Washington, DC

Welcome to the community

District Dual Choice Program Enrollee Handbook

Enrollee Services:
1-866-242-7726, TTY **711**
8:00 a.m.–8:00 p.m., 7 days a week, October–March;
8:00 a.m.–5:30 p.m., Monday–Friday, April–September

myuhc.com/CommunityPlan

United Healthcare Community Plan

DHCF Department of Health Care Finance

CSDC22MC5132270_000

UnitedHealthcare Community Plan

You can call us toll-free at **1-866-242-7726**, TTY **711**,
8:00 a.m.–5:30 p.m., Monday through Friday.
This number is also on the back of your Enrollee ID Card.

655 New York Avenue NW
Washington, DC 20001

English

If you do not speak and/or read English, please call **1-866-242-7726**, TTY **711**, between 8:00 a.m.–5:30 p.m. EST, Monday–Friday, months April–September; 8:00 a.m.–8:00 p.m. EST, 7 days a week, months October–March. A representative will assist you.

Spanish

Si no habla ni lee en inglés, llame al **1-866-242-7726**, TTY **711**, de lunes a viernes, de 8:00 a.m. a 5:30 p.m. hora del este, de abril a septiembre; y los 7 días de la semana, de 8:00 a.m. a 8:00 p.m., hora del este, de octubre a marzo. Un representante le brindará asistencia.

Amharic

እንግሊዘኛ የማይናገሩ እና/ወይም የማያነቡ ከሆነ፣ እባክዎን በ1-866-242-7726፣ TTY 711፣ ከቀኑ 8፡00am - 5፡30pm EST፣ ከሰኞ - አርብ፣ ወራት ከኤፕሪል - ሴፕቴምበር፣ 8:00am - 8:00pm EST፣ በሳምንት 7 ቀናት፣ ወራት ከአክቶበር - ማርች። አንድ ተወካይ ይረዳዎታል።

Vietnamese

Nếu quý vị không nói và/hoặc đọc được tiếng Anh, vui lòng gọi đến số 1-866-242-7726, TTY (Thoại văn bản) 711, từ 8:00 sa – 5:30 ch, giờ Chuẩn Miền Đông (EST), từ thứ Hai – thứ Sáu trong tháng Tư – tháng Chín; 8:00 sa – 8:00 tối, giờ Chuẩn Miền Đông (EST), 7 ngày một tuần trong tháng Mười – tháng Ba. Một nhân viên sẽ hỗ trợ cho quý vị.

Korean

영어로 말하거나 읽지 못하시는 경우, 4월~9월에는 월요일~금요일 오전 8시~오후 5시 30분(동부 표준시), 10월~3월에는 주 7일 오전 8시~오후 8시(동부 표준시)에 1-866-242-7726, TTY 711로 전화하십시오. 담당자가 도움을 드릴 것입니다.

French

Si vous ne savez pas parler et/ou lire l’anglais, veuillez composer le numéro 1-866-242-7726, téléscripteur 711, de 8:00 à 17:30 (heure normale de l’Est), du lundi au vendredi, d’avril à septembre ; de 8:00 à 20:00 (heure normale de l’Est), 7 jours sur 7, d’octobre à mars. Un représentant vous aidera.

Arabic

إذا كنت لا تتحدث الإنجليزية و/أو لا تجيد قراءتها، فيُرجى الاتصال على 1-866-242-7726، الهاتف النصي 711، بين 8:00 صباحًا و5:30 مساءً بتوقيت شرق الولايات المتحدة، من الإثنين إلى الجمعة، من أبريل إلى سبتمبر؛ ومن 8:00 صباحًا إلى 8:00 مساءً بتوقيت شرق الولايات المتحدة، 7 أيام في الأسبوع، من أكتوبر إلى مارس. وسيُساعدك أحد ممثلي الخدمة.

Mandarin

如果您不会说和/或阅读英语，请在四月至九月之间，于周一至周五，上午 8:00 至下午 5:30（美国东部标准时间）；在十月至三月之间，每周 7 天，上午 8:00 至晚上 8:00（美国东部标准时间），致电 1-866-242-7726，听障专线 (TTY) 711。一位代表将为您提供帮助。

Russian
Если вы не говорите и/или не читаете по-английски, позвоните по телефону 1-866-242-7726, TTY 711, 08:00 – 17:30 по восточному поясному времени, с понедельника по пятницу, с апреля по сентябрь; 08:00 – 20:00 по восточному поясному времени, 7 дней в неделю, с октября по март. Наш представитель поможет Вам.

Burmese
သင်အင်္ဂလိပ်စကား မပြောလျှင် နှင့်/သို့မဟုတ် အင်္ဂလိပ်ဘာသာစကားကို မဖတ်တတ်လျှင်၊ ဖုံးလွှမ်း စက်တင်ဘာလအတွင်းဖြစ်ပါက၊ တနလ်ာနေ့မှ သောကြာနေ့၊ အရှေ့ပိုင်းစံတော်ချိန် နံနက် 8:00 နာရီမှ ညနေ 5:30 အတွင်းနှင့် အောက်တိုဘာလမှ မတ်လအတွင်းဖြစ်ပါက၊ တစ်ပတ်လျှင် 7 ရက်လုံး၊ အရှေ့ပိုင်းစံတော်ချိန်၊ နံနက် 8:00 နာရီမှ ည 8:00 နာရီအတွင်း 1-866-242-7726၊ TTY 711 ကို ဖုန်းခေါ်ဆိုပါ။ ကိုယ်စားလှယ်တစ်ဦးက သင့်အား အကူအညီပေးသွားပါမည်။

Cantonese
如果您不會說和/或閱讀英語，請在美國東部標準時間週一至週五、四月至九月的上午 8:00 至下午 5:30 之間致電 1-866-242-7726，聽障專綫（TTY）711；美國東部標準時間上午 8:00 至晚上 8:00，每週 7 天，十月至三月。代表將為您提供協助。

Farsi
اگر به زبان انگلیسی صحبت نمی‌کنید و یا متن نمی‌خوانید، لطفاً از ساعت 8:00 صبح تا 5:30 عصر EST، از دوشنبه تا جمعه، ماههای آوریل تا سپتامبر؛ 8:00 صبح تا 8:00 شب EST،7 روز هفته، ماههای اکتبر تا مارس با 1-866-242-7726، TTY 711 تماس بگیرید. یکی از نمایندگان به شما کمک خواهد کرد.

Polish
Jeśli nie mówisz i/lub nie czytasz po angielsku, prosimy o kontakt pod numerem 1-866-242-7726, TTY 711, w godzinach 8:00 – 7:30 EST, od poniedziałku do piątku, w miesiącach kwiecień – wrzesień; 8:00 – 20:00 EST, 7 dni w tygodniu, w miesiącach październik – marzec. Przedstawiciel firmy udzieli Ci pomocy.

Portuguese
Se não fala e/ou não lê inglês, ligue para o 1-866-242-7726, TTY 711, entre as 8:00h - 17:30h EST, de segunda a sexta-feira, nos meses de abril - setembro; 8:00h - 20:00h EST, 7 dias por semana, nos meses de outubro – março. Um representante irá ajudá-lo(a).

Punjabi
ਜੇ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਨਹੀਂ ਬੋਲਦੇ ਅਤੇ/ਜਾਂ ਨਹੀਂ ਪੜ੍ਹਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-866-242-7726, TTY 711 ਨੂੰ, ਅਪ੍ਰੈਲ - ਸਤੰਬਰ ਮਹੀਨੇ ਲਈ ਸੋਮਵਾਰ - ਸ਼ੁੱਕਰਵਾਰ, ਸਵੇਰੇ 8:00 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 5:30 ਵਜੇ EST; ਅਕਤੂਬਰ – ਮਾਰਚ ਮਹੀਨੇ ਲਈ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ ਸਵੇਰੇ 8:00 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8:00 ਵਜੇ EST ਦੇ ਵਿਚਕਾਰ ਕਾਲ ਕਰੋ। ਇੱਕ ਪ੍ਰਤੀਨਿਧੀ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰੇਗਾ।

Haitian Creole
Si ou pa pale ak/oswa li anglè, tanpri rele 1-866-242-7726, TTY 711, ant 8:00am – 5:30pm EST, lendi – vandredi, pou mwa avril – septanm; 8:00am – 8:00pm EST, 7 jou nan yon semèn, pou mwa oktòb – mas. Yon reprezantan pral ede ou.

Hindi
यदि आप अंग्रेज़ी बोल और/या पढ़ नहीं पाते हैं, तो कृपया 1-866-242-7726, TTY 711 पर, सुबह 8:00 – शाम 5:30 EST, सोमवार – शुक्रवार, महीने अप्रैल – सितम्बर; सुबह 8:00 – शाम 8:00 EST, 7 दिन प्रति सप्ताह, महीने अक्टूबर – मार्च संपर्क करें। एक प्रतिनिधि आपकी सहायता करेगा।

Somali
Haddii aadan ku hadlin iyo/ama akhrin Ingiriisi, fadlan wac 1-866-242-7726, TTY 711, inta u dhexaysa 8:00 subaxnimo – 5:30 galabnimo EST, Isniinta – Jimcaha, billaha Abriil – Sitembar; 8:00 subaxnimo – 8:00 galabnimo EST, 7 maalin isbuucii, billaha Oktoobar – Maarso. Wakiil ayaa ku caawin doona.

Hmong
Yog koj hais lus As Kiv tsis tau thiab/los sis nyeem ntawv As Kiv tsis tau, ces hu rau 1-866-242-7726, TTY 711, thaj tsam thaum 8:00 teev sawv ntxov – 5:30 teev yav tsaus ntuj EST, hnub Monday – Friday, lub Plaub Hlis Ntuj – Cuaj Hli Ntuj; 8:00 teev sawv ntxov – 8:00 teev tsaus ntuj EST, 7 hnub hauv ib lub vij, Lub Kaum Hli Ntuj – Peb Hlis Ntuj. Ib tug neeg sawv cev yuav los pab koj.

Italian
Se non si parla e/o legge in lingua inglese, si prega di chiamare il numero +1 866 242 7726, TTY 711, dalle 8:00 alle 17:30 ora standard orientale, da lunedì a venerdì, nei mesi da aprile a settembre; e dalle 8:00 alle 20:00 ora standard orientale, 7 giorni su 7, nei mesi da ottobre a marzo. Si riceverà assistenza da un rappresentante.

Tagalog
Kung hindi ka nagsasalita at/o nagbabasa ng English, pakitawagan ang 1-866-242-7726, TTY 711, sa pagitan ng 8:00am – 5:30pm EST, Lunes – Biyernes, mga buwan ng Abril – Setyembre; 8:00am – 8:00pm EST, 7 araw sa isang linggo, mga buwan ng Okttubre – Marso. Tutulungan ka ng isang kinatawan.

Japanese
英語を話したり読んだりできない場合は、以下の時間帯に電話（1-866-242-7726、TTY 711）でお問合せください。4月～9月、午前8:00～午後5:30（東部標準時）、月曜日～金曜日。10月～3月、午前8:00～午後8:00（東部標準時）、週7日間。担当者がお手伝いいたします。

Important phone numbers

For questions about your plan:	Enrollee Services	**1-866-242-7726**, TTY **711** (toll free)	8:00 a.m.–5:30 p.m., Monday–Friday
	TTY/TDD Enrollee Services	**1-866-242-7726**, TTY **711** (toll free)	8:00 a.m.–8:00 p.m., 7 days a week
If you need care after your doctor's office is closed:	Nurse Helpline	**1-877-440-9407**, TTY **711** (toll free)	24 hours a day, 7 days a week
	TTY/TDD Nurse Helpline	**1-877-440-9407**, TTY **711** (toll free)	24 hours a day, 7 days a week
If you need to see a doctor within 24 hours ("Urgent Care"):	Your PCP's office	(fill in your PCP's information here)	
	Nurse Helpline	**1-877-440-9407**, TTY **711** (toll free)	24 hours a day, 7 days a week
If you need a ride to an appointment:	Enrollee Services	**1-866-242-7726**, TTY **711** (toll free)	8:00 a.m.–5:30 p.m., Monday–Friday
If you need Mental Health care or have a Mental Health question:	Your PCP's office	(fill in your PCP's information here)	
	Nurse Helpline	**1-877-440-9407**, TTY **711** (toll free)	24 hours a day, 7 days a week
	DC Department of Behavioral Health Access Hotline	**1-888-793-4357**	24 hours a day, 7 days a week
If you need someone who speaks your language or if you are Hearing Impaired:	Enrollee Services	**1-866-242-7726**, TTY **711** (toll free)	8:00 a.m.–5:30 p.m., Monday–Friday
	TTY/TDD Enrollee Services	**1-866-242-7726**, TTY **711** (toll free)	8:00 a.m.–5:30 p.m., Monday–Friday
Dental questions:	Enrollee Services	**1-866-242-7726**, TTY **711** (toll free)	8:00 a.m.–5:30 p.m., Monday–Friday
Vision questions:	Enrollee Services	**1-866-242-7726**, TTY **711** (toll free)	8:00 a.m.–5:30 p.m., Monday–Friday
Long-Term Care questions:	Enrollee Services	**1-866-242-7726**, TTY **711** (toll free)	8:00 a.m.–5:30 p.m., Monday–Friday
For an emergency, dial 911 or go to your nearest emergency room.			

Personal information

My Medicaid ID number:

_____

My Primary Care Provider (PCP):

_____

My Primary Care Provider (PCP) address:

_____

My Primary Care Provider (PCP) phone:

_____

My Primary Dental Provider (PDP):

_____

My Primary Dental Provider (PDP) address:

_____

My Primary Dental Provider (PDP) phone:

_____

My Care Manager:

_____

My Care Manager's phone:

_____

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Welcome to UnitedHealthcare Community Plan

Thank you for choosing UnitedHealthcare Community Plan. UnitedHealthcare Community Plan operates the District Dual Choice Program. The District Dual Choice Program provides both Medicaid and Medicare (UnitedHealthcare Community Plan® Dual Complete) covered benefits.

- Medicare is 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 (kidney failure)
- Medicaid is a joint Federal and District government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan. There are different types of Medicare health plans. UnitedHealthcare Community Plan offers a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs. This plan is designed specifically for people who have Medicare and who are also entitled to assistance from Medicaid.

UnitedHealthcare Community Plan is a private company. This plan is approved by Medicare. The plan is also approved by the District to cover your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage.

UnitedHealthcare Community Plan supports the District of Columbia's goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following enrollees under the program:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-sharing and are also eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. Your cost share is 0% when the service is covered by both Medicare and Medicaid.

- **Qualified Medicare Beneficiary (QMB):** You get Medicaid coverage of Medicare cost-sharing but are not eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts only for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

How this handbook works

This handbook gives you the details about your Medicare and Medicaid health care and prescription drug coverage for 2022. This handbook explains your rights and responsibilities, what is covered, and what you pay as an enrollee of the plan.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this handbook. If you are confused or concerned or just have a question, please contact our plan's Enrollee Services number at **1-866-242-7726**, TTY **711**.

How this handbook can help you

This enrollee handbook tells you:

- How to access health care
- Your covered services
- Services NOT covered
- How to pick your Primary Care Provider and Primary Dental Provider (your PCP or PDP)
- What to do if you get sick
- What you should do if you have a Grievance or want to change (Appeal) a decision by UnitedHealthcare Community Plan

This Enrollee Handbook gives you basic information about how the District Dual Choice Program works. Please call Enrollee Services between 8:00 a.m.–5:30 p.m., Monday through Friday if you have additional questions about your plan.

Your rights and responsibilities

Your rights

- Know that when you talk with your doctors and other providers it's private
- Have an illness or treatment explained to you in a language you can understand
- Participate in decisions about your care, including the right to refuse treatment
- Receive a full, clear, and understandable explanation of treatment options and risks of each option so you can make an informed decision
- Refuse treatment or care
- Can see and receive a copy of your medical records and request an amendment or change, if incorrect
- Be free from any form of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive access to health care services that are available and accessible to you in a timely manner
- Choose an eligible PCP/PDP from within UnitedHealthcare Community Plan's network and to change your PCP/PDP
- Make a Grievance about the care provided to you and receive an answer
- Request an Appeal or a Fair Hearing if you believe UnitedHealthcare Community Plan was wrong in denying, reducing, or stopping a service or item
- Receive Family Planning Services and supplies from the provider of your choice
- Obtain medical care without unnecessary delay
- Receive a second opinion from a qualified health care professional within the network, or, if necessary, to obtain one outside the network, at no cost to you
- Receive information on Advance Directives and choose not to have or continue any life sustaining treatment
- Receive a copy of UnitedHealthcare Community Plan's Enrollee Handbook and/or Provider Directory
- Continue treatment you are currently receiving until you have a new treatment plan
- Receive interpretation and translation services free of charge
- Refuse oral interpretation services

- Receive transportation services free of charge
- Get an explanation of prior authorization procedures
- Receive information about UnitedHealthcare Community Plan's financial condition and any special ways we pay our doctors
- Obtain summaries of customer satisfaction surveys
- Receive UnitedHealthcare Community Plan's "Dispense as Written" policy for prescription drugs
- Receive a list of all covered drugs
- Be treated with respect and due consideration for your dignity and right to privacy

There are several places where you can get more information about your rights:

- You can call Enrollee Services (phone numbers are printed on the back cover of this booklet)
- You can contact Medicare
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)
  - Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can contact Medicaid
  - You can visit the DHCF website (**https://www.dc-medicaid.com/dcwebportal/nonsecure/recipientInformation**)
  - You can call the District's Office of Health Care Ombudsman and Bill Of Rights at 202-724-7491, TTY 711

Your responsibilities

Things you need to do as an enrollee of the plan are listed below. If you have any questions, please call Enrollee Services at **1-866-242-7726**, TTY **711**. We're here to help.

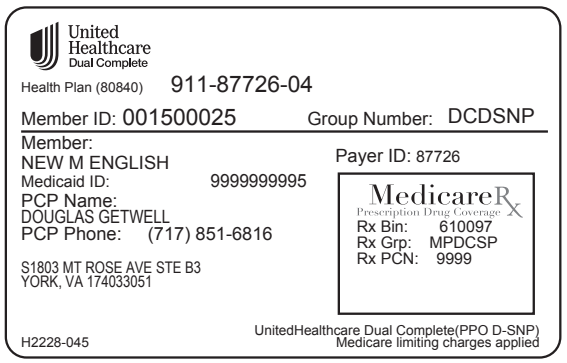
- Treating those providing your care with respect and dignity
- Getting familiar with your covered services and the rules you must follow to get these covered services. Use this handbook to learn what is covered for you and the rules you need to follow to get your covered services.
- Following the rules of the District Dual Choice Program and UnitedHealthcare Community Plan
- Following instructions, you receive from your doctors and other providers
- Going to scheduled appointments
- Telling your doctor at least 24 hours before the appointment if you must cancel
- Asking for more explanation if you do not understand your doctor's instructions
- Going to the Emergency Room only if you have a medical emergency
- Telling your PCP/PDP about medical and personal problems that may affect your health
- Reporting to Economic Security Administration (ESA) and UnitedHealthcare Community Plan if you or a family member have other health insurance or if you have a change in your address or phone number
- Reporting to Economic Security Administration (ESA) and UnitedHealthcare Community Plan if there is a change in your family (i.e., deaths, births, etc.)
- Trying to understand your health problems and participate in developing treatment goals
- Helping your doctor in getting medical records from providers who have treated you in the past
- Telling UnitedHealthcare Community Plan if you were injured as the result of an accident or at work
- Telling your doctor and other health care providers that you are enrolled in our plan. Show your UnitedHealthcare Community Plan enrollee ID Card whenever you get your medical care or prescription drugs.
- Helping your doctors and other providers help you by giving them information, asking questions, and following through on your care
  - To help your doctors and other health providers give you the best care, learn as much as you can about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all the drugs you are taking, including over-the-counter drugs, vitamins, and supplements

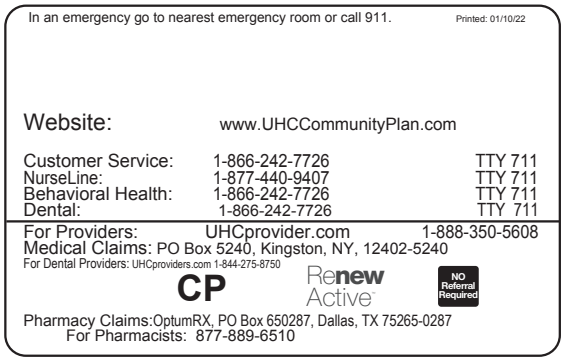
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- Being considerate. We expect all our enrollees to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Telling us if you move. If you are going to move, it's important to tell us right away. Call Enrollee Services (phone numbers are printed on the back cover of this booklet).
  - If you move outside of the District, you cannot remain an enrollee of our plan. We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - If you move within our service area, we still need to know so we can keep your enrollee record up to date and know how to contact you
  - If you move, it is also important to tell the DC Economic Security Administration and Social Security (or the Railroad Retirement Board)
- Calling Enrollee Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Enrollee Services are printed on the back cover of this booklet

Your Enrollee ID Card

Once you are enrolled in the Plan, we will send you an enrollee ID Card in the mail. This card lets your doctors, hospitals, drug stores and others know that you are an enrollee of UnitedHealthcare Community Plan. Please make sure that the information on your enrollee ID Card is correct. If there are any problems, or if you have lost your card, call Enrollee Services **1-866-242-7726**, TTY **711**. Each UnitedHealthcare Community Plan enrollee has his/her own card. It is against the law to let anyone else use your enrollee ID Card.

Your Enrollee ID Card looks like this:





Each UnitedHealthcare Community Plan enrollee has his/her own card. It is against the law to let anyone else use your enrollee ID Card.

Please remember to carry your Enrollee ID Card and picture ID with you all the time. Always show your card before receiving any medical care or getting medicine at a pharmacy.

Your Care Providers

Your Primary Care Provider (PCP)

Now that you are an enrollee of UnitedHealthcare Community Plan your PCP (Primary Care Provider) will help you and your family to get the health care you need.

What is a "PCP," and what does the PCP do for you?

- A Primary Care Provider (PCP) is a licensed network doctor who is selected by you to provide or coordinate your covered services

What types of providers may act as a PCP?

- PCPs are generally doctors specializing in Internal Medicine, Family Practice or General Practice

What is the role of my PCP?

- Your relationship with your PCP is an important one because your PCP is responsible for the coordination of your health care. Your PCP is also responsible for your routine health care needs. You may want to ask your PCP for assistance in selecting a network specialist and follow-up with your PCP after any specialist visits. It is important for you to develop and maintain a relationship with your PCP.

  It is important to call your PCP first when you need care. If you had a PCP before you signed up with UnitedHealthcare Community Plan, please call Enrollee Services at **1-866-242-7726**. We can help you stay with that PCP if you want to.

Picking your PCP

1. Pick a PCP at the time you enroll in the District Dual Choice program with UnitedHealthcare Community Plan. This person will be your PCP while you are enrolled in UnitedHealthcare Community Plan.
   - If your current PCP is a Provider in UnitedHealthcare Community Plan's network, you may stay with that doctor
   - If you don't have a PCP, you can choose from a list of doctors in our Provider Directory or at **https://connect.werally.com/state-plan-selection/uhc.medicaid/state**
   - Call Enrollee Services at **1-866-242-7726**, TTY **711** if you need help in picking a doctor
   - If you do not pick a PCP within the first 10 days of being in our plan, we will choose a doctor for you. If you do not like the PCP we pick for you, you may change your PCP. Call Enrollee Services at **1-866-242-7726**, TTY **711** to change your PCP.
   - UnitedHealthcare Community Plan will send you an enrollee ID Card. Your card will have your PCP's name and phone number on it.
2. Your PCP may be one of the following:
   - Family and General Practice Doctor — Usually can see the whole family
   - Internal Medicine Doctor — Usually sees only adults and children 14 years and older
   - Obstetrician/Gynecologist (OB/GYN) — Specializes in women's health and maternity care
   - If you have special health care needs, you may choose a specialist as your PCP
3. When you pick your PCP, please:
   - Try to pick a doctor who can send you to the hospital you want. Not all doctors can send patients to all hospitals. Our provider directory lists which hospitals a PCP can send you to. You can also call Enrollee Services for help.
   - Sometimes the PCP you choose won't be able to take new patients. We will let you know if you need to pick a different doctor.

How to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave UnitedHealthcare Community Plan's network of providers, and you would have to find a new PCP. If this happens, we will help you find a new PCP.

If you want to change your PCP, call Enrollee Services or go online. If you need help picking a new PCP, Enrollee Services can help you. If the PCP is accepting additional plan enrollees, the change will become effective on the first day of the following month. You will receive a new UnitedHealthcare Community Plan enrollee ID Card that shows your new PCP name and phone number.

Your Primary Dental Provider (PDP)

Now that you are an enrollee of UnitedHealthcare Community Plan, your PDP (Primary Dental Provider) will help you get the health care you need.

It is important to call your PDP first when you need care. If you had a dentist before you signed up with UnitedHealthcare Community Plan, please call Enrollee Services at **1-866-242-7726**, TTY **711**. We can help you stay with that dentist if you want to.

Picking your PDP

1. Pick a PDP at the time you enroll in UnitedHealthcare Community Plan. This person will be your PDP while you are an enrollee of UnitedHealthcare Community Plan.
   - If your current PDP is a Provider in UnitedHealthcare Community Plan's network, you may stay with that dentist
   - If you don't have a PDP, you can choose from a list of dentists in our Provider Directory or at **myuhc.com/CommunityPlan**
   - Call Enrollee Services at **1-866-242-7726**, TTY **711** if you need help in picking a dentist
2. When you pick your PDP, please:
   - Try to pick a dentist who can send you to the hospital you want. Not all doctors can send patients to all hospitals. Our provider directory lists which hospitals a PDP can send you to. You can also call Enrollee Services for help.
   - Sometimes the PDP you choose won't be able to take new patients. We will let you know if you need to pick a different dentist.

How to change your PDP

You can change your PDP anytime. Just pick a new PDP from the Provider Directory. Call Enrollee Services at **1-866-242-7726**, TTY **711** once you have picked a new PDP. If you need help picking a new PDP, Enrollee Services can help you.

Routine care, urgent care and emergency care

There are three (3) kinds of health care you may need: Routine care, urgent care, or emergency care.

Routine care

Routine Care is the regular care you get from your PCP. Routine Care is also care you get from other doctors that your PCP sends you to. Routine Care can be check-ups, physicals, health screenings, and care for health problems like diabetes, hypertension, and asthma. If you need Routine Care, call your PCP's office, and ask to make an appointment.

Urgent care

Urgent Care is medical care you need within 24 hours, but not right away. "Urgently needed services" are a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. An unforeseen condition could include an unexpected flare-up of a known condition that you have. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. If you need Urgent Care, call your PCP's office. If your PCP's office is closed, leave a message with the person who answers the phone when the office is closed. Then call the Nurse Help Line at 1-877-440-9407, TTY 711, 24 hours a day, 7 days a week. A nurse will help you decide if you need to go to the doctor right away. The nurse will tell you how to get care. You do not have to go to the Emergency Room or use an ambulance for routine or Urgent Care.

Emergency care

Emergency Care is medical care you need right away for a serious, sudden (sometimes life-threatening) injury or illness. You have the right to use any hospital for emergency care. Prior authorization is not required for emergency care services.

A "medical emergency" is when you, or any other person with average knowledge of medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- Get help as quickly as possible. Call **911** for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- As soon as possible, make sure that our plan has been told about your emergency. We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours by calling the Enrollee Services number.

Care when you are out of town

When you need to see a doctor, or get medicine when you are out of town, you should:

Routine care:

You must call us and ask if we will pay for you to see a doctor or other provider when you are out of town because doctors who are not in the District of Columbia may not be a part of UnitedHealthcare Community Plan. If UnitedHealthcare Community Plan does not say it is okay before you get the care, you must pay for the care yourself. If you need medicine from a doctor while you are out-of-town, your prescription may be covered in certain situations.

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a enrollee of our plan. If you cannot use a network pharmacy, here are the times we would cover prescriptions filled at an out-of-network pharmacy:

- **Prescriptions for a medical emergency:** We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Formulary without restrictions, and are not excluded from Medicare Part D coverage.
- **If you are traveling within the United States and become ill or run out of or lose your prescription drugs**, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules
  - If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service
  - If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or network preferred mail-order pharmacy (including high cost and unique drugs)
  - If you need a prescription while a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting

Coverage when traveling or out of the service area

Be sure to check your supply of the drug before you leave if you take a prescription drug on a regular basis and you are going on a trip, when possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network preferred mail service pharmacy or through our other network pharmacies. Contact Enrollee Services at **1-866-242-7726**, TTY **711** to find out about ordering your prescription drugs ahead of time.

In these situations, please check first with Enrollee Services to see if there is a network pharmacy nearby. (Phone numbers for Enrollee Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Urgent care:

Call your PCP. If your PCP's office is closed, call the Nurse Help Line at 1-877-440-9407, TTY 711, 24 hours a day, 7 days a week. A nurse will help you decide if you need to go to the doctor right away. The nurse can tell you how to get care. You do not have to go to the Emergency Room or use an ambulance for routine or Urgent Care.

Emergency care:

If you have an emergency, including a mental health, alcohol, or other drug emergency, go to the nearest Emergency Room (ER) to get care right away. If you go to the emergency room, you should ask the ER staff to call your PCP. If you go to the emergency room, you should call Enrollee Services as soon as you can. **Prior authorization is not required for emergency care services.**

Long-Term Services and Supports (LTSS)

You may be eligible for long-term care services (LTSS). This includes care in a nursing facility or care in your own home. These services require prior authorization from UnitedHealthcare Community Plan and may require you to meet certain requirements.

Your LTSS Care Manager can help you with:

- Getting covered services, including long-term care
- Arranging and providing care for enrollees in their homes through clinical exams, complete and emergent care management, and transitional care coordination following an acute inpatient stay
- Providing an integrated approach to managing all benefits for enrollees, including Long Term Services and Supports
- Developing and authorizing enrollee service plans and coordinating Home and Community Based Services (HCBS)
- Setting up medical appointments and tests
- Setting up transportation
- Finding ways to make sure you get the right service
- Finding resources to help with special health care needs and/or your caregivers manage day-to-day stress
- Connecting with community and social services
- Tracking clinical outcomes
- Meeting with care providers to review patient gaps in care
- Transitioning to other care when your benefits end, or you choose to move to another type of health care coverage

For more information about the clinical care program for individuals needing long-term services and supports, please contact the UnitedHealthcare at Home clinical care program at 855-409-7073. Our staff can give you more information.

Care management and care coordination

UnitedHealthcare Community Plan offers special services and programs to give you extra help with your health care needs. You will have a care management team who will help you get the services and information you need to manage your illness and improve your health. To learn more about your care management team, please contact the UnitedHealthcare at Home clinical care program at 855-409-7073. Our staff can give you more information.

In-network and out-of-network providers

UnitedHealthcare Community Plan will pay for the care you get when you go to one of our doctors or other health care providers. We call these doctors and other health care providers our "network" providers. All these "In-Network" doctors can be found in your Provider Directory. A doctor or provider who is not one of ours is called an "Out-of-Network" Provider.

If you go to an "Out-of-Network" doctor or provider, you may have to pay for the care you get. UnitedHealthcare Community Plan may not cover services if you go to an out-of-network provider. Call Enrollee Services at **1-866-242-7726**, TTY **711** for a list of in-network providers, labs, or hospitals.

If UnitedHealthcare Community Plan does not have an in-network provider who can perform a covered service, we will approve an out-of-network provider. The covered service must be a service your PCP or care team says you need (this is called a medically necessary service). Approval will be given to the out-of-network provider in writing. This service will be provided at no cost to you. The out-of-network provider will be paid for all approved services for as long as you need the services.

You will not have to pay if you have asked us first, and we have told you, usually in writing, that it is okay. We call this "prior authorization." An exception is emergency care or urgent care: your plan covers any of these services that you get from an out-of-network provider. UnitedHealthcare Community Plan will provide (adequately and timely) covered services from an approved out-of-network provider if UnitedHealthcare Community Plan does not have an in-network provider who can perform a covered service.

Prior Authorization (PA) means approval for a health service that is not routinely covered by UnitedHealthcare Community Plan. You must get this approval before you receive the service. Call Enrollee Services at **1-866-242-7726**, TTY **711** to ask about getting a PA. You do not need a PA to receive emergency care.

You may also go to a Family Planning provider of your choice even if they are Out-of-Network. No prior authorization is required.

Making an appointment

Making an appointment with your PCP

- Have your enrollee ID Card and a pencil and paper close by
- Call your PCP's office. Look for your PCP's phone number on the front of your enrollee ID Card. You can also find it in your Provider Directory or online at **https://connect.werally.com/state-plan-selection/uhc.medicaid/state**.
- Tell the person who answers that you are a UnitedHealthcare Community Plan enrollee. Tell them you want to make an appointment with your PCP.
- Tell the person why you need an appointment. For example:
  - You or a family enrollee is feeling sick
  - You hurt yourself or had an accident
  - You need a check-up or follow-up care
- Write down the time and date of your appointment
- Go to your appointment on time and bring your enrollee ID Card and picture ID with you
- If you need help making an appointment, call Enrollee Services at **1-866-242-7726**, TTY **711**

Changing or canceling an appointment

- It is very important to come to your appointment and to be on time
- If you need to change or cancel your appointment, please call the doctor at least 24 hours before your appointment
- For some appointments, you may have to call more than 24 hours before to cancel. If you do not show up for your appointment, or if you are late, your doctor may decide you cannot be his or her patient.

Getting care when your PCP's or PDP's office is closed

If you need to speak to your PCP or PDP when the office is closed, call your PCP's or PDP's office, and leave a message including your phone number with the person who answers the phone. Someone will call you back as soon as possible. You can also call the Nurse Help Line 24 hours a day at: 1-877-440-9407, TTY 711. If you think you have an emergency, call **911** or go to the Emergency Room.

How long does it take to see your doctor?

Your doctor's office must give you an appointment within a certain number of days after you call. The table below shows how long it will take to get an appointment. Please call **1-866-242-7726**, TTY **711** if you cannot get an appointment during these time periods.

Type of visit	Your condition	How long it takes to see your doctor
Urgent visit	You are hurt or sick and need care within 24 hours to avoid getting worse, but you don't need to see a doctor right away. Some examples of when you need urgent care include a sprain or strain, diarrhea, throwing up, a cut or scrape, an earache, a sore throat, a cough or cold, diaper rash, refills for medicine, mild headache, lice, scabies, and ringworm.	Within 24 hours
Routine visit	You have a minor illness or injury, or you need a regular checkup, but you don't need an urgent appointment.	Within 30 calendar days

Making an appointment

Type of visit	Your condition	How long it takes to see your doctor
Follow-up visit	You need to see your doctor after a treatment you just had to make sure you are healing well.	Within 1–2 weeks, depending on the kind of treatment
Adult wellness visits	• You are having your first appointment with a new doctor • You are due for a regular adult checkup • You are due for a prostate exam, a pelvic exam, a PAP smear, or a breast exam	Within 30 calendar days or sooner if necessary
Non-urgent appointments with specialists (by referral)	Your PCP referred you to see a specialist for a non-urgent condition.	Within 30 calendar days

Support services

Transportation services

UnitedHealthcare Community Plan will provide transportation to your doctor's appointments if you need it. You are eligible for 24 one-way rides to or from approved locations, such as medically related appointments, gyms, and pharmacies. Once you use the 24 one-way rides, you may be eligible for additional rides to approved locations under your Medicaid Benefit. This benefit covers rides to for routine and urgent provider appointments, follow-up visits, hospital discharges and urgent care services.

To use the transportation services under this plan, you should:

- Call ModivCare for transportation an tell the representative what time and what day you need to be picked up
  - 8:00 a.m.–5:00 p.m. local time, Monday–Friday
  - Initial 24 visits: 1-866-418-9812, TTY 1-866-288-3133
  - Additional Medicaid transportation: 1-866-475-5886
- You must call at least three days (not including Saturday, Sunday, and holidays) before your appointment to get transportation. If you need transportation to urgent visits, you can call the day before the appointment to ask for transportation.
  - The types of transportation are bus, metro, vouchers to pay for a taxi, wheelchair vans, and ambulances. The type of transportation you get depends on your medical needs.
  - When you call, give our transportation provider your enrollee ID, phone number and address where you can be picked up. Also, tell them the name, address, and phone number of the medical/dental facility or doctor's office where you are going.
  - If you need to check on status of your ride please call ModivCare
  - Have your enrollee ID Card and photo ID with you when you are picked up

* Requires or may require prior authorization.

Interpretation and translation services

Interpretation services

UnitedHealthcare Community Plan provides oral Interpretation Services if you need them for FREE, including at the hospital.

Please call Enrollee Services at **1-866-242-7726**, TTY **711** to get Interpretation Services. Please call us before your doctor's appointment if you need Interpretation Services.

Translation services

If you get information from UnitedHealthcare Community Plan and need it translated into another language, please call Enrollee Services at **1-866-242-7726**, TTY **711**.

Auxiliary aid services for the hearing and visually impaired

If you have trouble hearing, call Enrollee Services at **1-866-242-7726**, TTY **711**.

If you have trouble seeing, call Enrollee Services at **1-866-242-7726**, TTY **711**.

We can give you information on an audio tape, in Braille or in large print.

Specialty care and referrals

A specialist is a doctor who provides health care services 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 conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

Even though your PCP is trained to handle most common health care needs, there may be a time when you feel that you need to see a network specialist. You do not need a referral from your PCP to see a network specialist or behavioral/mental health provider. Although you do not need a referral from your PCP to see a network specialist, your PCP can recommend an appropriate network specialist for your medical condition, answer questions you have regarding a network specialist's treatment plan and provide follow-up health care as needed. For coordination of care, we recommend you notify your PCP and care team when you see a network specialist.

Please refer to the Provider Directory for a listing of Plan specialists available through your network, or you may consult the Provider Directory online at **myuhc.com/CommunityPlan**.

How to get specialty care

It is important that you and each member of your family have a PCP. Your PCP will help you know when you need to see a specialist, but a referral from him or her is not required. A referral is a written note given to you by your PCP to see a different provider. For all UnitedHealthcare Community Plan enrollees, referrals are not required to see any specialist who is part of our provider network.

If you want to see a specialist, but UnitedHealthcare Community Plan said it wouldn't pay for the visit, you can:

- Make an appointment with another doctor in the UnitedHealthcare Community Plan's network, and get a second opinion
- Appeal our decision (see page 63 on Appeals)
- Ask for a Fair Hearing (see page 67 on Fair Hearings)

Self-referral services

There are certain services you can get without getting prior permission from your PCP. These are called self-referral services and are listed below.

You DO NOT need a referral to:

- See your PCP
- Get care when you have an emergency
- Receive services from your OB/GYN doctor in your network for routine or preventive services (females only)
- Receive Family Planning Services
- Receive services for sexually transmitted infections (STIs)
- Receive Immunizations (shots)
- Visit a vision provider in the network
- Receive mental health or services for problems with alcohol or other drugs

Mental health services

Mental health care helps when you feel depressed or anxious.

To directly access your behavioral/mental health benefits, please call the behavioral health number on the back of your Enrollee ID Card 24 hours a day, 7 days a week. When you call, you will speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on the help you need, a clinician may then talk with you about the problem you are experiencing and assess which provider and treatment would be appropriate for your situation. You may also ask your PCP to call the number on the back of your Enrollee ID Card and arrange a referral on your behalf. You may also call to receive information about in-network practitioners, subspecialty care and obtaining care after normal office hours. Confidentiality is maintained, so please be assured that personal information you discuss with their staff will be kept strictly confidential.

If you need help, or someone from your family needs help, call

- The DC Department of Behavioral Health Hotline at 1-888-793-4357, 24 hours a day, 7 days a week
- **911** for help or go to the nearest emergency room or hospital

 Questions? Visit **myuhc.com/CommunityPlan**, or call Enrollee Services at **1-866-242-7726**, TTY **711**.

Services for alcohol or other drug problems

Problems with alcohol or other drugs are dangerous to your health and can be dangerous to the health of people around you. It is important to go to the doctor if you need help with these problems. UnitedHealthcare Community Plan will help you arrange for detoxification services and provide care coordination to help you get other services. To get services for these problems, you can:

- Call Enrollee Services at **1-866-242-7726**, TTY 711
- Call the Department of Behavioral Health (DBH) Assessment and Referral Center (ARC) directly at 202-727-8473

All mental health, alcohol and drug abuse services are confidential.

Birth control and other family planning services

You do NOT need a Referral to receive birth control or other Family Planning Services. All birth control and other Family Planning Services are confidential.

You can get birth control and other Family Planning Services from any provider you pick. You do not need a referral to get these services. If you choose a Family Planning Services doctor other than your PCP, tell your PCP. It will help your PCP take better care of you. Talk to your PCP or call UnitedHealthcare Community Plan Enrollee Services at **1-866-242-7726**, TTY **711**for more information on birth control or other Family Planning Services.

Family Planning Services include:

- Pregnancy testing
- Counseling for the woman and the couple
- Routine and emergency contraception
- Counseling and Immunizations
- Screening for all sexually transmitted infections
- Treatment for all sexually transmitted infections
- Sterilization procedures (requires you to sign a form 30 days before the procedure)
- HIV/AIDs testing and counseling

Family Planning Services do not include:

- Routine infertility studies or procedures
- Hysterectomy for sterilization
- Reversal of voluntary sterilization
- HIV/AIDs treatment
- Abortion

HIV/AIDS testing, counseling, and treatment

You can get HIV/AIDS testing and counseling:

- When you have Family Planning Services
- From your PCP
- From an HIV testing and counseling center

For information on where you can go for HIV testing and counseling, call Enrollee Services at **1-866-242-7726**, TTY **711**. If you need HIV treatment, your PCP will help you get care or you can call Enrollee Services **1-866-242-7726**, TTY **711**. You can also get Pre-exposure prophylaxis (PrEP) if you are your doctor believe you are at high risk for HIV/AIDs.

Pharmacy services and prescription drugs

Pharmacies are where you pick up your medicine (drugs). If your doctor gives you a prescription, you must go to a pharmacy in UnitedHealthcare Community Plan's network.

You can find a list of all the pharmacies in the UnitedHealthcare Community Plan's network in your provider directory or online at **myuhc.com/CommunityPlan**.

If you are out of town and have an emergency or need Urgent Care, UnitedHealthcare Community Plan will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Formulary without restrictions, and are not excluded from Medicare Part D coverage.

To get a prescription filled:

- Pick a pharmacy that is part of the UnitedHealthcare Community Plan network and is close to your work or home
- When you have a prescription, go to the pharmacy, and give the pharmacist your prescription and your UnitedHealthcare Community Plan enrollee ID Card
- If you need help, please call **1-866-242-7726**, TTY 711

Coverage when traveling or out of the service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network preferred mail service pharmacy or through our other network pharmacies. Contact Enrollee Services to find out about ordering your prescription drugs ahead of time.

If you are traveling within the United States and become ill or run out of or lose your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules:

- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or network preferred mail-order pharmacy (including high cost and unique drugs)
- If you need a prescription while a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting. In these situations, please check first with Enrollee Services to see if there is a network pharmacy nearby. (Phone numbers for Enrollee Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Things to remember:

- You should not be asked to pay for your medicines. Call UnitedHealthcare Community Plan Enrollee Services if the pharmacy or drug store asks you to pay.
- Sometimes, your doctor may need to get prior authorization (PA) from UnitedHealthcare Community Plan for a drug. While your doctor is waiting for the prior authorization, you have a right to get the medication:
  - For up to 72 hours or
  - For one full round of the medicine if you take it less than once a day
- You can find a complete list of covered drugs in the online formulary at **https://www.uhcprovider.com/en/health-plans-by-state/district-of-columbia-health-plans/dc-comm-plan-home/dc-cp-pharmacy.html**. Medicines not listed in the formulary may not be covered. The covered drugs listed in the formulary may change from time to time. You will be notified when any updates affect you.
- You may also get your medicines through our mail-order program or delivered to you from a participating pharmacy. Contact the **1-866-242-7726**, TTY **711** for details and to see if you qualify.

Disease Management

If you have a chronic illness or special health care need such as asthma, high blood pressure, or mental illness, we may put you in our Disease Management Program. This means you will have a Disease Manager. A Disease Manager is someone who works for UnitedHealthcare Community Plan and who will help you get the services and information you need to manage your illness and be healthier.

Services to keep adults from getting sick

UnitedHealthcare Community Plan wants you to take care of your health. We also want you to sign up for health and wellness services we offer to you. Health and wellness services include screenings, counseling, and immunizations.

Recommendations for check-ups ("screenings")

Please make an appointment and go see your PCP at least one time every year for a check-up. See the list of "Adult Wellness Services" in the "Your Health Benefits" section for things to talk with your PCP about during your check-up.

Make an appointment to see your PCP at least once a year for a check-up.

Preventive counseling

Preventive counseling is available to help you stay healthy. You can get preventive counseling on:

- Diet and exercise
- Alcohol and drug use
- Smoking cessation
- HIV/AIDS prevention
- Sexually transmitted infections (STIs) prevention
- Lung cancer
- Cardiovascular disease

Adult immunizations

You may need some immunizations (shots). Please talk to your PCP about which ones you may need.

Pregnancy

If you are pregnant or think you are pregnant, it is very important that you go to your OB/GYN doctor right away. You do not need to see your PCP before making this appointment.

If you are pregnant, please call:

- Economic Security Administration (ESA) at 202-727-5355 — To report your pregnancy
- Enrollee Services at **1-866-242-7726**, TTY **711**
- Your PCP

There are certain things that you need to get checked if you are pregnant. These will help make sure that you have a healthy pregnancy, delivery, and baby. This is called Prenatal Care. You get prenatal care before your baby is born.

Remember, if you are pregnant or think you are pregnant, do not drink alcohol, use drugs or smoke.

Once you have your baby, call Enrollee Services **1-866-242-7726** and ESA at 202-727-5355.

Your health benefits

Because you are covered by Medicaid, you pay nothing for your covered services if you follow the UnitedHealthcare Community Plan's rules for getting your care. As a UnitedHealthcare Community Plan enrollee, you will not be responsible for any copayments, deductibles or coinsurance for covered services provided by network providers, or in certain circumstances, out-of-network providers.

Make sure to present your UnitedHealthcare Community Plan Enrollee ID Card when accessing services to ensure correct billing. If you are asked to pay for covered services or if your provider will not see you, please contact Enrollee Services at **1-866-242-7726**.

The Medical Benefits Chart on the following pages lists the services UnitedHealthcare Community Plan covers. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered.
- You have a Primary Care Provider (a PCP) who is providing and overseeing your care

Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. There are also some services that require you to obtain approval by working directly with your assigned Care Team.

Other important things to know about our coverage

You are covered by both Medicare and Medicaid. Generally, Medicare covers health care and prescription drugs. You may be eligible for full Medicaid benefits depending on your Medicaid coverage. Medicaid covers your cost-sharing for Medicare services. Medicaid also covers services Medicare does not cover, like long-term care, over-the-counter drugs, and home and community-based services.

Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2022 Handbook. View it online at **www.medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.

Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.

Health services covered by UnitedHealthcare Community Plan

The list below shows the health care services and benefits for all UnitedHealthcare Community Plan enrollees. For some benefits, you must be a certain age or have a certain need for the service. UnitedHealthcare Community Plan will not charge you for any of the health care services in this list if you go to a network provider or hospital.

If you have a question about whether UnitedHealthcare Community Plan covers certain health care and how to access services, call UnitedHealthcare Community Plan Enrollee Services at **1-866-242-7726**.

Benefit	What you get	Who can get this benefit
Adult Wellness Services	• Immunizations • Routine screening for sexually transmitted infections • HIV/AIDS screening, testing and counseling • Breast cancer screening • Cervical cancer screening (women only) • Osteoporosis screening (post-menopausal women) • HPV screening • Prostate cancer screening (men only) • Abdominal aortic aneurysm screening • Obesity screening • Diabetes screening • High blood pressure and cholesterol (lipid disorders) screening • Depression screening • Colorectal cancer screening (Enrollees 50 years and older) • Smoking cessation counseling • Diet and exercise counseling • Mental Health counseling • Alcohol and drug screening	All enrollees
Alcohol and Drug Abuse Treatment	• Inpatient detoxification • Other alcohol/drug abuse services are provided by the Addiction, Prevention and Recovery Administration (DBH) • Help with getting care from DBH	All enrollees

Benefit	What you get	Who can get this benefit
Dental Services	• General dental exams and routine cleanings every six (6) months • Surgical services and extractions • Emergency dental care • X-rays (full series limited to one (1) time every three (3) years) • Fillings • Full mouth debridement • Prophylaxis limited to two (2) times per year • Bitewing series • Palliative treatment • Sealant application • Removable partial and full dentures • Root Canal treatment limited to two (2) molars per year • Periodontal scaling and root planning • Dental crowns • Removal of impacted teeth • Initial placement of a removeable prosthesis (any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted), once every five (5) years. Some limitations may apply. • Removable partials prosthesis • Any dental service that requires inpatient hospitalization must have prior authorization (preapproval) • Elective surgical procedures requiring general anesthesia	All enrollees

Benefit	What you get	Who can get this benefit
Dialysis Services	Treatment up to 3 times a week (limited to once per day).	All enrollees
Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS)	• Durable medical equipment (DME) • Disposable medical supplies (DMS)	All enrollees
Emergency Services	• A screening exam of your health condition, post-stabilization services, and stabilization services if you have an emergency medical condition, regardless if the provider is in or out of the UnitedHealthcare Community Plan network • Treatment for emergency condition	All enrollees
Family Planning	• Pregnancy testing; counseling for the woman • Routine and emergency contraception • Voluntary sterilizations (requires signature of an approved sterilization form by the enrollee 30 days prior to the procedure) • Screening, counseling, and Immunizations (including for Human Papilloma Virus – HPV) • Screening and preventive treatment for all sexually transmitted infections	All enrollees, as appropriate
Hearing Benefits	Diagnosis and treatment of conditions related to hearing, including hearing aids and hearing aid batteries.	All enrollees

Benefit	What you get	Who can get this benefit
Home and Community-Based Long-Term Services and Supports	In-home health care services, including: • Nursing and home health aide care • Personal care aide services provided by a home health agency • Physical therapy, occupational therapy, speech pathology and audiology services EPD Waiver services, including: • Assisted living services in an assisted living facility • Participant-directed in-home services and supports • Personal care aide services provided by a home health agency • Chore aide or homemaker supports Adult Day Health Program Services Care coordination for enrollees enrolled in: • The Medicaid Waiver for People with Intellectual or Developmental Disabilities • The Medicaid Individual and Family Support Waiver You must get prior authorization for long-term services and supports.	All enrollees, as appropriate Not available to enrollees in a hospital or Nursing Home
Hospice Care	Support services for people who are nearing end of life.	All enrollees
Hospital Services	• Outpatient services (preventive, diagnostic, therapeutic, rehabilitative, or palliative services) • Inpatient services (hospital stay)	Enrollees with a Referral from their PCP or who has an emergency

Benefit	What you get	Who can get this benefit
Laboratory and X-ray Services	Lab tests and X-rays.	All enrollees
Nursing Home Care	• Full-time skilled nursing or long-term care provided in a nursing facility • You must get prior approval for long-term care	All enrollees
Mental Health Services	Services provided by mental health providers, including: • Diagnostic and assessment services • Physician and mid-level visits, including: – Individual counseling – Group counseling – Family counseling • Federally Qualified Health Center (FQHC) Services • Medication/Somatic treatment • Crisis services • Inpatient hospitalization and emergency department services • Intensive day treatment • Case management services • Treatment for any mental condition that could complicate pregnancy (continues on next page)	All enrollees, as appropriate

Benefit	What you get	Who can get this benefit
Mental Health Services (continued)	Care coordination for enrollees receiving the following Services from DBH: • Community–based interventions • Multi-Systemic Therapy (MST) • Assertive community treatment • Community support • Transitional Assertive Community Treatment (TACT) • Recovery support services • Vocational supported employment • Clubhouse services • Trauma Recovery Empowerment Model (TREM) • Trauma Systems Therapy (TST) • Functional Family Therapy (FFT) • Outpatient alcohol and drug abuse treatment – Outpatient rehabilitation services • Other services provided by DBH Mental health and substance abuse services in an Institution for Mental Disease.	All enrollees, as appropriate

Benefit	What you get	Who can get this benefit
Pharmacy Services (prescription drugs)	Prescription drugs included on the UnitedHealthcare Community Plan drug formulary. You can find the drug formulary at **myuhc.com/CommunityPlan** or by calling Enrollee Services. Only includes medications from network pharmacies. Includes the following non-prescription (over the counter) medicines: • Fever and pain relievers like Tylenol® or Advil® • Sinus and allergy medicines like Benadryl® • Cough and cold medicines • Hydrocortisone one (1) percent for rashes	All enrollees
Podiatry	• Special care for foot problems • Regular foot care when medically needed	All enrollees
Primary Care Services	• Preventive, acute, and chronic health care services generally provided by your PCP	All enrollees
Prosthetic devices	• Replacement, corrective, or supportive devices prescribed by a licensed provider	All enrollees
Rehabilitation Services	• Physical, speech and occupational therapy	All enrollees
Specialist Services	• Health care services provided by specially trained doctors or advanced practice nurses • Referrals are not required • Does not include cosmetic services and surgeries except for surgery required to correct a condition resulting from surgery or disease, created by an accidental injury or a congenital deformity, or is a condition that impairs the normal function of your body	All enrollees

Benefit	What you get	Who can get this benefit
Transportation Services	Transportation to and from medical appointments to include services covered by DHCF.	All enrollees
Vision Care	One (1) pair of eyeglasses or contract every year except when the enrollee has lost his or her eyeglasses or when the prescription has changed by more than 0.5 diopter. **And** $250 allowance toward your purchase of frames (fitting and evaluation may be an additional cost) or contact lenses (fitting and evaluation may be an additional cost).	All enrollees

Services we do not pay for

- Services Provided/Funded by DBH:
  - Community-Based Interventions
  - Multi-Systemic Therapy (MST)
  - Assertive Community Treatment (ACT)
  - Transitional Assertive Community Treatment (TACT)
  - Community Support
  - Recovery Support Services
  - Vocational Supported Employment
  - Clubhouse Services
  - Trauma Recovery Empowerment Model (TREM)
  - Trauma Systems Therapy (TST)
  - Functional Family Therapy (FFT)
  - Outpatient Alcohol and Drug Abuse Treatment — Outpatient rehabilitation services
  - Other Services Provided by DBH
- Medicaid health home services (not covered for D-SNP enrollees)
- 1915(c) IDD Waiver and IFS Waiver services
- Program of All-Inclusive Care for the Elderly (PACE)

Services not covered

- Cosmetic surgery: except in cases of accidental injury, for improvement of the functioning of the malformed body member, or for all stages of reconstruction for a breast after a mastectomy (including for the unaffected breast to produce a symmetrical appearance)
- Experimental or investigational services, surgeries, treatments, and medications
- Services that are part of a clinical trial protocol
- Abortion, or the voluntary termination of a pregnancy, not required under Federal law
- Infertility treatment
- Elective hysterectomy, tubal ligation, or vasectomy if the primary indication for these procedures is sterilization

- Reversal of sterilization procedures, penile vacuum erection devices, or non-prescription contraceptive supplies
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary
- Equipment or supplies that condition the air and other primarily non-medical equipment
- Immunizations for foreign travel purposes
- Naturopath services (uses natural or alternative treatments)
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television
- Private room in a hospital, unless medically necessary
- Surgical treatment for morbid obesity, unless medically necessary
- Services that are considered not reasonable or medically necessary
- Any medical care, except emergency and urgently needed services, received outside of the United States and U.S. Territories
- Certain dental services:
  - Local anesthetic that is used in conjunction with a surgical procedure and billed as a separate procedure
  - Hygiene aids, including toothbrushes
  - Medication dispensed by a dentist that a beneficiary is able to obtain from a pharmacy
  - Acid etch for a restoration that is billed as a separate procedure
  - Prosthesis cleaning
  - Removable unilateral partial denture that is a one-piece cast metal including clasps and teeth
  - Replacement of a denture when reline or rebase would correct the problem
  - Duplicative X-rays
  - Space maintainers
  - Fixed prosthodontics (bridge), unless it is cost effective for a beneficiary who cannot use a removable prosthesis and prior authorization is required
  - Gold restoration, inlay or onlay, including cast nonprecious and semiprecious metals
  - Dental services for cosmetic or aesthetic purposes
  - Dental implants replacing wisdom teeth

For transplants: items not covered include but are not limited to the below.

- For transportation:
  - Vehicle rental, purchase, or maintenance/repairs
  - Auto clubs (roadside assistance)
  - Parking fees incurred other than at lodging or hospital
- Gas, as a separate expense for:
  - Travel by air or ground ambulance (may be covered under your medical benefit)
  - Air or ground travel not related to medical appointments
- For lodging:
  - Deposits
  - Utilities (if billed separate from the rent payment)
  - Phone calls, newspapers, movie rentals and gift cards
  - Expenses for lodging when staying with a relative or friend
- Meals

Transition of care

If UnitedHealthcare Community Plan is new for you, you can keep your scheduled doctor's appointments and prescriptions for the first 30 days, or more in special circumstances.

If your provider is not currently in UnitedHealthcare Community Plan network, then you may be asked to select a new provider that is within UnitedHealthcare Community Plan's provider network.

If your health care provider leaves UnitedHealthcare Community Plan's network, we will notify you within 15 calendar days, so that you have time to select another provider. If UnitedHealthcare Community Plan terminates your provider, we will notify you within 30 calendar days prior to the effective date of termination.

Other important things to know

What to do if I move?

- Call the District of Columbia (DC) Economic Security Administration (ESA) Change Center at 202-727-5355
- Call UnitedHealthcare Community Plan Enrollee Services at **1-866-242-7726**, TTY **711**

What to do if I have a baby?

- Call DC Economic Security Administration (ESA) Change Center at 202-727-5355
- Call UnitedHealthcare Community Plan Enrollee Services at **1-866-242-7726**, TTY **711**

What to do if I adopt a child?

- Call DC Economic Security Administration (ESA) Change Center at 202-727-5355
- Call UnitedHealthcare Community Plan Enrollee Services at **1-866-242-7726**, TTY **711**

What to do if someone in my family dies?

- Call DC Economic Security Administration (ESA) Change Center at 202-727-5355
- Call UnitedHealthcare Community Plan Enrollee Services at **1-866-242-7726**, TTY **711**

How to change my plan?

- If you don't want to be in the expanded program, you may leave the program at any time. You can join a different Medicare health plan or change to fee-for-service Medicare. This can be done once per quarter or during other special periods during the year. To learn more about the different types of Medicare coverage, you can call the State Health Insurance Assistance Program at 202-727-8370.
- Call UnitedHealthcare Community Plan Enrollee Services at **1-866-242-7726**, TTY **711**

You will not be allowed to get health care from UnitedHealthcare Community Plan anymore if you:

- Lose your Medicaid or Medicare eligibility
- Choose to disenroll

The DC government may remove you from UnitedHealthcare Community Plan if you:

- Let someone else use your enrollee ID Card
- The District finds you committed Medicaid fraud
- You do not follow your enrollee responsibilities

What to do if I get a bill for a covered service

- If you get a bill for a covered service that is in the list above, call Enrollee Services at **1-866-242-7726**

Paying for non-covered services

- If you decide you want a service that we do not pay for and you do not have written permission from UnitedHealthcare Community Plan, you must pay for the service yourself
- If you decide to get a service that we do not pay for, you must sign a statement that you agree to pay for the service yourself
- Remember to always show your enrollee ID Card and tell doctors that you are an enrollee of UnitedHealthcare Community Plan before you get services

Advance Directives

An Advance Directive is a legal document you sign that lets others know your health care choices. It is used when you are not able to speak for yourself. Sometimes this is called a "living will" or a "durable power of attorney."

An Advance Directive can let you pick a person to make choices about your medical care for you. An advance directive also allows you say what kind of medical treatment you want to receive if you become too ill to tell others know what your wishes are.

It is important to talk about an Advance Directive with your family, your PCP, or others who might help you with these things.

If you want to fill out and sign an Advance Directive, ask your PCP for help during your next appointment, or call Enrollee Services at **1-866-242-7726**, TTY **711**, and they will help you.

What to do if I have other insurance

If you are an enrollee of UnitedHealthcare Community Plan, you must tell us right away if you have any other health insurance. Please call Enrollee Services at **1-866-242-7726**.

Fraud

Fraud is a serious matter. What is fraud? Fraud is making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. An example of fraud for enrollees is falsely claiming that you live in the District when you live outside the boundaries of the District of Columbia. An example of fraud for providers is billing for services that were not furnished and/or supplies not provided.

If you suspect fraud or any other misuse of services, please let us know. It is not required that you identify yourself or give your name. If you would like more information about what fraud is, visit UnitedHealthcare Community Plan's website at **https://www.uhc.com/fraud**. To report fraud, call UnitedHealthcare Community Plan Compliance Hotline, 1-844-359-7736, or call the DC Department of Health Care Finance's Fraud Hotline at 1-877-632-2873.

Special information about how we pay your doctors

You have the right to find out if UnitedHealthcare Community Plan has special financial arrangements with doctors.

Please call UnitedHealthcare Community Plan Enrollee Services at **1-866-242-7726**, TTY **711** for this information.

Problems and complaints

The process you use to handle your problem depends on the type of problem you are having:

- For some types of problems, you need to use the process for coverage decisions and appeals
- For other types of problems, you need to use the process for making complaints

To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

You can also get help from government organizations that are not connected with us. Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected with us.

For more information and help in handling a problem, you can contact Medicare. Here are three ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048
- You can visit the Medicare website (**www.medicare.gov**)
- You can get help from the District of Columbia's Office of Health Care Ombudsman and Bill of Rights:

  One Judiciary Square
  441 4th Street, NW, Suite 250 North
  Washington, DC 20001

  Phone: 202-724-7491

  Fax: 202-442-6724

  Toll Free Number: 1-877-685-6391

  Email: **healthcareombudsman@dc.gov**

Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare or Medicaid for you. If you disagree with this coverage decision, you can make an appeal.

Requesting a coverage decision

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request.

- For a request for a medical item or service, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network health care providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals.)

If your health requires it, ask us to give you a "fast coverage decision." A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

To get a fast coverage decision, you must meet two requirements:

- You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
- You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function

If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision. If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.

- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead)
- This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision
- The letter will also tell you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested

Grievances, appeals, and Fair Hearings

UnitedHealthcare Community Plan and the District government both have ways you can complain about the care you get or the services UnitedHealthcare Community Plan provides to you. You may choose how you would like to complain as described below.

Grievances

The formal name for making a complaint is "filing a grievance."

If you are unhappy with something that happened to you, you can file a grievance. Examples of why you might file a grievance include:

- You feel you were not treated with respect
- You are not satisfied with the health care you got
- It took too long to get an appointment

To file a grievance, call Enrollee Services at 1-866-242-7726, TTY 711. Or you can file a grievance in writing by mailing to the following address:

UnitedHealthcare Community Plan
Appeals and Grievances
P.O. Box 6103, MS CA124-0187
Cypress, CA 90630-0023

Your doctor can also file a grievance for you with your written consent.

You can file a grievance at any time. UnitedHealthcare Community Plan will usually give you a decision within 30 calendar days but may ask for extra time (but not more than 44 calendar days total) to give a decision.

Appeals and Fair Hearings

If you believe your benefits were unfairly denied, reduced, delayed, or stopped, you have a right to file an appeal with UnitedHealthcare Community Plan. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, it's called a Level 1 Appeal. In this appeal, we review the coverage decision we made to see if we were following all the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

Note: In order to file a District Fair Hearing (which is described on page 67), you must first complete the Level 1 Appeal process.

Appeals – Level 1 – Medical, Part B, and Part D

Who may file an appeal?

You, your doctor, or your representative may file an appeal on your behalf. If your appeal is being filed by someone other than you or your doctor, your appeal must include an Appointment of Representative form or similar document authorizing them to represent you. To get the form, call Enrollee Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at **cms.gov/Medicare/CMS-Forms/CMS-forms/downloads/cms1696.pdf**.

Medical appeals only — If you are appealing an existing service that has been reduced, delayed, or terminated, and you are requesting that your benefits be continued during your appeal, you, your representative, or your doctor may file on your behalf. For this type of appeal, your doctor must have your written consent to request continuing services.

When to appeal

You must make your appeal request **within 60 calendar days** from the date on the written notice of our coverage decision that we sent you. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good reasons for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

Filing your appeal

To file an appeal with UnitedHealthcare Community Plan, call Enrollee Services at 1-866-242-7726, TTY 711. Or you can file an appeal in writing by mailing to the following address:

UnitedHealthcare Community Plan
Appeals and Grievances
P.O. Box 6103, MS CA124-0187
Cypress, CA 90630-0023

Request a fast appeal if you believe standard appeal timeframes (30 calendar days for medical, 7 calendar days for Part D) could cause serious harm to your health or hurt your ability to function. Our clinical staff will determine if a fast appeal is appropriate. However, if your doctor tells us that your health requires a fast appeal, we will automatically agree to give you one. We will resolve your fast appeal within 72 hours.

You have the right to ask us for a free copy of the information regarding your appeal. If you wish, you and your doctor may give us additional information to support your appeal.

Reviewing your appeal

When we are reviewing your appeal, we take another careful look at all the information about your request for coverage of medical care. Your appeal is reviewed by staff who were not involved in the original decision. We check to see if we were following all the rules when we said no to your request. We will gather more information if we need it. We may contact you or your doctor to get more information.

Standard Appeals – Medical, Part B drugs

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
- For requests regarding a medical item or service, if you ask for more time or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide we need to take extra time to make the decision, we will tell you in writing. We can't take extra time to decide if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra time, you can file a fast complaint about our decision to do so. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. Information regarding how to file a fast complaint will be included within our notification to you.
- If we do not give you an answer by the applicable deadline above (or by the end of the extended time if we needed it for your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process. If we do not give you an answer by the applicable deadline, then the appeal process will be considered complete and you may request a Fair Hearing. If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal, or within 7 calendar days if your request is for a Medicare Part B prescription drug.
- If our answer is no to part or all of what you requested, we will automatically send your appeal to an Independent Review Organization for a Level 2 Appeal. If your appeal is regarding a Medicaid benefit, we will let you know how to request a District Fair Hearing.

Standards Appeals – Part D

- If we are using the standard deadlines, we must give you our answer on a request for a Part D drug appeal **within 7 calendar days** after we receive your appeal if your appeal is about drugs you have not yet received. If your appeal is regarding drugs you have received for which payment is being requested, your appeal will be resolved within 14 calendar days.
- For requests regarding a medical item or service, if you ask for more time or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide we need to take extra time to make the decision, we will tell you in writing.
- If you believe we should not take extra time, you can file a fast complaint about our decision to do so. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. Information regarding how to file a fast complaint will be included within our notification to you.
- If we do not give you an answer by the applicable deadline above (or by the end of the extended time if we needed it for your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process
- If our answer is no to part or all of what you requested, we will automatically send your appeal to an Independent Review Organization for a Level 2 Appeal
- Fair Hearings are not available for Part D

Fast Appeals – Medical, Part B, and Part D

- When we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal
- For requests regarding a medical item or service, if you ask for more time or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide to take extra time to make the decision, we will tell you in writing. We can't take extra time to decide if your request is for a Medicare Part B prescription drug.
- If we do not give you an answer within 72 hours (or by the end of the extended time if we needed it), we are required to automatically send your request on to Level 2 of the appeals process where it will be reviewed by an Independent Review Organization
- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal
- If our answer is no to part or all of what you requested, we will automatically send your appeal to an Independent Review Organization for a Level 2 Appeal. If your appeal is regarding a Medicaid benefit, we will let you know how to request a District Fair Hearing. Fair Hearings are not available for Part D.
- If UnitedHealthcare Community Plan does not give you notice regarding your appeal or does not give you notice in a timely manner, then the appeal process will be considered complete, and you may request a Fair Hearing. Fair Hearings are not available for Part D.

In limited circumstances, a request for an appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for an appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Appeals – Level 2

Level 2 appeals occur outside of the health plan and are available after completion of the Level 1 Appeal at the health plan. The following explains how Level 2 appeals are filed.

- We will send you a letter with our decision for your Level 1 Appeal. If we say no to part or all your Level 1 Appeal, the letter will tell you what happens next.
- If your problem is about a service or item that is usually covered by Medicare (excluding Part D), we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete. Level 2 Appeals are reviewed by an Independent Review Organization (IRO). The IRO will provide you with notification of their findings as well as what to do next if you continue to disagree.

- If your problem is about a service or item that is usually covered by Medicaid, you can file a Level 2 Appeal (District Fair Hearing) yourself. The letter with our decision will tell you how to do this. Services covered by Medicaid will not be forwarded to the IRO.
- If your problem is about a service or item that could be covered by both Medicare (excluding Part D) and Medicaid, you will automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the District.
- If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2
- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the Independent Review Organization
- If your problem is about a service that is usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 Appeal within 10 calendar days after receiving the plan's decision letter

Fair Hearings

If you are not satisfied with the outcome of the appeal you filed with UnitedHealthcare Community Plan for services covered by Medicaid, you can request a Fair Hearing with the District's Office of Administrative Hearings. You must request your Fair Hearing within 120 calendar days from the date of UnitedHealthcare Community Plan's Level 1 decision.

If you want to continue receiving the benefit during your Fair Hearing or appeal, you must request the Fair Hearing within 10 calendar days from the postmark on UnitedHealthcare Community Plan's Appeal Resolution Notice or by the intended effective date of UnitedHealthcare Community Plan's proposed action (in other words, when the benefit is to stop) — whichever is later.

To file a request for a Fair Hearing, call the District government at 202-442-9094 or write to:

District of Columbia Office of Administrative Hearings
Clerk of the Court
441 4th Street, NW, Room N450
Washington, DC 20001

Your rights during the grievances, appeals, and Fair Hearings processes

You have the right to a Fair Hearing for services covered by Medicaid. You may request a Fair Hearing from the Office of Administrative Hearings after you have completed the Level 1 Appeal process with UnitedHealthcare Community Plan. You must request a Fair Hearing within 120 calendar days from the mail date of the notice upholding the adverse benefit determination.

- If UnitedHealthcare Community Plan does not give you notice regarding your appeal or does not give you notice in a timely manner, then the appeal process will be considered complete and you may request a Fair Hearing
- You have a right to keep receiving the benefit we denied while your appeal or Fair Hearing is being reviewed. To keep your benefit during a Fair Hearing, you must request the Fair Hearing within 10 calendar days of receiving the appeal decision.
- You have a right to have someone from UnitedHealthcare Community Plan help you through the grievance or appeal processes
- You have a right to represent yourself or be represented by your family caregiver, lawyer, or other representative
- You have a right to have accommodations made for any special health care need you have
- You have a right to adequate TTY/TTD capabilities and services for the visually impaired
- You have a right to adequate translation services and an interpreter
- You have a right to see all documents related to the grievance, appeal, or Fair Hearing

If you have any questions about the grievances or appeals/Fair Hearings process, please call Enrollee Services at **1-866-242-7726**, TTY **711**.

Ending your membership in the plan

Ending your membership may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave
  - There are certain times during the year, or certain situations, when you may voluntarily end your membership in the plan
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing
- There are also limited situations where you do not choose to leave, but we are required to end your membership
- If you are leaving our plan, you must continue to get your medical care and prescription drugs through our plan until your membership ends

Ending membership voluntarily:

You may leave the program at any time. You can join a different Medicare health plan or change to fee-for-service Medicare. This can be done once per quarter or during other special periods during the year.

Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Ending membership involuntarily:

In certain circumstances, UnitedHealthcare Community Plan must end your membership in the plan. These circumstances are:

- If you do not stay continuously enrolled in Medicare Part A and Part B
- If you are no longer eligible for Medicaid. Our plan is for people who are eligible for both Medicare and Medicaid. We must notify you in writing that you have up to a one-month grace period to regain eligibility before you are disenrolled from Medicaid.
- If you move out of the District of Columbia
- If you are away from the District of Columbia for more than three months

- If you move or take a long trip, you need to call Enrollee Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Enrollee Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison)
- If you are not a United States citizen or lawfully present in the United States
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare and Medicaid first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other enrollees of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare and Medicaid first.)
- If you let someone else use your UnitedHealthcare Community Plan enrollee ID card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare and Medicaid first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

  We **cannot** ask you to leave our plan for a reason related to your health. We will not disenroll you from our product due to health status or service utilization. if you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

  If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership, as is your right.

  Grace period:

  If you are a Qualified Medicare Beneficiary (QMB) or have Medicaid benefits (QMB+) and lose your Medicaid eligibility, we will provide you up to a one-month grace period while you reapply for assistance. You will remain enrolled in our Plan during this time. During the grace period, you will not be responsible for copayments or coinsurance for covered services.

If you require covered services during this time and receive any bills from your provider, do not pay the bill and contact Enrollee Services. If you have already paid copayments or coinsurance during the grace period, please contact Enrollee Services and we will reimburse you.

Please keep copies of your bills and receipts for any care received during the grace period. Also keep a copy of any letter or other documentation regarding your loss of Medicaid eligibility so we can verify eligibility for the grace period.

If you do not regain Medicaid eligibility during the grace period, you will be disenrolled from our plan and will return to Original Medicare if you are eligible for Original Medicare. If you are not eligible for Medicare benefits you must check with the Economic Security Administration to see if there are any other public programs available to you. If you receive notice that your Medicaid coverage has expired, please contact the Medicaid office as soon as possible to reapply for assistance. Please contact Enrollee Services if you have questions.

Notice of Privacy Practices

This Notice describes how **medical information** about you may be used and disclosed, and how you can get this information. Please read it carefully.

Federal and District laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care
  - Because you are a enrollee of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations. You can see the information in your records and know how it has been shared with others You have the right to look at your medical records held at the plan, and to get a copy of your records. We can charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made. You have the right to know how your health information has been shared with others for any purposes that are not routine. If you have questions or concerns about the privacy of your personal health information, please call Enrollee Services (phone numbers are printed on the cover of this booklet).

By law, we must protect the privacy of your health information ("HI"). We must send you a notice about this. 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 e-mail. We will also post the new notice at this website (**www.myuhc.com/CommunityPlan**). 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.
- **For Communications to You**

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 District 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 may use the phone number or email you gave us to contact you about your benefits, healthcare or payments. 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.myuhc.com/CommunityPlan**).

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the enrollee Call Center at **1-866-242-7726**, or TTY/RTT **711**.
- **To Submit a Written Request**, mail it 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.

Financial Information Privacy Notice

We 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 Information

Please **call the toll-free Enrollee Services phone number on health plan ID card** or contact the enrollee Call Center at **1-866-242-7726**, or TTY/RTT **711**.

Health Care Ombudsman Program

The Health Care Ombudsman Program is a District of Columbia Government program that provides assistance and advise to you in receiving health care from your Plan. The Health Care Ombudsman can provide the following services:

- Explain the health care you have a right to receive,
- Respond to your questions and concerns about your health care,
- Help you understand your rights and responsibilities as an enrollee in a Plan,
- Help in obtaining the medically necessary services that you need,
- Answer questions and concerns you may have about the quality of your health care,
- Help you resolve problems with your doctor or other health care provider,
- Help in resolving complaints and problems with your Plan,
- Assist with appeal processes, and
- Help in filing a Fair Hearing request for you.

To reach the Health Care Ombudsman, please call 202-724-7491 or 1-877-685-6391 (Toll Free). The Health Care Ombudsman does not make decisions on grievances, appeals or Fair Hearings. The Office of Health Care Ombudsman and Bill of Rights is located at:

One Judiciary Square
441 4th Street, NW
Suite 250 North
Washington, DC 20001

Phone: 202-724-7491

Fax: 202-442-6724

Toll-free number: 1-877-685-6391

Email: **healthcareombudsman@dc.gov**

Definitions

Advance Directive — A written, legal paper that you sign that lets others know what health care you want, or do not want, if you are very sick or hurt and cannot speak for yourself.

Advocate — A person who helps you get the health care and other Services you need.

Appeal — An Appeal is a special kind of complaint you make if you disagree with a decision UnitedHealthcare Community Plan makes to deny a request for health care services or payment for services you already received. You may also make this kind of complaint if you disagree with a decision to stop services that you are receiving.

Appointment — A certain time and day you and your doctor set aside to meet about your health care needs.

Care Manager — Someone who works for UnitedHealthcare Community Plan who will help you get the care, support, and information you need to stay healthy.

Check-Up — See Screening.

Contraception — Supplies related to birth control.

Covered Services — Health care services that UnitedHealthcare Community Plan will pay for when completed by a provider.

Detoxification — Getting rid of harmful substances from the body such as drugs and alcohol.

Disease Management Program — A program to help people with chronic illnesses or Special Health Care Needs such as asthma, high blood pressure or mental illness, get the care and services they need.

Durable Medical Equipment (DME) — Special medical equipment that your doctor may ask or tell you to use in your home.

Emergency Care — Care you need right away for a serious, sudden, sometimes life-threatening condition.

Definitions

Enrollee — The person who gets health care through a UnitedHealthcare Community Plan's provider network.

Enrollee Identification (ID) Card — The card that lets your doctors, hospitals, pharmacies, and others know that you are an enrollee of UnitedHealthcare Community Plan.

Fair Hearing — You can request a fair hearing with DC's Office of Administrative Hearings if you are not satisfied with the decision regarding your appeal.

Family Planning — Services such as pregnancy tests, birth control, testing and treatment for sexually transmitted infections, and HIV/AIDs testing and counseling.

Family and General Practice Doctor — A doctor that can treat the whole family.

Grievance — If you are unhappy with the care you get or the health care services UnitedHealthcare Community Plan gives you, you can call Enrollee Services to file a grievance.

Handbook — This book that gives you information about UnitedHealthcare Community Plan and our services.

Hearing Impaired — If you cannot hear well, or if you are deaf.

Immunization — Shot or vaccination.

Internal Medicine Doctor — Doctor for adults and children over 14 years old.

Interpretation/Translation Services — Help from UnitedHealthcare Community Plan when you need to talk to someone who speaks your language, or you need help talking with your doctor or hospital.

Long-term Services and Supports — Health care provided over a longer period of time that helps you stay safe and healthy at home, such as a home health aide, or in a health care setting, like a nursing facility.

Maternity — The time when a woman is pregnant and shortly after childbirth.

Mental Health — How a person thinks, feels, and acts in different situations.

Network Providers — Doctors, nurses, dentists, and other people who take care of your health and are a part of UnitedHealthcare Community Plan.

Non-Covered Services — Health care that UnitedHealthcare Community Plan does not pay for when completed by a provider.

OB/GYN — Obstetrician/Gynecologist; a doctor who is trained to take care of a woman's health, including when she is pregnant.

Out-of-Network Providers — Doctors, nurses, dentists, and other people who take care of your health, but are **not** a part of UnitedHealthcare Community Plan.

Pediatrician — A children's doctor.

Pharmacy — Where you pick-up your medicine.

Physician Incentive Plan — Tells you if your doctor has any special arrangements with UnitedHealthcare Community Plan.

Post-Partum Care — Health care for a woman after she has her baby.

Prenatal Care — Care that is given to a pregnant woman the entire time she is pregnant.

Prescription — Medicine that your doctor orders for you; you must take it to the pharmacy to pick-up the medicine.

Preventive Counseling — When you want to talk to someone about ways to help you stay healthy or keep you from getting sick or hurt.

Primary Care Provider (PCP) — The doctor that takes care of you most of the time.

Prior Authorization — Written permission from UnitedHealthcare Community Plan to get health care or treatment.

Provider Directory — A list of all providers who are part of UnitedHealthcare Community Plan.

Providers — Doctors, nurses, dentists, and other people who take care of your health.

Referral — When your main doctor gives you a written note that sends you to see a different doctor.

Routine Care — The regular care you get from your primary care provider or a doctor that your primary care provider sends you to. Routine Care can be a check-up, physical, health screen and regular care for health problems like diabetes, asthma, and hypertension.

Definitions

Screening — A test that your doctor or other health care provider may do to see if you are healthy. This could be a hearing test, vision test, or a test to see if your child is developing normally.

Self-Referral Services — Certain services you can get without getting a written note or referral from your main doctor.

Services — The care you get from your doctor or other health care provider.

Special Health Care Needs — Children and adults who need health care and other special services that are more than or different from what other children and adults need.

Specialist — A doctor who is trained to give a special kind of care like an ear, nose and throat doctor or a foot doctor.

Specialty Care — Health care provided by doctors or nurses trained to give a specific kind of health care.

Sterilization Procedures — A surgery you can have if you do not want children in the future.

Transportation Services — Help from UnitedHealthcare Community Plan to get to your appointment. The type of transportation you get depends on your medical needs.

Treatment — The care you get from your doctor.

Urgent Care — Care you need within 24 hours, but not right away.

Visually Impaired — If you cannot see well or are blind.

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

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

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

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call **1-866-242-7726**, TTY **711**, between 8:00 a.m.–5:30 p.m. EST, Monday–Friday, months April–September; 8:00 a.m.–8:00 p.m. EST, 7 days a week, months October–March.

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

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

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

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

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

UnitedHealthcare Community Plan can provide free services to help you communicate with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English including qualified language interpreters and information written in other languages

To ask for help, please call **1-866-242-7726**, TTY **711**, between 8:00 a.m.–5:30 p.m. EST, Monday–Friday, months April–September; 8:00 a.m.–8:00 p.m. EST, 7 days a week, months October–March.

If you need any other assistance, please contact the Office of Health Care Ombudsman at 202-724-7491.

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We're here for you

Remember, we're always ready to answer any questions you may have. Just call Enrollee Services at **1-866-242-7726**, TTY **711**. You can also visit our website at **myuhc.com/CommunityPlan**.

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655 New York Avenue NW
Washington, DC 20001

myuhc.com/CommunityPlan

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This number is also on the back of your Enrollee ID Card.

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Washington, DC 20001