New York

# Welcome to the community

**UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP)**
**Medicaid Advantage Plus (MAP) Program**
**Member Handbook**

CSNY24MD0167619_002

United Healthcare Community Plan

# Important phone numbers

| | |
|---|---|
| **Member Services Department** | **1-866-547-0772** |
| Monday through Friday, 8:00 a.m. until 8:00 p.m.,<br>from April 1 to September 30<br>Seven days a week from 8:00 a.m. until 8:00 p.m.<br>from October 1 to March 31 | |
| TTY/TDD (for the hearing impaired) | **711** |
| **Your Primary Care Physician** | See Your United Healthcare Community Plan ID Card |
| **NurseLine** | **1-877-597-7801** |
| **Prior Authorization Department** | **1-866-362-3368** |
| **Pharmacy Department** | **1-800-310-6826** |
| **Transportation** | **1-866-932-7740** |
| **New York State Department of Health** (complaints) | **1-800-206-8125** |
| **New York Medicaid CHOICE** | **1-800-505-5678** |
| **New York State Growing Up Healthy Hotline** | **1-800-522-5006** |
| **New York State Department of Financial Services** | **1-800-342-3736** |
| **Upstate County Departments of Social Services:** | |
| Erie County Department of Social Services | **1-716-858-8000** |
| Genesee County Department of Social Services | **1-585-344-2580** |
| Monroe County Department of Social Services | **1-585-753-2760** |
| Niagara County Department of Social Services | **1-716-439-7600** |
| Orleans County Department of Social Services | **1-585-589-7000** |
| Wyoming County Department of Social Services | **1-585-786-8900** |

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# Welcome to UnitedHealthcare (UHC) Dual Complete NY-Y001 (HMO D-SNP) Medicaid Advantage Plus Program

Welcome to UnitedHealthcare (UHC) Dual Complete NY-Y001 (HMO D-SNP) Medicaid Advantage Plus (MAP) Program. The MAP Program is designed for people who have Medicare and Medicaid and who need health services and Community Based Long Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits UHC Dual Complete NY-Y001 covers since you are enrolled in the UHC Dual Complete NY-Y001 MAP Program. It also tells you how to request a service, file a complaint or disenroll from UHC Dual Complete NY-Y001 MAP Program. The benefits described in this handbook are in addition to the Medicare benefits described in the UHC Dual Complete NY-Y001 Medicare Evidence of Coverage. Keep this handbook with the UHC Dual Complete NY-Y001 Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

## Help from Member Services

There is someone to help you at Member Services:

- Monday through Friday, 8:00 a.m. until 8:00 p.m., from April 1 to September 30
- 7 days a week from 8:00 a.m. until 8:00 p.m., from October 1 to March 31
- Call **1-866-547-0772**, TTY/TDD **711**
  If you call us after hours, leave a message. We will call you back the next workday.

**NurseLine after hours**

If you have questions about your healthcare and cannot reach your care manager before 8:30 a.m. or after 5:00 p.m., Monday through Friday, you can always call our 24/7 NurseLine and speak directly to a nurse. Call **877-597-7801**, TTY/TDD **711**.

**Interpreter services**

UHC Dual Complete NY-Y001 understands that our members are part of a population with unique needs, varying cultures and educational challenges. Our Member Services Representatives speak a wide variety of languages, but if you speak a language that our staff does not know, you can ask for a translator and we will access a translation service line to assist with the call. We also can provide written information in the most prevalent languages of our members. Oral interpretation of UHC Dual Complete NY-Y001 materials are also available to members in different languages.

**Services for the visually impaired, hearing impaired and developmentally disabled**

The plan provides a TTY/TDD number 711 for hearing and speech impaired individuals, which communicates with the Member Services team to provide assistance to members. Member handbooks in Braille, large print and CD (compact disc) will be made available for members with visual impairments, and information can be read to members, as requested. Member Services will address other needs as they arise, including those related to physical or developmental disabilities. Member Services staff will provide additional support for members as needed, including assisting with making calls and connecting you to your Care Coordination team.

# Eligibility for enrollment in the MAP Program

MAP is a program for people who have both Medicare and Medicaid. You are eligible to join the MAP Program if you meet all of the following requirements:

1. Are age 18 and older,
2. Reside in the Plan's service area which is Erie, Genesee, Monroe, Niagara, Orleans and Wyoming county,
3. Have Medicaid,
4. Have evidence of Medicare Part A & B coverage,
5. Are eligible for nursing home level of care (as of time of enrollment) using the Community Health Assessment (CHA),
6. Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety,
7. Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the Medicaid Advantage Plus Plan for more than 120 days from the effective date of enrollment:

    a. Nursing services in the home

    b. Therapies in the home

    c. Home health aide services

   d. Personal care services in the home
   e. Adult day health care,
   f. Private duty nursing; or
   g. Consumer Directed Personal Assistance Services, **and**

8. Must enroll in UHC Dual Complete NY-Y001 Medicare Advantage Dual Special Needs Plan.

**Equality of access to enrollment**

UHC Dual Complete NY-Y001 shall accept enrollments of Eligible Persons in the order in which they are received without restriction and without regard to the Eligible Person's age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services or to the Capitation Rate that the UHC Dual Complete NY-Y001 will receive for such Eligible Person. Applicants cannot be discriminated against based on their health status and/or the need for or cost of covered services.

Network providers will be paid directly by UHC Dual Complete NY-Y001 for each service authorized and provided to you with no copay or cost to you. If you receive a bill for covered services authorized by UHC Dual Complete NY-Y001 you are not responsible to pay the bill, please contact your Care Manager.

You must choose one of the doctors from the plan to be your Primary Care Provider (PCP). If you decide later to change your Medicare plan, you will also have to leave UHC Dual Complete NY-Y001 MAP.

The coverage explained in this handbook becomes effective on the effective date of your enrollment in UHC Dual Complete NY-Y001 MAP Program. Enrollment in the MAP Program is voluntary.

**New York Independent Assessor Program (NYIAP) – initial assessment process**

The NYIAP will conduct an initial assessment for individuals who have expressed an interest in enrolling in a Managed Long Term Care plan. The initial assessment process includes completing the:

- **Community Health Assessment (CHA):** The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in an MLTC plan.
- **Clinical appointment and Practitioner Order (PO):** The PO documents your clinical appointment and indicates that you:
  - Have a need for help with daily activities, **and**
  - That your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIAP will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIAP will complete a clinical appointment and PO a few days later.

UHC Dual Complete NY-Y001 will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIAP Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care and any other necessary medical documentation. If more information is needed, someone on the panel may ask to examine you and/or discuss your needs with you. The IRP will make a recommendation to UHC Dual Complete NY-Y001 about whether the plan of care meets your needs.

Once NYIAP has completed the initial assessment steps and determined that you are eligible for Medicaid Managed Long Term Care, you can then choose which MLTC Care plan in which to enroll. Because you also are enrolled in Medicare for this same plan, you have chosen to combine your benefits and enroll in UHC Dual Complete NY-Y001.

**Joining UHC Dual Complete NY-Y001**

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in UHC Dual Complete NY-Y001 MAP Plan. Enrollment in the MAP Plan is voluntary. Your expected coverage date will be stated in your Enrollment Agreement. In general, coverage starts the first day of the month following your signing the Enrollment Agreement. If you are new to needing Medicaid Community-Based Long-Term Care Services, you will need to be evaluated by a Registered Nurse from the NYIAP. This nurse will determine whether you are eligible for the long-term care services provided.

As part of the enrollment process, and following the initial membership assessment telephone call, a Registered Nurse from UnitedHealthcare will come to your home. During this meeting, the following will occur:

- A comprehensive health assessment must be conducted within thirty (30) days of your request for enrollment
- Your home environment will be assessed for safety
- Rules and responsibilities of plan membership will be explained. Assistance will be provided in completing the enrollment process.
- Once the RN completes the assessment, a New York State Licensed Medicare Agent will contact you to explain the Medicare benefits and complete a Medicare application to enroll you into UHC Dual Complete NY-Y001

### Denial of enrollment

UnitedHealthcare may find an applicant ineligible to enroll in our MAP program if he/she does not meet the age requirements, is not a resident of UnitedHealthcare's service areas, or is not eligible for Medicaid. If you do not meet the eligibility criteria, UnitedHealthcare will recommend denial of your enrollment to the Local District of Social Services (LDSS), if you do not choose to withdraw your application. Only the LDSS may deny enrollment and will notify you of your rights.

You may withdraw your application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicating your wishes verbally or in writing and a written acknowledgment of your withdrawal will be sent to you. If the 20th day of the month falls on a weekend or holiday, the date reverts to the Friday prior to the 20th day of the month.

If you are determined to be clinically ineligible for UHC Dual Complete NY-Y001, you will be advised and you may withdraw your application. Clinical ineligibility means that, based on the assessment completed by the UnitedHealthcare Registered Nurse, you do not meet one or more of the following criteria:

- You do not meet health and safety criteria; and/or
- You do not require Community-Based Long-Term Care Services for more than 120 days
- You do not require nursing home level of care

If you do not withdraw your application, your application will be processed as a proposed denial, pending review by LDSS.

### Plan member (ID) card

You will receive your UHC Dual Complete NY-Y001 identification (ID) card within 14 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at **1-866-547-0772**, TTY/TDD **711**.

# Services covered by the UHC Dual Complete NY-Y001 MAP Program

## Deductibles and copayments on Medicare covered services

Many of the services that you receive, including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests, are covered by Medicare and are described in the UHC Dual Complete NY-Y001 Medicare Evidence of Coverage. Chapter 3 of the UHC Dual Complete NY-Y001 Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or urgent care situation. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Chapter 4 of UHC Dual Complete NY-Y001 Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined UHC Dual Complete NY-Y001, and you have Medicaid, UHC Dual Complete NY-Y001 will pay these amounts. You do not have to pay these deductibles and copayments except for those that apply to some pharmacy items.

If there is a monthly premium for benefits (see Chapter 1 of the UHC Dual Complete NY-Y001 Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

## Care Management services

As a member of our plan, you will get Care Management services. Our plan will provide you with a Care Manager who is a health care professional — usually a nurse or a social worker. Your Care Manager will work with you and your doctor to decide the services you need and develop a care plan. Your Care Manager will also arrange appointments for any services you need and arrange for transportation to those services. Your Care Management Team will consist of your Care Manager, assessment RNs, social workers, your personal PCP and other UHC Dual Complete NY-Y001staff. The staff that may be involved in your care may include Member Services Advocates, Pharmacists, Clinical Director and Medical Director. An important benefit of joining UHC Dual Complete NY-Y001 is that you will be assigned a Care Manager who will be responsible for managing all of your services. He or she will have clinical expertise about your chronic health conditions and will help you get the right care, including long-term care services. A Registered Nurse is an important member of your

Care Management Services team and will make periodic visits to your home to reassess your condition. Your Care Manager will work with you to help you manage your chronic condition and live in your home as independently as possible, for as long as possible, with the goal to enhance your functionality and quality of life. Your Care Manager will continue to manage your care if you require residential nursing home care as well. Your Care Manager will be matched, based upon availability, to best meet your individual language and cultural needs.

### How your Care Manager can assist you

Complete a comprehensive, individual assessment of your health and long-term care needs and help you determine the services most appropriate to meet your needs.

- Help you develop your person-centered service plan
- Make sure the right health care professionals are consulted during your person-centered service plan progress
- Give you information to help you choose long-term care providers contracted with UHC Dual Complete NY-Y001
- Contact you by telephone at least every month and coordinate your reassessment visit every six months
- If your condition changes or you are hospitalized, your Care Manager will review your current needs and revise your person-centered service plan to meet your needs
- Make sure your person-centered service plan is carried out and works the way it needs to so that your needs are met
- Monitor your health status to make sure you are getting what you need and that gaps in care are addressed right away
- Give you information about community resources that might be helpful to you
- Make sure that services you receive at home are based on your needs
- Help you coordinate your care and service needs
- Educate and inform you, as applicable, about Consumer Directed Personal Assistance Services (CDPAS) and other service options

### Contacting your Care Manager

You can contact your Care Manager anytime you have a question or concern about your health care by calling Member Services, who will access your Care Manager. You do not need to wait until a scheduled home visit or a phone call from the Care Manager. You should contact your Care Manager when you have a change in your status that may affect the kind or amount of care you need. If you need help after regular business hours and cannot wait until the next day, you can call UHC Dual Complete NY-Y001 at **1-866-547-0772**, TTY/TDD **711** for assistance.

### Changing your Care Manager

If you are unhappy with your Care Manager, it is important that you let us know by calling **1-866-547-0772**, TTY/TDD **711**. If we cannot resolve your concern, you may have a new Care Manager assigned to you.

### How your Care Manager will work with your doctor

- Your Care Manager can help make sure that your personal PCP and other providers are working with you
- A copy of your person-centered service plan will be shared with your personal PCP
- Your Care Manager will work with your personal PCP to make sure that you have the services you need if you are hospitalized and when you come out of the hospital
- Your Care Manager will advise your personal PCP of any assessments and/or screenings that you have had

## Additional covered services

Because you have Medicaid and qualify for the MAP program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary. Your Care Manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in UHC Dual Complete NY-Y001 network.

### Out-of-network care

If you cannot find a provider in our Plan, with appropriate training or experience to meet your medical necessity needs, you may speak to your primary care physician to obtain a referral to an out-of-network health care provider. If you need help, please contact your Care Coordinator so he or she can assist you in requesting a service authorization.

Before you see any out-of-network provider for covered services, you must get a service authorization from UHC Dual Complete NY-Y001 plan. If you see the provider without a service authorization, the provider will not be paid. If you have any questions regarding out-of-network care and/or authorizations, please call Member Services at **1-866-547-0772**, TTY/TDD **711**.

## Benefits and services

Some covered services require Prior Authorization (approval in advance) from your physician, UHC Dual Complete NY-Y001 plan or both, before you can receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The list below is some of the services that may need prior authorization. This list is subject to change so you may want to call Member Services or contact your Primary Care Provider (PCP). The check mark (4) will tell you if the treatment or service requires prior authorization from UHC Dual Complete NY-Y001 plan or an order from your personal Primary Care Provider (PCP), or both, before you can access the benefit see **Section 1: Service authorization request (also known as coverage decision request)**.

*** Some Services require prior authorization. Your provider should contact Provider Services at 866-362-3368 to inquire if prior authorization is required.**

For those UHC Dual Complete NY-Y001 Benefits with no check mark (✔), you may access the service or treatment directly. You can call Member Services toll-free at **1-866-547-0772**, TTY/TDD **711** for assistance in accessing these benefits as well.

| UHC Dual Complete NY-Y001 benefits | Prior authorization required |
|---|---|
| **Adult Day Health Care** | ✔ |
| **Audiology** | ✔ |
| **Consumer Directed Personal Assistance Services** | ✔ |
| **Dental*** | ✔ |
| **Durable Medical Equipment (DME)** (For items over $500) | ✔ |
| **Home Delivered Meals and/or meals in a group setting such as a day care** | ✔ |
| **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies | ✔ |
| **Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit, see Prior Authorization** | ✔ |

| UHC Dual Complete NY-Y001 benefits | Prior authorization required |
|---|---|
| **Medical Social Services** | ✔ |
| **Medical Supplies** | |
| **Nursing Home Care Not Covered by Medicare**<br>(Provided you are eligible for institutional Medicaid) | ✔ |
| **Nutrition** | ✔ |
| **Optometry** | |
| **Outpatient Rehabilitation** | ✔ |
| **Personal Care**<br>(Such as assistance with bathing, eating, dressing, toileting and walking) | ✔ |
| **Personal Emergency Response System** | ✔ |
| **Private Duty Nursing** | ✔ |
| **Prosthetics and Orthotics*** | ✔ |
| **Social Day Care** | ✔ |
| **Social/Environmental Support**<br>(Such as chore services, home modification or respite) | ✔ |

## Covered behavioral health (mental health and addiction) services

**Adult outpatient mental health care**

- **Continuing Day Treatment (CDT):** Provides seriously mentally ill adults with the skills and supports necessary to remain in the community and be more independent. You can attend several days per week with visits lasting more than an hour.
- **Partial Hospitalization (PH):** A program which provides mental health treatment designed to stabilize or help acute symptoms in a person who may need hospitalization.

**Adult outpatient rehabilitative mental health care**

- **Assertive Community Treatment (ACT):** ACT is a team approach to treatment, support, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT is for individuals that have been diagnosed with serious mental illness or emotional problems.
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS):** A program that provides treatment, assessment, and symptom management. Services may include individual and group therapies at a clinic location in your community.
- **Personalized Recovery Oriented Services (PROS):** A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, and therapy to aid in your recovery.

**Adult outpatient rehabilitative mental health and addiction services for members who meet clinical requirements. These are also known as CORE.**

**Community Oriented Recovery and Empowerment (CORE) Services:** Person-centered, recovery program with mobile behavioral health supports to help build skills and promote community participation and independence. CORE Services are available for members who have been identified by the State as meeting the high need behavioral health risk criteria. Anyone can refer someone, or self-refer, to CORE Services.

- **Psychosocial Rehabilitation (PSR):** This service helps with life skills, like making social connections; finding or keeping a job; starting or returning to school; and using community resources.
- **Community Psychiatric Supports and Treatment (CPST):** This service helps you manage symptoms through counseling and clinical treatment.

- **Family Support and Training (FST):** This service gives your family and friends the information and skills to help and support you.
- **Empowerment Services – Peer Supports:** This service connects you to peer specialists who have gone through recovery. You will get support and assistance with learning how to:
  - Live with health challenges and be independent,
  - Help you make decisions about your own recovery, **and**
  - Find natural supports and resources.

**Adult mental health crisis services**

- **Comprehensive Psychiatric Emergency Program (CPEP):** A hospital-based program which provides crisis supports and beds for extended observation (up to 72 hours) to individuals who need emergency mental health services.
- **Mobile Crisis and Telephonic Crisis Services:** An in-community service that responds to individuals experiencing a mental health and/or addiction crisis.
- **Crisis Residential Programs:** A short term residence that provides 24 hours per day services for up to 28 days, for individuals experiencing mental health symptoms or challenges in daily life that makes symptoms worse. Services can help avoid a hospital stay and support the return to your community.

**Adult outpatient addiction services**

**Opioid Treatment Centers (OTP)** are Office of Addiction Services and Supports certified sites where medication to treat opioid dependency is given. These medications can include methadone, buprenorphine, and suboxone. These facilities also offer counseling and educational services. In many cases, you can get ongoing services at an OTP clinic over your lifetime.

**Adult residential addiction services**

Residential Services are for people who are in need of 24-hour support in their recovery in a residential setting. Residential services help maintain recovery through a structured, substance-free setting. You can get group support and learn skills to aid in your recovery.

### Adult inpatient addiction rehabilitation services

State Operated Addiction Treatment Center's (ATC) provide care that is responsive to your needs and supports long-term recovery. Staff at each facility are trained to help with multiple conditions, such as mental illness. They also support aftercare planning. Types of addiction treatment services are different at each facility but can include medication-assisted treatment; problem gambling, gender-specific treatment for men or women, and more.

Inpatient Addiction Rehabilitation programs can provide you with safe setting for the evaluation, treatment, and rehabilitation of substance use disorders. These facilities offer 24- hour, 7-day-a-week care that is supervised at all times by medical staff. Inpatient services include management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.

Inpatient Medically Supervised Detox programs offer inpatient treatment for moderate withdrawal and include supervision under the care of a physician. Some of the services you can receive are a medical assessment within twenty-four (24) hours of admission and medical supervision of intoxication and withdrawal conditions.

### Limitations

- Nursing Home Care is covered for individuals who are considered to be permanently placed in a nursing home, provided you are eligible for institutional Medicaid coverage
- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:
  1. Tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and
  2. Individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.

Under certain conditions, adults who have HIV, AIDS, or HIV-related illness, or other disease or condition, may be eligible for additional oral nutrition.

Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein, or which contain modified protein.

## Telehealth

You can receive some services through telehealth when appropriate. It is your choice if you receive services in person or through telehealth. If you have additional questions on telehealth, please contact your Care Manager.

## Getting care outside the service area

You must inform your Care Manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your Care Manger should be contacted to assist you in arranging services.

## Emergency service

Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial **911**. Prior authorization is not needed for emergency service. However, you should notify UHC Dual Complete NY-Y001 within 24 hours of the emergency. You may be in need of long term care services that can only be provided through UHC Dual Complete NY-Y001.

If you are hospitalized, a family member or other caregiver should contact UHC Dual Complete NY-Y001 within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact UHC Dual Complete NY-Y001 so that we may work with them to plan your care upon discharge from the hospital.

## Transitional care procedures

New enrollees in UHC Dual Complete NY-Y001 may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the Plan rate, adheres to UHC Dual Complete NY-Y001 quality assurance and other policies, and provides medical information about the care to the Plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the Plan rate, adheres to Plan quality assurance and other policies, and provides medical information about the care to the Plan.

## Monthly spenddown

**Medicaid spenddown/surplus/net allowable monthly income (NAMI)**

Some members may have a monthly spenddown/surplus or a NAMI to be eligible for Medicaid services. The amount is determined by the Local Department of Social Services or entity designated by the NYSDOH. If this applies to you, payments are to be made to UnitedHealthcare, on a monthly basis. If you have a spenddown amount owed to UnitedHealthcare and you do not submit payments, you may be disenrolled from UHC Dual Complete NY-Y001.

Spenddown/NAMI payments can be in the form of check or money order (not cash), and should be sent to the following address:

UnitedHealthcare
P.O. Box 785462
Philadelphia PA 19178-5462

If you have any questions, please call your Care Coordinator toll-free at 1-866-214-1746, TTY 711, 9:00 a.m.–5:00 p.m. EST, Monday–Friday.

## Money Follows the Person (MFP)/Open Doors

This section explains the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community. You may qualify for MFP/Open Doors if you:

- Have lived in a nursing home for three months or longer and
- Have health needs that can be met through services in their community.

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- Giving you information about services and supports in the community
- Finding services offered in the community to help you be independent
- Visiting or calling you after you move to make sure that you have what you need at home

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email **mfp@health.ny.gov**. You can also visit MFP/Open Doors on the web at **www.health.ny.gov/mfp** or **www.ilny.org**.

# Medicaid services not covered by our plan

There are some Medicaid services that UHC Dual Complete NY-Y001 does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at **1-866-547-0772**, TTY/TDD **711** if you have a question about whether a benefit is covered by UHC Dual Complete NY-Y001 or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

**Pharmacy**

Most prescription drugs are covered by UHC Dual Complete NY-Y001 Medicare Part D as described in section 6 of the UHC Dual Complete NY-Y001 Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by UHC Dual Complete NY-Y001 Medicare Part D. Medicaid may also cover drugs that we deny.

**Certain mental health services, including:**

- Health Home (HH) and Health Home Plus (HH+) Care Management services
- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs
- OMH Day Treatment
- OASAS Residential Rehabilitation for Youth
- Certified Community Behavioral Health Clinics (CCBHC)
- OMH Residential Treatment Facility (RTF)

**For MAP enrollees up to the age of 21**

- Children and Family Treatment and Support Services (CFTSS)
- Children's Home and Community Based Services (HCBS)

**Certain intellectual disability and developmental disabilities services, including:**

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

**Other Medicaid services**

- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management

- Medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs, for members meeting criteria

**Family planning**

- Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

Non-Emergency Medical Transportation

**Non-emergency medical transportation scheduling**

Starting March 1, 2024, UHC Dual Complete NY-Y001 will no longer cover non-emergency transportation as part of your Plan benefits. Non-emergency medical transportation services for members enrolled in a UHC Dual Complete NY-Y001, Medicaid Advantage Plus will now be arranged by the New York State Department of Health Statewide Transportation Broker, known as Medical Answering Services (MAS). This will not change any of your other medical benefits.

To arrange non-emergency medical transportation on or after March 1, 2024, you or your provider must contact MAS at **https://www.medanswering.com/** or call 844-666-6270 (Downstate) or 866-932-7740 (Upstate). If possible, you or your medical provider should contact MAS at least three days before your medical appointment and provide the details of your appointment (date, time, address, and name of provider) and your Medicaid identification number.

To learn more about these services, visit Department of Health Transportation web page.

# Services not covered by UHC Dual Complete NY-Y001 or Medicaid

You must pay for services that are not covered by UHC Dual Complete NY-Y001 or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by UHC Dual Complete NY-Y001 or Medicaid are:

- Cosmetic surgery, if not medically needed
- Personal and comfort items
- Infertility treatment
- Services from a provider that is not part of the plan outside of a medical emergency (unless UHC Dual Complete NY-Y001 authorizes you to see that provider)

If you have any questions, call Member Services at **1-866-547-0772**, TTY/TDD **711**.

# Service authorization, appeals and complaints processes

You have Medicare and also get assistance from Medicaid. Information in this section covers your rights for all of your Medicare and most of your Medicaid benefits. In most cases, you will use one process for both your Medicare Medicaid benefits. This is sometimes called an "integrated process" because it integrates Medicare and Medicaid processes.

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page 33 for more information on the External Appeals process.

## Section 1: Service authorization request (also known as coverage decision request)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get a service authorization request, you must follow the steps noted in this Section.

To get approval for treatments or services, your doctor or health care provider must call UHC Dual Complete NY-Y001 Prior Authorization Department at 866-362-3368, or your physician or health care provider may send a request in writing by facsimile (fax) at 866-950-4490.

We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period**.

Some Medicare and/or Medicaid medical services and treatment are covered only if your doctor or other network provider gets approval before you receive them or continue to receive them, this does not include emergency services. This is called prior authorization. Your health care provider can ask for this on your behalf.

## Prior authorization

Some covered services require **prior authorization** (approval in advance) from UHC Dual Complete NY-Y001 before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved **before** you get them:

Examples of treatments and services that must be approved before you get them are in the list below. This information is not a complete description of benefits**.

- Admissions to Inpatient Facilities: Includes inpatient hospital, inpatient rehabilitation, long-term care hospitals and skilled nursing facilities
- Advanced Radiology Testing such as Nuclear and PET scans
- Certain Dental services
- Cardiac Diagnostic Testing
- Chemotherapy Drugs, and the Administration of chemotherapy drugs
- Cosmetic and Reconstructive Surgery
- Durable Medical Equipment over $500
- All Power Wheelchairs
- Experimental or investigational health care services
- Gastric bypass surgery
- Home health care services
- Home and Community Based Services including:
  - Adult Day Healthcare
  - Home Delivered Meals
  - Home Modification
  - Personal Care and Consumer Directed Personal Assistance Services
  - Private Duty Nursing
  - Social Day Care
- Some Mental health or substance abuse services
- Out-of-Network/Out-of-State services
- Physical, Occupational and Speech therapy
- Prosthetics and Orthotics over $500
- Transplant services

** Contact your physician or Member Services to find out if a service your provider wants you to have needs approval before you get that service. This list is subject to change so you may want to call Member Services or contact your Primary Care Provider (PCP).

For information on Medicare covered benefits and services that may require prior approval, see your UHC Dual Complete NY-Y001 Evidence of Coverage (EOC).

### Dental services

Starting January 31, 2024, UnitedHealthcare Community Plan will be covering crowns and root canals in certain circumstances so that you can keep more of your natural teeth. In addition, replacement dentures and implants will only need a recommendation from your dentist to determine if they are necessary. This will make it easier for you to access these dental services.

To learn more about these services, call Member Services at **1-866-547-0772**, TTY **711**.

### Mobile Crisis Telephonic Triage Response service

Starting March 1, 2024, UnitedHealthcare Community Plan will cover the Mobile Crisis Telephonic Triage and Response service for members under the age of 21. This service is already available to members 21 years of age and older.

Currently, members under the age of 21 can access the Mobile Crisis Telephonic Triage and Response service by using their Medicaid card. Effective March 1, 2024, you can use your UnitedHealthcare Community Plan card to receive this service.

Mobile Crisis teams can help you, your child, or other members of your family with mental health and addiction crisis symptoms. These symptoms can be things like:

- Increased anxiety,
- Depression,
- Stress due to a major life event or changes, or
- Needing to speak with someone to prevent relapse.

You and your family can call and talk to a professional about a crisis, get support, and be linked to other services when needed.

If you are experiencing a crisis, you can call or text **988** or chat at **www.988lifeline.org** 24 hours a day, 7 days a week.

To learn more about these services, call Member Services at **1-866-547-0772**, TTY **711**, Monday through Friday, 8:00 a.m. until 8:00 p.m., from April 1 to September 30; 7 days a week from 8:00 a.m. until 8:00 p.m., from October 1 to March 31.

### Concurrent review

You can also ask UHC Dual Complete NY-Y001 to get more of a service than you are getting now. This is called **concurrent review**.

### Retrospective review

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

### What happens after we get your service authorization request?

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

We may decide to deny a service authorization request or to approve it for an amount that is less than you asked for. A qualified health care professional will make these decisions. If we decide that the service you asked for is not medically necessary, a clinical peer reviewer will make the decision. A clinical peer reviewer may be a doctor, a nurse, or a health care professional who typically provides the care you asked for. You can ask for the specific medical standards, called **clinical review criteria**, used to make the decision about medical necessity.

After we get your request, we will review it under either a **standard** or a **fast-track** process. You or your provider can ask for a fast-track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast-track review, we will tell you and handle your request under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below. More information on the fast-track process is below.

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

## Standard process

Generally, we use the **standard timeframe** for giving you our decision about your request for a medical item, treatment, or service unless we have agreed to use the fast-track deadlines.

- A **standard review** for a prior authorization request means we will give you an answer within 3 workdays of when we have all the information we need, but no later than **14 calendar days** after we get your request. If your case is a **concurrent review** where you are asking for a change to a service you are already getting, we will make a decision within 1 workday of when we have all the information we need but will give you an answer no later than 14 calendar days after we get your request.
- **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 providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should **not** take extra days, you can file a **fast complaint**. 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 service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see **Section 5: What to do if you have a complaint about our plan**.)

If we do not give you our answer within 14 calendar days (or by the end of the extra days if we take them), you can file an appeal.

- **If our answer is yes to part or all of what you asked for,** we will authorize the service, or treatment, or give you the item that you asked for
- **If our answer is no to part or all of what you asked for,** we will send you an Appeal Decision Notice that explains why we said no. More information about how to appeal this decision can be found in Section 2: Level 1 Appeals.

## Fast track process

If your health requires it, ask us to give you a **fast service authorization**.

- A **fast review** of a prior authorization request means we will give you an answer within 1 workday of when we have all the information, we need but no later than 72 hours from when you made your request to us
- We can take **up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should not take extra days, **you can file a fast complaint**. For more information about the process for making complaints, including fast complaints, see **Section 5: What to do if you have a complaint about our plan**, below, for more information. We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See **Section 2: Level 1 Appeals**, below for how to make an appeal.

To get a **fast service authorization**, you must meet two requirements:

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a **fast service authorization** if your request is about payment for medical care, you already got.)
2. Using the standard deadlines could cause serious harm to your life or health or hurt your ability to function.

**If your provider tells us that your health requires a fast service authorization, we will automatically agree to give you a fast service authorization.**

If you ask for a fast service authorization on your own, without your provider's support, we will decide whether your health requires that we give you a **fast service authorization**.

If we decide that your medical condition does not meet the requirements for a **fast service authorization**, 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 provider asks for the **fast service authorization**, we will automatically give a **fast service authorization**
- The letter will also tell how you can file a **fast complaint** about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see **Section 5: What to do if you have a complaint about our plan** later in this chapter.)

**If our answer is yes to part or all of what you asked for**, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

**If our answer is no to part or all of what you asked for**, we will send you a detailed written explanation as to why we said no. If you are not satisfied with our answer, you have the right to file an appeal with us. See **Section 2: Level 1 Appeals**, below for more information.

If you do not hear from us on time, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See **Section 2: Level 1 Appeals**, below for more information.

## If we are changing a service you are already getting

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service
- If we are reviewing care that you got in the past, we will make a decision about paying for it within 30 days of getting necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day we deny the payment. **You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.**

You may also have special **Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF)** services is ending. For more information about these rights, refer to Chapter 9 of the UHC Dual Complete NY-Y001 Evidence of Coverage.

## What to do if you want to appeal a decision about your care

If we say no to your request for coverage for a medical item or service, you decide if you want to make an appeal.

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below)
- UHC Dual Complete NY-Y001 can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at **1-866-547-0772**, TTY/TDD **711** to get more information on your rights and the options available to you.

**At any time in the process, you, or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.**

# Section 2:
# Level 1 Appeals (also known as a Plan Level Appeal)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

There are some treatments and services that you need approval for before you get them or to be able to keep getting them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. We describe this process earlier in Section 1 of this chapter. If we decide to deny a service authorization request or to approve it for an amount that is less than asked for, you will receive a notice called an Integrated Coverage Determination Notice.

If you receive an Integrated Coverage Determination Notice and disagree with our decision, you have the right to make an appeal. Making an appeal means trying to get the medical item or service you want by asking us to review your request again.

**You can file a Level 1 Appeal:**

When you appeal a decision for the first time, this is called a Level 1 Appeal, or a Plan Appeal. In this appeal, we review the decision we made to see if we properly followed all the rules. Your appeal is handled by reviewers not previously involved during the original decision. When we complete the review, we will give you our decision. Under certain circumstances, which we discuss below, you can request a fast appeal.

**Steps to file a Level 1 Appeal:**

- If you are not satisfied with our decision, you have **60 days** from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause may include 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.
- If you are appealing a decision, we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a **fast appeal**
  - The requirements and procedures for getting a **fast appeal** are the same as for getting a fast track service authorization. To ask for a **fast appeal**, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 1, in the Fast Track Process section.)
  - If your provider tells us that your health requires a **fast appeal**, we will give you a **fast appeal**
  - If your case was regarding a termination, denial or reduction of services you are already getting also known as a concurrent review, you will automatically get a fast appeal

- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call Member Services at **1-866-547-0772**, TTY/TDD **711** if you need help filing a Level 1 Appeal.
  - After your call, we will send you a form that summarizes your phone appeal. You can make any needed changes to the summary before signing and returning the form to us.
  - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an Appointment of Representative form, or write and sign a letter naming your representative.
    - To get an Appointment of Representative form, call Member Services and ask for the form. You can also get the form on the Medicare website at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. The form gives the person permission to act for you. You must give us a copy of the signed form, OR
    - You can write a letter and send it to us. (You or the person named in the letter as your representative can send us the letter.)
- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal
- You can make the Level 1 Appeal by phone or in writing
- You can file a Level 1 Appeal in writing by sending your Appeal to:

  UnitedHealthcare UHC Dual Complete NY-Y001
  P.O. Box 6103
  Mail Stop CA124-0187
  Cypress, CA 90630-0016

**Continuing your service or item while appealing a decision about your care**

If your services were terminated, denied or you had a reduction of services you are already getting, also known as a concurrent review, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking action
- If you disagree with the action, you can file a Level 1 Appeal
- We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

- Note: If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative

**What happens after we get your Level 1 Appeal**

- Within 15 days when asking for a standard appeal, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we will use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information. You will receive our decision in a shorter time than you would have received a standard appeal acknowledgment.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision
- You can also provide information to be used in making the decision in person or in writing. Call us at **1-866-547-0772**, TTY/TDD **711** if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for, we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will automatically send your case on to the next level of the appeals process.

**Timeframes for a standard appeal**

- If we are using the standard appeal timeframes, we must give you our answer on a request within 30 calendar days after we get your appeal if your appeal is about coverage for services, you have not gotten yet
- We will give you our decision sooner if your health condition requires us to
- However, 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 days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
  - 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.

- For more information about the process for making complaints, including fast complaints, see **Section 5: What to do if you have a complaint about our plan** below, for more information.

  If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process where an independent outside organization will review it.

  We talk about this review organization and explain what happens at Level 2 of the appeals process in **Section 3: Level 2 Appeals**.

**If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision about coverage for services you have not gotten yet.

**If our answer is no to part or all of what you asked for**, to make sure we followed all the rules when we said no to your appeal, **we are required to send your appeal to the next level of appeal**. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

**Timeframes for a fast appeal**

- When we are using the fast timeframes, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to do so.
- 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 days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 3: Level 2 Appeals

**If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we get your appeal.

**If our answer is no to part or all of what you asked for**, we will automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal.

- During the Level 2 Appeal, an independent review organization, called the **Administrative Hearing Office or Hearing Office**, reviews our decision on your first appeal. This organization decides whether the decision we made should be changed.

- We tell you about this organization and explain what happens at Level 2 of the appeals process later in Section 3: Level 2 Appeals

**At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.**

# Section 3: Level 2 Appeals

Information in this section applies to **all** your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

If we say **no** to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Hearing Office** reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency.** It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a free copy of your case file.**
- You have a right to give the Hearing Office additional information to support your appeal
- Reviewers at the **Hearing Office** will take a careful look at all the information related to your appeal. The **Hearing Office** will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it gets your appeal.
- If the **Hearing Office** needs to gather more information that may benefit you, **it can take up to 14 more calendar days**

**If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2**

- If you had a **standard appeal** to our plan at Level 1, you would automatically get a **standard appeal** at Level 2
- The review organization must give you an answer to your Level 2 Appeal **within 60 calendar days** of when it gets your appeal. There is a total of 90 days available between the date you request a plan appeal (Level 1) and the date that the Hearing Office decides your Level 2 appeal.
- If the **Hearing Office** needs to gather more information that may benefit you, it can take up to 14 more calendar days

**If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 28 for information about continuing your benefits during Level 1 Appeals.**

**The Hearing Office will tell you about its decision in writing and explain the reasons for it.**

- If the Hearing Office says **yes** to part or all your request, we must authorize the service or give you the item **within one business day of when we get the Hearing Office's decision**
- If the Hearing Office says **no** to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

**If the Hearing Office says no to part or all your appeal, you can choose whether you want to take your appeal further.**

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal)
- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.
- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.

**At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.**

# Section 4: External appeals for Medicaid only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only**.

You can ask New York State for an independent **external appeal** if our Plan decides to deny coverage for a medical service you and your doctor asked for because it is:

- Not medically necessary or
- Experimental or investigational or
- Not different from care you can get in the Plan's network or
- Available from a participating provider who has correct training and experience to meet your needs.

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State (the State). The service must be in the Plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

**Before** you appeal to the State:

- You must file a Level 1 appeal with the Plan and get the Plan's Appeal Decision Notice; **or**
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); **or**
- You and the Plan may agree to skip the Plan's appeals process and go directly to External Appeal; **or**
- You can prove the Plan did not follow the rules correctly when processing your Level 1 appeal.

You have **4 months** after you get the Plan's **Appeal Decision Notice** to ask for an External Appeal. If you and the Plan agreed to skip the Plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal fill out an application and send it to the Department of Financial Services.

- You can call Member Services at **1-866-547-0772**, TTY/TDD **711** if you need help filing an appeal
- You and your doctors will have to give information about your medical problem
- The External Appeal application says what information will be needed

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at **www.dfs.ny.gov**
- Contact the Health Plan at **1-866-547-0772**, TTY/TDD **711**

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five workdays) may be needed. The reviewer will tell you and the Plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the Plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling **1-866-712-7197**.

# Section 5:
# What to do if you have a complaint about our plan

Information in this section applies to **all** of your Medicare and Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

We hope our Plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Member Services at **1-866-547-0772**, TTY/TDD **711** or write to Member Services. **The formal name for making a complaint is filing a grievance.**

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

Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an Appointment of Representative form, or write and sign a letter naming your representative. To get an Appointment of Representative form, call Member Services and ask for the form. You can also get the form on the Medicare website at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. The form gives the person permission to act for you. You must give us a copy of the signed form, OR you can write a letter and send it to us. (You or the person named in the letter as your representative can send us the letter.)

- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal
- You can make the Level 1 Appeal by phone or in writing
- You can file a Level 1 Appeal in writing by sending your Appeal to:

  UnitedHealthcare
  UHC Dual Complete NY-Y001
  P.O. Box 6103, Mail Stop CA124-0187
  Cypress, CA 90630-0016

**How to file a complaint:**

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
  **1-866-547-0772**, TTY/TDD **711**
  Monday through Friday, 8:00 a.m. until 8:00 p.m., from April 1 to September 30
  7 days a week from 8:00 a.m. until 8:00 p.m., from October 1 to March 31
- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us**. If you put your complaint in writing, we will respond to your complaint in writing.

  You can write us with your complaint. It should be mailed to:

  UHC Dual Complete NY-Y001
  P.O. Box 6103
  Mail Stop CA124-0187
  Cypress, CA 90630-0016
- **Whether you call or write, you should contact Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

**What happens next:**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- We answer complaints within 30 calendar days
- If you are making a complaint because we denied your request for a fast service authorization or a fast appeal, we will automatically give you a fast complaint. If you have a fast complaint, it means we will give you an answer within 24 hours.
- If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- However, if you have already asked us for a service authorization or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples of when you can make a complaint:
  - If you asked us to give you a fast service authorization or a fast appeal and we said, we will not
  - If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made
  - When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines

  - When we do not give you a decision on time and we do not forward your case to the Hearing Office by the required deadline
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

## Complaint appeals

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

**How to make a complaint appeal:**

- If you are not satisfied with what we decide, you have at least 60 workdays after hearing from us to file a complaint appeal
- You can do this yourself or ask someone you trust to file the complaint appeal for you
- You must make the complaint appeal in writing
  - If you make an appeal by phone, you must follow it up in writing
  - After your call, we will send you a form that summarizes your phone appeal
  - If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

**What happens after we get your complaint appeal:**

After we get your complaint appeal, we will send you a letter within 15 workdays. The letter will tell you:

- Who is working on your complaint appeal
- How to contact this person
- If we need more information

One or more qualified people will review your complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about your complaint.

If your complaint appeal involves clinical matters, one or more qualified health professionals will review your case. At least one of them will be a clinical peer reviewer who was not involved in making the first decision about your complaint.

We will let you know our decision within 30 workdays from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 workdays of when we have all the information, we need to decide the appeal. We will give you the reasons for our decision and our clinical rationale if it applies.

**If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866-712-7197.**

## Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can call ICAN to get free, independent advice about your coverage, complaint, and appeal options. They can help you manage the appeal process.

Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)

Web: **www.icannys.org** | Email: **ican@cssny.org**

# Disenrollment from UHC Dual Complete NY-Y001 MAP Program

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Product based on any of the following reasons:

- High utilization of covered medical services, an existing condition or a change in the Enrollee's health, or
- Diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs unless the behavior results in the Enrollee becoming ineligible for Medicaid Advantage Plus.

### You can choose to voluntary disenroll

You can ask to leave the UHC Dual Complete NY-Y001, MAP Program at any time for any reason.

To request disenrollment, call your case manager. It could take up to six weeks to process, depending on when your request is received.

You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require Community Based Long Term Services and Supports (CBLTSS), like personal care, you must join another MLTC Plan or Home and Community Based Waiver program, in order to continue to receive CBLTSS services.

**You will have to leave UHC Dual Complete NY-Y001, MAP Program if:**

- You are no longer enrolled in UHC Dual Complete NY-Y001 for your Medicare coverage
- You are no longer Medicaid eligible
- You need nursing home care, but are not eligible for institutional Medicaid
- You are out of the Plan's service area for more than 30 consecutive days
- You permanently move out of UHC Dual Complete NY-Y001 service area
- You are no longer eligible for nursing home level of care as determined using the Community Health Assessment (CHA), unless the termination of the services provided by the Plan could reasonably be expected to result in you being eligible for nursing home level of care within the succeeding six-month period
- At the point of any reassessment while living in the community, you are determined to no longer demonstrate a functional or clinical need for Community Based Long Term Services and Supports (CBLTSS)
- Your sole service is identified as Social Day Care
- You join a Home and Community Based Services waiver program, or become a resident of an Office for People with Developmental Disabilities residential program
- You become a resident of an Office of Mental Health, or Office of Addiction Services and Supports (OASAS) residential program (that is not a MAP plan covered benefit) for forty-five (45) consecutive days or longer

**We may ask you to leave the UHC Dual Complete NY-Y001, MAP Program if:**

- You or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the Plan's ability to furnish services
- You knowingly provide fraudulent information on an enrollment form, or you permit abuse of an enrollment card in the MAP Program;
- You fail to complete and submit any necessary consent or release; or
- You fail to pay or make arrangements to pay the amount of money, as determined by the Local District of Social Services (LDSS), owed to the Plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, UHC Dual Complete NY-Y001 will obtain the approval of New York Medicaid Choice (NYMC) or an entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed. If you continue to need CBLTSS, you will be required to choose another plan or you will be auto assigned to another plan to provide you with coverage for needed services.

# Other plan details

## Cultural and linguistic competency

UHC Dual Complete NY-Y001 honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all enrollees. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

## Member rights and responsibilities

UHC Dual Complete NY-Y001 will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

**Member rights**

- You have the Right to receive medically necessary care
- You have the Right to timely access to care and services
- You have the Right to privacy about your medical record and when you get treatment
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand
- You have the Right to get information in a language you understand; you can get oral translation services free of charge
- You have the Right to get information necessary to give informed consent before the start of treatment
- You have the Right to be treated with respect and dignity
- You have the Right to get a copy of your medical records and ask that the records be amended or corrected
- You have the Right to take part in decisions about your health care, including the right to refuse treatment
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

- You have the Right to get care without regard to gender, race, health status, color, age, national origin, sexual orientation, marital status, or religion
- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out- of-network providers if they are not available in the plan network
- You have the right to complain to the New York State Department of Health or your Local Department of Social Services; and the right to request a fair hearing through the Office of Administrative Hearing and/or a New York State External Appeal, where appropriate
- You have the right to appoint someone to speak for you about your care and treatment
- You have the right to seek assistance from the Participant Ombudsman program

**Member responsibilities**

- Receiving covered services through UHC Dual Complete NY-Y001
- Using UHC Dual Complete NY-Y001 network providers for covered services to the extent network providers are available
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies
- Being seen by your physician if a change in your health status occurs
- Sharing complete and accurate health information with your health care providers
- Informing UHC Dual Complete NY-Y001 staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions
- Following the plan of care recommended by the UHC Dual Complete NY-Y001 staff (with your input)
- Cooperating with and being respectful with the UHC Dual Complete NY-Y001 staff and not discriminating against UHC Dual Complete NY-Y001 staff because of race, color, national origin, religion, gender, age, mental or physical ability, sexual orientation, or marital status
- Notifying UHC Dual Complete NY-Y001 within two business days of receiving non-covered or non- pre-approved services
- Notifying your UHC Dual Complete NY-Y001 health care team in advance whenever you will not be home to receive services or care that has been arranged for you
- Informing UHC Dual Complete NY-Y001 before permanently moving out of the service area, or of any lengthy absence from the service area
- Your actions if you refuse treatment or do not follow the instructions of your caregiver
- Meeting your financial obligations

# Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your Care Manager.

# Information available on request

- Information regarding the structure and operation of UHC Dual Complete NY-Y001
- Specific clinical review criteria relating to a particular health condition and other information that UHC Dual Complete NY-Y001 considers when authorizing services
- Policies and procedures on protected health information
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program
- Provider credentialing policies
- A recent copy of the UHC Dual Complete NY-Y001 certified financial statement; and policies and procedures used by UHC Dual Complete NY-Y001 to determine eligibility of a provider

# Health Plan Notices of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective January 1, 2024

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

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

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

HI is information about your health or medical services. We have the right to make changes to this notice of privacy practices. If we make important changes, we will notify you by mail or e-mail. We will also post the new notice on our website. We will notify you of a breach of your HI.

**How we collect, use, and share your information**

**We collect, use, and share your HI with:**

- You or your legal representative.
- Certain government agencies. To check to make sure we are following privacy laws.

**We have the right to collect, use and share your HI for certain purposes.** This may 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.** To process payments and pay claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** To help with your care. For example, we may share your HI with a hospital you are in, to help them provide medical care to you.
- **For Health Care Operations.** To run your business. For example, we may talk to your doctor to tell him or her about a special disease management or wellness program available to you. 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.** If you receive health insurance through your employer, 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.** To make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may send reminders about appointments you have and information about your health benefits.
- **For Communications to You.** We may contact you about your health insurance benefits, healthcare or payments.

**We may collect, use, and share your HI as follows:**

- **As Required by Law.** To follow the laws that apply to us.
- **To Persons Involved with Your Care.** A family member or other person that helps with your medical care or pays for your care. This also may be to a family member in an emergency. This may happen if you are unable to tell us if we can share your HI or not. If you are unable to tell us what you want, we will use our best judgment. If allowed, after you pass away, we may share HI with family members or friends who helped with your care or paid for your care.
- **For Public Health Activities.** For example, to prevent diseases from spreading or to report problems with products or medicines.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with certain 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.** For example, 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.** To public health agencies or law enforcement, for example, in an emergency or disaster.
- **For Government Functions.** For military and veteran use, national security, or certain protective services.
- **For Workers' Compensation.** If you were hurt at work or to comply with labor laws.
- **For Research.** For example, to study a disease or medical condition. We also may use HI to help prepare a research study.
- **To Give Information on Decedents.** For example, to a coroner or medical examiner who may help to identify the person who died, why they died, or to meet certain law. We also may give HI to funeral directors.
- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissue.

- **To Correctional Institutions or Law Enforcement.** For persons in custody, for example: (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.** To give you services, if needed. These are companies that provide services to us. They agree to protect your HI.
- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
    1. Alcohol and Substance Use Disorder
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

We will only use or share your HI as described in this notice or with your written consent. We will get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. 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 marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your health insurance ID card.

**Your rights**

You have the following rights.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.** Your request to limit our use or sharing must be made in writing.
- **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 as allowed by state and federal law. We take verbal requests but may ask you to confirm your request in writing. 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. 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. We will respond to your request in the time we must do so under the law. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of when we shared your HI in the six years prior to your request. This will not include when we shared HI 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.
- **In certain states, you may have the right to ask that we delete** your HI. Depending on where you live, you may be able to ask us to delete your HI. We will respond to your request in the time we must do so under the law. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

**Using your rights**

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

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

[1] This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

# Financial Information Privacy Notice

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

Effective January 1, 2024

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

**Information we collect**

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

**Sharing of FI**

We will only share FI as permitted by law.

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

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

**Confidentiality and security**

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

## Other plan details

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### Questions about this notice

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

[2] For purposes of this Financial Information Privacy Notice, “we” or “us” refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Health Care Solutions, Inc.; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

## NOTICE OF NON-DISCRIMINATION

UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) complies with Federal civil rights laws. UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) provides the following:

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

If you need these services, call UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) at **1-866-547-0772**. For TTY/TDD services, call **711**.

If you believe that UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) by:

Mail: UnitedHealthcare Civil Rights Grievance
Attn: Civil Rights Coordinator
P.O. Box 30608, Salt Lake City, UT, 84130

Email: **UHC_Civil_Rights@uhc.com**

Phone: **1-866-547-0772** (TTY/TDD Services, call **711**)

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

Web: Office for Civil Rights Complaint Portal at
**https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

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

Complaint forms are available at
**hhs.gov/civil-rights/filing-a-complaint/index.html**

Phone: 1-800-368-1019 (TTY/TDD 1-800-537-7697)

| ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-547-0772, TTY/TDD 711. | English |
|---|---|
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-547-0772, TTY/TDD 711. | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-547-0772, TTY/TDD 711. | Chinese |
| ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-866-547-0772، TTY/TDD 711. | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-547-0772, TTY/TDD 711.번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-547-0772 (телетайп: TTY/TDD 711). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-547-0772, TTY/TDD 711. | Italian |
| ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-866-547-0772, TTY/TDD 711. | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-547-0772, TTY/TDD 711. | French Creole |
| אויפמערקזאם: אויב אי ר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-866-547-0772, TTY/TDD 711. | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-547-0772, TTY/TDD 711. | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-547-0772, TTY/TDD 711. | Tagalog |
| লক্ষ্য করুন: যদি আপনি বাংলা কথা বলেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-866-547-0772, TTY/TDD 711. | Bengali |
| VINI RE: Shërbime të ndihmës gjuhësore, falas, janë në dispozicion për ju. Telefononi në 1-866-547-0772, TTY/TDD 711. | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-547-0772, TTY/TDD 711. | Greek |
| توجہ فرمائیں: اگر آپ اردو بولتے ہیں تو آپ کو زبان میں مدد کی خدمات مفت دستیاب ہیں۔ 1-866-547-0772, TTY/TDD 711 پر کال کریں۔ | Urdu |

## Civil Rights Notice

**The company complies with applicable federal civil rights laws and does not treat members differently because of sex, age, race, color, disability, or national origin.**

If you think you were treated unfairly because of your sex, age, race, color, disability, or national origin, you can send a complaint to our Civil Rights Coordinator.

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

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on the front of the booklet or your membership identification card (TTY **711**).

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

- **Online:** **https://www.hhs.gov/civil-rights/filing-a-complaint/index.html**
- **Phone:** Toll-free **1-800-368-1019**, **800-537-7697** (TDD)
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Ave SW
  HHH Building, Room 509F
  Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on the front of the booklet or your membership identification card (TTY **711**), Monday through Friday, 8 a.m. to 8 p.m. ET.

## Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, please call us using the toll-free number on your member identification card. Someone who speaks your language can help you. This is a free service.

Spanish: Contamos con servicios gratuitos de intérprete para responder cualquier pregunta que pudiera tener sobre nuestro plan de salud o de medicamentos. Para obtener los servicios de un intérprete, llámenos al número de teléfono gratuito que figura en su tarjeta de identificación de miembro. Una persona que habla su idioma podrá ayudarle. Es un servicio gratuito.

Chinese Mandarin: 我们提供免费口译服务，解答您对我们的健康或药物计划的任何疑问。如需寻找一名口译员，请使用您的会员身份证上的免费电话号码联系我们。一名与您讲相同语言的人可以为您提供帮助。这是一项免费服务。

Chinese Cantonese: 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打您的會員識別卡上的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

Tagalog: Mayroon kaming libreng serbisyo ng interpreter para sagutin anumang tanong na maaaring mayroon ka tungkol sa kalusugan o plano ng gamot. Para makakuha ng interpreter, pakitawagan kami gamit ang libreng numero sa iyong kard ng pagkakakilanlan ng kasapi. Sinumang nagsasalita ng wika mo ay puwedeng makatulong sa iyo. Ang serbisyong ito ay libre.

French: Nous disposons de services d’interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser sur notre régime d’assurance maladie ou d’assurance-médicaments. Pour recevoir l’aide d’un interprète, veuillez nous appeler en composant le numéro gratuit figurant sur votre carte d’identification de membre. Quelqu’un parlant votre langue peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi mà bạn có về chương trình sức khoẻ hay thuốc của chúng tôi. Để gặp thông dịch viên, vui lòng gọi cho chúng tôi theo số điện thoại miễn phí trên thẻ nhận dạng thành viên của bạn. Người nói cùng ngôn ngữ với bạn có thể giúp bạn. Đây là dịch vụ miễn phí.

German: Wir verfügen über kostenlose Dolmetscherdienste, um alle Fragen zu beantworten, die Sie über unseren Gesundheits- oder Medikamentenplan haben mögen. Um einen Dolmetscher zu erhalten, rufen Sie uns bitte unter der kostenfreien Nummer auf Ihrem Mitgliedsausweis an. Jemand, der Ihre Sprache spricht, kann Ihnen helfen. Dies ist eine kostenlose Dienstleistung.

**Korean:** 건강 또는 의약품 플랜에 관한 질문에 답변해드리기 위해 무료 통역 서비스를 제공합니다. 통역 서비스를 이용하려면, 가입자 ID 카드에 있는 수신자 부담 전화번호로 전화해 주십시오. 한국어를 사용하는 통역사가 도움을 드릴 수 있습니다. 이 서비스는 무료입니다.

**Russian:** Если у Вас возникнут какие-либо вопросы о нашем плане медицинского страхования или плане по приобретению препаратов, мы предоставим Вам бесплатные услуги устного перевода. Для того чтобы воспользоваться услугами устного перевода, пожалуйста, свяжитесь с нами по бесплатному номеру телефона, указанному на Вашей идентификационной карте участника плана. Сотрудник, который говорит на Вашем языке, сможет Вам помочь. Данная услуга предоставляется бесплатно.

**Arabic:** لدينا خدمات ترجمة فورية للرد على أي أسئلة قد تكون لديك حول الخطة الصحية أو خطة الأدوية الخاصة بنا. للحصول على مترجم، اتصل بنا باستخدام رقم الهاتف المجاني على بطاقة تعريف عضويتك. سيساعدك شخص ما يتحدث لغتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा प्लान के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं मौजूद हैं। दुभाषिया पाने के लिए, कृपया अपने सदस्य पहचान पत्र पर टोल-फ्री नंबर का उपयोग करके हमें कॉल करें। आपकी भाषा बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

**Italian:** Mettiamo a disposizione un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per avvalersi di un interprete, si prega di chiamare il numero verde riportato sulla tessera identificativa. Una persona che parla italiano potrà fornire l’assistenza richiesta. Il servizio è gratuito.

**Portuguese:** Dispomos de serviços de intérprete gratuitos para esclarecer quaisquer dúvidas que tenha sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número gratuito no seu cartão de identificação de membro. Alguém que fala a sua língua pode ajudá-lo(a). Este é um serviço gratuito.

**French Creole:** Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou gendwa genyen konsènan plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, tanpri rele nou apati nimewo apèl gratis ki sou kat idantifikasyon kòm manm ou an. Yon moun ki pale lang ou ka ede ou. Sa se yon sèvis gratis.

**Polish:** Oferujemy bezpłatne usługi tłumaczeniowe, aby odpowiedzieć na wszelkie pytania dotyczące naszego planu ubezpieczenia zdrowotnego lub planu refundacji leków. Aby skorzystać z pomocy tłumacza, proszę zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej członka planu. Osoba posługująca się Pana/Pani językiem Panu/Pani pomoże. Usługa ta jest bezpłatna.

**Japanese:** 当社の医療または処方薬プランに関する質問にお答えするために、無料の通訳サービスをご利用いただけます。通訳が必要な場合には、会員IDカードに記載されているフリーダイヤル番号を使用して、当社までお問い合わせください。お客様の言語を話す通訳者がお手伝いいたします。これは無料のサービスです。

# We’re here for you

Remember, we’re always ready to answer any questions you may have. Just call Member Services at **1-866-547-0772**, TTY/TDD **711**, 8:00 a.m.–8:00 p.m., Monday–Friday, from April 1 to September 30; and 8:00 a.m.–8:00 p.m., 7 days a week from October 1 to March 31. You can also visit our website at **myuhc.com/CommunityPlan**.

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