



Welcome to the community

UnitedHealthcare Community Plan of Ohio provides health care services to Ohio residents eligible for Aged, Blind, or Disabled, Covered Families and Children (including Healthy Start and Healthy Families), and adult extension Medicaid benefits.

**United
Healthcare®**
Community Plan

Welcome

Welcome to UnitedHealthcare Community Plan. You are now a member of a health care plan, also known as a managed care organization (MCO). UnitedHealthcare Community Plan provides health care services to Ohio residents who are eligible, including individuals with low income, individuals who are pregnant, infants, and children, older adults, and individuals with disabilities. As a member, you are now eligible for exciting benefits at no cost to you, including no copays. In addition, we have disease and care management programs for conditions such as asthma and diabetes and Healthy First Steps™ Pregnancy Program.

Please take a few minutes to review this Member Handbook. We're ready to answer any questions you may have. You can find answers to most questions at myuhc.com/CommunityPlan. Just call Member Services at **1-800-895-2017**, TTY **711**, 7:00 a.m. to 7:00 p.m., Monday through Friday.

The information provided in this Member Handbook is meant to serve as an informative and quick reference guide.



Getting started

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

- 1. Call your Primary Care Provider (PCP) and schedule a checkup.** Regular checkups are important for good health. Your PCP's phone number should be listed on the member ID card that you recently received in the mail. If you don't know your PCP's number, or if you'd like help scheduling a checkup, call Member Services at **1-800-895-2017**, TTY **711**. We're here to help.
- 2. Take your Health Assessment.** This is a short and easy way to get a big picture of your current lifestyle and health. This helps us match you with the benefits and services available to you. Go to myuhc.com/CommunityPlan to complete the Health Assessment today. Also, we will call you soon to welcome you to the UnitedHealthcare Community Plan. During this call, we can explain your health plan benefits. We can also help you complete the Health Assessment over the phone.
- 3. Get to know your health plan.** Start with the Health Plan Highlights section on page 8 for a quick overview of your new plan. And be sure to keep this booklet handy, for future reference.

Member Services 1-800-895-2017, TTY 711

7:00 a.m.–7:00 p.m., Monday–Friday

Our office is closed on these major holidays:

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day

Table of contents

Welcome 2

Health plan highlights 8

 Member ID card 8

 Benefits at a glance 9

 Your Health Assessment 10

 Member support 11

 You can start using your pharmacy benefit right away 13

Going to the doctor 15

 Your Primary Care Provider (PCP) 15

 Annual checkups 17

 Making an appointment with your PCP 18

 Preparing for your PCP appointment 19

 NurseLine Services – Your 24-hour health information resource 19

 If you need care and your doctor’s office is closed 20

 Health care away from home 21

 Medical home 21

 Self-referred services 22

 Additional benefits for Adult Extension population members 23

 Getting a second opinion 24

 Prior authorizations 24

 Continued care if your PCP leaves the network 24

 Transportation services – Non-emergency 25

Hospitals and emergencies	<u>26</u>
Urgent care	<u>26</u>
Hospital services	<u>26</u>
Emergency dental care	<u>27</u>
Medically necessary services	<u>27</u>
No medical coverage outside of United States	<u>28</u>
 Ohio Department of Medicaid Member Handbook	 <u>30</u>
Welcome from the State of Ohio	<u>30</u>
Ohio Department of Medicaid Member Handbook	<u>32</u>
Identification (ID) cards	<u>33</u>
New member information.	<u>34</u>
Prescription drugs	<u>35</u>
Services not covered by UnitedHealthcare Community Plan	<u>35</u>
Services not covered by UnitedHealthcare Community Plan unless medically necessary . .	<u>36</u>
Care management services	<u>36</u>
Member Services	<u>37</u>
Behavioral health services, mental health and substance use disorder treatment services .	<u>38</u>
OhioRISE	<u>39</u>
Coordinated services program	<u>41</u>
Healthchek.	<u>42</u>
Choosing a Primary Care Provider (PCP).	<u>43</u>
Changing your PCP.	<u>44</u>
Telehealth.	<u>44</u>
Your membership rights.	<u>45</u>
How to let UnitedHealthcare Community Plan know if you are unhappy or do not agree with a decision we made – Appeals and grievances	<u>47</u>
Member appeal form.	<u>51</u>
Grievance and appeal form	<u>53</u>

State Hearings	55
Estate recovery	56
Emergency services	56
Accidental injury or illness (subrogation)	57
Other health insurance (Coordination of Benefits – COB)	58
Loss of insurance notice (Certificate of creditable coverage)	58
Loss of Medicaid eligibility	58
Automatic renewal of MCP membership	58
Ending your MCP membership	59
Medicaid services table	63
Services covered by UnitedHealthcare Community Plan	63
Additional UnitedHealthcare benefits	71
Additional benefits	71
Other plan details	78
Finding a network provider	78
Provider Directory	78
If you get a bill for services	79
Advance Directives	79
Fraud and abuse	81
Reporting incidents	82
Your opinion matters	85
Utilization management	86
Quality program	86
Safety and protection from discrimination	87
Clinical practice guidelines and new technology	87
Your membership responsibilities	88
Managed care terminology	89
Health Plan Notices of Privacy Practices	95

Appendix A	<u>103</u>
Ohio Single Pharmacy Benefit Manager (SPBM)	<u>103</u>
1. Member Handbook Contents	<u>103</u>
1.1 Corporate Identity	<u>103</u>
1.2 Available Services	<u>103</u>
1.2.1 Preferred Drug List (PDL)	<u>104</u>
1.2.2 Prior Authorizations	<u>104</u>
1.2.3 Pharmacy Utilization Management Strategies	<u>105</u>
1.2.4 Excluded Services	<u>106</u>
1.2.5 Additional Services	<u>106</u>
1.3 Request for Appeals, Grievances, or State Hearings	<u>106</u>
1.4 Change Recommendations	<u>109</u>
1.5 Pharmacy Access	<u>109</u>
1.6 Emergency Outpatient Drug	<u>109</u>
1.7 Non-Discrimination Statement	<u>109</u>
1.8 Provider Network Statement	<u>110</u>
1.9 Pharmacy Provider Network	<u>110</u>

Health plan highlights

Member ID card

The diagram shows a Member ID card for United Healthcare Community Plan. The card contains the following information:

- Member Services | Phone: 800-895-2017**
24 Hour Emergency Services | Phone: 800-542-8630
- Member Name:** JaneHasVeryLongName
Veryloooooonglastname
- Member ID Number:** 000000000000
- Plan ID Number:** 000000000000
- Primary Care Provider:** Dr. John Doe
Phone: 000-000-0000
- Pharmacy Benefit:** gwinwell
Rx Bin: 024251
Rx PCN: OHRXPROD
Phone: 833-491-0344
- Issuance Date:** MM/DD/YYYY
- Use Member ID for Billing**

Callouts from the right side of the card point to the following information:

- Your member ID number** (points to the Member ID Number)
- Your plan ID number** (points to the Plan ID Number)
- Member Services phone number** (points to the Member Services phone number)
- Name of your Primary Care Provider** (points to the Primary Care Provider name)
- Information for your pharmacist** (points to the Pharmacy Benefit section)

Information for Members
If you have an emergency, call 911 or go to the nearest emergency room. This card does not guarantee coverage. By using this card for services, you agree to the release of medical information, as stated in your Member handbook. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider or the 24/7 NurseLine 800-542-8630. To verify benefits or to find a provider, visit the website www.myuhc.com/communityplan.

Information for Providers
Please verify member eligibility on Date of Service via the ODM provider portal before rendering services. Please visit UHCprovider.com for detailed billing instructions or call 800-600-9007 for assistance. Providers may also call the ODM IHD at 800-686-1516 for assistance. For utilization management call 1-800-600-9007.

Ohio | Department of Medicaid

Lost your member ID card?

If you or a family member loses a card, you can print a new one at myuhc.com/CommunityPlan. Or call Member Services at **1-800-895-2017**, TTY **711**.

Benefits at a glance

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

Primary Care services

You are covered for all visits to your Primary Care Provider (PCP). Your PCP is the main doctor you will see for most of your health care. This includes checkups, treatment for colds and flu, health concerns and health screenings.

Large provider network

You can choose any PCP from our large network of providers. Our network also includes specialists, hospitals and drug stores — giving you many options for your health care. Find a complete list of network providers at myuhc.com/CommunityPlan or call **1-800-895-2017**, TTY **711**.

NurseLine

NurseLine gives you 24/7 telephone access to experienced registered nurses. They can give you information, support and education for any health-related question or concern. Call **1-800-542-8630**, TTY **1-800-855-2880**.

Specialist services

Your coverage includes services from specialists. Specialists are doctors or nurses who are highly trained to treat certain conditions. You may need a referral from your PCP first. See page 15 of the handbook.

Medicines

Your plan covers prescription drugs with no copays for members of all ages. Also covered: insulin, needles and syringes, birth control, coated aspirin for arthritis, iron pills and chewable vitamins.

Hospital services

You are covered for hospital stays and for outpatient services (services you get in the hospital without spending the night).

Laboratory services

Covered services include tests and X-rays that help find the cause of illness.

Welcome

Well-child visits

All well-child visits and immunizations are covered by your plan.

Maternity and pregnancy care

You are covered for doctor visits before and after your baby is born. That includes hospital stays. If needed, we also cover home visits after the baby is born.

Family planning

You are covered for services that help you manage the timing of pregnancies. These include birth control products and procedures.

Vision care

Your vision benefits include routine eye exams and glasses. See page 69.

Dental care

Your dental benefits are covered by UnitedHealthcare Community Plan. For more information about your dental coverage or to find a dentist, sign in to myuhc.com/CommunityPlan or the UnitedHealthcare® app, or call Member Services at **1-800-895-2017**, TTY **711**.

Transportation services are available

If you need a ride to your PCP or other medical provider, we may be able to help. Medical transport is covered for some medical care. If you have no other way to get to the doctor, live in an area with no public transport or cannot use public transport due to a health condition or disability, call **1-800-895-2017**, TTY **711** at least 48 hours in advance. To learn more, sign in to myuhc.com/CommunityPlan and select “Coverage & Benefits” to search for transportation coverage.

Your Health Assessment

A Health Assessment is a short and easy survey that asks you simple questions about your lifestyle and your health. When you fill it out and mail it to us, we can get to know you better. And it helps us match you with the many benefits and services available to you.

Please take a few minutes and fill out the Health Assessment form. Or call **1-800-895-2017** to complete it by phone.

Member support

We want to make it as easy as possible for you to get the most from your health plan. As our member, you have many services available to you, including transportation and interpreters if needed. And if you have questions, there are many places to get answers.

Website offers 24/7 access to plan details

Go to myuhc.com/CommunityPlan to sign up for web access to your account. This secure website keeps all of your health information in one place. In addition to plan details, the site includes useful tools that can help you:

- Find a provider
- Search for a medicine in the Preferred Drug List
- Get benefit details
- Download a new Member Handbook
- Print a new member ID card
- Find information on available healthy rewards for meeting certain health goals

Member Services is available 7:00 a.m. to 7:00 p.m., Monday through Friday

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

- Understanding your benefits
- Help getting a replacement member ID card
- Finding a doctor or urgent care clinic
- How to access specialty care
- How to file a grievance or appeal

Call **1-800-895-2017**, TTY **711**.

Care Management program

UnitedHealthcare Community Plan offers care management services. If you have a chronic health condition, like asthma or diabetes, you may benefit from our Care Management program. We can help with a number of things, like scheduling doctor appointments and keeping all your providers informed about the care you get. To learn more, call **1-800-895-2017**, TTY **711**.

Welcome

We speak your language

If you speak a language other than English, we can provide translated printed materials and language services free of charge, written information in the non-English languages identified as a member’s primary language, written information in alternate formats and other axillary aid or services to persons with disabilities. Or we can provide an oral interpreter who can help you understand these materials. You’ll find more information about Interpretive Services and Language Assistance in the section called Other Plan Details. Or call Member Services at **1-800-895-2017**, TTY **711**.

Si usted habla un idioma que no sea inglés, podemos proporcionar materiales impresos traducidos. O podemos proporcionar un intérprete que puede ayudar a entender estos materiales. Encontrará más información acerca de servicios de interpretación y asistencia lingüística en la sección Otros detalles del plan. O llame a Servicios para Miembros al **1-800-895-2017**, TTY **711**.

Emergencies

In case of emergency, call **911**

Other important numbers

24/7 NurseLine	1-800-542-8630
(available 24 hours a day, 7 days a week)	
TTY	1-800-855-2880
Healthy First Steps (for mothers-to-be)	1-800-599-5985
Care Management	1-800-895-2017
Fraud and Abuse Hotline	
UnitedHealthcare	1-877-766-3844
Ohio Department of Insurance	1-800-686-1527
.	1-614-644-2671
Ohio Medicaid Consumer Hotline.	1-800-324-8680
TTY	1-800-292-3572

If your address changes, please contact your local Job and Family Services (JFS) office.

You can start using your pharmacy benefit right away

UnitedHealthcare Community Plan members will use Gainwell to process prescription claims and will need to refer to the Gainwell member handbook for assistance. Your plan covers a long list of prescription medicines, or drugs. Medicines that are covered are shown on the preferred drug list (PDL). This list is also known as a formulary. Your doctor uses this list/the PDL to make sure the medicines you need are covered by your plan. Gainwell manages your prescription coverage and may cover other medicines with prior approval. If your drug does need prior approval, your care provider can request it for you. You can find the Preferred Drug List (PDL) for your plan on our website at myuhc.com/CommunityPlan. There, you can also search for a medicine by name.

It's easy to start getting your prescriptions filled. Here's how:

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

If yes

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

View the Preferred Drug List online at myuhc.com/CommunityPlan. You can also call Gainwell Member Services at **1-833-491-0344** (TTY **1-833-655-2437**). We're here to help.

If no

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

Welcome

2. Do you have a prescription?

When you have a prescription from your doctor, or need to refill your prescription, go to a network pharmacy. Show the pharmacist your member ID card. You can find a list of network pharmacies in the Provider Directory online at spbm.medicaid.ohio.gov or call Gainwell Member Services at 1-833-491-0344.

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

Visit a network pharmacy and show your member ID card. If you don't have your member ID card, you can show the pharmacist the information below. Talk to your doctor about your prescription options.

Attention Pharmacist

Please process this member's Gainwell claim using:

BIN: 02451

Processor Control Number: OHRXPROD

If you receive a message that the member's medication needs a prior authorization or is not on our formulary, please call Gainwell at **1-833-491-0344** or visit spbm.medicaid.ohio.gov for more information.

Going to the doctor

Your Primary Care Provider (PCP)

We call the main doctor you see a Primary Care Provider, or PCP. When you see the same PCP over time, it's easier to develop a relationship with them. Each family member can have their own PCP, or you may all choose to see the same person. You will see your PCP for:

- Routine care, including yearly checkups
- Coordinate your care with a specialist
- Treatment for colds and flu
- Other health concerns

You have options

You can choose between many types of network providers for your PCP. Some types of PCPs include:

- Family doctor (also called a general practitioner) — cares for children and adults
- Internal medicine doctor (also called an internist) — cares for adults
- Nurse Practitioner (NP) — cares for children and adults
- Pediatrician — cares for children
- Physician Assistant (PA) — cares for children and adults

What is a Network Provider?

Network Providers have contracted with UnitedHealthcare Community Plan to care for our members. You don't need to call us before seeing one of these providers. Sometimes members need to see a very specialized type of doctor. We will work with your PCP to make sure you get the specialist or service when you need it, for as long as you need it, even if the provider is not currently a network provider. There is no cost to you when we authorize the care or service in advance, before you see the non-network provider.

If you see a specialist without being sent by your PCP and without UnitedHealthcare Community Plan authorization in advance, you may have to pay the bill. Always work with your PCP first for any services you need.

Welcome

UnitedHealthcare Community Plan providers

UnitedHealthcare Community Plan contracts with providers who meet UnitedHealthcare Community Plan's quality standards.

There are 3 ways to find the right PCP for you.

1. Look through our printed Provider Directory. The Provider Directory lists all our network providers. You can ask for a printed Provider Directory by calling Member Services or by returning the postcard you received with your new member materials which includes your member identification (ID) card.
2. Use the Find-A-Doctor search tool at myuhc.com/CommunityPlan.
3. Call Member Services at **1-800-895-2017**, TTY **711**. We can answer your questions and help you find a PCP close to you.

Your plan has a network of quality doctors, hospitals, and other care providers, all working together to help you get the best care. Check your plan's provider directory for a list of network providers. Providers can change through the year as we continue to build a quality network for you. You can find the most up-to-date provider directory at myuhc.com/CommunityPlan or the UnitedHealthcare app.

If you need help finding a provider for any of our services, or a provider that works with our services and a second insurer, you can also call Member Services **1-800-895-2017**, TTY **711**. We're happy to help you find a network PCP that works for you. Let your Member Services Advocate know if you have any location, language, or cultural preferences. A free paper copy of the provider directory can also be sent to you by calling Member Services.

Once you choose a PCP, call Member Services and let us know. We will make sure your records are updated. If you don't want to choose a PCP, UnitedHealthcare can choose one for you, based on your location and language spoken.

Learn more about network doctors

You can learn information about network doctors at myuhc.com/CommunityPlan, or by calling Member Services. We can tell you the following information:

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board Certification status
- Languages spoken

- 16 **Questions?** Visit myuhc.com/CommunityPlan, or call Member Services at **1-800-895-2017**, TTY **711**.

Annual checkups

The importance of your annual checkup

You don't have to be sick to go to the doctor. In fact, yearly checkups with your PCP can help keep you healthy. In addition to checking on your general health, your PCP will make sure you get the screenings, tests and shots you need. And if there is a health problem, they're usually much easier to treat when caught early.

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

For women

- Pap smear — helps detect cervical cancer
- Breast exam/Mammography — helps detect breast cancer

For men

- Testes exam — helps detect testicular cancer
- Prostate exam — helps detect prostate cancer

Well-child visits

Well-child visits are a time for your PCP to see how your child is growing and developing. They will also give the needed screenings, like speech and hearing tests, and immunizations during these visits. These routine visits are also a great time for you to ask any questions you have about your child's behavior and overall well-being, including:

- Eating
- Sleeping
- Behavior
- Social interactions
- Physical activity

Checkup schedule

It's important to schedule your well-child visits for these ages:

3 to 5 days	15 months
1 month	18 months
2 months	24 months
4 months	30 months
6 months	Every year after age 3
9 months	Adolescent well-checks
12 months	

Welcome

Here are shots the doctor will likely give, and how they protect your child:

- **Hepatitis A and Hepatitis B:** prevent two common liver infections
- **Rotavirus:** protects against a virus that causes severe diarrhea
- **Diphtheria:** prevents a dangerous throat infection
- **Tetanus:** prevents a dangerous nerve disease
- **Pertussis:** prevents whooping cough
- **HiB:** prevents childhood meningitis
- **Meningococcal:** prevents bacterial meningitis
- **Polio:** prevents a virus that causes paralysis
- **MMR:** prevents measles, mumps and rubella
- **Varicella:** prevents chickenpox
- **Influenza:** protects against the flu virus
- **Pneumococcal:** prevents ear infections, blood infections, pneumonia and bacterial meningitis
- **HPV:** protects against a sexually transmitted virus that can lead to cervical cancer in women and genital warts in men

Making an appointment with your PCP

Call your doctor's office directly. The number should be on your member ID card. When you call to make an appointment, be sure to tell the office what you're coming in for. This will help make sure you get the care you need, when you need it.

This is how quickly you can expect to be seen:

- **Emergency** — Immediately or sent to an emergency facility
- **Non-life-threatening emergencies** — Immediately or referred to an emergency facility
- **Urgent (but not an emergency)** — Within 1 day or 24 hours
- **Routine** — Within 6 weeks
- **Preventive and wellness** — Within 6 weeks

Preparing for your PCP appointment

Before the visit

1. Go in knowing what you want to get out of the visit (relief from symptoms, a referral to a specialist, specific information, etc.).
2. Make note of any new symptoms and when they started.
3. Make a list of any drugs or vitamins you take on a regular basis.

During the visit

When you are with the doctor, feel free to:

- Ask questions
- Take notes if it helps you remember
- Ask the doctor to speak slowly or explain anything you don't understand
- Ask for more information about any medicines, treatments or conditions

NurseLine Services – Your 24-hour health information resource

Call 1-800-542-8630, TTY 1-800-855-2880

When you're sick or injured, it can be difficult to make health care decisions. You may not know if you should go to the emergency room, visit an urgent care center, make a provider appointment or use self-care. An experienced NurseLine nurse can give you information to help you decide.

Welcome

Nurses can provide information and support for many health situations and concerns, including:

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

You may just be curious about a health issue and want to learn more. Experienced registered nurses can provide you with information, support and education for any health-related question or concern.

Simply call the toll-free number **1-800-542-8630**, TTY **1-800-855-2880**. You can call the toll-free NurseLine number anytime, 24 hours a day, 7 days a week. And, there's no limit to the number of times you can call.

If you need care and your doctor's office is closed

Call your doctor if you need care that is not an emergency. Your doctor's phone is answered 24 hours a day, 7 days a week. Your doctor or the doctor on call will help you make the right choice for your care.

You may be told to:

- Go to an after-hours clinic or urgent care center
- Go to the office in the morning
- Go to the emergency room (ER)
- Get medicine from your pharmacy

Health care away from home

- If you need urgent health care when you are away from home, call your PCP or UnitedHealthcare Community Plan at **1-800-895-2017**, TTY **711**, for help
- In an emergency, you do not need to call your PCP first. Go to the nearest emergency room or call 911.
- Call your PCP after an emergency room visit
- Get your follow-up care from your PCP
- Routine health care services must be received from your PCP when you get back home
- All services outside the United States and its Territories are not covered

If you get medical emergency care while you are away from home, the doctor can send claims electronically or to this address:

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

If you are away from home and you need non-emergency care but cannot find a network provider near you, call Member Services at the phone number on your member ID card.

Medical home

What is a medical home?

A medical home is a source for medical care that you use all the time and that you trust. If you go to the same doctor or medical practice all the time, this doctor is your “medical home.”

Why would I want a medical home?

A medical home makes it easier for you to get medical care and advice. There are lots of reasons for you to have a medical home.

- A medical home will already have your medical records. This lets the doctor see you faster.
- A medical home will know what shots, illnesses and prescriptions you have had and what works best
- A medical home will know what your allergies and other health issues are
- A medical home will know what behavior and health is normal for you
- A medical home can answer your questions about previous treatment

We suggest that all of our members have a medical home.

Questions? Visit myuhc.com/CommunityPlan, 21
or call Member Services at **1-800-895-2017**, TTY **711**.

[Table of contents](#)

Self-referred services

You can receive some services without your PCP referring or recommending you to another doctor. These are called self-referred services. Examples of services that you can receive without your PCP referring you to another doctor include:

- Dental care
- Vision care
- Women's routine and preventive health care services provided by a women's health specialist (obstetrics, gynecology, certified nurse midwife)
- Specialty care (except for chemotherapy and pain management specialist services)
- Emergency care
- Services provided by Qualified Family Planning Providers (QFPP)
- Behavioral health services, mental health and substance use services
- Services provided at Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs) and certified nurse practitioner services
- Dialysis
- Radiation therapy
- Mammograms

You must go to a network provider for all self-referred services except for emergency care or for services provided at Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs), Qualified Family Planning Providers (QFPPs), and Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified treatment centers which are Medicaid providers. Participating providers would be those providers listed in your UnitedHealthcare Community Plan Provider Directory. Your Provider Directory will include specialists such as oncologists, gynecologists, optometrists, dentists and psychologists. If you do not see your provider listed, call Member Services or visit myuhc.com/CommunityPlan to find out if your provider is now accepting UnitedHealthcare Community Plan. To make sure you receive the best care, tell your PCP about any self-referred visits to specialists and other providers. By doing this, your PCP can help coordinate your health care. If you visit a provider that is not a participating provider with UnitedHealthcare Community Plan, these services may require a prior authorization.

Out-of-network providers

A provider who is not in the UnitedHealthcare Community Plan network is an out-of-network provider. If you go to an out-of-network provider, UnitedHealthcare will usually not pay for the care unless it is a family planning covered service, an emergency or you have an approved prior authorization from us. Please call Member Services at **1-800-895-2017** (hard-of-hearing: **711**). We will help you. Member Services can also provide you with a list of specialists, including a mental health provider.

Additional benefits for Adult Extension population members

Institutional services, specifically nursing facility and intermediate care facility for individuals with intellectual disabilities (ICF-IID) services, are covered for the Adult Extension population without limit, when medically necessary.

Nursing Facility (NF) services

OAC rules 5160-26-02 and 5160-26-03 permit ODM to disenroll members upon request to ODM. For the existing CFC and ABD populations, MCP members may be disenrolled after the second month of continuous nursing facility stay and covered through the fee-for-service (FFS) program when certain requirements are met. Adult Extension MCP members will, however, not be disenrolled and will remain in the managed care program throughout the duration of any medically necessary NF stay(s), as long as they remain eligible in the Adult Extension Medicaid category. ICF-IID admissions: If you are aware that an Adult Extension member is admitted to an ICF-IID facility, please contact ODM immediately and ODM will work with the MCP to determine the next steps for coverage.

Psychologist services

There are no benefit limits (also known as “hard limits”) for psychologist services for adults; medically necessary psychologist services must be provided without limit to all Adult Extension members. This benefit was designed without hard limits in order to ensure compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.

Getting a second opinion

A second opinion is when you want to see a second doctor for the same health concern. You can get a second opinion from a network provider for any of your covered benefits. This is your choice. You are not required to get a second opinion.

Prior authorizations

In some cases your provider must get permission from the health plan before giving you a certain service. This is called prior authorization. This is your provider's responsibility. If they do not get prior authorization, you will not be able to get those services.

A prior authorization may be needed

Some services that need prior authorization include:

- Hospital admissions
- Home health care services
- Certain outpatient imaging procedures, including MRIs, MRAs, CT scans and PET scans

Continued care if your PCP leaves the network

Sometimes PCPs leave the network. If this happens to your PCP, you will receive a letter from us letting you know. Sometimes UnitedHealthcare Community Plan will pay for you to get covered services from doctors for a short time after they leave the network. You may be able to get continued care and treatment when your doctor leaves the network if you are being actively treated for a serious medical problem. For example, you may qualify if you are getting chemotherapy for cancer or are at least six months pregnant when your doctor leaves the network. To ask for this, please call your doctor. Ask them to request an authorization for continued care and treatment from UnitedHealthcare.

Transportation services – Non-emergency

If you need a ride to your PCP or other medical provider, we may be able to help. UnitedHealthcare Community Plan will provide you with 30 one-way or 15 round trips per year to and from your PCP, WIC, pharmacy, or other participating health care or behavioral health care providers, such as vision, dental, and mental health and substance use providers. You may also request help to get to your Medicaid redetermination visits.

In addition to the required transportation, UnitedHealthcare Community Plan offers these additional transportation services:

- Mileage reimbursement is now available for those members or their representative that would prefer to use their own vehicle for trips to medical appointments. Members must call for trips 5 days in advance.
- Unlimited trips for pregnancy, prenatal, post-partum, WIC appointments, NICU and children (younger than age 1) well visits. Advance notification waived. Stand-alone pharmacy trips allowed.

Hospitals and emergencies

Urgent care

Urgent care clinics are there for you when you need to see a doctor for a non-life-threatening condition but your PCP isn't available or it's after clinic hours. Common health issues ideal for urgent care include:

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

If you or your children have an urgent problem, call your PCP first. Your doctor can help you get the right kind of care. Your doctor may tell you to go to urgent care or the emergency room.

Planning ahead

It's good to know what urgent care clinic is nearest to you. You can find a list of urgent care clinics in your Provider Directory. Or you can call Member Services at **1-800-895-2017**, TTY **711**.

Hospital services

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

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

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

Going to the hospital

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

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

Emergency dental care

Emergency dental care services to control pain, bleeding or infection are covered by your plan.

Medically necessary services

Those medical services which:

- Are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a UnitedHealthcare Community Plan member;
- Are provided at an appropriate facility and at the appropriate level of care for the treatment of UnitedHealthcare Community Plan member's medical condition; and
- Are provided in accordance with generally accepted standards of medical practice.

Freestanding birth center services at a freestanding birth center. Members should call Member Services to see if there are any qualified centers in Ohio.

Medically necessary health care services shall be obtained through the providers in the MCO's provider network with the exception of emergency services.

If a member is in need of nursing facility services, they should call Member Services for information on available providers.

The respite benefit includes short-term, temporary relief to the primary caregiver of an individual under the age of 21 to: help with meal preparation and hands-on assistance provided during the respite/supervision of the child; and services can be provided on a planned or emergency basis and in the child's home by individuals employed by enrolled Medicaid providers that are either Medicare-certified home health agencies or otherwise accredited agencies. Respite services cannot be delivered by the child's legally responsible family member or foster caregiver. Providers must be awake during the provision of respite services and cannot be provided overnight. There is a limit of no more than 24 hours of respite per month, and not to exceed 250 hours per calendar year.

Welcome

Member eligibility for respite benefit:

- Children under the age of 21 and determined eligible for SSI
- Enrolled in a Medicaid Managed Care Organization (MCO) care management program
- Resides with an informal, unpaid primary caregiver
- Determined by the MCO to meet an institutional level of care
- Determined by the MCO to require skilled nursing or skilled rehab services at least once per week
- Has received at least 14 hours per week of home health aide services for at least 6 consecutive months immediately preceding the date respite services are requested
- MCO has determined that the primary caregiver has a need for temporary relief from the care of the child as a result of the long-term services and supports needs or in order to prevent the provision of institutional or out-of-home placement

Some medically necessary services must get prior authorization before you can get them. Please see page 24 of this handbook for more information on prior authorization.

No medical coverage outside of United States

If you are outside of the United States or its territories and need medical care, any health care services you receive will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services you get outside of the United States.

Don't wait

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

Ohio Department of Medicaid Member Handbook

Ohio Department of Medicaid Member Handbook

Welcome from the State of Ohio

Dear UnitedHealthcare Community Plan Member:

Welcome to UnitedHealthcare Community Plan. If you have a problem reading or understanding this information, please contact Member Services at **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday for help, at no cost to you. We can explain this information in English or in your primary language by providing oral interpretation or translation services. We can have this information printed in non-English languages identified as a member’s primary language. You can get this document for free in other formats, such as large print, Braille, or audio, other auxiliary aids or services for persons with disabilities. If you are visually or hearing-impaired, special help can be provided. Call Member Services at **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday. The call is free.

If you have a health condition that requires ongoing medical care, call Member Services as soon as possible. For example: If you need surgery; are pregnant; or if you are seeing a specialist, receiving physical therapy, or home health services, please call Member Services right away.

Enclosed is your member handbook. Your member handbook gives you a lot of information you need to know as a UnitedHealthcare Community Plan member. It is very important that you read these materials.

The following information will help you get health care services through UnitedHealthcare Community Plan:

- Your ID card lists the name and telephone number of your primary care provider (PCP). Your PCP will treat you for most of your health care needs. If you do not want the PCP listed on your ID card, you must call UnitedHealthcare Community Plan Member Services to change your PCP. Your PCP must be part of UnitedHealthcare Community Plan’s provider network.
- A provider directory lists the names of the providers who are part of UnitedHealthcare Community Plan’s provider network. For most of your health care services, you must see providers who are part of UnitedHealthcare Community Plan’s provider network. Your member handbook explains how to access services from these providers. You can also call Member Services for help.

- If you asked for a printed provider directory when you contacted the Medicaid Hotline to select a managed care plan, you should also receive the directory in the next few days. If you did not contact the Medicaid Hotline to enroll and you were assigned to UnitedHealthcare Community Plan, you can request a printed provider directory by calling the Member Services department at **1-800-895-2017**, TTY **711**, 7:00 a.m. to 7:00 p.m., Monday through Friday, or by returning the enclosed postcard. Members can also visit our website at myuhc.com/CommunityPlan to view up-to-date provider network information.

If you did not receive the above items, or if you do not understand the information, please contact our Member Services as soon as possible for help.

If you must travel 30 miles or more from your home to receive covered health care services, UnitedHealthcare Community Plan will provide transportation to and from the provider's office. In addition, we also provide transportation for some other provider visits as explained in your member handbook. When you are a member, you can call **1-800-895-2017**, TTY **711**, at least 48 hours in advance, to schedule transportation.

In addition to the transportation assistance that UnitedHealthcare Community Plan provides, you can get transportation for certain services through the local county department of job and family services Non-Emergency Transportation (NET) program. Call your county department of job and family services for questions or assistance with NET services.

Optional MCP membership

- Members of a federally recognized Indian tribe, regardless of age
- Individuals receiving home and community-based waiver services through the Ohio Department of Developmental Disabilities

Excluded from MCP membership

The following individuals are not permitted to join UnitedHealthcare Community Plan:

- Dually eligible under both the Medicaid and Medicare programs
- Institutionalized (in a nursing home and are not eligible under the Adult Extension category, long-term care facility, ICF-IID, or some other kind of institution)
- Receiving Medicaid Waiver services and are not eligible under the Adult Extension category

If you believe that you or your child meet any of the above criteria and should not be a member of a managed care plan, you must call the Medicaid Hotline at 1-800-324-8680 (TTY 1-800-292-3572). If any of the above criteria are met, MCP membership will be ended.

If you have questions about any of the information above or other questions we can help with, please call our Member Services at **1-800-895-2017**, TTY **711**. We are happy to have you as a member and look forward to working with you for better health care.

Ohio Department of Medicaid Member Handbook

ATTENTION: If you do not speak English, language services, free of charge, are available to you. Call toll-free **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday.

Si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-895-2017**. TTY **711**.

Nepali - तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। टोल-फ्री नम्बर **1-800-895-2017**, TTY **711** मा फोन गर्नुहोस्।

Somali – Haddii aad ku hadasho Soomaali, adeegyada kaalmada luuqadda, oo bilaash ah, ayaad heli kartaa. Wac lambarka lacag la’aanta lagu waco **1-800-895-2017**. TTY **711**.

Russian – Если Вы говорите по-русски, Вы можете бесплатно воспользоваться помощью переводчика. Звоните по бесплатному номеру **1-800-895-2017**. TTY **711**.

Arabic - إذا كنت تتحدث اللغة العربية، فيمكنك الاستعانة بخدمات المساعدة اللغوية المتاحة إليك مجاناً. اتصل . **711** :، والهاتف النصي رقم **1-800-895-2017** برقم

If you have a problem reading or understanding this information or any other UnitedHealthcare Community Plan information, please contact our Member Services toll-free at **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday for help at no cost to you. We can explain this information, in English or in your primary language. You can get this document for free in other formats, such as large print, braille, or audio. Call toll-free **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday.

Welcome to UnitedHealthcare Community Plan. You are now a member of a health care plan, also known as a managed care plan (MCP). UnitedHealthcare Community Plan provides health care services to Ohio residents who are eligible, including individuals with low income, individuals who are pregnant, infants, and children, older adults, and individuals with disabilities. The information provided in this Member Handbook is meant to serve as an informative and quick reference guide.

UnitedHealthcare Community Plan may not discriminate on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran’s status, ancestry, health status, military status, gender identity, genetic information or the need for health services.

It is important to remember that you must receive services covered by UnitedHealthcare Community Plan from facilities and providers in the UnitedHealthcare Community Plan network. Providers in the UnitedHealthcare Community Plan network agree to work with your health plan to give you needed care. See pages 63–70 for information on services covered by UnitedHealthcare Community Plan. The only time you can use providers that are not on UnitedHealthcare Community Plan's network is for:

- emergency services
- federally qualified health centers (FQHC)/rural health clinics (RHC)
- qualified family planning providers
- certified nurse midwives or certified nurse practitioners
- an out of network provider that UnitedHealthcare Community Plan has approved you to see

The Provider Directory lists all our network providers as well as other non-network providers you can use to receive services. You should have received a postcard with an option to request a UnitedHealthcare Community Plan Provider Directory. You can ask for a printed Provider Directory by calling Member Services or by returning the postcard you received with your new member materials which includes your member identification (ID) card. The Provider Directory lists all of our network providers as well as other non-network providers you can use to receive services. You can also visit our website at myuhc.com/CommunityPlan to view up to date provider network information or call Member Services at **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday for assistance.

Identification (ID) cards

You should have received a UnitedHealthcare Community Plan membership ID card. Each member of your family who has joined UnitedHealthcare Community Plan will receive their own card. These cards replace your monthly Medicaid card. Each card is good for as long as the person is a member of UnitedHealthcare Community Plan. You will not receive a new card each month as you did with the Medicaid card.

If you are pregnant, you need to let UnitedHealthcare Community Plan know. You must also call when your baby is born so we can send you a new ID card for your baby.

Call UnitedHealthcare Community Plan Member Services as soon as possible at **1-800-895-2017** or TTY **711** if:

- You have not received your ID cards yet, or if
- Any of the information on the cards is wrong
- You lose your cards
- You have a baby

Always keep your ID card(s) with you

You will need your ID card each time you get medical services. This means that you need your UnitedHealthcare Community Plan ID card when you:

- see your primary care provider (PCP)
- see a specialist or other provider
- go to an emergency room
- go to an urgent care facility
- go to a hospital for any reason
- get medical supplies
- get a prescription
- have medical tests
- schedule transportation

New member information

If you have health care services already approved or scheduled, it is important that you call Member Services immediately. In certain situations and for a specified time period after you enroll, you may be allowed to receive care from a provider that is not a UnitedHealthcare Community Plan network provider. **You must call UnitedHealthcare Community Plan before you receive the care.** If you do not call us, you may not be able to receive the care and/or the claim may not be paid. For example, you need to call Member Services if you have the following services already approved and/or scheduled:

- Organ, bone marrow, or hematopoietic stem cell transplant
- Third trimester prenatal (pregnancy) care, including delivery
- Inpatient/outpatient surgery
- Appointment with a primary care or specialty provider
- Chemotherapy or radiation treatments
- Treatment following discharge from the hospital in the last 30 days
- Non-routine dental or vision services (for example braces or surgery)
- Medical equipment (examples: hospital beds, motorized wheelchairs, home oxygen and respiratory supplies, incontinence supplies, enteral nutrition and supplies)
- Services you receive at home, including home health, therapies, and nursing

After you enroll, UnitedHealthcare Community Plan will tell you if any of your current medications require prior authorization that did not require authorization when they were paid by Medicaid fee-for-service. It is very important that you look at the information UnitedHealthcare Community Plan provides and contact UnitedHealthcare Community Plan Member Services if you have any questions. You can also look on the UnitedHealthcare Community Plan website myuhc.com/CommunityPlan to find out if your medication(s) require prior authorization. You may need to follow up with the prescriber's office to submit a prior authorization request to UnitedHealthcare Community Plan if it is needed. If your medication(s) requires prior authorization, you cannot get the medication(s) until your provider submits a request to UnitedHealthcare Community Plan and it is approved.

Prescription drugs

MCO members will use Gainwell ODM's contracted SPBM to fill prescriptions and will need to refer to the Gainwell member handbook in Appendix A of this handbook for assistance.

Services not covered by UnitedHealthcare Community Plan

UnitedHealthcare Community Plan will not pay for services or supplies received that are not covered by Medicaid:

- All services or supplies that are not medically necessary
- Paternity testing
- Services to find cause of death (autopsy) or services related to forensic studies
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual

If you have a question about whether a service is covered, please call Member Services at **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday.

Services not covered by UnitedHealthcare Community Plan unless medically necessary

UnitedHealthcare Community Plan reviews applicable State regulations and conducts a medical necessity review if needed. UnitedHealthcare Community Plan will not pay for the following services that are not covered by Medicaid unless determined medically necessary:

- Abortions except in the case of a reported rape, incest or to save the life of the mother
- Biofeedback services
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered)
- Plastic or cosmetic surgery that is not medically necessary
- Services for the treatment of obesity unless determined medically necessary
- Services determined by Medicare or another third-party payer as not medically necessary
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or cannot legally consent to the procedure

Frequency limitations

This is not a complete list of the services that are not covered by Medicaid or UnitedHealthcare Community Plan. Your managed care organization will review all requests for services from your provider. If you have a question about whether a service is covered, please call Member Services at **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday.

Care management services

UnitedHealthcare Community Plan offers care management services.

- If you have a chronic health condition, like asthma or diabetes, you may benefit from our Care Management program. UnitedHealthcare Community Plan staff, including nurses, care managers and outreach workers may contact members if a Doctor has requested a phone call, if the member requests the phone call, or if the MCO feels that care management services would be helpful to the member. Additionally, UnitedHealthcare Community Plan provides care management to members who use services in an amount or frequency that exceeds medical necessity.

- UnitedHealthcare Community Plan staff may ask the member questions to learn more information about his/her conditions, e.g., the Health Risk Assessment (HRA) and other condition or situation specific questions
- UnitedHealthcare Community Plan staff will provide information to help members understand how to care for themselves and how to access services (including local resources)
- UnitedHealthcare Community Plan staff will talk to the member's PCP and other services providers to coordinate care
- Support of cross collaboration with other care coordination entities which may include waiver service providers and community mental health providers
- UnitedHealthcare Community Plan staff will go over your health, social and mental health history and make sure we have everything ready. A team of registered nurses and social workers will work with you, your family, your PCP, other health care providers and community resources to design a plan of care to meet your needs in the most appropriate setting.
 - We'll create a customized plan of care based on your individual needs
 - We'll coordinate with family members, caregivers and health care providers
 - We'll help you to make sure you get the services they may need

Members should call if they have any questions about the care management services, or feel they would benefit from care management services, call us at 1-800-508-2581. Members can also be referred for care coordination by a provider.

Member Services

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

- Understanding your benefits
- Services covered
 - Help in finding a provider
 - Telephone numbers to call
 - Hours of operation
- How to access specialty care or services
- Changing PCPs
- How to file a complaint about the MCP/providers/discrimination
- How to file a grievance or appeal
- Accessing language assistance

- If you speak a language other than English, we can provide translated printed materials
Or we can provide an interpreter who can help you understand these materials
- Members should call Member Services when there is a change to their demographic information and if they are pregnant
- Help in finding a provider
- Filing a complaint about UnitedHealthcare Community Plan/providers/discrimination

Contact Member Services at **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday for assistance.

Behavioral health services, mental health and substance use disorder treatment services

Mental health and substance use disorder treatment services are available.
These services include:

- Medical services
- Medication-assisted treatment for addiction
- Psychological testing
- Substance use disorder treatment services to include peer recovery support, partial hospitalization, and residential treatment, case management, intensive outpatient, withdrawal management
- Therapeutic behavioral service
- Psychosocial rehabilitation
- Community psychiatric support treatment
- Diagnostic evaluation and assessment
- Psychotherapy and counseling
- Crisis intervention
- Opioid treatment program services
- Behavioral health nursing services
- Treatment for adults
- Assertive community treatment for adults
- Mobile Response and Stabilization Service (MRSS)
- Intensive home-based treatment for children/adolescents

You're covered

It's important to know where to turn for help when needed. We are here for our members. Visit [Liveandworkwell.com](https://liveandworkwell.com) for straight talk on mental health topics.

How to contact the 24-hour behavioral health crisis line

You can also call us if you are in crisis. You can talk to someone right away and we can help you get the care you need. Just call our 24-hour behavioral health crisis line is 877-542-9236. This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.

If you need mental health and/or substance use disorder treatment services, please call Member Services at **1-800-895-2017**, TTY **711**. You can also find additional UnitedHealthcare Community Plan providers on our website at myuhc.com/CommunityPlan, in our Provider Directory or by calling Member Services at **1-800-895-2017**, TTY **711**.

OhioRISE

OhioRISE (Ohio Resilience through Integrated Systems and Excellence) is a managed care program for children and youth with complex behavioral health and multisystem needs. Children and youth with multisystem needs are often involved in multiple community systems such as juvenile justice, child protection, developmental disabilities, education, mental health and addiction, and others. OhioRISE aims to support these children and youth succeed in their schools, homes, and communities. This support is provided through care coordination and specialized services that are provided in-home or in the young person's community.

Children and youth who may benefit from OhioRISE:

- Have multiple needs that result from behavioral health challenges
- Have multisystem needs or are at risk for deeper system involvement
- Are at risk of out-of-home placement or are returning to their families from out-of-home placement

An individual who is enrolled in the OhioRISE program has their physical health services covered by the managed care organization (MCO) or fee-for-service (FFS) Medicaid.

OhioRISE eligibility:

A child and youth may be eligible for OhioRISE if they:

- Are eligible for Ohio Medicaid,
- Are under the age of 21, and
- Need significant behavioral health treatment as identified by the Ohio Child and Adolescent Needs and Strengths (CANS) assessment, or
- Are in a hospital for mental health or substance abuse needs.

OhioRISE services:

In addition to the behavioral health services already available through Medicaid, OhioRISE offers the following services:

- Care Coordination — Assistance with planning support and care for a child or youth's behavioral health needs. Their care coordinator through their managed care organization (MCO) can also be part of this process.
- Intensive Home-Based Treatment (IHBT) — Intensive short-term services within a child or youth's home to help stabilize and improve their behavioral health.
- Behavioral Health Respite — Short-term relief to the primary caregivers of a child or youth who is in a home or community-based environment.
- Primary Flex Funds — \$1,500 in a 365-day period to purchase certain resources that address a specific need for a child or youth.
- Psychiatric Residential Treatment Facility (PRTF) — Facilities, other than hospitals, that provide intensive psychiatric residential treatment services to individuals ages 20 or younger.
- Mobile Response and Stabilization services (MRSS) — Immediate behavioral services for children/youth in crisis. MRSS helps to ensure children and youth receive urgent, necessary care in their home and communities. This service is also provided through Medicaid managed care organizations (MCO) and fee-for-service (FFS) Medicaid.

CANS assessments

To have a child or youth assessed for OhioRISE, contact UnitedHealthcare Community Plan, Member Services at **1-800-895-2017**, TTY **711**. We will help find a CANS assessor in the child or youth's community to have the CANS assessment completed.

OhioRISE contact information

For more information on OhioRISE, contact UnitedHealthcare Community Plan Member Services at **1-800-895-2017**, TTY **711** or Aetna OhioRISE Member Services at 833-711-0773, TTY 711.

Coordinated services program

UnitedHealthcare Community Plan provides care management to members who use services in an amount or frequency that exceeds medical necessity. This is done to make sure you get high-quality, coordinated health care. If you are chosen to be part of this program, you will be offered care coordination with a Care Manager. Once enrolled in the program, a Care Manager will reach out to you after one has been assigned.

If you are part of the program, you will get a letter asking you to pick a pharmacy and confirm your PCP. If you do not choose a pharmacy within 30 days from the date the letter was mailed, UnitedHealthcare Community Plan will pick a network pharmacy based on the following:

- Where you have gone before
- Open 24 hours, if possible
- Close to your home

Except in an emergency or for after-hours services, CSP members:

- Must have one pharmacy to fill your prescriptions
- May be assigned to one PCP who will coordinate care with other providers

Members can ask to change their pharmacy or PCP under limited circumstances.

Before your start date with this program, you will get a new ID card that will list your pharmacy and PCP. If you need to change the pharmacy on your ID card, call Member Services at **1-800-895-2017**, TTY **711**. Requests for pharmacy changes will be reviewed on an individual basis.

Those chosen for the program will get more details in the mail and will be notified of their right to a state hearing.

Healthchek

Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for members under the age of 21. These exams make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at birth, 3-5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year.

Healthchek also covers medical, vision, dental, hearing, nutritional, developmental, and behavioral health exams, in addition to other care to treat physical, behavioral or other problems or conditions found by an exam. Some of the tests and treatment services may require prior authorization.

Healthchek is available at no cost to members and include:

- Preventive checkups for newborns, infants, children, teens, and young adults under the age of 21
- Healthchek screenings:
 - Medical exams (physical and development screenings)
 - Vision exams
 - Dental exams
 - Hearing exams
 - Nutrition checks
 - Developmental exams
 - Lead testing
- Laboratory tests (age and sex appropriate exams)
- Immunizations
- Medically necessary follow-up care to treat health problems or issues found during a screening. This could include, but is not limited to:
 - visits with a primary care provider, specialist, dentist, optometrist and other UnitedHealthcare Community Plan providers to diagnose and treat problems or issues
 - inpatient or outpatient hospital care
 - clinic visits
 - prescription drugs
- Health education

It is very important to get preventive checkups and screenings so your providers can find any health problems early. That way your provider can treat them, or make a referral to a specialist for treatment, before the problem gets more serious. **Remember: Some services may require a referral from your PCP or prior authorization by UnitedHealthcare Community Plan.**

Also, for some EPSDT items or services, your provider may ask for prior authorization for UnitedHealthcare Community Plan to cover things that have limits or are not covered for members over the age of 20. Please see page 24 to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members under the age of 21 who have special health care needs. Please see page 36 to learn more about the care management services offered by UnitedHealthcare Community Plan.

Member can obtain Healthchek services by:

- Calling your PCP and dentist to make appointments for regular checkups (making sure to ask for a Healthchek exam when you call the PCP), or by
- Calling UnitedHealthcare Community Plan Member Services if you have any questions or need assistance with accessing care, including finding a provider or making an appointment; services covered; transportation; prior authorizations; referrals for Women, Infants, and Children (WIC), Help Me Grow, Bureau for Children with Medical Handicaps (BCMH), Head Start, and community services such as food, heating assistance, etc.

Choosing a Primary Care Provider (PCP)

Each member of UnitedHealthcare Community Plan must choose a primary care provider (PCP) from UnitedHealthcare Community Plan provider directory. Your PCP is an individual provider, provider group practice, advanced practice nurse or advanced practice nurse group practice trained in obstetrics/gynecology (OB/GYN), family medicine (general practice), internal medicine, or pediatrics.

Your PCP will work with you to direct your health care. Your PCP will do your checkups and shots and treat you for most of your routine health care needs. If needed, your PCP will send you to providers, specialists or admit you to the hospital.

You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your UnitedHealthcare Community Plan ID card.

Changing your PCP

If you want to change your PCP, you must first call the Member Services department to ask for the change. Members can change their PCP monthly. You can change your PCP at any time. PCP changes within the first month of membership will be effective the date of the request. If you request a PCP change after your first month of membership, the change will be effective on the first day of the next month.

UnitedHealthcare Community Plan will send you a new ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP.

For the name of the PCPs in UnitedHealthcare Community Plan, you may look in your provider directory if you requested a printed copy, on our website at www.uhc.com/communityplan/ohio/plans/medicaid/community-plan, or you can call UnitedHealthcare Community Plan Member Services at **1-800-895-2017**, TTY **711**. We're happy to help you find a network PCP that works for you.

Telehealth

Telehealth is the direct delivery of health care using audio and/or video. Instead of coming into the office for your appointment, you stay at your home or office and use your smartphone, tablet or computer to see and talk to your medical and behavioral health professionals. There is no cost for Medicaid members to use telehealth and telehealth removes the stress of needing transportation services.

Medicaid members can see medical and behavioral health professionals via telehealth for many illnesses and injuries, common health conditions, follow-up appointments and screenings as well as prescribing medication(s).

Check with your health care provider to see if they offer telehealth.

Your membership rights

As a member of UnitedHealthcare Community Plan, you have the following rights:

- To receive all information and services that UnitedHealthcare Community Plan must provide
- To be treated with respect and with regard for your dignity and privacy
- To be sure that your medical record information will be kept private
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To participate with providers in making decisions relating to your health care
- To be able to take part in decisions about your health care as long as the decisions are in your best interest
- To get information on any medical care treatment, given in a way that you can follow
- To be sure others cannot hear or see you when you are getting medical care
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed
- To say yes or no to having any information about you given out unless UnitedHealthcare Community Plan must by law
- To say no to treatment or therapy. If you say no, the provider or UnitedHealthcare Community Plan must talk to you about what could happen and they must put a note in your medical record about it.
- To file an appeal, a grievance (complaint) or state hearing. See page 49 of this handbook to learn more.
- To get all written member information from UnitedHealthcare Community Plan:
 - At no cost to you
 - In the prevalent non-English languages of members in the UnitedHealthcare Community Plan service area
 - Oral interpretation or translation services
 - Written information in alternate formats
 - Other auxiliary aids or services for person with disabilities
 - In other ways, to help with the special needs of members who may have trouble reading the information for any reason

- To get help free of charge from UnitedHealthcare Community Plan and its providers if you do not speak English or need help in understanding information
- To be able to get help with sign language if you are hearing impaired
- To be told if the health care provider is a student and to be able to refuse their care
- To be told of any experimental care and to be able to refuse to be part of the care
- To make Advance Directives (a living will). See page 79 to learn more about Advance Directives.
- To file any complaint about not following your Advance Directive with the Ohio Department of Health
- A right to discuss medically necessary treatment options for your conditions, no matter the cost or benefit coverage
- A right to make recommendations regarding the organization's member rights and responsibilities
- To know that the MCP shall review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, shall meet the following time frames:
 - (a) Within two business days of receipt if the grievance is about not being able to get services
 - (b) Within thirty calendar days for all other grievances except for grievances that are about getting a bill for care you have received
 - (c) Within sixty calendar days for grievances about getting a bill for care you have received
- To change your primary care provider (PCP) to another PCP in UnitedHealthcare Community Plan's network, at least monthly UnitedHealthcare Community Plan must send you something in writing that says who the new PCP is by the date of the change
- To be free to carry out your rights and know that UnitedHealthcare Community Plan, UnitedHealthcare Community Plan's providers or the Ohio Department of Medicaid will not hold this against you
- To know that UnitedHealthcare Community Plan must follow all federal and state laws, and other laws about privacy that apply
- To choose the provider that gives you care whenever possible and appropriate
- If you are a female, to be able to go to a woman's health provider in the UnitedHealthcare Community Plan network for covered women's health services
- To use any hospital or other appropriate setting for emergency services
- To get a second opinion from a qualified provider in the UnitedHealthcare Community Plan network. If a qualified provider is not able to see you, UnitedHealthcare Community Plan must set up a visit with a provider not in our network.

- To get information about UnitedHealthcare Community Plan from us. You can ask for more information about our plan, including information about our structure and operations and any physician incentive plans we operate.
- To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint of discrimination based on ethnicity, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services

The Ohio Department of Medicaid
Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709
E-mail ODM: EmployeeRelations@medicaid.ohio.gov
Fax: 614-644-1434

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601
Phone: 312-886-2359, TTY 312-353-5693

How to let UnitedHealthcare Community Plan know if you are unhappy or do not agree with a decision we made – Appeals and grievances

If you are unhappy with UnitedHealthcare Community Plan or our providers, or do not agree with a decision we made, contact us as soon as possible. You, or someone you want to speak for you can contact us. If you want someone to speak for you, for example your doctor or provider with your consent, give us your approval in writing. UnitedHealthcare Community Plan wants to help. To contact us, you can:

- Call the Member Services department at **1-800-895-2017**, TTY **711**, or
- Fill out the form in your member handbook, or
- Call the Member Services department to ask for a printed copy, or
- Visit our website at myuhc.com/CommunityPlan, or
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your UnitedHealthcare Community Plan member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

Mail the form or your letter to:

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

UnitedHealthcare Community Plan will send you something in writing if we make a decision to:

- deny a request to cover a service for you;
- reduce, suspend or stop services before you receive all of the services that were approved; or
- deny payment for a service you received that is not covered by UnitedHealthcare Community Plan.

We will also send you something in writing if we did not:

- decide on whether to cover a service requested for you, or
- give you an answer to something you told us you were unhappy about.

Appeals

If you do not agree with the decision/action listed in the letter, and you contact us **within 60 calendar days** to ask that we change our decision/action, this is called an **appeal**. The 60 calendar day period begins on the day after the mailing date on the letter. If we have decided to reduce, suspend or stop services before you receive all of the services that were approved, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services.

Unless we tell you a different date, we must give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we do not change our decision or action as a result of your appeal, we will notify you of your right to request a state hearing. **You may only request a state hearing after you have gone through UnitedHealthcare Community Plan appeal process.**

Grievance

If you contact us because you are unhappy with something about UnitedHealthcare Community Plan or our providers, this is called a **grievance**. UnitedHealthcare Community Plan will give you an answer to your grievance by phone (or by mail if we can't reach you by phone) within the following time frames:

- 2 working days for grievances about not being able to get services
- 30 calendar days for all other grievances except grievances that are about getting a bill for care you have received
- 60 calendar days for grievances about getting a bill for care you have received

If we need more time to make a decision for either an appeal or a grievance, we will send you a letter telling you that we need to take up to 14 more calendar days. That letter will also explain why we need more time. If you think we need more time to make a decision on your appeal or grievance, you can also ask us to take up to 14 calendar days.

You also have the right to file a complaint **at any time** by contacting the:

Ohio Department of Medicaid
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709

1-800-605-3040 or 1-800-324-8680
TTY 1-800-292-3572

Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, Ohio 43215

1-800-686-1526

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Member appeal form

If you do not agree with a decision made by your managed care entity (MCE), you should contact the MCE as soon as possible. You, or someone you want to speak for you can contact the MCE using this form.

Instructions: Complete Sections I and II of this form entirely, describe the issue(s) in as much detail as possible, and submit the completed form to the appropriate MCE. To ensure a decision can be made by the MCE, the following documentation should be submitted with the form:

- Attach copies of any records you wish to submit (do not send originals)
- If you have someone else submit for you, you must give your consent below

Section I – Member Information		
Member Name		Date of Request (mm/dd/yyyy)
Member ID Number	Member Phone Number	Date of Birth (mm/dd/yyyy)
Member Address		
Reason for Request ☐ Service(s) denied, reduced, or ended ☐ Other (explain): ☐ Payment or claim denied ☐ Untimely decision on prior authorization request ☐ I believe waiting on this decision could seriously jeopardize my life, physical or mental health, or ability to attain, maintain or regain maximum function. I understand by checking this box that it may reduce the amount of time that myself and/or provider have to send in additional information regarding my appeal unless an extension is requested. If no extension is requested and meets criteria, I will receive a decision within 72 hours. ☐ I believe waiting on this decision would not jeopardize my health. Unless an extension is requested, I will receive a decision on my appeal within 15 calendar days.		

Section II – Description of Specific Issue

Please state all details relating to your request including names, dates, places, provider information, and prior authorization request number if known. Attach another sheet of paper to this form if more space is needed.

By signing below, you agree that the information provided is true and correct.

Member's Signature

Date (mm/dd/yyyy)

If someone else is completing this form for you, you are giving written consent for the person named below to submit on your behalf. By signing below, your authorized representative agrees that the information provided is true and correct.

Member's Authorized Representative Name (if applicable)

Relationship to Member

Authorized Representative Signature (if applicable)

- ☐ Check this box if you are a provider submitting this form on behalf of a member. In accordance with Ohio Administrative Code rule 5160-26-08.4, any provider acting on the member's behalf must have the member's written consent to file an appeal. The MCE will begin processing the appeal upon receipt of written consent.

Grievance and appeal form

Member's Name _____ ID # _____

Address _____

Telephone Number (Home) _____ (Work) _____

Please describe your concern in detail using names, dates, places of services, time of day and issues that occurred. If applicable, also state why UnitedHealthcare Community Plan should consider payment for requested services that are not normally covered. Please mail this completed form to the address listed at the bottom.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

(Signature)

(Date)

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

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State Hearings

A State Hearing is a meeting with you or someone you want to speak on your behalf, for example your doctor or provider, someone from the County Department of Job and Family Services, someone from UnitedHealthcare Community Plan, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why you think UnitedHealthcare Community Plan did not make the right decision and UnitedHealthcare Community Plan will explain the reasons for making our decision. The hearing officer will listen and then decide who is right based on the rules and the information given.

UnitedHealthcare Community Plan will notify you of your right to request a state hearing if:

- we do not change our decision or action as a result of your appeal
- a decision is made to propose enrollment or continue enrollment in the UnitedHealthcare Community Plan Coordinated Services Program
- a decision is made to deny your request to change your UnitedHealthcare Community Plan Coordinated Services Program provider

You may only request a state hearing after you have gone through UnitedHealthcare Community Plan's appeal process

If you want a state hearing, you or someone you want to speak on your behalf, for example your doctor or provider, must request a hearing **within 90 calendar days**. The 90 calendar day period begins on the day after the mailing date on the hearing form. If your appeal was about a decision to reduce, suspend, or stop services before all of the approved services are received, your letter will tell you how you can keep receiving the services if you choose to and when you may have to pay for the services. If we propose to enroll you in the UnitedHealthcare Community Plan Coordinated Services Program and you request the hearing within 15 calendar days from the mailing date on the form, we will not enroll you in the program until the hearing decision.

To request a hearing:

- you can sign and return the state hearing form to the address of fax number listed on the form
- call the Bureau of State Hearings at 1-866-635-3748
- submit your request online at https://hearings.jfs.ohio.gov/apps/SHARE/#_frmLogin
- submit your request via email at bsh@jfs.ohio.gov

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 1-800-589-5888, for the local number.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if the MCO or Bureau of State Hearings may decide that the health condition meets the criteria for an expedited decision. An expedited decision will be issued as quickly as needed but no later than 3 working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life, your health or your ability to attain, maintain, or regain maximum function.

Estate recovery

If you are permanently institutionalized or age 55 or older when you receive Medicaid benefits, the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payment that Medicaid pays to your managed care plan, even if the capitation payment is greater than the cost of the services you received. **Estate Recovery only happens after the death of the Medicaid recipient.**

Emergency services

Emergency services are services for a medical problem that must be treated right away by a provider. We cover care for emergencies both in and out of the county where you live. Some examples of when emergency services are needed include:

- Miscarriage/pregnancy with vaginal bleeding
- Heart attacks
- Severe chest pain
- Severe bleeding that does not stop
- Serious breathing difficulties
- Possible stroke
- Mental health: Threat of suicide, homicide or self-injury, mania or psychosis that needs immediate medical attention

Emergency medical condition

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Post-stabilization services

Post-stabilization care services” means covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 (October 1, 2019) to improve or resolve the member’s condition.

You do not have to contact UnitedHealthcare Community Plan for an okay before you get emergency services. Prior authorization is not required for emergency services. If you have an emergency, call 911 or go to the NEAREST emergency room (ER) or other appropriate care setting.

If you are not sure whether you need to go to the emergency room, call your primary care provider or the 24/7 NurseLine services at 1-800-542-8630 (TTY 1-800-855-2880). Your PCP or 24/7 NurseLine Representative can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Be sure to tell them that you are a member of UnitedHealthcare Community Plan and show them your UnitedHealthcare Community Plan member ID card.
- If the provider treats your emergency, thinks you need other medical care to treat the problem that caused your emergency, the provider must call UnitedHealthcare Community Plan
- You will need to call your Primary Care Provider as soon as possible after the emergency is under control
- If the hospital has you stay, please make sure that UnitedHealthcare Community Plan is called within 24 hours

Accidental injury or illness (subrogation)

If you have to see a doctor for an injury or illness that was caused by another person or business, you must call the Member Services department to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store then another insurance company might have to pay for the care or services you received. When you call us give the name of the person at fault, their insurance company and the name(s) of any attorneys involved.

Other health insurance (Coordination of Benefits – COB)

If you or anyone in your family has health insurance with another company, it is very important that you call the Member Services department and your county caseworker about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent, then you need to call the Member Services department to give us the information. It is also important to call Member Services and your county caseworker if you have lost health insurance that you had previously reported. Not giving us this information can cause problems with getting care and with payment of medical bills.

Loss of insurance notice (Certificate of creditable coverage)

Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company. This notice says you no longer have insurance. It is important that you keep a copy of this notice for your records because you might be asked to provide a copy.

Loss of Medicaid eligibility

It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this happened, UnitedHealthcare Community Plan would be told to stop your membership as a Medicaid member and you would no longer be covered by UnitedHealthcare Community Plan.

Automatic renewal of MCP membership

If you lose your Medicaid eligibility but it is started again within 90 days, you will automatically become a UnitedHealthcare Community Plan member again.

Ending your MCP membership

As a member of a managed care organization, you have the right to choose to end your membership at certain times during the year. You can choose to end your membership during the first three months (90 days) or at least once every 12 months during the annual open enrollment month. The Ohio Department of Medicaid will send you something in the mail to tell you when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care organization to cover your health care services.

If you want to end your membership during the first three months of your membership or during the open enrollment month, you can call the Medicaid Hotline at 1-800-324-8680. TTY 711. You can also submit a request online by visiting the Medicaid Hotline website at www.ohiomh.com. If you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care organization, your new managed care organization will send you information in the mail before your membership start date.

Choosing a new plan

If you are thinking about ending your membership to change to another managed care organization (MCO), you should learn about your choices, especially if you want to keep your current provider(s). Remember, each MCO has its own list of doctors and hospitals that are in the network. In addition, each MCO has written information which explains the benefits it offers and the rules that it has. If you would like written information about a managed care organization you are thinking of joining or if you simply have questions about the MCO you may either call the plan or call the Medicaid Hotline at 1-800-324-8680; TTY 1-800-292-3572. You can also find information about the MCOs in your area by visiting the Medicaid Hotline website at www.ohiomh.com.

Just Cause membership terminations

Sometimes there may be a special reason that you need to end your membership with a plan. This is called a "Just Cause" membership termination. Just cause requests apply to periods outside of open enrollment and the first three months of enrollment. To ask for a just cause membership termination, you may first call UnitedHealthcare Community Plan and give us a chance to resolve the issue. If we cannot resolve the issue, you can ask for a just cause termination at any time if you have one of the following reasons:

1. You move and your current MCO is not available where you now live and you need non-emergency medical care in your new area before your MCO membership ends.
2. Your current MCO does not, for moral or religious objections, cover a medical service that you need.

3. Your doctor has said that some of the medical services you need must be received at the same time and the services are not all in the MCO's network.
4. You have concerns that you are not receiving quality care and the services you need are not available from another provider in the UnitedHealthcare Community Plan network.
5. You do not have access to medically necessary Medicaid-covered services or do not have access to providers that are experienced in dealing with your special health care needs.
6. The PCP that you chose is no longer on your UnitedHealthcare Community Plan's network and that was the only in-network PCP who spoke your language and was located within a reasonable distance from you; or another plan has a PCP in their network that speaks your language that is located within a reasonable distance from you and will accept you as a patient.
7. If you think staying as a member in your current managed care plan is harmful to you and not in your best interest.

You may ask to end your membership for Just Cause by calling the Medicaid Hotline at 1-800-324-8680; TTY 1-800-292-3572. The Ohio Department of Medicaid will review your request and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your membership and the date your membership ends. If you live in a mandatory enrollment area, you will have to choose another plan to receive your health care unless the Ohio Department of Medicaid tells you differently. If your just cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

Things to keep in mind if you end your membership

If you have followed any of the above steps to end your membership, remember:

- Continue to use UnitedHealthcare Community Plan doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid
- If you chose a new MCO and have not received a member ID card before the first day of the month when you are a member of the new plan, call the UnitedHealthcare Community Plan Member Services department. If they are unable to help you, call the Medicaid Hotline at 1-800-324-8680; TTY 1-800 292-3572.
- If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker
- If you have chosen a new MCO and have any medical visits scheduled, please call your new plan to be sure that these providers are in the new plan's provider network and any needed paperwork is done. Some examples of when you should call your new plan include:
when you have an appointment to see a new doctor, a surgery, blood test or X-ray scheduled and especially if you are pregnant.
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card

Optional membership terminations

You have the option not to be a member of a managed care organization (MCO) if:

- you are a member of a federally recognized Indian tribe, regardless of your age
- you are an individual who receives home and community based waiver services through the Ohio Department of Developmental Disabilities

If you believe that you or your child meet any of the above criteria and do not want to be a member of a managed care organization, you can call the Medicaid Hotline at 1-800-324-8680 (TTY 1-800-292-3572). If you meet the above criteria and do not want to be an MCO member, your membership will be ended.

Exclusions — Individuals that are not permitted to join a Medicaid MCO.

You may not be allowed to join a Medicaid managed care organization (MCO) if you are:

- Dually eligible under both the Medicaid and Medicare programs;
- Institutionalized (in a nursing home and are not eligible under the Adult Extension category, long-term care facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or some other kind of institution); or
- Receiving Medicaid Waiver services and are not eligible under the Adult Extension category.
 - * If you are eligible for Medicaid under the Adult Extension category, you will receive your nursing home services through the Managed Care Organization. Additionally, Adult Extension members approved for waiver services will remain in the Managed Care Organization.

If you believe that you meet any of the above criteria and should not be a member of a Managed Care Organization, you must call the Medicaid Hotline at 1-800-324-8680 (TTY 1-800-292-3572). If you meet the above criteria, your MCO membership will be ended.

Can UnitedHealthcare Community Plan end my membership?

UnitedHealthcare Community Plan may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio Department of Medicaid must okay the request before your membership can be ended.

The reasons that UnitedHealthcare Community Plan can ask to end your membership are:

- For fraud or for misuse of your UnitedHealthcare Community Plan ID card
- For disruptive or uncooperative behavior to the extent that it affects the MCO's ability to provide services to you or other members

Ohio Department of Medicaid Member Handbook

UnitedHealthcare Community Plan provides services to our members because of a contract that UnitedHealthcare Community Plan has with the Ohio Department of Medicaid. If you want to contact the Ohio Department of Medicaid, you can call or write to:

Ohio Department of Medicaid
Office of Managed Care
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709
Phone: 1-800-324-8680
TTY: 1-800-292-3572

You can also visit the Ohio Department of Medicaid on the web at
www.medicaid.ohio.gov.

You can contact UnitedHealthcare Community Plan to get any other information you want including the structure and operation of UnitedHealthcare Community Plan and how we pay our providers. If you want to tell us about things you think we should change, please call the Member Services department at **1-800-895-2017**, TTY **711**.

Medicaid services table

Services covered by UnitedHealthcare Community Plan

As a UnitedHealthcare Community Plan member, you will receive all medically-necessary Medicaid-covered services at no cost to you. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.

If you have any questions about your benefits, please talk to your PCP or call Member Services at **1-800-895-2017**, TTY **711**. You can also sign in to myuhc.com/CommunityPlan and search under “Benefits” or use the UnitedHealthcare app to learn more about your benefits.

Service	Coverage
Acupuncture to treat certain conditions	Covered for pain management of headaches and lower back pain. There is a 30-visit limit unless medically necessary.
Allergy Services	Covered
Ambulance and wheelchair van transportation	Covered for emergency situations both in and out of network.

Medicaid services table

Service	Coverage
Behavioral health services, mental health and substance use disorder treatment	Covered; call Member Services to find qualified center/provider or self-refer directly to an Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified community mental health center or certified treatment center. How to contact the 24-hour behavioral health crisis line You can also call us if you are in crisis. You can talk to someone right away and we can help you get the care you need. Just call our 24-hour behavioral health crisis line is 877-542-9236. This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. Opioid treatment programs: including Medically Assisted Treatment (MAT) including Suboxone, Buprenorphine, and Methadone. • Assertive Community Treatment (ACT) for members age 18 and older • Intensive Home Based Treatment (IHBT). This service is for individuals age 18 and under; however, in some circumstances may be available to members aged 18–21. • Comprehensive addiction treatment, including residential and partial hospitalization services
Certified nurse midwife services	Covered
Certified nurse practitioner services	Covered
Chemotherapy services	Covered
Chiropractic (back) services	Covered; 30 visits per calendar year for members under age 21 unless medically necessary. 15 visits per calendar year for members age 21 and older.
Dental services	Covered; two examinations and two cleanings per calendar year, X-rays, fillings, simple extractions, full and partial dentures, general anesthesia and anterior (front teeth) root canals. Some procedures require prior authorization.

Service	Coverage
Developmental therapy services for children aged birth to 6 years	Covered; prior authorization may be required.
Diagnostic services (X-ray, lab)	Covered; Diagnostic and Lab Testing covered with Par provider. Some testing may require a prior authorization.
Doula services	Covered
Durable medical equipment (for example breast pump, breast milk storage bags, walking aid, blood pressure)	Most DME item under \$500 will be covered with a prescription to a participating vendor. - Exclusions apply, refer to DME auth grid. - Wigs are not a covered service. - In-Network: Breast pumps covered as DME. No authorization required for In-Network DME providers. - Out-of-Network: Authorization required.
Emergency services	Covered; services for a medical problem that you think is so serious that it must be treated right away by a doctor.
Family planning services and supplies	Covered
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	Covered
Freestanding birth center services at a freestanding birth center	Call Member Services to find a qualified clinic in Ohio.
Gynecological services (OBGYN)	Covered
Home health services	Covered; may require prior authorization.

Medicaid services table

Service	Coverage
Hospice care	Prior authorization required for room and board.
Inpatient hospital services	Prior authorization required for elective admissions.
Maternity care – prenatal and postpartum, including at-risk pregnancy services	Covered
Medical nutrition therapy (MNT) services	Covered
Medical supplies	Covered; may require prior authorization.
Nursing facility services	Plan will cover the stay for members unless the Ohio Department of Medicaid determines that the member will return to fee-for-service Medicaid and if the member needs nursing services, they should call the plan for information on available providers.
Outpatient hospital services	Covered
Pharmacist services: Provider-administered drugs (all other pharmacy services are covered by ODM's contracted Single Pharmacy Benefit Manager (SPBM))	Covered
Physical and occupational therapy	Covered

Service	Coverage
Physical exam required for employment or for participation in job training programs	Covered if the exam is not provided free of charge by another source.
Physician services	Covered
Podiatry (foot) services	Covered In-Network — No prior authorization required for visits, certain procedures may require prior authorization. Gold Star PCPs — Prior authorization not required.
Preventive mammogram, breast cancer and cervical cancer screenings	Covered
Primary care provider services	Covered
Private duty nursing services	Covered
Radiology (MRI, CT and nuclear studies)	Covered; may require prior authorization.
Renal dialysis (kidney disease services)	Covered

Medicaid services table

Service	Coverage
Respite services	Covered: Respite Benefit Eligibility Criteria The Ohio Department of Medicaid has made rules for this benefit, including: • Lives with his or her unpaid primary caregiver in a home or an apartment. Not in foster care. • Must be working with a Plan care manager • Require skilled services at least once per week • Have received at least 14 hours per week of home health aide services for at least six months before requesting respite services • Service is for members under the age of 21 who have LTC or BH needs • Members age 21 and over: not covered
Respite services (continued)	Behavioral health respite benefit eligibility criteria: The Ohio Department of Medicaid has made rules for this benefit, including: • Had a need for at least 14 hrs of home health aide services for at least TWO consecutive months immediately preceding the date respite services are requested • The member's caregiver has a need for temporary relief from the care of the member as a result of the member's LTSS or behavioral health needs, or in order to prevent an inpt, institutional, or out-of-home stay • Be diagnosed with a serious emotional disturbance resulting in a functional impairment • Not be exhibiting symptoms or behaviors that indicate imminent risk of harm to self or others
Screening and counseling for obesity	Covered

Service	Coverage
Services for children with medical handicaps (Title V)	Covered
Shots (immunizations)	Covered
Specialist services	Covered in-network in most cases
Speech and hearing services, including hearing aids	Covered
Telehealth services	Covered; medical and behavioral health professionals via telehealth for many illnesses and injuries, common health conditions, follow-up appointments and screenings as well as prescribing medication(s).
Tobacco cessation services	Including tobacco cessation counseling and FDA approved medications for tobacco cessation Ohio Tobacco Quit Line Call 1-800-QUIT-NOW (1-800-784-8669) and speak with an intake specialist to discuss assistance to help you quit tobacco.
Vision (optical) services, including eyeglasses	Covered; all members can receive an eye exam every 12 months. They also have a choice of glasses with a retail frame allowance of up to \$25 or retail allowance of \$150 toward any type of contacts (must use at one time) every 12 months.
Well-child (Healthchek) exams for children under the age of 21	Covered; medical, vision, dental, hearing, nutritional, developmental, and behavioral health exams, immunizations (shots), health education, and laboratory tests in addition to other care to treat physical, behavioral or other problems or conditions found by an exam.
Yearly well-adult exams	Covered

Medicaid services table

Your doctor must call UnitedHealthcare Community Plan’s Utilization Management department at 1-800-366-7304 to get approval for some services.

Transportation

If you must travel 30 miles or more from your home to receive covered health care services, UnitedHealthcare Community Plan will provide transportation to and from the provider’s office. UnitedHealthcare Community Plan also covers all necessary transportation by ambulance or wheelchair van, regardless of distance. Please call UnitedHealthcare Member Services at **1-800-895-2017**, TTY **711**, 7:00 a.m.–7:00 p.m., Monday–Friday, 48 hours in advance (unless the transport is for a hospital discharge) to set up your transport or for assistance. Additionally, UnitedHealthcare Community Plan offers transportation for same or next-day urgent appointments.

In addition to the transportation assistance that UnitedHealthcare Community Plan provides, you can get transportation for certain services through the local county department of job and family services Non-Emergency Transportation (NET) program. Call your county department of job and family services for questions or assistance with NET services.

Additional UnitedHealthcare benefits

Additional benefits

UnitedHealthcare Community Plan also offers the following extra services and/or benefits to their members.

Wellness programs

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

- Classes to help you quit smoking
- Pregnancy care and parenting classes
- Nutrition classes
- Well-care reminders

Your provider may suggest one of these programs for you. If you want to know more, or to find a program near you, talk to your PCP or call Member Services at **1-800-895-2017**, TTY **711**.

Smart tools for health

- Members can go to myuhc.com/CommunityPlan to help manage their health. The site helps keep a health history. It educates on working with their doctor. They can also track future visits.
- **Findhelp.org** — A program on the internet. The program helps members find services close to where they live. Find food assistance, help paying bills, and other free/reduced cost programs in your ZIP code.
- As a member, or as the guardian of a UnitedHealthcare member, you may qualify for **Pulsewrx's Wireless Lifeline Service**. Eligible members will receive a mobile phone and internet service plan, at no cost. Visit <https://www.mybenefitphone.com> to apply or learn more about the program. Get ready to enjoy mobile health support at no cost to you.

Additional UnitedHealthcare benefits

Live and Work Well

You're covered

It's important to know where to turn for help when needed. We are here for our members. Visit [Liveandworkwell.com](https://liveandworkwell.com) for straight talk on mental health topics.

Healthy First Steps™

Our Healthy First Steps program makes sure that both mom and baby get good medical attention. Earn great rewards (8 rewards in all), including a \$20.00 gift card for just signing up. Sign up for our maternity rewards program. Prenatal, delivery, postpartum care along with healthy tips for you and your baby.

We will help:

- Get good advice on nutrition, fitness and safety
- Get supplies, including breast pumps for nursing moms
- Choose a doctor or nurse midwife
- Schedule visits and exams
- Arrange rides to doctor's visits
- Connect with community resources such as Women, Infants and Children (WIC) services
- Get care after your baby is born
- Choose a pediatrician (child's doctor)
- Get family planning information

Call us toll-free at **1-800-599-5985**, TTY **711**, 8:00 a.m.–5:00 p.m. EST, Monday–Friday.

It's important to start pregnancy care early. Be sure to go to all of your doctor visits, even if this isn't your first baby.

Wellhop

<https://momandbaby.wellhop.com>

For mom and baby to connect with a community of moms.

Dental

- No copays for dental services
- For 21 and older, one additional exam per year

If you want to know more, call Member Services at **1-800-895-2017**, TTY **711**.

Vision

- One eye exam every year
- \$150.00 allowance toward the purchase and fitting of contact lenses per calendar year

If you want to know more, call Member Services at **1-800-895-2017**, TTY **711**.

Transportation

In addition to the required transportation, UnitedHealthcare Community Plan offers these additional transportation services:

- Unlimited trips for pregnancy, prenatal, post-partum, WIC appointments, Neonatal Intensive Care Unit (NICU) and well visits for children younger than age one
- Mileage reimbursement is available for transportation to provider visits
- Transportation for food resources (food bank, food pantry, grocery store for curbside pickup). (This counts toward the trip maximum of 15 round trip or 30 one way trips.)
- Additional unlimited trips allowed for critical care trip types including dialysis, chemo/radiation, wound care, pregnancy, substance abuse. (This does not count toward the trip maximum of 15 round trips or 30 one way.)

If you want to know more, call Member Services at **1-800-895-2017**, TTY **711**.

Housing navigator

Provide support by assessing the housing needs and preferences of members with unstable housing, identifying qualifying housing options, and assisting with the housing application process.

If you want to know more, call Member Services at **1-800-895-2017**, TTY **711**.

Meal delivery

- Meals delivered post discharge from hospital for up to 14 days for our pregnant moms

If you want to know more, call Member Services at **1-800-895-2017**, TTY **711**.

On MyWay

<http://www.uhcOMW.com>

Resource for members to help make the move to independent living.

Additional UnitedHealthcare benefits

Telehealth

Telehealth is the direct delivery of health care using audio and or video. Instead of coming into the office for your appointment, you stay at your home and use your smartphone, tablet or computer to see and talk to your medical and behavioral health professionals. There is no cost to use telehealth and telehealth removes the stress of needing transportation services.

You can see medical and behavioral health professionals via telehealth for many illnesses and injuries, common health conditions, follow-up appointments and screenings as well as for prescribing medication(s).

Check with your providers to see if they offer telehealth.

If you want to know more, call Member Services at **1-800-895-2017**, TTY **711**.

UnitedHealthcare® app

UnitedHealthcare Community Plan has a new member app. It's called UnitedHealthcare® app. The app is available for Apple® or Android® tablets and smartphones. UnitedHealthcare app makes it easy to:

- Find a doctor, ER or urgent care center near you
- View your ID card
- Read your handbook
- Learn about your benefits
- Contact Member Services

Download the free UnitedHealthcare app today. Use it to connect with your health plan wherever you are, whenever you want.

Healthy rewards

An ounce of prevention can be worth a pound of cure. It can also be worth great rewards. To find information on programs that rewards you for meeting certain health goals go to: www.uhccommunityplan.com/oh under Healthy rewards.

Earn great gifts for you or your child by doing things like:

- Completing well-child exams
- Preventative care and screenings
- Getting lab tests
- Immunizations

Dr. Health E. Hound® program

We are proud of our mascot — Dr. Health E. Hound. Dr. Health E. Hound's goal is to help teach your kids about fun ways to stay fit and healthy. Dr. Health E. Hound loves to travel around the state and meet kids of all ages. He likes to hand out flyers, posters, stickers and coloring books to remind kids to eat healthy foods and to exercise. He also helps kids understand that going to the doctor for checkups and shots is an important way to stay healthy.

You and your family can meet Dr. Health E. Hound in person at some of our health plan events. We encourage you to come to an event and learn about the importance of healthy eating and exercise. Bring a camera to these events and get your picture taken with Dr. Health E. Hound.

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Other plan details

Other plan details

Finding a network provider

We make finding a network provider easy. To find a network provider close to you:

Visit myuhc.com/CommunityPlan for the most up-to-date information. Click on “Find a Provider.”

Call Member Services at **1-800-895-2017**, TTY **711**. We can look up network providers for you. Or, if you’d like, we can send you a Provider Directory in the mail.

Provider Directory

You have a directory of providers available to you in your area. The directory lists addresses and phone numbers of our in-network providers.

Provider information changes often. Visit our website for the most up-to-date listing at myuhc.com/CommunityPlan. You can view or print the provider directory at myuhc.com/CommunityPlan, or click on “Find a Provider” to use our online searchable directory.

You can find the most up-to-date provider directory at myuhc.com/CommunityPlan or the UnitedHealthcare app. If you would like a printed copy of our directory, please call Member Services at **1-800-895-2017**, TTY **711**, and we will mail one to you.

Thank you for being a valued member of United Healthcare Community Plan. If you are looking for any vision or dental services, you can find lists of providers at:

Vision providers — <https://www.marchvisioncare.com/>

Dental providers — myuhc.com

Or to locate a vision or dental provider please call **1-800-895-2017**, TTY **711**, or go to myuhc.com.

If you get a bill for services

Hospitals and doctors cannot bill members for covered services. If you get a bill, call Member Services at **1-800-895-2017**, TTY **711**. A representative will work with you to find out if you need to pay the bill or if you should send it to us at:

Medicaid Program
UnitedHealthcare Community Plan
5600 Parkwood Place
Dublin, OH 43016

Keep a copy of the bill for yourself. We will review these bills to make sure the services are covered benefits. If they are covered, we will pay the health care provider right away. Call Member Services at **1-800-895-2017**, TTY **711**, with any questions.

Providers will bill your primary insurance first. After your primary insurance pays the allowed amount, the provider will bill UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will pay the provider the amount agreed upon in our contract with the provider.

Advance Directives

An Advance Directive is a set of written steps you want to be taken when you can no longer make health care choices for yourself. It tells what health care you want or do not want. You should talk about your wishes with your doctor, family and friends. These steps will not change your health care benefits. Some examples of Advance Directives include:

Living Wills

A Living Will tells your doctor the kinds of life support you want or do not want.

Power of Attorney for health care

In this form, you name another person who can make health choices for you. It would be used only if you cannot make choices yourself.

Other plan details

Declaration for Mental Health Treatment

A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows a person, while capable, to appoint a proxy to make decisions on his or her behalf when he or she lacks the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. The person can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

The Declaration for Mental Health Treatment supersedes a Durable Power of Attorney for mental health care, but does not supersede a Living Will.

You can ask your doctor for more information about Advance Directives. You can also find some sample forms at [Familydoctor.org](https://www.familydoctor.org).

What kinds of forms are there?

Under Ohio law, there are four different forms, or Advance Directives, you can use. You can use either a Living Will, a Declaration for Mental Health Treatment, or a Durable Power of Attorney for medical care or a Do Not Resuscitate (DNR) Order. You fill out an Advance Directive while you're able to act for yourself. The Advance Directive lets your doctor and others know your wishes about medical care.

Do Not Resuscitate order

State regulations offer a Do Not Resuscitate (DNR) Comfort Care and Comfort Care Arrest Protocol as developed by the Ohio Department of Health. A DNR Order means a directive issued by a physician or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, which identifies a person and specifies that CPR should not be administered to the person so identified. CPR means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person's airway for a purpose other than as a component of CPR.

The DNR Comfort Care and Comfort Care Arrest Protocol lists the specific actions that paramedics, emergency medical technicians, physicians or nurses will take when attending to a DNR Comfort Care or Comfort Care Arrest order. The protocol also lists what specific actions will not be taken.

You should talk to your doctor about the DNR Comfort Care and Comfort Care Arrest order and protocol options.

Fraud and abuse

Anyone can report potential fraud and abuse. If you become aware of fraud or abuse, call Member Services at **1-800-895-2017**, TTY **711**, to report it. Some examples of fraud and abuse are:

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

You may also write to ODI at:

Ohio Department of Insurance: Fraud Unit
2100 Stella Court
Columbus, OH 43215

Fraud and abuse hotline

You can also report suspected fraud and abuse to UnitedHealthcare Community Plan by calling toll-free at 1-877-766-3844 and leaving a detailed message. This also has been set up so that you do not have to give your name.

Remember: Never give your member ID card to anyone else to use.

Reporting incidents

Incident investigation and reporting

UnitedHealthcare and the State of Ohio are required to perform incident investigation activities to ensure you are protected and safe from harm. These activities include:

- Taking immediate steps to ensure your health and welfare, and if appropriate, ensure medical attention is sought
- Looking into incidents to ensure your health and safety and prevent incidents from happening again
- Looking for patterns to see if you or your providers could benefit from education in a particular area
- Making sure providers know how to keep you safe and cause no harm to you
- Informing you of the findings from the investigation of a critical incident and potentially developing a prevention plan to lessen the risk of the incident happening again

What are incidents?

An “incident” is an alleged, suspected, or actual event that is inconsistent with your routine care and/or service delivery. Critical incidents include any of the following:

- Abuse: the injury, confinement, control, intimidation, or punishment of an individual, that has resulted in physical harm, pain, fear, or mental anguish. Abuse includes physical, emotional, verbal, and/or sexual abuse, the use of restraint, seclusion, or restrictive intervention without authorization.
- Neglect: when it is a duty to do so, failing to provide treatment, care, goods, or services necessary to maintain your health and welfare, including self-neglect
- Exploitation: the unlawful or improper act of using a member or a member’s resources using manipulation, intimidation, threats, deception, or coercion for monetary or personal benefit, profit, or gain
- Misappropriation: depriving, defrauding or otherwise obtaining money or real or personal property (including prescribed medication) belonging to you by any means prohibited by law that could impact your health and welfare
- Unnatural or accidental death
- Self-harm or suicide attempt that includes a physical attempt by an individual to harm themselves that results in emergency room treatment, in-patient observation, or hospital admission

If you have questions, please call UnitedHealthcare at **1-800-895-2017, TTY 711**, 7:00 a.m. to 7:00 p.m. Monday through Friday. The call is free. For more information, visit myuhc.com/communityplan.

What to do if any of these things happen?

How to report an incident: You and/or your authorized representative or legal guardian should report incidents to your Care Manager or UnitedHealthcare member services.

If the incident is serious in nature and you believe your health and welfare is in jeopardy, you should also notify the appropriate authorities. If you are unsure who to contact, ask your care manager or UnitedHealthcare member services. The appropriate authority is dependent upon the nature of the incident.

Examples of serious incidents include but are not limited to the following:

Medical emergency: If you have a medical emergency, call your doctor or 911. Situations causing you concern should be communicated to your Care Manager or UnitedHealthcare Member Services. It is best to bring these concerns to them before they become an emergency.

Abuse, neglect, or exploitation of an adult over 60: If the incident involves the abuse, exploitation, or neglect of an adult age 60 or older, contact Adult Protective Services (APS) in the county where the individual resides or where the incident occurred. During non-business hours, contact local law enforcement. To find the number for your local APS agency, click or visit https://jfs.ohio.gov/county/County_Directory.pdf.

Child Protective Services: If the incident involves abuse, exploitation, or neglect of a child, contact Child Protective Services in the county where the individual resides or where the incident occurred. During non business hours contact local law enforcement. To find the phone number for your local CPS agency, click or visit jfs.ohio.gov/county/County_Directory.pdf.

Criminal activity: If the incident involves conduct you believe may be criminal, call your local law enforcement.

Medicaid fraud: If you suspect the incident involves Medicaid fraud, file a complaint with the Ohio Attorney General. To contact them, click or visit <http://www.ohioattorneygeneral.gov/About-AG/Contact>.

Legal guardian: If the incident involves a legal guardian, you can contact your local probate court. To find your local court, click or visit <https://www.supremecourt.ohio.gov/courts/judicial-system/ohio-trial-courts/>.

Other plan details

Advocacy agencies

Organizations that can educate you and advocate for your interests.

Concerns about UnitedHealthcare: If you have concerns about UnitedHealthcare, contact your care manager or UnitedHealthcare Member Services. If you feel that UnitedHealthcare does not address your concerns, you may seek assistance from ODM by contacting the Medicaid Consumer Hotline. Click or visit <http://www.ohiomh.com/> or call 800-324-8680.

Ombudsman: The Ohio long term care Ombudsmen voice member needs and concerns regarding long-term care services to nursing homes, home health agencies, and other providers. They will work with the UnitedHealthcare long term care provider and you, your family, or other representatives to resolve problems and concerns you may have about the quality of services, you receive. Regional Long term Care Ombudsman Programs help safeguard individuals. Call the state office at 1-800-282-1206 or email OhioOmbudsman@age.ohio.gov for assistance.

Ohio Association of Centers for Independent Living (CIL): CILs help ensure people with disabilities have complete access to the communities in which they wish to live as well as opportunities to make decisions that affect one's life, being able to pursue activities of one's own choosing. For more information, click or go to <http://www.ohiosilc.org/>.

Legal Aid: Provides legal assistance to protect and enforce the legal rights of low-income Ohioans. Call 866-LAW-OHIO.

Disability Rights Ohio: Advocates for the human, civil, and legal rights of people with disabilities in Ohio. For more information, click or go to <http://www.disabilityrightsohio.org/> or call 614- 466-7264 or 800-282-9181.

UnitedHealthcare Member Handbook acknowledgement

I have received the UnitedHealthcare Member Handbook. It includes information about my rights and protections, and how to report alleged incidents.

Member Signature: _____ (or Authorized Representative)

Date: _____

If you have questions, please call UnitedHealthcare at **1-800-895-2017**, TTY **711**, 7:00 a.m. to 7:00 p.m. Monday through Friday. The call is free. For more information, visit myuhc.com/communityplan.

Your opinion matters

Do you have any ideas about how to make UnitedHealthcare Community Plan better? There are many ways you can tell us what you think.

- Call Member Services at **1-800-895-2017**, TTY **711**
- Write to us at:

UnitedHealthcare Community Plan
5600 Parkwood Place
Dublin, OH 43016

Member Advisory Board

The Member Advisory Board is an advisory council to ensure that UnitedHealthcare actively engages consumers, families, advocacy groups, and other key stakeholders as partners in the complex care program design and delivery system.

Who can join?

- UnitedHealthcare Community Plan members
- Family members and caregivers of UnitedHealthcare Community Plan members
- Representatives from community and consumer advocacy groups

Participants can:

- Share feedback and ideas with the UnitedHealthcare team
- Join a monthly call with UnitedHealthcare leaders about health and wellness
- Attend an annual regional meeting
- Sign up for free advocacy trainings

For information about the advisory council, contact:

Member Services at **1-800-895-2017**, TTY **711**

Member Advisory Committee

We also have a Member Advisory Committee that meets every three months. If you'd like to join us, call Member Services.

Utilization management

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

There are also some treatments and procedures we need to review before you can get them. Your providers know what they are, and they take care of letting us know to review them. The review we do is called Utilization Review. We do not reward anyone for saying no to needed care. If you have questions about UM, you can talk to our Medicaid Care Management staff. Our nurses are available 8:00 a.m. to 5:00 p.m., Monday through Friday at 1-800-504-9669, TTY 711; language assistance is available.

Quality program

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

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

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

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

If you would like to know more about the quality program, call Member Services at **1-800-895-2017**, TTY **711**.

Safety and protection from discrimination

Patient safety is very important to us. Although we do not direct care, we want to make sure that our members get safe care. We track quality-of-care issues, develop guidelines to promote safe care, provide information to members about patient safety, and work with hospitals, doctors and others to improve continuity and coordination between sites of care. If you would like more information on patient safety or places to get information, call Member Services at **1-800-895-2017**, TTY **711**.

UnitedHealthcare Community Plan and its providers are prohibited from discriminating against anyone because of age, race, ethnicity, religion, color, gender, gender identity, sexual orientation, disability, national origin, military status, veteran status, ancestry, genetic information, health status, or need for health services in the receipt of health services. UnitedHealthcare Community Plan providers must follow the Americans with Disabilities Act and cannot discriminate on the basis of health or mental health, need for health care or pre-existing conditions. If you think you have been subject to any form of discrimination, please call Member Services at **1-800-895-2017**, TTY **711**, immediately.

Clinical practice guidelines and new technology

UnitedHealthcare Community Plan gives our providers clinical guidelines that have information about the best way to provide care for some conditions. Each clinical guideline is an accepted standard of care in the medical profession, which means other doctors agree with that approach. We want to improve your health by giving our providers information that supports their clinical practices, consistent with nationally recognized standards of care.

If you have any questions about UnitedHealthcare Community Plan's clinical guidelines or would like a paper copy of a clinical practice guideline, please call Member Services at **1-800-895-2017**, TTY **711**. You can also find the clinical practice guidelines on our website at myuhc.com/CommunityPlan.

New technology assessment

Some medical practices and treatments are not yet proven to be effective. New practices, treatments, tests and technologies are reviewed nationally by UnitedHealthcare Community Plan to make decisions about new medical practices and treatments and what conditions they can be used for. This information is reviewed by a committee of UnitedHealthcare Community Plan doctors, nurses, pharmacists and guest experts who make the final decision about coverage. If you would like more information about how we make decisions about new medical practices and treatments, call us at **1-800-895-2017**, TTY **711**.

Your membership responsibilities

As a member of UnitedHealthcare Community Plan, you have the responsibility:

- To understand how UnitedHealthcare Community Plan works by reading this handbook
- To choose your Primary Care Provider
- To carry your UnitedHealthcare Community Plan card. (You must show your card when receiving services and must report a stolen or lost card as soon as possible. You also must inform UnitedHealthcare Community Plan of any other insurance you may have, and must present current insurance information to your Primary Care Provider.)
- To seek medical attention as needed
- To be on time for all appointments
- To tell your PCP's office or any medical office if you need to change an appointment
- To respect the rights and property of your PCP, other health care workers, and other patients
- To know when to take your medicine, how to take your medicine and to follow your doctor's instructions for care that you have agreed to
- To give the right medical information and any information needed to provide your care to UnitedHealthcare Community Plan and your health care providers
- To take full responsibility, think about the consequences of your decision if you refuse care (say no to treatment), and ask questions if you don't understand
- To understand as best you can your health problems and take part in developing mutually agreed upon treatments
- To be sure that your Primary Care Provider has all your medical records. (This includes all medical records from other doctors.)
- To let UnitedHealthcare Community Plan know if you are in the hospital. (Do this in 24 hours or as soon as possible.)
- To consent to the proper use of your health information
- To keep your Medicaid eligibility current so you do not lose your UnitedHealthcare Community Plan membership

Managed care terminology

Abuse: Harming someone on purpose. (Includes yelling, ignoring a person's need and inappropriate touching.)

Advance Directive: A decision about your health care that you make ahead of time in case you are ever unable to speak for yourself. This will let your family and your doctors know what decisions you would make if you were able to.

Appeal: A member's request for the UnitedHealthcare Community Plan to review an adverse benefit determination.

Authorization: An O.K. or approval for a service.

Benefits: Services, procedures and medications that UnitedHealthcare Community Plan will cover for you.

Copayment: A fixed amount a member pays for a covered health care service.

Disenrollment: To stop your membership in UnitedHealthcare Community Plan.

Durable Medical Equipment (DME): Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

Emergency: A sudden and, at the time, unexpected change in a person's physical or mental condition which, if a procedure or treatment is not performed right away, could be expected to result in (1) the loss of life or limb, (2) significant impairment to a bodily function, or (3) permanent damage to a body part or health of unborn child. (Mental Health: Threat of suicide, homicide or self-injury, mania or psychosis that needs immediate medical attention.)

Emergency Medical Condition: Means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Medical Transportation: Transportation, by ambulance, of sick, injured or otherwise incapacitated persons who require emergency medical care.

Other plan details

Emergency – Non-Life-Threatening Mental Health: When symptoms first develop, but are not life-threatening, like suicidal ideation without a plan to implement or the member is starting to show signs of a mania or psychosis.

Emergency Room Care: Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care treatment or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Emergency Services: Covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. Providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with the UnitedHealthcare Community Plan.

Excluded Services: Health services that the UnitedHealthcare Community Plan does not pay for or cover.

Fraud: An untruthful act (example: if someone other than you uses your member ID card and pretends to be you).

Grievance: A member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance include a member's right to dispute an extension of time proposed by an MCE to make an authorization decision.

Habilitation Services and Devices: Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Health Information: Facts about your health and care. This information may come from UnitedHealthcare Community Plan or a provider. It includes information about your physical and mental health, as well as payments for care.

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

Home Health Care: Services that include home health nursing, home health aide services and skilled therapies.

Hospice Services: A public agency, a private organization, or a subdivision of either, subject to the conditions of participation pursuant to 42 C.F.R. Part 418 (October 1, 2017), that is licensed in the state of Ohio and approved by the ODM to engage in providing care to terminally ill individuals. (5160-56-01 (V).

Hospitalization: Care in a hospital that requires admission as an inpatient.

Hospital Outpatient Care: Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a practitioner of physician services which are furnished to a patient by a hospital.

Mental Health Information: Facts about your mental health and care. This information may come from UnitedHealthcare Community Plan or a provider. It includes information about your physical and mental health, as well as payments for care.

ID Card: An identification card that says you are a UnitedHealthcare Community Plan member. You should have this card with you at all times.

Immunization: A shot that protects from a disease. Children should get a variety at specific ages. Shots are often given during regular doctor visits.

Informed Consent: That all medical treatments have been explained to you; you understand and agree to them.

In-Network: Doctors, specialists, hospitals, pharmacies and other providers who have an arrangement with UnitedHealthcare Community Plan to provide health care services to members.

Inpatient: When you are admitted into a hospital for a length of time.

Medically Necessary: Criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increase or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Member: An eligible person enrolled with UnitedHealthcare Community Plan in the Medicaid or DHCP programs.

Network: The UnitedHealthcare Community Plan's contracted providers available to the UnitedHealthcare Community Plan's members.

Other plan details

Non-Participating Provider: Any provider with an ODM provider agreement who does not contract with an UnitedHealthcare Community Plan but delivers health care services to an UnitedHealthcare Community Plan's members.

ODM: Ohio Department of Medicaid.

Out-of-Network: Doctors, specialists, hospitals, pharmacies and other providers who do not have an arrangement with UnitedHealthcare to provide health care services to members.

Outpatient: When you have a procedure done that does not require a hospital stay overnight.

Participating Provider: Any provider, group of providers, or entity that has a network provider contract with the UnitedHealthcare Community Plan in accordance with rule 5160-26-05 of the Administrative Code and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the UnitedHealthcare Community Plan's provider agreement or contract with ODM.

Physician Services: (L) "Practitioner of physician services": are physicians, podiatrists, dentists, clinical nurse specialists, certified nurse-midwives, certified nurse practitioners or physician assistants. (5160-2-02(L))

Plan: (X) "Managed care organization (MCO)" or "managed care plan (MCP)" means a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM. 5160-26-01(X)

Post-Stabilization Care Services: Covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 to improve or resolve the member's condition.

Preauthorization: A decision by the UnitedHealthcare Community Plan that a health care service, treatment plan or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.

Premium: "Premium" means the monthly payment amount per member to which the MCO is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM. (516026-01(NN))

Prescription Drug Coverage: Drugs covered by the Single Pharmacy Benefit Manager (SPBM) that are dispensed to members for the use in a patients' resident, including a nursing facility or intermediate care facility for individuals with intellectual disabilities.

Prescription Drugs: Simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and dispensed by the license pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Primary Care Physician or Provider (PCP): An individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Ohio Revised Code, an advance practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Ohio Administrative Code contracting with UnitedHealthcare Community Plan to provide services as specified in rule 5160-26-03.1 of the Ohio Administrative Code.

Prior Authorization: Process that your doctor uses to get approval for services that need to be approved before they can be done.

Provider Directory: A list of providers who participate with UnitedHealthcare Community Plan to help take care of your health care needs.

Provider: A hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care-related services rendered to UnitedHealthcare Community Plan's members.

Referral: When you and your PCP agree you need to see another doctor and your PCP sends you to a network specialist.

Rehabilitation Services and Devices: Specific tasks that must, in accordance with Title 47 of the Ohio Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel.

Self-Referred Services: Services for which you do not need to see your PCP for a referral.

Skilled Nursing Care: Specific tasks that must, in accordance with Chapter 4723 of the Ohio Revised Code, be provided by a license practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Other plan details

Substance Use Information: Facts about your substance use and care. This information may come from UnitedHealthcare Community Plan or a provider. It includes information about your substance use history and current use, as well as payments for care.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

WIC: Supplemental food program for Women, Infants and Children that provides nutrition counseling, nutrition education, and nutritious foods to pregnant and postpartum women, infants and children up to the age of 2. Children deemed nutritionally deficient are covered up to age 5 if they are low income and are determined to be at nutritional risk.

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

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

Other plan details

- **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.

Other plan details

- **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

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

Information we collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and security

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

Other plan details

Questions about this notice

Please **call the toll-free member phone number on 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>.

Civil Rights Notice

Discrimination is against the law. UnitedHealthcare Community Plan of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of any of the following:

- Race
- Color
- National origin
- Military Status
- Religion
- Genetic information
- Age
- Disability (including physical or mental impairment)
- Ancestry
- Political beliefs
- Public assistance status
- Medical condition
- Sex (including sex stereotypes and gender identity)
- Sexual orientation
- Health status (including the need for health services)

UnitedHealthcare Community Plan of Ohio provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

UnitedHealthcare Community Plan of Ohio provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call Member Services using the toll-free number on your member identification card.

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by **UnitedHealthcare Community Plan of Ohio**. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

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

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

Online: <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>

By mail: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

By phone: **1-800-368-1019** (TDD: **1-800-537-7697**)

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. If you need help, please call the toll-free number on your member identification card.

Spanish: ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles para usted sin cargo. Si necesita ayuda, llame al número de teléfono gratuito que aparece en su tarjeta de identificación de miembro.

Ukrainian: УВАГА! Якщо ви говорите українською мовою, ви можете скористатися безкоштовними послугами перекладача. Якщо вам потрібна допомога, зателефонуйте за безкоштовним номером, вказаним у вашій ідентифікаційній картці учасника.

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Si ou bezwen èd, tanpri rele nimewo gratis lan ki sou kat idantifikasyon ou kòm manm lan.

Nepali: ध्यान दिनुहोस्: तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निः शुल्क रूपमा उपलब्ध छन्। कृपया तपाईंलाई मद्दत चाहिएमा तपाईंको सदस्यता परिचय कार्डमा भएको टोल-फ्री नम्बरमा फोन गर्नुहोस्।

Arabic: تنبيه: إذا كنت تتحدث العربية، فنتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم المجاني أعلاه. إذا كنت بحاجة إلى مساعدة، يُرجى الاتصال بالرقم المجاني المدوّن على بطاقة تعريف العضو الخاصة بك.

Russian: Внимание! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться помощью переводчика. Если Вам нужна помощь, позвоните по номеру телефона для бесплатных звонков, указанному на Вашей идентификационной карточке участника.

Somali: OGSOONOW: Haddii aad ku hadasho Soomaali, adeegyada kaalmada luuqadda, oo bilaash ah, ayaad heli kartaa. Haddii aad u baahan tahay caawimaad, fadlan wac lambarka sida bilaashka loo waco ee ku yaala kaarkaaga aqoonsiga xubinnimo.

French: ATTENTION : si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Si vous avez besoin d'aide, veuillez composer le numéro gratuit figurant sur votre carte de membre.

Kinyarwanda (Burundi): ICYITONDERWA: Niba uvuga Ikinyarwanda, serivisi z'ubufasha mu by'indimi zirahari ku buntu. Niba ukeneye ubufasha, hamagara nimero itishyurwa iri ku karita yawe iranga umunyamuryango.

Swahili: TAZAMA: : Ikiwa unasungumza Kiswahili, huduma za usaidizi kuhusu lugha, bila malipo, zinapatikana kwa ajili yako. Ikiwa unahitaji msada, tafadhali piga simu bila malipo kwa nambari iliyo kwenye kitambulisho chako cha mshiriki.

Uzbek: DIQQAT: Agar ingliz tilida soʻzlasangiz, til masalasida yordam beradigan bepul xizmatlar mavjud. Agar yordam zarur boʻlsa, aʼzo identifikatsiya kartasidagi bepul raqamga telefon qiling.

Pashto: پاملرنه: که تاسو په پښتو ژبه خبرې کوئ، د ژبې د مرستې خدمتونه، په وړیا توګه، تاسو لپاره شتون لري. که تاسو مرستې ته اړتیا لرئ، مهرباني وکړئ خپل د غړی پیژندنې کارت کې ورکړل شوې وړیا شمیرې ته ټولګه ووهئ.

Turkish: DİKKAT: İngilizce konuşuyorsanız, size ücretsiz dil yardımı hizmetleri sunulabilir. Yardıma ihtiyaç duyarsanız, lütfen üye kimlik kartınızdaki ücret telefon numarasını arayın.

Dari: توجه: اگر شما به لسان دری صحبت میکنید، خدمات اسیستانت لسان به قسم رایگان در دسترس تان قرار میگیرد. اگر به کمک ضرورت پیدا کردید، لطفاً به نمبر رایگان مندرج در کارت هویت اعضا به تماس شوید.

Vietnamese: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Nếu quý vị cần trợ giúp, vui lòng gọi số miễn cước trên thẻ nhận dạng hội viên của quý vị.

Appendix A

Ohio Single Pharmacy Benefit Manager (SPBM)

1. Member Handbook Contents

1.1 Corporate Identity

Gainwell Technologies is a company with over 50 years of proven experience, and a reputation for service excellence and unparalleled expertise. Gainwell does not operate under any other trade names or DBA. At Gainwell, everything we do focuses on people.

The mission at Gainwell is to empower clients through innovative technologies and solutions to deliver great health and human services outcomes.

You are now a member of our Single Pharmacy Benefit Manager (SPBM). Here at Gainwell, we believe you deserve quality pharmacy services and should receive the most up-to-date services that we can provide.

Online: <https://spbm.medicaid.ohio.gov>

Email: OH_MCD_PBM@gainwelltechnologies.com

If you suspect provider or consumer fraud, please contact our Fraud, Waste, and Abuse toll free tip line at **1-833-491-0344** (TTY **1-833-655-2437**) and select the option to report Fraud, Waste, and Abuse concerns.

1.2 Available Services

Gainwell covers all Medicaid-covered, medically necessary prescription and over-the-counter (OTC) medications. We use a preferred drug list (PDL) which is a list of drugs we prefer your provider prescribe. We may require your prescriber to submit a prior authorization request, which is where your prescriber would provide us additional information explaining why a specific medication and/or a certain dose or quantity of a medication may be required.

Other plan details

The below services are available to you to support any additional needs you may have:

- Oral interpretation
- Translation services
- Auxiliary aids and services
- Written information in alternative formats including, braille and large print

1.2.1 Preferred Drug List (PDL)

Gainwell uses a PDL which is a list of drugs we prefer your provider prescribes. You can find a copy of the PDL in the following locations:

- Under the Reference Material tab at: <https://spbm.medicaid.ohio.gov>
- Logging in to your Gainwell Member Portal at <https://spbm.medicaid.ohio.gov>
- The Ohio Department of Medicaid pharmacy website at:
<https://medicaid.ohio.gov/stakeholders-and-partners/phm/unified-pdl>
- A paper copy can be requested by calling Member Services at **1-833-491-0344** (TTY **1-833-655-2437**)

1.2.2 Prior Authorizations

Your prescriber may be required to submit a prior authorization request for certain medications. Gainwell accepts prior authorization submissions via phone, fax, mail, web portal, or ePA. In these circumstances, your provider will send an authorization request to the Gainwell Pharmacy Services team, where they will complete a clinical review of the medication your prescriber is requesting. Gainwell Pharmacy Services team will work closely with your prescriber to provide the best clinical decision. You will receive a letter in the mail with the outcome of the decision made.

If you do not agree with the decision that is made by Gainwell, you will be sent detailed information on how you can appeal the decision.

You have the option to call Member Services toll free at **1-833-491-0344** (TTY **1-833-655-2437**) to obtain information regarding the PDL, medications that may require prior authorization, or to ask any medication related questions you may have. The PDL and a list of medications that require prior authorization are available for you to access online at: <https://spbm.medicaid.ohio.gov>. It is important that you and/or your prescriber reference the PDL and/or the list of medications that require prior authorizations each time you have questions, as these are documents that can change.

1.2.3 Pharmacy Utilization Management Strategies

The PDL will be used with each prior authorization review that is completed by the Gainwell Pharmacy Services team. When a prior authorization is required, Gainwell must approve the prescriber's request before you will be able to fill your medication at your preferred, in-network pharmacy. A prior authorization may be required if:

- A generic drug is available
- The requested drug can be misused/abused
- Other medications must be tried first
- Quantity limits for the requested medication have been exceeded
- The medication your provider has prescribed is not included on the PDL

The PDL usually includes multiple medication options for treating a particular condition. These different drugs are referred to as “alternative” drugs and are just as effective as other drugs with no additional side effects or health problems.

Specific reasons your prescriber may be required to submit a prior authorization request include:

Step Therapy — In some cases, our plan requires you first try certain drugs to treat your medical condition.

Generic Substitution — This is where a pharmacy will be required to provide a generic drug in place of a brand-name drug when available. Generic drugs are just as safe and effective as brand name drugs and should be prescribed first.

Therapeutic Interchange — This is where you are unable to take a medication for reasons like an allergy, intolerance, etc., a medication might not work for you and your prescriber may write a prescription for a medication that is not on the approved drug list.

Specialty Medications — This is a review of a medication that is considered more complex for a specific disease and requires specific attention and handling during the prior authorization review process. For these medications, you may have to get them through a specialty pharmacy. Your prescriber will work with Gainwell Pharmacy Services to make sure you can obtain the medication you need as quickly as possible.

Other plan details

1.2.4 Excluded Services

Gainwell will not pay for the following categories that are not covered by the Ohio Medicaid pharmacy program:

- Drugs for the treatment of obesity
- Drugs for the treatment of infertility
- Drugs for the treatment of erectile dysfunction
- DESI drugs or drugs that may have been determined to be identical, similar, or related
- Drugs that are eligible to be covered by Medicare Part D
- Over-the-counter drugs that are not listed in accordance with paragraph C of OAC rule 5160-9-03
- Drugs being used for indications not approved by the Food and Drug Administration (FDA) unless supported by compelling clinical evidence

1.2.5 Additional Services

The Gainwell Pharmacy team can also assist you with the below services by calling your member help desk at **1-833-491-0344** (TTY **1-833-655-2437**). You can also access this information on your member portal by logging in at <https://spbm.medicaid.ohio.gov>.

- Locating a pharmacy to fill the prescription you were given by your provider
- Verifying you have active pharmacy coverage
- Obtaining diabetic supplies covered through your pharmacy benefit
- Obtaining durable medical equipment (DME) covered through your pharmacy benefit

1.3 Request for Appeals, Grievances, or State Hearings

Grievance

If you are unhappy with anything in relation to Gainwell Pharmacy Services or our providers, please contact us as soon as possible. This is called a grievance.

To contact us you can:

- Call Member Services at **1-833-491-0344** (TTY **1-833-655-2437**) and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below or online through your member portal
- Visit our website at <https://spbm.medicaid.ohio.gov>
- Write a letter telling us you are unhappy. Please be sure to include your first and last name, your Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

106 **Questions?** Visit myuhc.com/CommunityPlan, or call Member Services at **1-800-895-2017**, TTY **711**.

Email: OH_MCD_PBM@gainwelltechnologies.com

Mail:

Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

Once you contact Gainwell to submit your grievance, we will follow up with you by telephone, mail delivery, or other appropriate means within the below timeframes:

- Two (2) working days for grievances about not being able to get the medications you need
- Thirty (30) calendar days for all other grievances

Appeal

If you receive a notice from us that you disagree with, you may ask for an appeal within sixty (60) calendar days after the date of the notice. Gainwell will provide you with an answer to your appeal within fifteen (15) calendar days from the date you contacted us. If you believe fifteen (15) calendar days could seriously jeopardize your life, physical or mental health or ability to attain, maintain, or regain maximum function, contact Gainwell Member Services at the number listed below as soon as possible to expedite your review process. To request an appeal, you can:

- Call Member Services at **1-833-491-0344** (TTY **1-833-655-2437**) and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below, or complete online through your member portal
- Visit our website at <https://spbm.medicaid.ohio.gov>
- Write a letter. Please be sure to include your first and last name, your Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

Email: OH_MCD_PBM@gainwelltechnologies.com

Mail:

Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

Other plan details

When submitting an appeal, please include the following information:

- Your name and Medicaid ID number on your card
- Your prescriber's name
- The reason you disagree with the outcome provided by Gainwell
- Any documentation or information to support your request to have your decision overturned

Gainwell must provide you with an answer to your appeal within fifteen (15) calendar days from the date you contacted us. If we do not change our decision, you will be notified in writing and will be provided your right to request a State hearing. You must complete the appeal process before you are able to request a State hearing.

If we need more time to make a decision for either a grievance or appeal, we will send you a letter telling you we need to take up to fourteen (14) more calendar days. That letter will also provide you with information as to why we need more time to complete your request.

State Hearing

You must complete the Gainwell appeal process before you are able to request a State hearing. A State hearing is a meeting with you or your authorized representative, someone from the County Department of Job and Family Services, someone from Gainwell, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). During this meeting, you will explain why you think Gainwell Pharmacy Services did not make the right decisions and Gainwell will explain the reasons for making our decision. A decision will be made by the hearing officer based on rules, regulations, and information provided during the hearing.

You will be notified of your right to request a State hearing if we do not change our decision as a result of your appeal to Gainwell. If you would like to request a State hearing, you or your authorized representative must request a hearing within ninety (90) calendar days of your denied appeal from Gainwell.

To request a hearing, you can sign and return the State hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at **1-866-635-3748** (TTY/TDD **614-728-2985**), or submit your request via email to bsh@jfs.ohio.gov. If you want information on free legal services, you can call the Ohio State Legal Services Association at 1-800-589-5888 for the local number to your local legal aid office.

State hearing decisions are usually issued no later than seventy (70) calendar days after the request is received. If it is determined that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than three (3) business days after the request is received. Expedited decisions are for situations when the standard review time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

108 **Questions?** Visit myuhc.com/CommunityPlan, or call Member Services at **1-800-895-2017**, TTY **711**.

1.4 Change Recommendations

As a member of Gainwell Pharmacy Services, you have a membership right to make recommendations regarding rights and responsibilities surrounding your medication coverage.

Recommendations can be emailed to Gainwell Pharmacy Services at OH_MCD_PBM@gainwelltechnologies.com or call Member Services at **833-491-0344** (TTY/TDD **614-728-2985**).

1.5 Pharmacy Access

Gainwell Pharmacy Services offers a member portal for you to log in and manage your pharmacy needs. To log in to your personal member portal, visit <https://spbm.medicaid.ohio.gov> and log in with your personal information that you have set up for your account.

To sign-up for an account through the Gainwell Member Portal, you can follow the directions on the website at <https://spbm.medicaid.ohio.gov> or call Member Services toll free at **1-833-491-0344** (TTY **1-833-655-2437**) to speak with a Gainwell Pharmacy Services agent to receive step-by-step assistance to sign up for access.

1.6 Emergency Outpatient Drug

In the event of an emergency situation, you will have the option to receive a 72-hour (3 day) supply of your medically necessary medication. If you have difficulties with this process, please contact Gainwell Pharmacy Services at **1-833-491-0344** (TTY **1-833-655-2437**).

1.7 Non-Discrimination Statement

Gainwell Pharmacy Services follows State and Federal civil rights laws that protect you from discrimination or unfair treatment. We do not treat people unfairly because of a person's age, race, color, national origin, religion, gender, gender identity, sexual orientation, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, military status, veteran status, ancestry, the need for health services to receive any of the covered services or geographic location.

Gainwell has no moral or religious objections to services that we provide for Ohio Department of Medicaid members.

Other plan details

If you are in need of any of the additional services below, please contact Member Services toll free at **1-833-491-0344** (TTY **1-833-655-2437**) to speak to a team member at no additional charge:

- Oral interpretation
- Translation services
- Auxiliary aids and services
- Written information in other languages, including, but not limited to, Spanish, Somali, and Arabic
- Written information in alternative formats including, but not limited to, braille and large print

1.8 Provider Network Statement

Gainwell works with pharmacies to fill prescriptions close to your home for easy access to any of your medication needs. Many of the pharmacies offer services including prescription home delivery, medication management and assistance if you have limited English, hearing or sight difficulties, or a disability needing extra support. Specialty pharmacies also are available to provide medications with specific handling, storage, and distribution requirements to treat high risk, complex, or rare disease(s). If there are any changes to these pharmacies, we will be sure to let you know via the website, Gainwell Member Portal, or mailings as determined by your preferred communication request.

Gainwell does not cover prescription fills at pharmacies that are not signed up (Out of Network) to dispense medications for Ohio Medicaid members, which includes, but is not limited to, pharmacies that are far away from your home, except for emergency situations (if out of the State in an emergency or if an Ohio pharmacy cannot supply the medication).

1.9 Pharmacy Provider Network

You can obtain information on how to locate a pharmacy covered in your network by accessing the Pharmacy Provider Directory online at <https://spbm.medicaid.ohio.gov> or through logging in to your Gainwell Member Portal at <https://spbm.medicaid.ohio.gov>. You can request a paper copy of the Pharmacy Provider Directory by calling Member Services toll free at **1-833-491-0344** (TTY **1-833-655-2437**).



We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-895-2017**, TTY **711**. You can also visit our website at myuhc.com/CommunityPlan.

UnitedHealthcare Community Plan
5600 Parkwood Place
Dublin, OH 43016

myuhc.com/CommunityPlan

1-800-895-2017, TTY **711**

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Questions? Visit myuhc.com/CommunityPlan, 111
or call Member Services at **1-800-895-2017**, TTY **711**.

[Table of contents](#)

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