and definitions used in this handbook

Adverse Benefit Determination: Any decision to deny a service authorization request or to approve it for an amount that is less than requested.

Appeal: A way for you to challenge an adverse benefit determination (such as a denial or reduction of benefits) made by UnitedHealthcare Community Plan if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Activities of Daily Living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Balance Billing: A situation when a provider (such as a doctor or hospital) bills a person more than UnitedHealthcare Community Plan's cost-sharing amount for services. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.

Brand-Name Drug: A prescription drug that is made and sold by the company that originally made the drug. Brand-name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Coordinator: One main person from our UnitedHealthcare Community Plan who works with you and with your care providers to make sure you get the care you need.

Care Coordination: A person-centered individualized process that assists you in gaining access to needed services. The Care Coordinator will work with you, your family members, if appropriate, your providers and anyone else involved in your care to help you get the services and supports that you need.

Care Plan: A plan for what health and support services you will get and how you will get them.

21. Important words and definitions used in this handbook

Care Team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

CCC Plus Helpline: An Enrollment Broker that DMAS contracts with to perform choice counseling and enrollment activities.

Centers for Medicare and Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid programs.

Coinsurance: See the definition for cost sharing.

Copayment: See the definition for cost sharing.

Cost Sharing: The costs that Members may have to pay out of pocket for covered services. This term generally includes deductibles, coinsurance, and copayments, or similar charges. Also see the definition for patient pay.

Coverage Decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services.

Covered Drugs: The term we use to mean all of the prescription drugs covered by UnitedHealthcare Community Plan.

Covered Services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by UnitedHealthcare Community Plan.

Durable Medical Equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency Medical Condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.

Emergency Medical Transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling **911** for an ambulance.

Emergency Room Care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Emergency Services: Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.

Excluded Services: Services that are not covered under the Medicaid benefit.

Fair Hearing: See State Fair Hearing. The process where you appeal to the State on a decision made by us that you believe is wrong.

Fee-for-Service: The general term used to describe Medicaid services covered by the Department of Medical Assistance Services (DMAS).

Generic Drug: A prescription drug that is approved by the federal government to use in place of a brand-name drug. A generic drug has the same ingredients as a brand-name drug. It is usually cheaper and works just as well as the brand-name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Habilitation Services and Devices: Services and devices that help you keep, learn, or improve skills and functioning for daily living.

Health Insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Health Plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Health Risk Assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home Health Aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care: Health care services a person receives in the home including nursing care, home health aide services and other services.

Hospice Services: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: The act of placing a person in a hospital as a patient.

Hospital Outpatient Care: Care or treatment that does not require an overnight stay in a hospital.

List of Covered Drugs (Drug List): A list of prescription drugs covered by UnitedHealthcare Community Plan. UnitedHealthcare Community Plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-Term Services and Supports (LTSS): A variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and maintain maximum independence. Examples include assistance with bathing, dressing, toileting, eating, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital.

Medically Necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

Medicaid (or Medical Assistance): A program run by the federal and the state government that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").

Medicare-Covered Services: Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid Enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid.

Member Services: A department within UnitedHealthcare Community Plan responsible for answering your questions about your Membership, benefits, grievances, and appeals.

Model of Care: A way of providing high-quality care. The CCC Plus model of care includes care coordination and a team of qualified providers working together with you to improve your health and quality of life.

Network: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them "network providers" when they agree to work with the UnitedHealthcare Community Plan and accept our payment and not charge our Members an extra amount. While you are a Member of UnitedHealthcare Community Plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Network Pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for UnitedHealthcare Community Plan Members. We call them "network pharmacies" because they have agreed to work with UnitedHealthcare Community Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-Participating Provider: A provider or facility that is not employed, owned, or operated by UnitedHealthcare Community Plan and is not under contract to provide covered services to Members of UnitedHealthcare Community Plan.

Nursing Facility: A medical care facility that provides care for people who cannot get their care at home but who do not need to be in the hospital. Specific criteria must be met to live in a nursing facility.

Ombudsman: An office in your state that helps you if you are having problems with UnitedHealthcare Community Plan or with your services. The ombudsman's services are free.

Out-of-Network Provider or Out-Of-Network Facility: A provider or facility that is not employed, owned, or operated by UnitedHealthcare Community Plan and is not under contract to provide covered services to Members of UnitedHealthcare Community Plan.

Participating Provider: Providers, hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports that are contracted with UnitedHealthcare Community Plan. Participating providers are also "in-network providers" or "plan providers."

Patient Pay: The amount you may have to pay for long-term care services based on your income. The Department of Social Services (DSS) must calculate your patient pay amount if you live in a nursing facility or receive CCC Plus Waiver services and have an obligation to pay a portion of your care. DSS will notify you and UnitedHealthcare Community Plan if you have a patient pay, including the patient pay amount (if any).

Physician Services: Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.

Plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Prescription Drug Coverage: Prescription drugs or medications covered (paid) by your UnitedHealthcare Community Plan. Some over-the-counter medications are covered.

Prescription Drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary Care Physician (PCP): Your primary care physician (also referred to as your primary care provider) is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.

Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with UnitedHealthcare Community Plan, including doctors, nurses, behavioral health providers and specialists.

Premium: A monthly payment a health plan receives to provide you with health care coverage.

Private Duty Nursing Services: Skilled in-home nursing services provided by a licensed RN, or by an LPN under the supervision of an RN, to waiver Members who have serious medical conditions or complex health care needs.

Referral: In most cases your PCP must give you approval before you can use other providers in UnitedHealthcare Community Plan's network. This is called a referral.

Rehabilitation Services and Devices: Treatment you get to help you recover from an illness, accident, injury, or major operation.

Service Area: A geographic area where a UnitedHealthcare Community Plan is allowed to operate. It is also generally the area where you can get routine (non-emergency) services.

Service Authorization: Also known as preauthorization. Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from UnitedHealthcare Community Plan.

Skilled Nursing Care: Care or treatment that can only be done by licensed nurses. Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings or rapidly changing health status.

Skilled Nursing Facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Specialist: A doctor who provides health care for a specific disease, disability, or part of the body.

Urgently Needed Care (Urgent Care): Care you get for a non-life-threatening sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-866-622-7982**, TTY **711**, 8:00 a.m.–8:00 p.m. ET, daily. You can also visit our website at **myuhc.com/CommunityPlan**.

UnitedHealthcare Community Plan
9020 Stony Point Parkway, Suite 400
Richmond, VA 23235

United Healthcare
Community Plan