Welcome to the

community.

Combined Evidence of Coverage and Disclosure Form

California

Medi-Cal

UnitedHealthcare®
Community Plan

CSCA15MC3716137_000 CST14998

UnitedHealthcare®
Community Plan

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

UnitedHealthcare Community Plan:

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

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

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

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

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

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

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

Phone: Toll-free 1-800-868-1019, 1-800-537-7697 (TDD).

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number on your health plan member ID card, TTY 711, Monday through Friday, 7:00 a.m. to 7:00 p.m.

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-866-270-5785, TTY: 711**.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-270-5785, TTY 711**.

Vietnamese
LƯU Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **1-866-270-5785, TTY 711**.

Tagalog
ATENSYON: Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-866-270-5785, TTY 711**.

Korean
참고: 한국어를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다.
1-866-270-5785, TTY 711 로 전화하십시오.

Traditional Chinese
注意：如果您說中文，您可獲得免費語言協助服務。請致電 **1-866-270-5785**，或聽障專線 **TTY 711**。

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե հայերեն եք խոսում, Ձեզ տրամադրվում են անվճար թարգմանչական ծառայություններ: Զանգահարեք **1-866-270-5785** հեռախոսահամարով, **TTY. 711**.

Russian
ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел. **1-866-270-5785, TTY 711**.

Farsi
توجه: اگر به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان در اختیارتان قرار می گیرد. با **1-866-270-5785** (**TTY 711**) تماس بگیرید.

Japanese
ご注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。電話番号 **1-866-270-5785**、または**TTY 711**（聴覚障害者・難聴者の方用）までご連絡ください。

Mon-Khmer
បំរុងប្រយ័ត្ន៖ ប្រសិនបើលោកអ្នកនិយាយភាសាខ្មែរ លោកអ្នកអាចរកបានសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃបាន។ សូមទូរស័ព្ទមកលេខ **1-866-270-5785**, **TTY៖ 711**។

Hmong
CEEB TOOM: Yog koj hais Lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau **1-866-270-5785, TTY 711**.

Punjabi
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ।
1-866-270-5785, TTY: 711 ਤੇ ਕਾਲ ਕਰੋ।

Arabic
تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم **1-866-270-5785**، الهاتف النصي **711**.

Hindi

ध्यान दें: यदि आप हिन्दी भाषा बोलते हैं तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **1-866-270-5785, TTY 711.**

Thai

โปรดทราบ : หากท่านพูดภาษาไทย จะมีบริการให้ความช่วยเหลือด้านภาษาแก่ท่านฟรีโดยไม่มีค่าใช้จ่าย

โทร 1-866-270-5785, TTY: 711

Welcome.

Welcome to UnitedHealthcare Community Plan.

Please take a few minutes to review this Member Handbook. We're ready to answer any questions you may have. You can find answers to most questions at **myuhc.com/CommunityPlan**. Or you can call Member Services at **1-866-270-5785, TTY 711**, 7:00 a.m. to 7:00 p.m. Monday through Friday.

Summary of Plan.

This combined evidence of coverage and disclosure form constitutes only a summary of the UnitedHealthcare Community Plan of California, Inc. You should review the contract UnitedHealthcare Community Plan of California, Inc. has with the California Department of Health Care Services to determine the exact terms and conditions of coverage.

If you would like a copy of the UnitedHealthcare Community Plan of California, Inc. contract, please call our Member Services department at **1-866-270-5785, TTY 711**.

Website **myuhc.com/CommunityPlan**

Address UnitedHealthcare Community Plan of California, Inc.
4365 Executive Drive, Suite 500, San Diego, CA 92121
8880 Call Center Drive, Suite, 300, Sacramento, CA 95826

Important Telephone Numbers

24/7 NurseLine℠ **1-866-270-5785**

(available 24 hours a day, 7 days a week)

TTY 711

Americans with Disabilities Act (ADA) Information **1-800-514-0301**

TDD 1-800-514-0383

California Children's Services (CCS) **1-800-288-4584**

Child Health and Disability Prevention (CHDP) **1-800-993-2437**

Department of Health Care Services (DHCS) **1-916-445-4171**

DHCS Ombudsman Office **1-888-452-8609**

Department of Managed Health Care (DMHC) **1-888-466-2219**

TDD 1-877-688-9891

Department of Social Services **1-800-952-5253**

TTY 1-800-952-8349

Health Care Options:

English 1-800-430-4263

Spanish 1-800-430-3003

Member Services

7:00 a.m. to 7:00 p.m. (Pacific Standard Time) Monday through Friday. 1-866-270-5785
TTY (Hard-of-hearing)

Sacramento County Department of Human Assistance **1-888-747-1222**

Sacramento County Mental Health Crisis Line: **1-916-732-3637**

Sacramento County Adult Access (Mental health resources) **1-916-875-1055**

San Diego County Department of Health and Human Services **1-866-262-9881**

San Diego County Mental Health Plan 24-hour Access and Crisis Line **1-888-724-7240**

U.S. Behavioral Health Care Services, California **1-866-270-5785**

Your Health Providers

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Emergency Room: _____ Phone: _____

Pharmacy: _____ Phone: _____

If you have questions about your health plan, please call us. Our toll-free Member Services number is 1-866-270-5785 (**TTY 711**, for the hard-of-hearing).

Getting started.

Welcome to the Community.

We are happy to have you as a new member of UnitedHealthcare Community Plan of California, Inc. Our first priority is your health. This handbook explains how to get the most out of your new health plan. To help, do this new member checklist. This will get you and your family on the path to good health.

1

Review Member ID Card.
A few days ago you got a UnitedHealthcare Community Plan of California, Inc. ID card (Plan ID card). If you don't have your Plan ID card, you can print one at **myuhc.com/CommunityPlan**. The card has the UnitedHealthcare Community Plan of California, Inc. logo on it. This is your member Plan ID card. You should have received a separate Plan ID card for each member of your family in our plan.

Take your Plan ID card with you when you go to the doctor or get a prescription. This card is only for the person whose name is on the card. Never give your card to anyone else to use, not even your family. For more information, see the **Member ID Cards** section of this handbook.

2

Confirm or Choose Primary Care Provider (PCP).
Your Plan ID card may have the name of a doctor on it. If you have seen this doctor and want to keep seeing this doctor, you don't need to do anything. This will be your main doctor for all of your health needs. Use this card for all of your Medi-Cal benefits. If you also have Medicare, you will need to use your Medicare ID Card for your benefits covered under Medicare.

If the doctor's name on your card is not one you have seen, call Member Services. If your card says "**Please call to select a PCP**," call our Member Services department toll-free at **1-866-270-5785, TTY 711**. We will help you pick a doctor in your area. If you already have a doctor, tell them your doctor's name. If the doctor is in our network, you can keep seeing them.

3

Complete Health Risk Assessment.
You will soon get a welcome call from us. We will discuss all of your benefits. We will make sure you have a PCP. We will help you take a survey about your health. This helps us understand your health needs so that we can serve you better. If you prefer, you can call our Member Services department toll-free at **1-866-270-5785, TTY 711**, at a time that works best for you.

4

Schedule first appointment with your doctor.
It is good to have regular wellness visits. Make an appointment now to see your doctor. Schedule your exam with your provider. It is important to get your exam within 120 days of becoming a member. During your first visit, your PCP will complete an initial Health Assessment. This assessment assists the doctor in identifying your current health care and preventive health needs.

5

Read Member Handbook.
After you pick your doctor and set up your first visit, read this handbook. It tells about your health plan and programs to keep you healthy. It also tells about your rights and responsibilities.

Contents

Welcome to UnitedHealthcare Community Plan of California, Inc.

Welcome.
Welcome to the community. UnitedHealthcare Community Plan of California, Inc. is a health plan that participates in Medi-Cal. We give health coverage in partnership with the California Department of HealthCare Services (DHCS). With UnitedHealthcare Community Plan of California, Inc., you get all of your regular benefits plus more services at no cost to you.

This handbook provides information related to your coverage through the health plan, which also includes your rights, responsibilities and benefits as a Member of UnitedHealthcare Community Plan of California, Inc. Please read this handbook and keep for future reference.

Welcome call.
You will get a welcome call from one of our team members. We will tell you about your benefits. We will connect you with a doctor. We will help you take a survey about your health. This helps us know your health needs to serve you better.

You may have a question before you get our call. Our Member Services can help you. We can answer your questions and help you get care. You can call Member Services toll-free at **1-866-270-5785 (TTY 711 for the hard-of-hearing)**.

Our Member Services hours are from 7:00 a.m. – 7:00 p.m. (Pacific Standard Time) Monday to Friday, except for state holidays. If you call after-hours, your call will be answered by voicemail. A representative will call you back in one business day.

Enrolling in UnitedHealthcare Community Plan of California, Inc.
If you are eligible for Medi-Cal benefits and want to enroll with UnitedHealthcare Community Plan of California, Inc., you can fill out an enrollment form. You can get this form from Health Care Options. Health Care Options is a branch of the California Department of Health Care Services, and helps Medi-Cal members enroll into a Medi-Cal Managed Care Health Plan. Medi-Cal members can choose from a list of health plans, including UnitedHealthcare Community Plan of California, Inc. The enrollment process can take up to 45 days before you become a health plan member.

Member ID Cards

You should receive a UnitedHealthcare Community Plan of California, Inc. ID card (Plan ID card) for every member of your family covered by Medi-Cal and enrolled with us.

Review the information on each Plan ID card to make sure it is all correct. If you did not receive your Plan ID card, if information on your Plan ID card is wrong, if you lose your Plan ID card, or if you have questions, call our Member Services department toll-free at **1-866-270-5785, TTY 711**. You can also view and print your Plan ID card online at **myuhc.com/CommunityPlan**.

Take your Plan ID card with you when you go to the doctor, hospital, or pharmacy, and when you need Emergency Care or Urgent Care. **If you do not have your Plan ID card with you, you can still get services. Your doctor, hospital, pharmacy, or other care provider can call us so you can get care.**

Your Medi-Cal Benefits Identification Card (BIC card).
When you became a Medi-Cal member, the State of California sent you another ID card. This card is called a Medi-Cal Benefits Identification Card, or "BIC card." Do not throw your BIC card away. You still need your BIC card. You receive Medi-Cal services from us and from other sources, such as other state government agencies. These services are discussed in the Additional Benefits and Services Available to You section of this handbook. You need to show your BIC card when you want to get the benefits and services available to you that we do not cover. If you've lost or thrown away your BIC card, contact the San Diego County Department of Health and Human Services or the Sacramento County Department of Human Assistance at the number listed in the Important Telephone Numbers section of this handbook. If you have questions, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Never give your Plan ID card or your BIC card to anyone else. Never let anyone else use your Plan ID card or your BIC card. If you do, this can be fraud. You can lose your Medi-Cal benefits if you allow someone else to use your ID cards to get care. If you lose your Medi-Cal benefits, we cannot give you care.

Helping You Along the Way

You can call our Member Services department at any time, any day for help toll-free at **1-866-270-5785 (TTY 711, for the hard-of-hearing)**. Our Member Services hours are from 7:00 a.m. – 7:00 p.m. (Pacific Standard Time) Monday to Friday, except for state holidays. If you call after-hours, your call will be answered by voicemail. A representative will call you back in one business day.

Member Services will help you with anything related to your plan. For example, they can:

- Explain your plan, options, and choices.
- Answer questions about how to get care.
- Help you with any problems you have with your health care.
- Help arrange a ride to and from your doctor's office or hospital.
- Help you with find a Primary Care Provider (PCP) or change your PCP if you need a new PCP for any reason.
- Help you file a grievance or ask for a State Hearing.

If you have an emergency, call 911 for help, or go to the nearest emergency room so that you can be seen.

Language help.
We can get your materials in a language or format that is easier for you. We have interpreters if your doctor does not speak your language. This is free when you speak to us, your doctors, your pharmacist, or other health care providers.

If you do not speak English, call our Member Services department toll-free at **1-866-270-5785, TTY 711**. They will connect you with an interpreter.

If you have trouble hearing, the Telecommunications Relay Service (TRS) can help. This lets people with hearing or speech issues make phone calls. The service is free. Call 711 and give them our Member Services department toll free telephone number, which is **1-866-270-5785, TTY 711**. They will connect you to us.

If you need information in another language, call our Member Services department toll-free at **1-866-270-5785, TTY 711**. You can also get information in large print, Braille, or audio tapes. For help to translate or understand this, call **1-866-270-5785, TTY 711**.

Other Charges

No premiums, prepayment fees, or periodic payments. As a member of the UnitedHealthcare Community Plan of California, Inc., you will not be required to pay any premiums, prepayment fees, or periodic payments.

No copayments, coinsurance, or deductibles for covered services. As a member of UnitedHealthcare Community Plan of California, Inc., you will not be required to pay any copayments, coinsurance, or deductibles for covered services under the UnitedHealthcare Community Plan.

Out-of-Network charge. If you get care without our authorization from doctors who are not in our network, you may have to pay the bill. If we do not pay for the services provided for an Out-of-Network provider, you may be liable to that provider for the cost of services. Please carefully review the In-Network and Out-of-Network Providers section of this handbook.

No liability for sums owed by UnitedHealthcare Community Plan of California, Inc. By statute, every contract between UnitedHealthcare Community Plan of California, Inc. and a provider shall provide that in the event UnitedHealthcare Community Plan of California, Inc. fails to pay the provider, you shall not be liable to the provider for any sums owed by UnitedHealthcare Community Plan of California, Inc.

If you would like to know how we pay your provider for services, please contact our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Access Your Information Online

Manage your health care information 24/7 on myuhc.com.
As a member of UnitedHealthcare Community Plan of California, Inc., you're just a click away from everything you need to take charge of your health benefits. Register on myuhc.com. The tools and new features can save you time and help you stay healthy. Registration on the site is free.

Great reasons to use myuhc.com:

- Look up your benefits.
- Find a doctor.
- Print a Plan ID card.
- Find a hospital.
- View your claims history.
- Keep track of your medical history, prescriptions and more on your personal health record.
- Take your own health assessment.
- Learn how to stay healthy.
- Chat with a nurse in real-time.

Get more from your health care. Register on myuhc.com today! Registration is easy and fast. Just visit **myuhc.com/CommunityPlan**, select "Register" on the home page, and follow the simple prompts. You're just a few clicks away from access to all types of information.

Getting Care (Choice of Physicians and Providers; Facilities)

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW WHAT PROVIDERS OR GROUP OF PROVIDERS CAN GIVE YOU HEALTH CARE.

In-Network and Out-of-Network Providers

We have agreements with doctors, specialists, hospitals, pharmacies, and other providers to provide health care to our Members. These are called "In-Network" providers. You can get a copy of our network by calling our Member Services department toll-free at **1-866-270-5785, TTY 711**, and asking for a copy of our Provider Directory. You can also find our In-Network providers on our website at **myuhc.com/CommunityPlan**.

You can find out if a provider is accepting new patients through the copy of the Provider Directory or on our website.

You can find the following in our Provider Directory:

- Provider names.
- Provider number.
- Telephone numbers.
- Addresses.
- Languages spoken.
- Availability of service locations.
- Accessibility of provider office locations, including parking, restrooms, exam rooms, etc.

An Out-of-Network provider is a provider who does not have an agreement with us to provide care to our Members. You may have to pay the bill if you get care without our authorization from doctors who are not in our network.

In most cases, you must get care from an In-Network provider. There are situations where you can see an Out-of-Network provider, and these are discussed more throughout this handbook. For example, you do not need to see an In-Network provider for Emergency Care, or for Urgent Care outside of our Service Area. See the Emergency Care and Urgent Care Services section of this handbook for more information. If you have any questions about In-Network and Out-of-Network providers, you can also call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Note: Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract that you or your family member might need: family planning contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion.

You should get more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call our Member Services department at **1-866-270-5785 (TTY for the hearing impaired, call 711)** to ensure that you can obtain the health care services that you need.

Your Primary Care Provider (PCP)

When you enroll, you will be assigned a Primary Care Provider (PCP) who is close to your home. If you have a PCP already and he or she is in our network, you will be assigned to that PCP. Each covered family member may pick his or her own PCP. Your family does not have to pick the same PCP.

If you are pregnant, you may choose your Obstetrician as your Primary Care Provider (PCP).

Your Primary Care Provider (PCP) is your personal care doctor. A PCP can be a family or general practitioner, internist, pediatrician, or other type of provider. If you are female, you may choose an OB/GYN as your PCP. Your PCP is shown on your Plan ID card.

Your PCP will give or manage most of your health care. There are no limits on the number of times you may see your PCP. Talk to your PCP about any health problems you have. During your first visit, your PCP will complete an Initial Health Assessment. This assessment assists the doctor in identifying your current health care and preventive health needs. Let your PCP know about your medical history. Tell your PCP about any Specialists that you are seeing. Follow all your PCP's instructions.

Part of good health is seeing your PCP for checkups, even if you don't feel sick. UnitedHealthcare Community Plan of California, Inc. will send you a reminder so you know when to go for a checkup.

When you don't feel well, your PCP will help you. Be sure to call your PCP right away.

Your PCP may refer you to a Specialist. Your PCP will help you get prior approval before getting services that require this.

If your PCP does not speak your language, call our Member Services department toll-free at **1-866-270-5785, TTY 711**, for an interpreter or to find a PCP who speaks your language. UnitedHealthcare Community Plan of California, Inc. will get you an interpreter at no cost to you.

Choosing a Certified Nurse Practitioner or Certified Nurse Midwife as your PCP.
Members may choose a Certified Nurse Practitioner or Certified Nurse Midwife (CNM) as a Primary Care Provider. Members may see a CNM who accepts Medi-Cal patients out of network. To learn more, or for help finding a CNM or Certified Nurse Practitioner, call Member Services at **1-866-270-5785, TTY 711.**

Choosing a Federally Qualified Health Center (FQHC) as your PCP.
As a member of UnitedHealthcare Community Plan of California, Inc., you have the right to receive your primary care at a Federally Qualified Health Center (FQHC). An FQHC is a health center that receives money from the federal government. Call our Member Services department toll-free at

1-866-270-5785, TTY 711, for the names and addresses of the Federally Qualified Health Centers that our in our network (In-Network providers).

Changing your PCP.
You can change your PCP doctor at any time. If you want to change your PCP, call our Member Services department toll-free at **1-866-270-5785, TTY 711**. We will be glad to help you find a new PCP. You may pick a new PCP from our online Provider Directory. Or you can ask Member Services to mail you a printed copy of the Provider Directory at no cost. When picking a PCP, you may want to consider their specialty, language, location, and gender. Most changes to your PCP will take place the first day of the next month.

Making an appointment with your PCP.
When you need to make an appointment, call your PCP. Your PCP's phone number is printed on your Plan ID card. To make the process go faster, tell the office:

- Your PCP's name.
- Your name.
- Your ID number (on your Plan ID Card).
- The name of the person who needs to see the doctor.
- Why you need to see the doctor.

You can expect to receive an appointment with your PCP within the following time frames:

- Urgent care appointment — within 48 hours of the request when no prior authorization is required, and within 96 hours if prior authorization is required.
- Routine/non-urgent appointment — within 10 business days of the request.
- Well-child visit — within 10 business days of the request.
- Physician exams and wellness checks — within 10 business days of the request.

Once you have made the appointment:

- Be on time.
- If you cannot keep the appointment, call the doctor right away.

If you need help with an appointment, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

If you need care and your PCP's office is closed. If you are having an emergency, call 911. See the Emergency Care and Urgent Care Services section of this handbook for more information. If you need care that is not an emergency and your PCP's office is closed, call your PCP's office anyway. Your doctor's phone is answered 24 hours a day, 7 days a week. Either the person answering will be able to help you, or a message will be sent to your doctor or the doctor on call and someone will call you back and talk to you about what to do. You may be told to:

- Go to an after-hours clinic or urgent care center.
- Go to your PCP's office in the morning.
- Go to the Emergency Room (ER).
- Get medicine from your pharmacy.

Timely Access to Care

As a UnitedHealthcare Community Plan member, we want you to get the right care at the right time. The table below shows the type of care available to you, when to use that type of care, and when you can expect to be seen.

Type of Care	When to use	When you can expect to be seen
NurseLine℠	Call our registered nurses when you have health questions or concerns. They can help you decide if you should treat at home, see your PCP, or get urgent or emergency care.	Phone line available 24 hours per day, 7 days per week
Emergency Care	For treatment of a medical or psychiatric (mental) condition with such severe symptoms, such as active labor or severe pain, that someone with the prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could: • Place your health or the health of your unborn baby in serious danger • Cause impairment to a body function • Cause a body part or organ to not work right	24 hours per day, 7 days per week
Urgent Care	For symptoms needing immediate attention, but are not life threatening	Within 48 hours of request
Urgent Care	Services that require a prior a prior authorization	Within 96 hours of request
First Prenatal Visit	First prenatal visit for pregnant members	Within 2 weeks of request
Non-urgent Primary Care (Routine Care)	For symptoms that do not require immediate attention	Within 10 business days of request
Specialist	For treatment from a network provider who specializes in a certain area of medicine	Within 15 business days of request
Non-urgent Ancillary Services	For diagnosis or treatment of injury, illness, or other health conditions	Within 15 business days of request

Our Service Area

As a Member of UnitedHealthcare Community Plan of California, Inc., your Service Area is the county of Sacramento or San Diego. In most cases, you will need to receive your care in your Service Area and from an In-Network provider. You must receive all routine and regular health care services in the Service Area. Routine and regular health care services received outside of the Service Area are not covered. You need prior authorization for any care out of the Service Area of Sacramento or San Diego County, unless you reasonably believe you are experiencing a medical emergency or require urgent services. You can receive Emergency Care or Urgent Care anywhere in the United States. No services are covered outside of the United States, except for Emergency Care services requiring you to be hospitalized in Mexico or Canada. See the Emergency Care and Urgent Care Services section of this handbook for more information.

If you get care from a provider who is not contracted with us (an Out-of-Network provider) or outside of your Service Area, the provider may send you a bill for the care and you may have to pay the bill. This is not true for Emergency Care, Urgent Care, Family Planning Services, Minor Consent Services, for sexually transmitted disease (STD) and HIV testing services and for pregnancy termination.

NurseLine^{SM} — Your 24-Hour Health Information Resource

Not sure what kind of care you need?
Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, 7 days a week. Here are some of the ways they can help you: They can answer questions about a health concern, and instruct you on self-care at home if appropriate. They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Care or Urgent Care, and how and where to get that care). They can tell you what to do if you need care and a Plan Medical Office is closed.

You can reach one of these licensed health care professionals by calling this toll-free number **1-866-270-5785 or TTY 711**. When you call, a trained support person may ask you questions to help determine how to direct your call.

What are NurseLine services?
NurseLine offers a variety of health information and resources. Registered nurses give information and support for any health question or concern.

How does it work?
Call the toll-free number **1-866-270-5785 or TTY 711 for the hearing impaired**. Nurses are ready to discuss your health concerns and answer your questions.

When can I call?
You can call the toll-free NurseLine anytime, 24 hours a day, 7 days a week. There is no limit to the number of times you can call.

How can NurseLine help me?
If you're sick or injured, it can be hard to make health care decisions. You may not know if you should go to the emergency room, visit an urgent care center, see your doctor or use self-care. A NurseLine nurse can help you decide. You may just want to learn more about a health issue. With NurseLine, answers are just a phone call away.

What kinds of issues can NurseLine address?
The nurses can address many health issues. These include:

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

If you have an emergency, call 911 for help, or go to the nearest emergency room so that you can be seen.

Seeing a Specialist

If you need care your PCP cannot give you, your PCP may send you to see a Specialist. A Specialist is a doctor or other health care professional who is board certified, accredited or otherwise recognized by a board of physicians or similar peer group, as having special expertise in a certain clinical area of practice to treat a special health problem. Your PCP will help you find the right Specialist. In some cases, you need a referral from your PCP to see a Specialist.

Your Specialist will need to be in our network (an In-Network Specialist) if this is possible. We will arrange for you to receive Specialist services from a Specialist outside of network when an In-Network Specialist is not available and when determined to be Medically Necessary.

If you have complex care needs, a Specialist can be your PCP. If you need this, call Member Services at **1-866-270-5785, TTY 711**. We will help you find a Specialist who can meet your needs.

If you have any questions or need information about any provider or facility locations, what services they provide or hours of operation, please contact Member Services toll-free at **1-866-270-5785, TTY 711**.

Standing Referrals to a Specialist.
If you have a condition or disease that requires you to see a Specialist many times, your PCP can give you a standing referral. A "standing referral" means a referral by your PCP to a Specialist for more than

one visit to the Specialist, without the PCP having to provide a specific referral for each visit. Your PCP can also give you a standing referral if your condition or disease is life threatening, worsening, or disabling and you need care from a Specialist or specialty care center because they have the expertise needed to treat your condition or disease. Standing referrals for the treatment of HIV/AIDS will be to an HIV/AIDS specialist.

To get a standing referral, call your PCP. Your PCP will work with our Medical Director and Specialists to ensure you receive a treatment plan based on your medical needs. If you have any problems getting a standing referral, call our Member Services department toll-free at **1-866-270-5785 (TTY for the hearing impaired at 711)**. If, after calling us, you feel your needs have not been met, you can file a grievance (a complaint) with us. See the Grievances, Appeals and State Hearings section of this handbook for information on how to file a grievance.

Women's Health Specialists.
Female members who need OB/GYN care do not need a referral from their PCP to see an In-Network OB/GYN. Female members can also choose an OB/GYN as their PCP. Female Members may get Family Planning Services from any health care provider licensed to provide these services. The provider does not need to be in our network (an In-Network provider). If you have questions, call our Member Services department toll-free at **1-866-270-5785 (TTY for the hearing impaired at 711)**.

Second Opinions

You have the right to ask for and get a second opinion from a qualified health care professional for free. This right includes second opinions from Specialists. The following are some reasons why you may get a second opinion:

- You do not agree with your PCP doctor or Specialist's treatment plan.
- Your PCP doctor or Specialist has not answered your concerns about your condition or treatment plan.
- You have followed the treatment plan for some time and your health has not improved.
- You do not agree with your doctor's diagnosis of a life-threatening or chronic condition.

Call your PCP if you want a second opinion. You can also call Member Services at **1-866-270-5785 (TTY for the hearing impaired, 711).** A second opinion must come from a qualified health care professional in our network (an In-Network provider), unless there is no qualified health care professional in our network who can provide the second opinion. If there is no qualified health care professional in our network, we will approve a second opinion from a doctor outside of our network.

If you have any problems with getting your second opinion, call our Member Services department toll-free at **1-866-270-5785 (TTY for the hearing impaired at 711)**. If, after calling us, you feel your needs have not been met, you can file a grievance (a complaint) with us. See the *Grievances, Appeals and State Hearings* section of this handbook for information on how to file a grievance.

Accessing Emergency Care and Urgent Care Services

Emergency Care Services

Emergency Care is covered twenty-four (24) hours a day, seven (7) days a week, anywhere in the United States. No services are covered outside of the United States, except for Emergency Care services requiring hospitalization in Mexico or Canada.

For emergency care, call 911 or go to the nearest emergency room (ER). You do not need pre-approval (prior authorization). Emergency care is for emergency medical conditions. It is for a medical or psychiatric (mental) condition with such severe symptoms, such as active labor or severe pain, that someone with the prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger.
- Cause impairment to a body function.
- Cause a body part or organ to not work right.

Examples include:

- Active labor.
- Broken bone.
- Severe pain, especially in the chest.
- Severe burn.
- Drug overdose.
- Fainting.
- Severe bleeding.
- Psychiatric emergency condition.

Emergency Care services include, but are not limited to, ambulance services, screening, examination and evaluation services to determine whether an Emergency Medical Condition exists, and the care, treatment or surgery needed to relieve or eliminate the Emergency Medical Condition.

Examples of conditions that are not an emergency include, but are not limited to, colds, flu, sore throats, and earaches.

Do not call 911 for non-emergency problems. Call your PCP doctor.

Do not use the hospital emergency room for care that isn't an emergency.

Do not use the ambulance if you are not having a real emergency. If you use an ambulance when you do not have a real emergency condition, we may refuse to pay for it.

If you are not sure if you are having an emergency, call your PCP. If your PCP's office is closed, someone will answer the call. Or call our NurseLine toll-free at **1-866-270-5785, TTY 711**. You can call

our NurseLine twenty-four (24) hours a day, seven (7) days a week. Registered nurses can give you information and support for your health questions and concerns.

Call our Member Services department toll-free at **1-866-270-5785, TTY 711**, within twenty-four (24) hours after receiving emergency care, or as soon as you can. You can ask the emergency staff to call us for you.

Emergency care outside of our Service Area.
If you have an emergency and you are outside of our Service Area (the county of Sacramento or San Diego), go to the nearest emergency room for care. Call our Member Services department toll-free at **1-866-270-5785, TTY 711**, within twenty-four (24) hours after receiving emergency care, or as soon as you can. You can ask the emergency staff to call us for you. When you receive Emergency Care services outside of our Service Area, only emergency services are covered. No services are covered outside of the United States, except for Emergency Care services requiring hospitalization in Canada and Mexico.

If you are admitted to a hospital that is not contracted with us (an Out-of-Network hospital), we have the right to move you as soon as it is medically safe to do so. Your PCP doctor must provide your follow-up care after you leave the hospital.

Emergencies outside of the United States.
If you have an emergency and you are outside of the United States, emergency services are covered by us in Mexico or Canada.

Urgent Care Services

Urgent Care services are services that are needed to prevent serious decline of health following an unforeseen medical condition or injury. Urgent Care services are for illness, injury, or condition that is not life threatening, but needs medical care right away.

Urgent Care services are available to you both inside and outside of our Service Area (the county of Sacramento or San Diego). However, if you are out of the United States, no services are covered except for Emergency Care services in Mexico or Canada.

If you are not sure if you are having an emergency or if Urgent Care will work for you, call your PCP. If your PCP's office is closed, someone will answer the call. You should be able to get an Urgent Care appointment within forty-eight (48) hours. You can also call our NurseLine toll-free at **1-866-270-5785, TTY 711**. You can call our NurseLine twenty-four (24) hours a day, seven (7) days a week. Registered nurses can give you information and support for your health questions and concerns.

If you or your child become sick after-hours, wait until your PCP doctor's office is open to make an appointment if you can. You can also call our NurseLine toll-free at **1-866-270-5785, TTY 711**. You can call our NurseLine twenty-four (24) hours a day, seven (7) days a week. Registered nurses can give you information and support for your health questions and concerns.

Pregnancy Care

If you are pregnant or become pregnant, please call your PCP doctor or OB/GYN if you are not receiving care related to your pregnancy. You may also call our Member Services department toll-free at 1-866-270-5785, TTY 711, to ask for assistance in finding an OB/GYN that is in the UnitedHealthcare Community Plan of California, Inc. provider network.

Care Management Programs

Do you or a family member have asthma or diabetes? Are you a pregnant woman with high risks? Do you need extra help using services or benefits? If yes, we have care programs to work with you.

UnitedHealthcare Community Plan of California, Inc.'s Care Management Programs are a holistic approach to helping our Members live healthier lives. We work with you and your PCP to keep you healthy and promote your involvement in your health care.

Our Care Managers give support and help educate you. They help you manage services. We work with you and your PCP to get care with the right provider, at the right time, at the right place. The main Care Management Programs include:

- Respiratory care with a focus on asthma or chronic obstructive pulmonary disease (COPD).
- Cardiac care with a focus on congestive heart failure, heart disease or hypertension.
- Diabetes care.
- Transplant care.
- HIV/AIDS care.
- High-risk pregnancy care.

To find out more about these programs, call toll-free **1-866-270-5785, TTY 711**.

Continuity of Care

If your doctor leaves our network.
At times, we may stop working with a provider (including doctors, Specialists and hospitals). If this happens, we will let you know as soon as we can. You can ask to keep seeing your provider if that provider agrees and has been treating you for any of the conditions listed below, for continuity of care.

If you are new to our health plan.
If you have just joined UnitedHealthcare Community Plan of California, Inc., and your existing provider (including doctors, Specialists and hospitals) is not associated with us, you may ask us to keep seeing your provider if you are in the middle of treatment or have scheduled treatments or procedures for any of the conditions listed below, for continuity of care.

Conditions:
The continuity of care benefit applies to the following conditions:

- Acute condition. An acute condition is a medical condition that is sudden and serious, needs prompt medical attention, and lasts for a short period of time, for example, pneumonia. You can keep seeing your provider for as long as the acute condition lasts.
- Serious chronic condition. A serious chronic condition is a medical condition that lasts a long time and requires ongoing treatment to keep you in remission or prevent you from getting worse, for example, severe diabetes or heart disease. You can keep seeing your provider for the period of time necessary to complete your course of treatment and arrange for a safe transfer to another provider, but for no longer than 12 months.
- Pregnancy. You can keep seeing your provider while you are pregnant and for the immediate postpartum period (six weeks after giving birth).
- Terminal illness. A terminal illness is an incurable condition that has a high probability of causing death within one year or less. You can keep seeing your provider for the duration of the illness.
- Care of a newborn child between the ages of birth and 36 months. The child can continue to see the provider for up to 12 months.
- You have surgery or other procedure authorized by us as part of a documented course of treatment that has been recommended and documented by the provider, for example, knee surgery or colonoscopy. The surgery or other procedure must be scheduled to happen within 180 days of the time the doctor stops working with us or within 180 days of the time you began coverage with us.

Your provider may not want to agree to continue to provide you services. If that happens, we will assign you to a new provider or send you to a new hospital for care.

If you want to ask us to stay with your provider or if you have any questions about continuity of care, call our Member Services department toll-free at **1-866-270-5785, TTY 711**. You can also ask us for a copy of our continuity of care policy.

What Is Covered? What Health Care Can I Get From UnitedHealthcare Community Plan of California, Inc.?

The medical services UnitedHealthcare Community Plan of California, Inc. covers are explained in this section. For more information and for questions about anything in this section, please call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Medical Necessity/Medically Necessary

For a medical service to be covered by UnitedHealthcare Community Plan of California, Inc., the medical service must be a Medi-Cal covered benefit and it must be Medically Necessary. A Medi-Cal

covered benefit is a medical service that is covered by Medi-Cal and us. A Medically Necessary medical service is a covered service that is reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

We review, change, approve and deny all covered health care services according to Medical Necessity.

Note: Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract that you or your family member may need. These could include: Family Planning Services, birth control (contraceptive) drugs and items including emergency contraception, sterilization (including tubal ligation at the time of labor and delivery), infertility treatments, or abortion. You should get more information before you enroll. Call the doctor, medical group, clinic, or independent practice association you are thinking about choosing, or call our Member Services department toll-free at **1-866-270-5785, TTY 711**, to make sure that you can get the health care services that you need.

Prior Authorization

All services require approved Prior Authorization unless the benefit indicates that Prior Authorization is not required.

"Prior Authorization" means that your doctor submits to us a request for services before the care is given to you. We review the Medical Necessity of the request with your doctor to ensure it is appropriate for your specific illness or condition.

If the service is not Medically Necessary or not a covered benefit, we may deny the Prior Authorization request. If that happens, you will get a letter telling you why the request was denied. You or your doctor can appeal this denial. The letter we send you will tell you how to appeal. You can read more about appeals in the Grievances, Appeals, and State Hearings section of this handbook.

We process routine (normal, non-urgent) Prior Authorization requests in five (5) business days once we've received all information. If your medical condition may cause an imminent and serious threat to your health, or if the routine time frame would be detrimental to your life or health or could jeopardize your ability to regain maximum function, the Prior Authorization request is processed by us within seventy-two (72) hours from when we receive it. We can process the Prior Authorization request more quickly than these time frames when needed for medical reasons. We process requests for urgent specialty services immediately by telephone.

If you do not get approval for a service that requires Prior Authorization before you receive the service, you may have to pay for the service.

You do not need a Prior Authorization for these services:

- Emergency Care services or Urgent Care services.
- PCP visits.
- Certified nurse midwife services if this provider is in our network.
- Female members who see an OB/GYN if this provider is in our PCP network.

- Family Planning services.
- Preventive Health Care services.
- Sexually transmitted disease services.
- HIV testing.
- Minor Consent services.
- Pregnancy termination.
- Basic prenatal care from a doctor that is in our network, unless you have been receiving prenatal care from another doctor when you become a member with us.

Call our Member Services department toll-free at **1-866-270-5785, TTY 711**, if you have questions about your benefits and services, how your services are approved, or what services are covered or not covered. You can also ask for a copy of the policies and procedures we use to determine if a service is Medically Necessary.

These Benefits Are Covered by Us (Medical Necessity and Prior Authorization Requirements Still Apply)

Acupuncture Services.
Limit of two services in any one calendar month. There may be additional services available under some circumstances. Check with your doctor or Member Services if you believe additional services are needed. You can call our Member Services department toll-free at **1-866-270-5785, TTY 711** for more information.

Alcohol/Drug Abuse.
We cover crisis intervention and health education services, and hospital care for acute drug overdose. We also cover Substance Use Disorder services.

Asthma Services.
We cover inhaler spacers, nebulizers (including facemask and tubing) and peak flow meters for the management and treatment of asthma. Your benefit also includes education on how to properly use inhaler spacers, nebulizers and peak flow meters for asthma.

Behavioral Health Treatment (BHT) for Autism Spectrum Disorder.
We have agreements with the Counties of San Diego and Sacramento regarding Autism Spectrum Disorder (ASD). This treatment includes applied behavior analysis and other evidence-based services. This means the services have been reviewed and have been shown to work. The services should develop or restore, as much as possible, the daily functioning of a Member with ASD.

BHT services must be medically necessary, prescribed by a licensed doctor or psychologist, approved by the plan, and provided in a way that follows the approved treatment plan.

You may qualify for BHT services if:

- You are under 21 years of age; and
- Have a diagnosis of ASD; and
- Have behaviors that interfere with home or community life. Some examples include anger, violence, self-injury, running away, or difficulty with living skills, play and/or communication skills.

You do not qualify for BHT services if you:

- Are not medically stable; and
- Need 24-hour medical or nursing services; or
- Have an intellectual disability (ICF/ID) and need procedures done in a hospital or an intermediate care facility.

Behavioral Health.
We cover mild to moderate behavioral (mental) health conditions. The County of San Diego or Sacramento covers severe behavioral (mental) health conditions. If you have questions about BHT, please call us at **1-866-270-5785, TTY 711**.

Cancer Clinical Trials.
Routine costs of cancer clinical trials may be covered if you have cancer. A cancer clinical trial is a research study that involves people who have cancer, and tries to find out if a new treatment works and is safe. To qualify for this coverage, you must:

- Be diagnosed with cancer,
- Be referred to the cancer clinical trial by a doctor who is in our network,
- Receive Prior Authorization or approval from us, and
- Be accepted into an approved clinical trial for your type of cancer. This means that the cancer clinical trial must have a meaningful potential to benefit you and must be approved by the National Institutes of Health, the United States Food and Drug Administration (FDA), the United States Department of Defense, or the United States Department of Veterans Affairs.

If you were eligible but denied coverage for a cancer clinical trial, you have the right to ask for an Independent Medical Review (IMR). See the Grievances, Appeals, and State Hearings section of this handbook for more information.

Cancer Screening.
We cover all generally medically accepted cancer-screening tests, including:

- Cervical cancer screening, including human papillomavirus (HPV) screening. HPV vaccinations for Members ages eighteen (18) through twenty-six (26) are covered. (For children younger than age eighteen (18), HPV vaccines are provided by the Vaccines for Children program.)
- Mammography for breast cancer screening.
- Prostate cancer screening and diagnosis.

Community-Based Adult Services (CBAS).
CBAS is a service you may qualify for if you have health problems that make it hard for you to take care of yourself and you need extra help. If you qualify, we will send you to a CBAS center that best meets your needs.

You receive covered CBAS services at no charge. These services may include, but are not limited to:

- Meals.
- Personal care.
- Physical therapy.
- Occupational therapy.
- Skilled nursing care.
- Social services.
- Speech therapy.

CBAS centers also offer training and support to your family and/or caregiver.

You may qualify for CBAS if:

- You used to get these services from an Adult Day Health Care (ADHC) center and you were approved to get CBAS.
- Your primary care doctor refers you for CBAS and you are approved to get CBAS by us.
- You are referred for CBAS by a hospital, skilled nursing facility or community agency and you are approved to get CBAS by us.

Chiropractic Services.
Limit of two services in any one calendar month. Services must be provided at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). There may be additional services available under some circumstances. Check with your doctor or Member Services if you believe additional services are needed. You can call our Member Services department toll-free at **1-866-270-5785 , TTY 711** for more information.

Diabetic Services.
We cover these services and supplies when Medically Necessary for the treatment of diabetes:

- Insulin, glucagon, needles and certain prescribed medications under the prescription drug benefit.
- Blood glucose monitors and blood glucose testing strips.
- Blood glucose monitors designed to assist those who are blind or otherwise visually impaired.
- Insulin pumps and all related necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin.
- Podiatric devices to prevent or treat diabetes-related foot problems.

- Insulin syringes.
- Visual aids, excluding eyewear, to assist the visually impaired with the proper dosing of insulin.

Members with diabetes who are younger than twenty-one (21) years old and have diabetes are eligible for California Children's Services (CCS). Please see the California Children's Services section of this handbook for more information.

Doctor Office Visits.
We cover the following services:

- All routine visits, exams, treatments, and shots that are provided to you by your doctor.
- Services you receive from a Specialist (Prior Approval requirements apply).
- Child Health and Disability Prevention Program (CHDP) visits to your doctor or received from school-based programs or a county (Sacramento or San Diego) program. Please see the Child Health and Disability Prevention Program section of this handbook for more information. Or you can call the CHDP at **1-800-993-2437**.

When you enroll with us, you be assigned a Primary Care Provider (PCP) who is close to your home. There are no limits on the number of times you may see your PCP. It is important to see your PCP for regular checkups to help you stay healthy.

Drugs and Medications.
We cover prescription drugs and over-the-counter drugs that are on our Formulary. In certain situations, we may cover prescription drugs and over-the-counter drugs that are not on our Formulary. Please see the Prescription Drug Coverage section of this handbook for more information.

Durable Medical Equipment (DME).
Durable medical equipment (DME) is equipment that is used over and over by a person who is injured or sick, is safe for use in or out of the home, and is generally not useful to people who do not have an illness or injury. Equipment that is used primarily for comfort is not DME.

We cover DME when Medically Necessary. DME is ordered by your doctor. We decide whether to rent or buy the DME, and where we will rent or buy it from. We also cover maintenance, delivery, and any related supplies. We will cover reasonable repairs, but if the repairs are needed because of misuse of the DME, you may be responsible for those repairs. If you lose your DME, you may be responsible for replacing it.

Here are some examples of the DME we cover. These are examples only, and not a complete list.

- Apnea monitors.
- Blood glucose monitors.
- Oxygen equipment.
- Standard curved handle cane.
- Standard crutches.
- Wheelchair.
- Hearing aids and batteries for hearing aids.

- Batteries for pacemakers.
- Colostomy bags, urinary catheters and supplies.

Here are some examples of the DME we do not cover. These are examples only, and not a complete list.

- Changes to your house or car.
- Furniture.
- Luxury items.

If your child is eligible for care with California Children's Services (CCS), your child will receive DME from CCS. We will help coordinate referral to the CCS for you. Please see the California Children's Services section of this handbook for more information.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
These services are also called well-child visits. These covered visits include health screens, diagnosis, treatment and shots for children through the month of their 21st birthday. EPSDT services include:

- Physical exams.
- Immunizations.
- Lab tests (as needed).
- Lead screenings.
- Vision screenings.
- Hearing screenings.
- Developmental or behavioral screenings.

Emergency Care Services.
We cover Emergency Care services twenty-four (24) hours a day, seven (7) days a week, anywhere in the United States. We will also cover Emergency Care if you are in Canada or Mexico. Please see the Emergency Care and Urgent Care Services section of this handbook for more information.

Enteral Nutrition Products.
For adult members age twenty-one (21) or older, we cover medically necessary enteral nutrition products that are given through a feeding tube. We do not cover products taken by mouth for inborn errors of metabolism and intestinal malabsorption diagnoses.

For members who are under twenty-one (21) years of age, we cover specific formulas or enteral nutrition products when medically necessary even if they are not given through a feeding tube.

Family Planning Services.
Family Planning Services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the United States Food and Drug Administration (FDA). As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians (PCPs) and OB/GYN specialists are available for Family Planning Services. For Family Planning Services, you may also pick a doctor or clinic not connected with UnitedHealthcare Community Plan of California, Inc. UnitedHealthcare Community Plan of California, Inc. will pay that doctor or clinic for the Family Planning

Services you get. DHCS' Office of Family Planning toll-free telephone number (1-800-942-1054) provides consultation and referral to family planning clinics.

You do not need Prior Authorization to receive Family Planning Services, even if the provider you chose is not in our network.

Family Planning Services include:

- Health education and counseling you need to help you make informed choices and to understand contraceptive methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated as part of your decision-making process for deciding what contraceptive methods you might want to use.
- Contraceptive pills, devices, and supplies.
- Follow-up care for complications associated with the contraceptive methods provided or prescribed by the family health-planning provider.
- Pregnancy testing and counseling, including counseling and surgical procedures for pregnancy termination (abortion).
- Tubal ligation (for females).
- Vasectomies (for males).
- Diagnosis and treatment of a sexually transmitted disease if medically indicated.
- Screening, testing and counseling of at-risk individuals for HIV and referral for treatment.

Note: Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract that you or your family member may need. These could include: Family Planning Services, birth control (contraceptive) drugs and items including emergency contraception, sterilization (including tubal ligation at the time of labor and delivery), infertility treatments, or abortion.

You should get more information before you enroll. Call the doctor, medical group, clinic, or independent practice association you are thinking about choosing, or call our Member Services department at **1-866-270-5785 (TTY for the hearing impaired, call 711)** to make sure that you can get the health care services that you need.

Eligible individuals can contact the California Department of Health Care Services' Office of Family Planning toll-free at **1-800-942-1054** to talk with someone or receive information on Family Planning Services. If you have questions about your eligibility, please call our Member Services department at **1-866-270-5785 (TTY for the hearing impaired, call 711)**.

Health Education Services.
We have a health education programs, services and materials to help you improve your health and manage illness. These are available to you for free. Many of the materials are offered in different languages and/or in formats for the hard of hearing and visually impaired. Topics include:

- How to effectively use your health care services, which include information about managed care, prevention and primary health care services, obstetrical care, and health education in general.
- How to reduce your risk of illness and maintain a healthy lifestyle, which includes programs to help you stop smoking, and to learn more about alcohol and drug use, injury prevention,

sexually transmitted disease prevention, HIV/AIDS prevention, pregnancy prevention when you do not want to become pregnant, nutrition, getting to and maintaining a healthy weight, exercise, and parenting.

- Self-care and how to manage health conditions, which includes information about self-care routines and treatment for existing illnesses, chronic diseases or health conditions, including programs for pregnancy, asthma, diabetes, and hypertension.

You do not need Prior Authorization or a referral from your doctor to obtain these services; however, your doctor may recommend one or more of these services to you.

HIV Testing and Counseling.
You can get confidential HIV testing from any health care provider licensed to provide these services. You do not need Prior Authorization or a referral from your PCP or from us. You can call us for a listing of confidential testing sites. Here are some examples of places where you can be tested for HIV confidentially:

- Your PCP or doctor.
- Family Planning Service providers.
- Local health department
- Prenatal clinics.
- Certain San Diego/Sacramento County clinics.

Minors 12 years and older may get medical care to diagnose or treat HIV without the consent of a parent. Members with HIV or AIDS may be eligible for other programs that provide special care like the California Children's Services Program and the AIDS Medi-Cal Waiver Program.

Home Health Services.
We cover services provided in the home by health care personnel at no charge only if you meet all of the following requirements:

- You are substantially unable to leave the residence where you are staying.
- Your medical condition requires services provided by a nurse, physical therapist, occupational therapist or speech therapist.
- Your PCP determines that it is possible that your care can be monitored and controlled in the residence where you are staying and that the services you need can be provided safely and effectively.
- You get the services in our Service Area.

Home health care services are limited to services that are covered by Medi-Cal, such as medical social services, medical supplies, part-time home health aide care, and part-time skilled nursing care. Your care may be provided for by home health aides, medical social workers, nurses, and/or physical, occupational or speech therapists.

Hospice Care.
Hospice care is voluntary. You can receive Hospice care services if you have been certified as terminally ill with a life expectancy of twelve (12) months or less if the illness runs its normal course, and you or your representative voluntarily choose to receive Hospice services.

Hospice care can be provided in your home, or you can choose to be admitted to a nursing facility. If you choose to receive your care in a nursing facility, this is not considered to be long-term care and you will not lose your eligibility with us, regardless of how long you expect to stay or actually stay in the nursing facility.

If you are age twenty-one (21) or older and choose to receive Hospice care, you are waiving all rights you have to be provided with, or to have payment made for, covered services that are related to the treatment of your terminal illness. If you are under the age of twenty-one (21), choosing Hospice care does not waive these rights.

Hospice care includes, but is not limited to:

- Nursing services
- Physician services
- Home health aide and homemaker services
- Medical supplies and appliances
- Counseling services, including bereavement, grief, dietary, and spiritual counseling
- Care for pain control or symptom management

Any other palliative item or service covered by the Medi-Cal program.

Hospital care.
Hospital care is services you get in a hospital, either as an inpatient or an outpatient. Hospital care includes, but is not limited to:

- Discharge planning.
- Inpatient services.
- Intensive care.
- Rehabilitative services.
- Operating room and related facility services.
- Outpatient services.

You must have an approved Prior Authorization to get hospital services, except for emergencies or for urgent care services when you are out of the Service Area. Note that no hospital services are covered outside of the United States, except for emergency services requiring your hospitalization while you are in Canada or in Mexico.

Immunizations
You may get your immunizations from your provider, the local health department or your local pharmacy.

Laboratory (Lab) Services.
Lab services include blood work, throat cultures, and urine tests. Lab services must be provided at a doctor's office that is contracted with us, hospital that is contracted with us or laboratory that is contracted with us, and must be Medically Necessary. We do not cover laboratory services provided under the State serum alphafetoprotein-testing program administered by the California Department of Health Care Services.

Mastectomy.
Mastectomy is a surgery to remove the breast to help treat or prevent breast cancer. Services include prosthesis and reconstructive surgery (please see the Reconstructive Surgery section of this handbook for more information).

This service is performed in a hospital. You and your doctor decide how long you need to stay in the hospital based on Medical Necessity.

Maternity Care.
If you are pregnant, please call our Member Services department toll-free at **1-866-270-5785, TTY 711**. We want to make sure you get the care you need. We will help you choose your maternity care doctor that is contracted with us.

We cover these maternity care services:

- Prenatal care. Prenatal care is the care you get while you are pregnant. Prenatal care includes regular visits to your doctor while you are pregnant (also called prenatal visits), prenatal supplements, diagnostic testing, and genetic testing.
- Postpartum care. This is the care you get for six weeks after the delivery of your baby.
- Nutrition counseling.
- Labor and delivery care.
- Diagnostic testing.
- Genetic testing.
- Inpatient care for forty-eight (48) hours after normal vaginal deliveries. Longer stays must be authorized by us. If you and your doctor decide that you can be discharged before the forty-eight (48) hours ends, we will cover a post-discharge follow-up visit for the mother and newborn if it is made within forty-eight (48) hours after discharge.
- Inpatient care for ninety-six (96) hours after a delivery by Cesarean section (C-section). Longer stays must be authorized by us. If you and your doctor decide that you can be discharged before the forty- eight (48) hours ends, we will cover a post-discharge follow-up visit for the mother and newborn if it is made within forty-eight (48) hours after discharge.

After giving birth, you will receive breastfeeding help and special equipment if you need it. You can ask your doctor or call our Member Services department toll-free at **1-866-270-5785, TTY 711**, if you have questions.

You may also be eligible for the Women, Infants and Children (WIC) Program. Please see the Women, Infants and Children (WIC) Program section of this handbook for more information.

Minor Consent Services.
Minor Consent Services are available for Members under the age of eighteen (18). Minor Consent Services are services related to:

- Sexual assault, including rape.
- Drug or alcohol abuse for children twelve (12) years of age or older.
- Pregnancy.
- Family planning.
- Sexually transmitted diseases (STD) for children twelve (12) years of age or older.
- Outpatient mental health care for children twelve (12) years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.

Prior Authorization is not needed to receive these services.

Members eligible for these services do not need the permission or consent of their parent or guardian to receive these services.

Eligible Members can receive these services from any qualified Medi-Cal provider, including providers who are not in our network or contracted with us (also called Out-of-Network providers). Information Members share with their provider will remain confidential, and will not be shared the parent or guardian without the Member's consent.

For more information, please call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Newborn Care.
Your newborn baby should see a doctor in our network for a checkup within three days after you are home from the hospital. If you need help finding a doctor in our network, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Your newborn baby is covered for the month of his or her birth and for the following month. This coverage is under your Medi-Cal. You must enroll your baby into Medi-Cal to continue coverage. When you enroll your baby into Medi-Cal, you can choose UnitedHealthcare Community Plan of California, Inc. to have your baby receive his or her Medi-Cal coverage from us. To enroll your baby into Medi-Cal, call your eligibility worker. If you do not know how to contact your eligibility worker, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Obstetrical/Gynecological (OB/GYN) Care.
Female Members do not need a referral or permission from their PCP or from us to see an OB/GYN who contracts with us (also called an In-Network provider). If you have questions, please call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Occupational Therapy.
Occupational therapy is used to help a person maintain or improve daily living skills after an illness or a disability. Up to two visits for occupational therapy, speech therapy, audiology, or podiatry (combined) in any one (1) calendar month are covered.

Physical Therapy.
Physical therapy uses exercises to help a person maintain or improve skills after an injury or illness. Physical therapy services are limited by the Medi-Cal program. Physical therapy is a covered service only if your doctor thinks that your condition will significantly improve in a short period of time and if the physical therapy will keep you out of the hospital or shorten your time in the hospital.

Podiatry Care Services.
Podiatry care services are services for your feet. Podiatry care services are limited to two services in any one calendar month and must be provided at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). Prior Authorization is required, unless it is an emergency.

Unless it is an emergency, only these Members are eligible to receive podiatry care:

a. Pregnant women if it is part of their pregnancy-related care or for services to treat a condition that may cause problems in pregnancy.
b. Children or young adults who are 20 years old and younger and receive full scope Medi-Cal.
c. People who live in a licensed nursing home such as a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), ICF for the Developmentally Disabled (ICF-DD) and Sub-Acute Facility.
d. If you are twenty-one (21) years of age or older and began a course of treatment before you turned twenty-one (21), your benefit may be continued. Your podiatrist must order the treatment. Check with your podiatrist or your Primary Care Provider.

Prenatal Care.
If you are pregnant, please call our Member Services department toll-free at **1-866-270-5785, TTY 711**. We want to make sure you get the care you need. We will help you choose a doctor that is contracted with us.

Prenatal care includes regular visits to your doctor while you are pregnant (also called prenatal visits), prenatal supplements, diagnostic testing, and genetic testing.

Please also see the Maternity Care section of this handbook for more information about your care during pregnancy and after giving birth. Please see the Newborn Care section of this handbook for more information about your baby's care after he or she is born.

Preventive Care
Preventive care includes annual well-check visits with your PCP, routine immunizations, and recommended health screenings. Coverage includes, but is not limited to, screenings for cholesterol, breast, cervical, and colon cancer, depression, high blood pressure and diabetes.

Female members may get covered preventive care from a women's health specialist. You do not need a referral from your PCP to get preventive services from a women's health specialist.

Reconstructive Surgery Services.
Reconstructive surgery is surgery to repair or correct problems with body parts caused by tumors or disease, infection, accidents or trauma, or birth defects or other abnormal development. We cover reconstructive surgery services if your doctor determines that the surgery will make a more normal look or improve the way your body works.

If all or part of your breast is removed for Medically Necessary reasons, we will cover reconstructive surgery. Please see the Mastectomy section of this handbook for more information.

Sexually Transmitted Disease (STD) Services.
STD services are confidential. You do not need a referral or Prior Authorization from your doctor or from us to get STD services. You can get STD services from any doctor or clinic. The doctor or clinic you go to does not need be In-Network. We will pay for the STD service even if the doctor or clinic you go to is Out-of-Network. STD services include:

- Counseling.
- Diagnosis.
- Preventive care.
- Screening.
- Testing.
- Treatment.
- Follow-up care.

If you are between the ages of twelve (12) and eighteen (18), you can receive STD services without the permission or consent of your parent or guardian. See the Minor Consent Services section of this handbook for more information.

Skilled Nursing Facility (SNF) Services.
An SNF is a facility that is licensed to provide inpatient skilled nursing care, rehabilitative services or other related health services. SNF services are covered when medically necessary and your PCP refers you. SNF services include room and board, doctor and nursing services, and medications and injections.

In Sacramento County, we cover SNF services for the month you are admitted and for the next month. If you need to stay in the SNF longer than this, you will be disenrolled from our health plan and Medi-Cal will provide you with these services. If you are disenrolled from our health plan, we will send you a letter that tells you when your coverage with us ends and why the coverage is ending. If you disagree with why the coverage is ending, you can file an appeal with the California Department of Managed Health Care (DMHC). You can also ask the California Department of Health Care Services (DHCS) to review your situation. Please see the Grievances, Appeals, and State Hearings section of this handbook for more information.

In San Diego County, we will cover SNF services for you through December 31, 2017 (or however long the Department of Health Care Services determines).

Speech Therapy.
Speech therapy is used to help a person who has speech problems. Up to two visits for occupational therapy, speech therapy, audiology, or podiatry (combined) in any one (1) calendar month are covered.

Transportation Services.
Emergency medical transportation (ambulance) services: Emergency medical transportation (ambulance) services provided through the "911" emergency response system are covered when Medically Necessary.

Non-Emergency Medical Transportation: You are entitled to use Non-Emergency Medical Transportation (NEMT) when you physically or medically are not able to get to your medical appointment by car, bus, train, or taxi, and the plan pays for your medical or physical condition.

NEMT is an ambulance, litter van, wheelchair van or air transport. NEMT is not a car, bus or taxi. UnitedHealthcare Community Plan allows the lowest cost NEMT for your medical needs when you need a ride to your appointment. That means, for example, if you are physically or medically able to be transported by a wheelchair van, UnitedHealthcare Community Plan will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation not possible.

NEMT must be used when it is:

- Physically or medically needed as determined with a written prescription by a physician; or
- You are not able to physically or medically use a bus, taxi, car or van to get to your appointment;
- Approved in advance by UnitedHealthcare Community Plan with a written prescription by a physician.

To ask for NEMT, please call UnitedHealthcare Community Plan at least 3 business days (Monday-Friday) before your appointment. For urgent appointments, please call as soon as possible. Please have your member ID card ready when you call.

Limits of NEMT.
There are no limits for receiving NEMT to or from medical appointments covered under UnitedHealthcare Community Plan when a provider has prescribed it for you.

What Does Not Apply?
If your physical and medical condition allows you to get to your medical appointment by car, bus, taxi, or other easily accessible method of transportation. Transportation will not be provided if the service is not covered by UnitedHealthcare Community Plan. A list of covered services is in this member handbook.

Cost to Member.
There is no cost when transportation is authorized by UnitedHealthcare Community Plan.

Non-Medical Transportation.
You can use Non-Medical Transportation (NMT) when you are:

- Traveling to and from an appointment for a UnitedHealthcare Community Plan covered service prescribed by your provider.

UnitedHealthcare Community Plan allows you to use a car, taxi, bus, or other public/private way of getting to your medical appointment for plan-covered medical services including mileage reimbursement when transportation is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers or train tickets. UnitedHealthcare Community Plan allows the lowest cost NMT type for your medical needs that is available at the time of your appointment.

To ask for NMT services, please call UnitedHealthcare Community Plan at 1-866-270-5785 or call LogistiCare at 1-844-772-6623 at least 3 business days (Monday-Friday) before your appointment or call as soon as you can when you have an urgent appointment. Please have your member ID card ready when you call.

Limits of NMT.
There are no limits for receiving NMT to or from medical appointments covered under UnitedHealthcare Community Plan when a provider has prescribed it for you.

What Does Not Apply?
NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service.
- The service is not covered by UnitedHealthcare Community Plan. A list of covered services is in this member handbook.

Cost to Member.
There is no cost when transportation is allowed by UnitedHealthcare Community Plan.

Vision Services.
Medi-Cal pays for these vision services, regardless of your age:

- To see an eye doctor to test your eyes.
- To test for a prescription for eyeglasses.
- To test for a prescription for contact lenses if you have eye diseases.
- To check the health of your eyes.
- To check to see if you have low vision.

Medi-Cal will pay for these vision services if you are twenty-one (21) years of age or older and you are either (1) pregnant and your doctor says that not having the service will be harmful to your baby or your pregnancy, or (2) you live in a nursing home:

- New eyeglasses or to fix your glasses.

- Contact lenses.
- Things that will help you see better (like magnifying glasses).

X-Ray Services.
We cover x-ray services when they are ordered by a doctor who is contracted with us (an In-Network doctor) and the service is received in a doctor's office, a hospital or a laboratory, and Medically Necessary.

Other services you can get through Fee-for-Service (FFS) Medi-Cal

Sometimes UnitedHealthcare Community Plan does not cover services, but you can still get them through FSS Medi-Cal. To learn more, call Member Services at **1-866-270-5785, TTY 711.**

Dental services.
Medi-Cal covers these dental services up to age 21:

- Diagnostic and preventive dental hygiene (e.g., exams, X-rays, and teeth cleanings)
- Emergency services for pain control;
- Tooth extractions;
- Root canal treatments;
- Prosthetic appliances; and
- Orthodontics for children who qualify.

If you have questions or want to learn more about dental services, call Denti-Cal at 1-800-322-6384 (TTY 1-800-735-2922). You may also visit the Denti-Cal website at denti-cal.ca.gov.

If you live in Sacramento County: Institutional long-term care.
If you live in Sacramento County, UnitedHealthcare Community Plan covers long-term care for the month you enter a facility and the month after that. UnitedHealthcare Community Plan does not cover long-term care if you stay longer. Regular Medi-Cal covers your stay if it lasts longer than the month after you enter a facility. To learn more, call Member Services at **1-866-270-5785, TTY 711**. (Members who live in San Diego County can continue to receive long-term care coverage through UnitedHealthcare Community Plan.)

Additional Benefits and Services That May Be Available to You

As a Medi-Cal Member, you have benefits and services available to you that are not provided by UnitedHealthcare Community Plan of California, Inc. Instead, they are provided to you by Medi-Cal or another state program. These benefits and services are explained below. We can help you if you have questions about these benefits and services. Call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

American Indians — Special Services
Medi-Cal Managed Care Enrollment: American Indians are not required to enroll in a Medi-Cal managed care plan. American Indians who do enroll may leave their plan at any time for any reason and return to Fee-for-Service Medi-Cal.

Indian Health Centers and Native American Health Clinics: American Indians may choose to receive their health care services from Indian Health Centers and Native American Health Clinics. American Indians who choose to do this may stay with or disenroll from UnitedHealthcare Community Plan of California, Inc.

Call Indian Health Services at **1-916-930-3927** to find out more, or visit their website at **www.ihs.gov**.

California Children's Services (CCS).
CCS is a state program that helps children under the age of twenty-one (21) who have certain diseases, physical limitations, or chronic health problems. To get CCS, your child must have a medical problem that CCS covers, be a resident of California, and meet family income requirements.

We identify children with CCS-eligible conditions, arrange for a referral to a CCS office and provide case management until your child's eligibility with CCS is established. We will continue to provide your child with covered services not provided by CCS.

If your child is already enrolled in CCS, please call us. We can arrange for the CCS services to continue, and your child will get services we cover that are not being provided by CCS.

Child Health and Disability Prevention (CHDP).
CHDP provides children under the age of twenty-one (21) with routine complete physical health checkups. CHDP includes immunizations, nutrition and tobacco education, tests for anemia, blood lead and tuberculosis (TB), and vision, dental and hearing screenings. Your child can receive CHDP services through his or her PCP. If you have questions, ask your child's PCP.

Childhood Lead Poisoning Screening.
We cover a blood lead screening test for Members at ages one (1) and two (2). Members who test above a certain blood lead level are referred to the Childhood Lead Poisoning Prevention Program (CLPPP), California Children's Services (CCS), and/or the local health department.

Developmental Disabilities.
You may be eligible for services from regional centers if you have a developmental disability. Talk to your doctor or call our Member Services department toll-free at **1-866-270-5785, TTY 711**, for more information.

Early Start Program.
Children ages birth to three (3) years old who have a developmental delay or disability, or an established risk condition with a high probability of resulting in a delay, may be eligible for the Early Start program. The Early Start program consists of teams of service coordinators, health care providers, early intervention specialists, therapists, and parent resource specialists who evaluate and assess infants or toddlers and provide appropriate early intervention and family support services for children who qualify from birth to three (3) years of age. For more information about the Early Start program, talk to your doctor or call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Local Education Agency (LEA) Assessment Services.
LEA provides certain health assessment services through schools. No PCP referral is needed to receive these services.

Mental Health Services.
We cover Outpatient mental health services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services may be provided by your PCP, psychiatrists, psychologists, licensed clinical social workers, or other specialty mental health providers.

Services include:

- Individual and group mental health evaluation and treatment (psychotherapy).*
- Psychological testing when clinically indicated to evaluate a mental health condition.*
- Psychiatric consultation for medical management.*
- Screening and Brief Intervention (SBI).
- Outpatient laboratory, supplies and supplements.
- Drugs (excluding anti-psychotic drugs which are covered by Medi-Cal fee-for-service).

*Services one through three (*) above will be provided through Optum Behavioral Health by providers contracted with OptumHealth Behavioral Solutions of California. Members should contact UnitedHealthcare at **1-866-270-5785** for information regarding access to behavioral health care services.

Primary care providers (PCP) are responsible for screening and brief intervention (SBI) and performing evaluations needed to develop a diagnosis before referring the member to Optum Behavioral Health, County Mental Health, or other programs. Outpatient laboratory, supplies, supplements and eligible drugs are administered through the Member's medical benefits. Screening tools are available on the

DHCS website and our provider website, and include the Individual Health Education Behavioral Assessment (IHEBA).

The following services for members with Serious Mental Illness (SMI) and/or Severe Emotional Disturbance (SED) condition(s) are not covered by UnitedHealthcare, however, will continue to be covered through the **County Mental Health system:**

Outpatient services for Members with SMI/SED.

- Mental health services, including assessments, plan development, therapy and rehabilitation, and collateral.
- Medication support.
- Day treatment services and day rehabilitation.
- Crisis intervention and stabilization.
- Targeted case management.
- Therapeutic behavior services.
- Residential services Adult residential treatment services.
- Crisis residential treatment services.

Inpatient services Acute psychiatric inpatient hospital services.

- Psychiatric inpatient hospital professional services.
- Psychiatric health facility services.

In addition, alcohol and drug treatment services are not covered under UnitedHealthcare. However, coverage may be available through County Alcohol and Other Drug (AOD) programs.

Organ Transplants — Major Organ Transplants, Excluding Kidney and Cornea.
We refer Members identified as major organ transplant candidates (except for kidney and cornea) to a Medi-Cal approved transplant center. We will cover the evaluation performed by the Medi-Cal approved transplant center.

Members who are accepted as transplant candidates and approved by Medi-Cal are disenrolled from UnitedHealthcare Community Plan of California, Inc. and transferred to Fee-for-Service (regular) Medi-Cal. We will continue to cover all Medically Necessary services until the Member is disenrolled.

Members who are eligible for a transplant through California Children's Services (CCS) are not disenrolled from UnitedHealthcare Community Plan of California, Inc. and are not transferred to Fee-For-Service (regular) Medi-Cal.

Pediatric Day Health Care.
We do not cover pediatric day health care.

Prayer Healing.
We do not cover prayer or spiritual healing.

Serum Alphafetoprotein-Testing Program Lab Services.
We do not cover laboratory services provided under the state of California serum alpha-fetoproteintesting program administered by the California Department of Health Care Service (DHCS).

Targeted Case Management (TCM) Services.
Targeted Case Management (TCM) services are services which help Medi-Cal Members within specified target groups gain access to needed medical, social, educational and other services. We will determine whether you need TCM services and if eligible, we will refer you to an appropriate regional center or local government health program for the TCM services. We will coordinate your care with your TCM services provider and we will determine the Medical Necessity of any diagnostic and treatment services recommended by your TCM services provider that are covered services.

Tuberculosis — Direct Observed Therapy Treatment.
Members who are diagnosed with active tuberculosis and at risk for noncompliance with (not following) the treatment are referred to the local health department for direct observed therapy treatment. Members at risk for noncompliance include, but are not limited to:

- Members with demonstrated multiple drug resistance.
- Members whose treatment failed or who have relapsed after completing a treatment.
- Children and adolescents.
- Members who have demonstrated noncompliance in the past (for example, failed to keep office appointments).

We will provide all Medically Necessary covered services to Members on direct observed therapy and will ensure joint case management and coordination of care with the local health department.

Women, Infants and Children (WIC) Program.
WIC is a federally-funded health and nutrition program for women, infants, and children. WIC helps families by providing checks for buying healthy supplemental foods from WIC-authorized vendors, nutrition education, and help finding health care and other community services. Participants must meet income guidelines and be pregnant women, new mothers, infants or children under age 5. To find out more about WIC, ask your health care provider.

We do not cover WIC services, but we do help identify and refer Members who may be eligible for WIC. Your provider helps identify and refer Members who may be eligible for WIC. Your provider may do this as part of your initial health assessment or as part of your initial evaluation if you are newly pregnant.

Our providers will refer and document the referral of a pregnant, breastfeeding, or postpartum woman, or a parent or guardian of a child less than five (5) years old to the WIC program. As part of the referral, WIC will be provided with a current hemoglobin or hematocrit laboratory value, and the laboratory value and referral will be documented in the medical record of the Member.

Services Not Covered by Us or by Medi-Cal

Services not covered by UnitedHealthcare Community Plan of California, Inc. or by Medi-Cal include:

- All services excluded from Medi-Cal under state or federal law.
- Circumcision (routine), unless Medically Necessary.
- Cosmetic surgery.
- Eye appliances.
- Experimental and investigational services. See the Grievances, Appeals, and State Hearings section of this handbook for more information.
- Immunizations for sports, work or travel.
- Infertility.
- Personal comfort items while in the hospital.

Prescription Drug Coverage

We cover prescription drugs and medications when:

- Your treating physician orders the drug and the drug is listed on our Formulary (our Formulary is explained below).
- Prescribed by a family planning doctor or other provider whose services do not require an approval.
- Ordered or given to you while you are in the emergency room or hospital.
- Given to you while you are in a nursing home and were ordered by an In-Network doctor for a covered service and you got them through an In-Network pharmacy.

Medi-Cal Members should not be asked to pay for a prescription. If you are asked to pay for a prescription, call our Member Services department toll-free at 1-866-270-5785, TTY 711.

If you have an emergency and need drugs, we will provide you with up to a seventy-two (72) hour supply of the drug to give you time to fill your prescription. If you feel you did not get the medically needed medications after an emergency visit to an In-Network hospital, you have the right to file a grievance. See the Grievances, Appeals and State Hearings section of this handbook for information about filing grievance.

Your prescriptions are covered through our In-Network pharmacies. This means you must get your prescriptions filled at one of our In-Network pharmacies. The In-Network pharmacies are listed in the provider directory, or you can find them on our website at **myuhc.com/CommunityPlan** or call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

If you have trouble getting a prescription filled at the pharmacy, call our Member Services department toll-free at **1-866-270-5785, TTY 711**, to tell us you are having trouble.

If you need an interpreter to communicate with the pharmacy, call our Member Services department toll-free at **1-866-270-5785, TTY 711**, and they will help you with an interpreter.

Our Formulary

We use a list of approved drugs, and this list is called a Formulary. Doctors order drugs for Members from the Formulary. Our Formulary is reviewed by a group of pharmacists and doctors every three months. They discuss the drugs that are on the Formulary, and new drugs and changes in health care, and decide if changes should be made to the Formulary. Changes to the Formulary are based on changes in medical practice, the availability of new drugs, and changes in medical technology. Drugs can be added to the Formulary only if they are approved by the United States Food and Drug Administration (FDA), are generally accepted to be safe and effective, and if they are cost-effective.

Just because a drug is on our Formulary does not mean your doctor will prescribe it for you for your particular medical condition. Also, we do not need to cover prescription drugs not required by the Medi-Cal program and we may limit or exclude drugs as required by the Medi-Cal program.

The pharmacist will give you generic drugs when they are available. Generic drugs are chemically the same as the brand-name version of the drug, and are approved by the FDA as safe and effective as the brand-name version. If your doctor wants you to have the brand-name drug instead of the generic drug, your doctor must ask us by submitting a Prior Authorization request to us.

You can look at our Formulary on our website at **myuhc.com/CommunityPlan**. If you have questions about a specific drug, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Drugs not on the Formulary.
Your doctor will usually prescribe drugs from our Formulary. If your doctor decides that you need a drug that is not on our Formulary, your doctor must contact us to request it. You have a right to a drug not on our Formulary if Medically Necessary. We may ask your doctor and your pharmacist for more information. We will make a decision within one (1) business day after getting the information, and we will let your doctor or your pharmacist know our decision. If we approved the drug, your doctor or pharmacist will tell you we approved the request. If we did not approve the drug, we will send you and your doctor a letter telling you why the request was denied. If you do not agree with us, you can appeal our decision. This means our decision will be reviewed. See the Grievances, Appeals and State Hearings section of this handbook for more information.

Drugs that are removed from the Formulary.
If you are taking a drug that is removed from our Formulary, your doctor can ask us to keep covering the drug by submitting a Prior Authorization request to us. For us to keep covering the drug, the drug must be safe and effective for your medical condition it is being prescribed to treat.

Other state programs may cover your drugs.
You may be eligible to receive drug coverage through fee-for-service (regular) Medi-Cal or through other state programs. If you have questions, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Specialty Pharmacy Medications

Our Specialty Pharmacy Program offers specialized services, support and information you need to stay healthy and make the best use of your pharmacy benefit.

What is a specialty medication?
Specialty medications, which may need special storage and handling, are often used to treat complex conditions and can be high-cost. These medications need to be filled by a network specialty pharmacy.

What is a specialty pharmacy? Why do I need to use one?
Specialty pharmacies provide resources, services, and support for complex conditions. To continue to receive network coverage for your specialty medication, you will need to fill your prescription through a network specialty pharmacy. You may fill your non-specialty medications at a network retail pharmacy.

If you have questions about where to find a specialty pharmacy, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

What is the Specialty Pharmacy Program?
Our Specialty Pharmacy Program provides personalized support and resources to help you manage your condition, including:

- Information on your medication(s) and condition.
- Eligibility for one-on-one support and counseling through our Clinical Management Program.
- 24/7 access to pharmacists to talk about your condition and medication therapy with you.
- Speedy delivery and shipping in confidential, temperature-sensitive packaging (as required).
- Free medication-related supplies such as alcohol swabs and sharps container.
- Refill reminders by phone and text (at your request).

Emergency Care and Urgent Care Services

Emergency Care Services

Emergency Care is covered twenty-four (24) hours a day, seven (7) days a week, anywhere in the United States. No services are covered outside of the United States, except for Emergency Care services requiring hospitalization in Mexico or Canada.

For emergency care, call 911 or go to the nearest emergency room (ER). You do not need preapproval (prior authorization). Emergency care is for emergency medical conditions. It is for a medical or psychiatric (mental) condition with such severe symptoms, such as active labor or severe pain, that someone with the prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger.
- Cause impairment to a body function.
- Cause a body part or organ to not work right.

Examples include:

- Active labor.
- Broken bone.
- Severe pain, especially in the chest.
- Severe burn.
- Drug overdose.
- Fainting.
- Severe bleeding.
- Psychiatric emergency condition.

Emergency Services are covered inpatient and outpatient services that are:

- Given by a provider who is qualified to provide these services.
- Needed to evaluate or stabilize an emergency medical condition.

If you need hospital care after your emergency (post-stabilization care), the hospital will call UnitedHealthcare Community Plan. If you are admitted to a non-contracted hospital for an emergency, UnitedHealthcare may request you be transferred to an in-network hospital once you are stable.

Post-stabilization Care Services means covered services that are related to an emergency medical condition and that are provided after a member is stabilized to maintain the stabilized condition; or in some cases to improve or resolve the condition.

Non-emergency care.
Examples of conditions that are not an emergency include, but are not limited to, colds, flu, sore throats, and earaches.

Do not call 911 for non-emergency problems. Call your PCP doctor.

Do not use the hospital emergency room for care that isn't an emergency.

Do not use the ambulance if you are not having a real emergency. If you use an ambulance when you do not have a real emergency condition, we may refuse to pay for it.

If you are not sure if you are having an emergency, call your PCP. If your PCP's office is closed, someone will answer the call. Or call our NurseLine toll-free at **1-866-270-5785, TTY 711**. You can call our NurseLine twenty-four (24) hours a day, seven (7) days a week. Registered nurses can give you information and support for your health questions and concerns.

Call our Member Services department toll-free at **1-866-270-5785, TTY 711**, within twenty-four (24) hours after receiving emergency care, or as soon as you can. You can ask the emergency staff to call us for you.

Emergency care outside of our Service Area.
If you have an emergency and you are outside of our Service Area (the county of Sacramento or San Diego), go to the nearest emergency room for care. Call our Member Services department toll-free at

1-866-270-5785, TTY 711, within twenty-four (24) hours after receiving emergency care, or as soon as you can. You can ask the emergency staff to call us for you. When you receive Emergency Care services outside of our Service Area, only emergency services are covered. No services are covered outside of the United States, except for Emergency Care services in Mexico and Canada. If you are admitted to a hospital that is not contracted with us (an Out-of-Network hospital), we have the right to move you as soon as it is medically safe to do so. Your PCP doctor must provide your follow-up care after you leave the hospital.

Emergencies outside of the United States.
If you have an emergency and you are outside of the United States, no emergency services are covered by us except for emergency services in Mexico or Canada.

Urgent Care Services

Urgent Care services are services that are needed to prevent serious decline of health following an unforeseen medical condition or injury. Urgent Care services are for illness, injury, or condition that is not life threatening, but needs medical care right away.

Urgent Care services are available to you both inside and outside of our Service Area (the county of Sacramento or San Diego). However, if you are out of the United States, no services are covered except for Emergency Care services in Mexico or Canada.

If you are not sure if Urgent Care will work for you, call your PCP. If your PCP's office is closed, someone will answer the call. You should be able to get an Urgent Care appointment within forty-eight (48) hours. You can also call our NurseLine toll-free at **1-866-270-5785, TTY 711**. You can call our NurseLine twenty-four (24) hours a day, seven (7) days a week. Registered nurses can give you information and support for your health questions and concerns.

If you or your child becomes sick after-hours, wait until your PCP doctor's office is open to make an appointment if you can. You can ask your PCP what urgent care facility you should use when your PCP's office is closed. This way, you will know ahead of time where to go in an urgent care situation. You can also call our NurseLine toll-free at **1-866-270-5785, TTY 711**. You can call our NurseLine twenty-four (24) hours a day, seven (7) days a week. Registered nurses can give you information and support for your health questions and concerns.

Interpreter Services

UnitedHealthcare Community Plan offers interpreter services free of charge.

If you want to get interpreter services, please tell your PCP doctor or call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

UnitedHealthcare Community Plan of California, Inc. will help you find a doctor that speaks your language or provide an interpreter.

Moral Objection

If you have questions about a covered service that a provider may not provide, please call your primary care doctor or call Member Services at **1-866-270-5785, TTY 711**. These services could include, but are not limited to, family planning counseling, birth control (including tubal ligation at the time of labor and delivery), or abortion.

Your Rights and Responsibilities

As a UnitedHealthcare Community Plan of California, Inc. member, you have certain rights and responsibilities.

You have the right to:

- Be treated with respect and dignity by everyone who works with UnitedHealthcare Community Plan of California, Inc.
- Not be treated badly or disrespectfully by us, your doctors, or the Department of Health Care Services for acting on these rights and when making decisions about your care.
- Receive information about your health plan, our doctors, our other providers, our services, and your rights and responsibilities.
- Choose your Primary Care Provider from our network.
- Receive information about your health and to have your questions about your health answered.
- Receive information about all of your treatment options if you are sick, regardless of benefit coverage or cost.
- Talk with your doctor about your care and treatment options, help make decisions about your treatment, regardless of your benefit coverage or costs, and ask for a second opinion.
- Decide to not be treated for your illness.
- Decide in advance how you want to be cared for in case you have a life-threatening illness or injury.
- Have your medical records kept private and confidential, receive a copy of your medical records, and ask us to make corrections to your medical records (to the extent allowed by State and Federal law).
- If you are a minor, receive certain services without the permission of your parents or guardian.
- Complain about UnitedHealthcare Community Plan of California, Inc., your care, and the providers we work with without being afraid of losing your benefits. We will help you with this process, and if you do not agree with our decision, you have the right to ask for a review of the decision (this review is also called an appeal). You can also request a State Hearing and to get information on how to get a State Hearing quickly.
- Disenroll from UnitedHealthcare Community Plan of California, Inc. at any time.
- Request an interpreter free of charge if you want to speak a language that is not English, and be asked to use a family member or friend to interpret for you.

- Get this handbook, information about your providers, your health, or us in the language that you want or in another format, such as Braille, audio, or larger font within a reasonable time and in accordance with State laws.
- Receive emergency or urgent services, family planning services, and sexually transmitted disease services from providers that are outside of UnitedHealthcare Community Plan of California, Inc.'s network.
- Receive information about your rights and responsibilities.
- Make recommendations about these rights and responsibilities.

You have the responsibility to:

- Treat your doctor, all providers, and their staff with courtesy and respect.
- Be on time for your appointments.
- Call your doctor at least one day before your scheduled appointment when you have to cancel or reschedule the appointment.
- Give the correct information, and give as much information as you can, to your doctor, other providers who treat you, and to us.
- Get regular checkups with your doctor, and tell your doctor about your health problems as soon as possible.
- Talk to your doctor about your health care needs and discuss your treatment choices. Follow your doctor's instructions and the treatment plans that you and your doctor have agreed to.
- Learn about your health benefits and ask any questions you might have. You can ask your doctor or us.
- Use the emergency room only when you feel it is necessary or when you have been told to do so by your doctor.
- Report health care fraud or wrongdoing by calling us. You can report without giving your name.

Public Policy Committee/Consumer Advisory Committee, Policy Changes, and Obtaining Copies

Public Policy Committee/Consumer Advisory Committee.
DHCS decides many of our policies. But there are some policies that are created by our members, through our Public Policy Committee.

You may join our Public Policy Committee. Our Public Policy Committee meets once every three (3) months to discuss member and health plan issues, including yours. The Public Policy Committee also works to assure the comfort, dignity, and convenience of members like you who rely on UnitedHealthcare Community Plan of California, Inc. to provide health care services to them, their families, and the public.

We want to hear what you think about UnitedHealthcare Community Plan of California, Inc. To join our Public Policy Committee or for more information, please call UnitedHealth Care Community Plan of California, Inc. at **1-866-270-5785, TTY 711**.

Policy changes.
You will get information on all policy changes that affect your health care.

Copies of policies.
If you would like to see copies of our non-proprietary administrative or clinical policies and procedures, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Grievances, Appeals and State Hearings

What Is a Grievance?
An expression of dissatisfaction about any matter other than a Notice of Adverse Benefit Determination (NABD).

Examples include but are not limited to:

- You are unhappy with the quality of your care.
- The doctor you want to see is not a UnitedHealthcare Community Plan of California, Inc. doctor.
- You are not able to receive culturally competent care.
- You got a bill from a provider for a service that should be covered by UnitedHealthcare Community Plan of California, Inc.
- Rights and dignity.
- Any other access to care issues.

Any other disputes related to your membership in the UnitedHealthcare Community Plan of California, Inc.

All levels of UnitedHealthcare Community Plan of California, Inc.'s grievances and appeals procedures will be completed in thirty (30) calendar days of receipt with the exception of those involving an imminent and serious threat to life. These grievances will be completed through an expedited review and a response provided no later than 72 hours.

Members are not required to participate in the plan's grievance process under the following circumstances:

- The case involves an imminent and serious threat to the health of the member, including but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan, contract, or in any other case where the department determines that an earlier review is warranted.
- The member has requested the Independent Medical Review process including the review for denials of experimental or investigational therapies.

What should I do if I have a grievance?
You or someone acting for you can file a grievance by calling or writing to UnitedHealthcare Community Plan of California, Inc. Call **1-866-270-5785, TTY 711**, or write to:

UnitedHealthcare Community Plan of California, Inc. Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

If you need help writing or filing a grievance, call Member Services at **1-866-270-5785, TTY 711**. If someone else is going to file for you, we need your written permission. If you are a person with disabilities, you may call UnitedHealthcare Community Plan of California, Inc. at **1-866-270-5785, TTY 711**, to file a grievance.

We will review your grievance and send our decision within 30 days of getting your grievance. We will send you a letter with the decision.

What Is an Appeal?

An appeal is your request for a review of a Notice of Adverse Benefit Determination (NABD). An NABD is when we:

- Deny or limit a service you want;
- Reduce, suspend or terminate payment for a service you are getting;
- Fail to authorize a service in the required time; or
- Fail to decide a grievance or appeal in the required time.

If any of the above occurs, UnitedHealthcare Community Plan of California, Inc. will send you an NABD.

How do I file an appeal with UnitedHealthcare Community Plan of California, Inc.?
You, your provider or someone acting for you can file an appeal by calling or writing to UnitedHealthcare Community Plan of California, Inc. Call **1-866-270-5785, TTY 711**, or write to:

UnitedHealthcare Community Plan of California, Inc. Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

You may also file an appeal form on our website at **myuhc.com/CommunityPlan**.

You must file your appeal within 90 days from the date you get an NABD. If you need help writing or filing an appeal, call Member Services at **1-866-270-5785, TTY 711**. If you file your appeal by calling us, we will send you a letter within 5 calendar days telling you that we got your appeal.

We will review your appeal and send you a decision within 30 days of getting the appeal.

You will get a letter telling the reason for our decision. We will tell you what to do if you don't like the decision. This letter will be an NABD.

Continuation of care.
You can ask for services to continue during the appeal. However, you may need to pay for the health service if you continue the service while we are reviewing the appeal and we decide that you should not have received the service.

Expedited appeal — What can I do if I need immediate care?
If you or your doctor wants a fast decision because your health is at risk, call Member Services at **1-866-270-5785, TTY 711**, for an expedited review. UnitedHealthcare Community Plan of California, Inc. will call you with our decision within 3 calendar days of getting your request for an expedited review. This time may be extended if you ask for this or if we show a need for more information and the delay is in your interest. If we ask for an extension, we will give you written notice of the reason. You will get a letter with the reason for our decision. We will tell you what to do if you don't like the decision.

Department of Managed Health Care (DMHC)

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-866-270-5785, TTY 711**, and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call DMHC for assistance.

You may also be eligible for an **Independent Medical Review (IMR)**. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The DMHC also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The DMHC's internet website **(www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions on the website.

Independent Medical Review of Grievances

The Independent Medical Review (IMR) is another appeal process that you may use when:

- UnitedHealthcare Community Plan of California, Inc. made a decision that a health care service is not medically necessary, and
- You believe that all or part of that health care service has been wrongly denied, changed or delayed. This is known as a *disputed health care service*.

You may still request a State Hearing if you request an IMR. However, you will not be able to use the IMR process if you have requested a State Hearing.

The IMR is filed with DMHC. You have up to 6 months from the date of denial to file an IMR. You will receive information on how to file an IMR with your denial letter. You may reach DMHC toll-free at **1-800-400-0815**.

There are no fees for an IMR. You have the right to provide information to support your request for an IMR. After the IMR application is submitted, a decision not to take part in the IMR process may cause you to forfeit certain legal rights to pursue legal action against the plan.

For more information regarding the IMR process, please contact our Member Services at **1-866-270-5785, TTY 711**.

When to file an IMR.

You may file an IMR if you meet the following requirements:

- Your doctor says you need a health care service because it is medically necessary and it is denied.
- You received urgent or emergency services determined to be necessary and it was denied; or
- You have seen a network doctor or PCP for the diagnosis or treatment of the medical condition (even if the health care service was not recommended by a network provider);
- The disputed health care service is denied, changed or delayed by UnitedHealthcare Community Plan of California, Inc. based in whole or in part on a decision that the health care service is not medically necessary, and
- You have filed a grievance with UnitedHealthcare Community Plan of California, Inc. and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 days.
- You must first go through the UnitedHealthcare Community Plan of California, Inc. grievance process, before applying for an IMR.
- You have up to 6 months from the date of denial to file an IMR.
- The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make an independent decision of whether or not the care is medically necessary. You will receive a copy of the IMR decision from DMHC. If it is decided that the service is medically necessary, **UnitedHealthcare Community Plan of California, Inc. will provide the health care service**.

Non-urgent cases.
For non-urgent cases, the IMR decision must be made within 30 days. The 30-day period starts when your application and all documents are received.

Urgent cases.
If your grievance is urgent and requires fast review, you may bring it to DMHC's attention right away. You will not be required to participate in the UnitedHealthcare Community Plan of California, Inc. grievance process.

For urgent cases, the IMR decision must be made within three (3) business days from the time your information is received. Examples of urgent cases include:

- Severe pain.
- Potential loss of life, limb, or major bodily function.
- Immediate and serious deterioration of your health.

External Independent Review (EIR)

You can request an EIR through DMHC when a medical service, drug or equipment is denied because it is experimental or investigational in nature. You have up to 6 months from the date of denial to file an EIR.

You may provide information to the EIR panel. The EIR panel will give you a written decision within 30 days from when your request was received. In urgent cases, the EIR panel will give you a decision within 3 business days from the time your information is received.

You may file an EIR if you meet the following requirements:

1. You have a very serious condition that is "life-threatening" or "debilitating" (for example, terminal cancer).
2. Your doctor must certify that:
   - the standard treatments were not or will not be effective; or
   - the standard treatments were not medically appropriate; or
   - the proposed treatment will be the most effective.
3. Your doctor will certify in writing that the drug, equipment, procedure, or the requested therapy is likely to work better than standard treatment.
4. You have been denied a drug, equipment, procedure, or other therapy requested by your doctor.
5. Your doctor certified in writing, based on certain medical and scientific evidence, that the requested treatment is likely to be more beneficial for you than any standard treatment.
6. The treatment would have been covered as a benefit, but UnitedHealthcare Community Plan of California, Inc. has determined that it is experimental and investigational.

For more information or help with the IMR or EIR process or to request an application form, please call UnitedHealthcare Community Plan of California, Inc.

How Do I File a State Hearing Request?

State Hearings
A State Hearing is a meeting with people from the California Department of Social Services (DSS). A judge will help to resolve your problem. You can ask for a State Hearing only if you have already filed an appeal with UnitedHealthcare Community Plan and you are still not happy with the decision or if you have not received a decision on your appeal after 30 days.

You can ask for a State Hearing by phone or mail. You must ask for a State Hearing within 120 calendar days from the date on the notice telling you of the appeal decision. Your PCP can ask for a State Hearing for you if he or she gets approval from DSS. Call DSS to ask the state to give approval for your PCP to ask for a State Hearing.

To ask for a State Hearing by phone, call the California Department of Social Services' (DSS) Public Response Unit at **1-800-952-5253 (TTD 1-800-952-8349).**

To ask for a State Hearing by mail, fill out the form provided to you with your appeals resolution notice. Send it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call **1-866-270-5785, TTY 711.**

At the hearing, you will give your side. We will give our side. It could take up to 90 days for the judge to decide your case. We must follow what the judge decides.

If you already had a State Hearing, you cannot ask for an IMR. But, if you ask for an IMR first and are not happy with the result, you can still ask for a State Hearing.

Expedited State Hearing.
You or your provider have the right to request an expedited State Hearing by calling, writing, or faxing the Department of Social Services, Expedited Hearing Unit, 744 P Street, MS19-65, Sacramento, CA 95814, Fax: 1-916-229-4267. UnitedHealthcare Community Plan of California, Inc. or your provider must indicate that taking the time for a standard resolution could seriously jeopardize your life, health, or ability to attain, maintain or regain maximum function. When the Expedited Hearing Unit determines that your appeal satisfies the expedited criteria and when all necessary clinical information has been received by the Unit, the expedited hearing will be scheduled. If the criteria are not met, it will be scheduled for a routine State Hearing as described above.

Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman Program

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman Program assists in the mediation of disputes between Medi-Cal Managed Care members and their health plans as well as plan providers, and to attempt to resolve these disputes informally outside of the

formal grievance and appeal processes. If you wish to use the services of the DHCS to address your concerns, complaints, or grievances, please call the Medi-Cal Managed Care Ombudsman program toll-free at 1-888-452-8609, Monday through Friday, between the hours of 8:00 a.m. and 5:00 p.m. (Pacific Standard Time). You can also call the DMHC HMO Consumer Service toll-free telephone number at 1-800-400-0815.

Additional Information

How We Pay Our Providers

UnitedHealthcare Community Plan of California, Inc. pays its providers for each covered service they give Members. Providers are paid in one of two ways:

- Fee-for-service basis — this means that providers are paid for each procedure they perform.
- Capitation — a flat rate paid each month per member whether you see the provider or not.

UnitedHealthcare Community Plan of California, Inc. pays its providers for services that need prior authorization if you or your doctor get an okay before you get the services. Utilization Management (UM) decisions are based on medical necessity and the suitability of care. We do not offer any rewards for denying coverage. We do not offer incentives to our employees, doctors or anyone related to our plan to use benefits inappropriately. We do offer qualified providers incentives tied to clinical activities that drive improved quality preventive care, better management of their patient population and better care for the individual member. If you have a question on the UM process or a denial, or how providers are paid, call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

If You Get a Medical Bill

You may get a bill that should not have been sent to you. If you get a bill, call our Member Services department toll-free at **1-866-270-5785, TTY 711**. We will help you find out if you need to pay the bill or if you should send it to us. You may have to pay the bill if you get care without our authorization from doctors who are not in our network.

If You Have Other Health Insurance

If you have other health insurance, contact our Member Services department toll-free at **1-866-270-5785, TTY 711**, to notify UnitedHealthcare Community Plan of California, Inc. that you have other health insurance.

Workers' Compensation

UnitedHealthcare Community Plan of California, Inc. will not pay for injuries that are a result from work- related injuries that are covered under Workers' Compensation. You will need to provide all information needed to recover costs for any services provided by UnitedHealthcare Community Plan of California, Inc.

Third-Party Liability

If another person (a third party) injures you, we will arrange for covered services. The California Department of Health Care Services (DHCS) may try to recover the cost of those services from the third party. DHCS may require that you help them with this recovery. If you get money directly from the third party, you must pay DHCS for the value of any services we provided and paid for.

Changing Your Health Plan

You may leave UnitedHealthcare Community Plan and join another health plan at any time. Call Health Care Options at **1-800-430-4263 (TTY 1-800-430-7077)** to choose a new plan. You can call between 8:00 a.m. and 5:00 p.m. Monday through Friday. Or visit http://www.healthcareoptions.dhcs.ca.gov.

If you want to leave UnitedHealthcare Community Plan sooner, you may ask Health Care Options for an expedited (fast) disenrollment. If the reason for your request meets the rules for expedited disenrollment, you will get a letter to tell you that you are disenrolled. Qualifying reasons include special health care needs, including a major organ transplant. Qualifying reasons may also include receiving services under the Foster Care or Adoption Assistance Programs, being enrolled in another Medi-Cal, Medicare or commercial managed care plan, or moving out of your current county.

You may ask to leave UnitedHealthcare Community Plan in person at your local county human services office. Find your local office at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx or call 1-800-300-1506 to reach Covered California.

Involuntary disenrollment.
You will lose managed care coverage with us, but not necessarily your Medi-Cal benefits, if any of the following happens:

- You permanently move outside of the Service Area.
- You become no longer eligible for Medi-Cal.
- You are a resident of Sacramento County and are in a long-term care, skilled nursing, or intermediate care facility for longer than the month of your admission plus the following month. These services are covered under regular Medi-Cal (fee-for- service program).
- Your doctor determines you need a major organ transplant, other than a kidney transplant. These services are covered under regular Medi-Cal (fee-for-service program).

If you are disenrolled from the health plan, we will send you a letter. You can appeal your disenrollment. See the Grievances, Appeals and State Hearings section of this handbook for more information on appeals. You can also call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Informed Consent

Consent means you say "yes" to treatment. Informed consent means:

- The treatment was explained to you and you understand.
- You say yes before getting any treatment.
- You may need to say yes in writing.
- If you do not want the treatment, your PCP will tell you about other options.
- You have the right to say yes or no.

Organ Donation

If you wish to become an organ or tissue donor in the event of your death, contact the California Department of Motor Vehicles (DMV) at 1-800-777-0133 or (TTY 1-800-368-4327).

Advance Directives

You have the right to make care decisions even when you can't speak for yourself. You need to make an advance directive. Then your doctor will know what you want done or not done if you can't talk. A living will and a durable power of attorney are two types of advance directives.

Living wills.
A living will lets you state your wishes about medical care if you are terminally ill, permanently unconscious or in a vegetative state and cannot make your own decisions.

Durable power of attorney for health care.
A durable power of attorney for health care lets you name someone to make medical decisions if you cannot speak for yourself. This can include decisions about life support. The person you appoint can speak for you at any time you are unable to make your own medical decisions, not just at the end of your life. Visit **UHCCommunityPlan.com** to learn more or to download the advance directive forms.

Privacy of Records

UnitedHealthcare Community Plan of California, Inc. takes privacy issues and laws seriously. Safeguards are in place to protect information about you. We don't share private information without your written okay unless there is a legal reason.

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability. The Act requires UnitedHealthcare Community Plan of California, Inc. and its contractors to make reasonable accommodations for Members with disabilities. Call our Member Services department toll-free at **1-866-270-5785, TTY 711**, if you are not able to find a doctor who meets your needs.

Disability access grievances: You may file a grievance with UnitedHealthcare Community Plan of California, Inc. if you feel the plan or its doctors have failed to meet your disability access needs. Please see the Grievances, Appeals and State Hearings section of this handbook for more information, or call our Member Services department toll-free at **1-866-270-5785, TTY 711**.

Nondiscrimination Policy

UnitedHealthcare members have the right to get care without regard to age, sex, color, race, religion, sexual orientation, cultural background, physical or mental disability, national origin, or genetic information. Any member who feels discriminated against should file a grievance (a complaint). For information on how to file a grievance, see the Grievances, Appeals and State Hearings section of this handbook for more information, or call our Member Services department toll-free at **1-866-270-5785, TTY 711**. We want to make sure our members are treated fairly.

New Technology

We look at and review new technologies, which include new treatments, drugs, devices and procedures. To do this, we look at scientific reports and government information, and information from the medical community. We do this to decide whether to cover new technology. Members and providers can ask us to review new technology.

Glossary/Important Terms

Active Labor: A labor at a time at which either (1) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (2) a transfer may pose a threat to the health and safety of you or the unborn child.

Adult Day Health Care (ADHC) Center: An organized day program of therapeutic, social and health activities and services provided to people age fifty-five (55) years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care.

Advance Directive: A decision a person makes ahead of time about the person's health care in case the person becomes unable to speak for himself or herself. Advance directives let family and doctors know what decisions the person would make.

AIDS (Acquired Immunodeficiency Syndrome): A chronic, potentially life-threatening condition caused by the human immunodeficiency virus (HIV).

Americans with Disabilities Act (ADA): A federal law that prohibits discrimination on the basis of disability.

Ambulance Services: See Emergency transportation.

Appeal: Request for a review of a Notice of Adverse Benefit Determination (NABD).

Authorization: An okay or approval for a service. See also Prior Authorization.

Benefits: Services, procedures and medications UnitedHealthcare Community Plan of California, Inc., Medi-Cal, or other State or Federal program will cover (pay for) for you.

BIC Card: See Medi-Cal Benefits Identification Card.

Braille: A tactile writing system used by the blind and the visually impaired.

California Children's Services (CCS): The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS-eligible conditions.

California Department of Health Care Services (DHCS): The California state agency that is responsible for the Medi-Cal program.

California Department of Health Care Services Office of Family Planning (OFP): See Office of Family Planning.

California Department of Health Care Services Ombudsman Office: See Medi-Cal Managed Care Ombudsman Program.

California Department of Managed Care (DMHC): The California state agency responsible for regulating health care service plans.

California Department of Social Services (CDSS): Responsible for the oversight and administration of programs serving California's most vulnerable residents.

Care Management Programs: UnitedHealthcare Community Plan of California, Inc. programs that provide a holistic approach to helping Members live healthier lives, and include programs on respiratory care and asthma, cardiac care, diabetes care, transplant care, HIV/AIDS care, and high-risk pregnancy care.

Care Managers: UnitedHealthcare Community Plan of California, Inc. people who give support to and help educate Members in who are in a Care Management Program.

Cesarean Section (C-Section): Surgical delivery of an infant through the mother's abdomen.

Certified Nurse Midwife (CNM): Non-Physician Medical Practitioner who is licensed as a Registered Nurse and certified as a nurse midwife by the California Board of Registered Nursing.

Certified Nurse Practitioner: A registered nurse who has completed an advanced training program in a medical specialty.

Child Health and Disability Prevention (CHDP) Program: A California Department of Health Care Services (DHCS) preventive program that delivers periodic health assessments and services to low-income children and youth in California.

Childhood Lead Poisoning Prevention Program (CLPPP): Provides services to the community for the purpose of increasing awareness regarding the hazards of lead exposure, reducing lead exposure and increasing the number of children assessed and appropriately blood tested for lead poisoning.

Community-Based Adult Services (CBAS): A California Department of Health Care Services (DHCS) outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries.

Department of Defense (DOD): See United States Department of Defense (DOD).

Department of Veterans Affairs (VA): See United States Department of Veterans Affairs (VA).

Diagnostic and Statistical Manual of Mental Disorders (DSM): The standard classification of mental disorders used by mental health professionals in the United States.

Disenrollment: To stop your membership in UnitedHealthcare Community Plan of California, Inc. Disenrollment can be voluntary (at the request of the Member) or involuntary (regardless of the Member's wishes).

DOD (Department of Defense): See United States Department of Defense (DOD).

Durable Medical Equipment: Medically necessary equipment that is used over and over by a person who is injured or sick, is safe for use in or out of the home, and is generally not useful to people who do not have an illness or injury.

Durable Power of Attorney for Health Care: Lets a person name someone to make medical decisions for the person if the person cannot speak for himself or herself. This can include decisions about life support.

Early Start Program: A program that consists of teams of service coordinators, health care providers, early intervention specialists, therapists, and parent resource specialists who evaluate and assess infants or toddlers and provide appropriate early intervention and family support services for children who qualify from birth to three (3) years of age.

Emergency Care: Medical care received when having an Emergency Medical Condition.

Emergency Medical Condition: A medical or psychiatric (mental) condition with such severe symptoms, such as active labor (see definition above) or severe pain, that someone with the prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger.
- Cause impairment to a body function.
- Cause a body part or organ to not work right.

Emergency Room (ER): An area of a health care facility used to provide rapid treatment to victims of sudden trauma or illness.

Emergency Transportation (Ambulance) Services: Emergency transportation services provided through the "911" emergency response system, typically by an ambulance.

Enteral Nutrition: The medical term for tube feeding.

External Independent Review (EIR): A California Department of Managed Care process for reviewing certain health care services disputes.

Family Planning Services: Covered services that help people learn about and plan the number and spacing of children they want, through the use of birth control.

FDA (United States Food and Drug Administration): See United States Food and Drug Administration (FDA).

Federal: The United States of America.

Federally Qualified Health Center (FQHC): A health center that receives money from the federal government to provide health care in areas that do not have a lot of health care services.

Fee-for-Service (FFS): A method of payment based upon per unit or per procedure billing for services rendered to a Member.

Fee-for-Service Medi-Cal: The component of the Medi-Cal program where Medi-Cal providers are paid directly by the state of California for their services. Also known as "regular" Medi-Cal.

Food and Drug Administration (FDA): See United States Food and Drug Administration (FDA).

Formulary: A list of approved drugs providers prescribe from.

Grievance: An expression of dissatisfaction (a complaint) about any matter other than an NABD.

Health Care Options: The California state program that enrolls and disenrolls Medi-Cal members into Medi-Cal Managed Care Plans, and helps Medi-Cal members choose or change Medi-Cal Managed Care Plans.

HIV (Human Immunodeficiency Virus): An infection that is transmitted through sex, contact with infected blood, or from mother to child during pregnancy, childbirth or breastfeeding caused by the virus that causes AIDS.

Hospice: Care and services provided in the home or a facility to people who have been diagnosed with a terminal illness and with a life expectancy of twelve (12) months or less if the illness runs its normal course.

In-Network: Doctors, Specialists, hospitals, pharmacies and other providers who have an agreement with UnitedHealthcare Community Plan of California, Inc. to give care to its members.

Independent Medical Review: A California Department of Managed Care process for reviewing certain health care services disputes.

Indian Health Centers: A facility that provides services to Native Americans.

Inpatient: When you are admitted to a hospital or services you get after being admitted to a hospital.

Intermediate Care Facility (ICF): A facility licensed to provide twenty-four (24) hour a day services, for the developmentally disabled, and those who need habilitative, nursing or continuous nursing care.

Intermediate Care Facility for the Developmentally Disabled (ICF-DD): A facility licensed to provide twenty-four (24) hour a day services for the developmentally disabled.

Living Will: A living will allows a person to communicate the person's wishes about his or her medical care if terminally ill, permanently unconscious, or in a vegetative state and can no longer make decisions.

Local Education Agency (LEA): A California Department of Health Care Services agency that provides certain health assessment services through schools.

Long-Term Care: Care in a facility for longer than the month of admission plus one month.

Medicaid: The federal and state health insurance program for low-income and needy people. This program is funded by state and federal dollars. In California, the Medicaid program is called "Medi-Cal."

Medi-Cal: The California health coverage program for Medicaid. This program is funded by state and federal dollars.

Medi-Cal Benefits Identification Card (also called a "BIC card"): The plastic card sent to everyone who is eligible for Medi-Cal. All Medi-Cal providers use the BIC card to check eligibility.

Medi-Cal Managed Care Health Plan: An organization with doctors, specialists, clinics, pharmacies and hospitals that provides health care services to its members.

Medi-Cal Managed Care Ombudsman Program: A California Department of Health Care Services program that assists in the mediation of disputes between Medi-Cal Managed Care health Plan Members and their Medi-Cal Managed Care Health Plan and providers, and attempts to resolve these disputes informally outside of the formal grievance and appeal processes.

Medically Necessary/Medical Necessity: All covered services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Medicare: A federal insurance program, mainly for people who are sixty-five (65) or older.

Member: An eligible person enrolled in Medi-Cal with UnitedHealthcare Community Plan of California, Inc.

Member Services Department: A department within UnitedHealthcare Community Plan of California, Inc. that can answer questions and help members use their Medi-Cal services and benefits.

Minor Consent Services: Those covered services of a sensitive nature which minors do not need parental consent to access, related to (1) sexual assault, including rape, (2) drug or alcohol abuse for children twelve (12) years of age or older, (3) pregnancy, (4) family planning, (5) sexually transmitted diseases (STDs) for children twelve (12) years of age or older, and (5) outpatient mental health care for children twelve (12) years of age or older who are mature enough to participate intelligently and where either (a) there is a danger of serious physical or mental harm to the minor or others or (b) the children are the alleged victims of incest or child abuse.

National Institutes of Health (NIH): A federal agency that conducts medical research.

Native American Health Clinic: A clinic that provides services to Native Americans.

Non-Emergency Medical Transportation Services (NEMT): Transportation to a medical facility for Members who cannot take regular transportation (bus, car, train, etc.) because of a physical or medical condition.

Non-Emergency Non-Medical Transportation Services: Transportation to a medical appointment for Members who cannot get themselves to the appointment because the Member is recovering from a medical procedure or serious injury and the Member has no other way to get to the appointment.

Notice of Adverse Benefit Determination (NABD): A notice that is sent by UnitedHealthcare Community Plan of California, Inc. when UnitedHealthcare Community Plan of California, Inc. denies or limits a medical service, reduces, suspends or terminates payment for a service a Member is receiving, fails to authorize a service within the required time frame, or fails to decide a grievance or appeal in the required time frame.

NurseLine℠: A service provided by UnitedHealthcare Community Plan of California, Inc. to its Members that offers a variety of health information and resources, and has registered nurses that give information and support for members' health questions and concerns.

OB/GYN: See Obstetrician.

Obstetrician (OB/GYN): A medical and surgical specialty providing comprehensive services for women throughout their lives, including adolescent care, pregnancy care, and menopause care.

Office of Family Planning (OFP): Part of the California Department of Health Care Services (DHCS), the Office of Family Planning provides people with the means by which they decide the number, timing, and spacing of their children.

Ombudsman Program: See Medi-Cal Managed Care Ombudsman Program.

Out-of-Network: Doctors, Specialists, hospitals, pharmacies and other providers who do not have an agreement with UnitedHealthcare Community Plan of California, Inc. to give care to its members.

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

Plan ID Card: See UnitedHealthcare Community Plan of California, Inc. ID card.

Preventive Health Care Services: Health care services designed to prevent disease and/or its consequences.

Post-Stabilization Services: Services you receive after an emergency medical condition is stabilized.

Primary Care Provider (PCP): The doctor who takes care of most of the health needs of the UnitedHealthcare Community Plan of California, Inc. member. This can be a family or general practitioner, internist, pediatrician, or other type of provider. Females may choose an OB/GYN as their Primary Care Provider.

Prior Authorization: A formal process where a doctor submits a request for services before the care is given to the Member to obtain approval for the services in advance.

Provider or Practitioner: A person or facility that offers care (doctor, Specialist, pharmacy, dentist, clinic, hospital, etc.).

Provider Directory: A list of providers who participate with UnitedHealthcare Community Plan of California, Inc. to take care of its members' health care needs.

Psychiatric Emergency Medical Condition: A mental disorder manifested by acute symptoms that render you (1) an immediate danger to yourself or others; or (2) immediately unable to provide for, or utilize, food, shelter or clothing.

Public Policy Committee/Community Advisory Committee: A UnitedHealthcare Community Plan of California, Inc. committee that works to assure the comfort, dignity, and convenience of Members, discusses Member issues, and creates policy.

Referral: A process where your PCP sends you to a Specialist.

Regular Medi-Cal: See Fee-for-Service Medi-Cal.

Sacramento County Department of Human Assistance: Provides a broad range of health and social services, promoting wellness, self-sufficiency, and a better quality of life for all individuals and families in Sacramento County.

San Diego Department of Health and Human Services: Provides a broad range of health and social services, promoting wellness, self-sufficiency, and a better quality of life for all individuals and families in San Diego County.

San Diego or Sacramento County Mental Health Plan: A County mental health program that provides certain mental health services to eligible Medi-Cal members.

Screening and Brief Intervention: A comprehensive, integrated, public health approach to the delivery of early intervention to individuals at risk for developing substance use disorders.

Service Area: The county of Sacramento or San Diego.

Skilled Nursing Facility: A facility licensed to provide inpatient skilled nursing care, rehabilitative services or other related health services.

Specialist: A doctor or other health care professional who is board certified, accredited, or otherwise recognized by a board of physicians or similar peer group, as having special expertise in a certain clinical area of practice to treat a special health problem.

Specialty Mental Health Provider: A person or entity that is licensed, certified or otherwise recognized or authorized under State law governing the health arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program.

Specialty Mental Health Service:

- Rehabilitative services, which includes mental health services, medication support services, day treatment intensive day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.
- Psychiatric inpatient hospital services.
- Targeted Case Management.
- Psychiatrist services.
- Psychologist services.
- Early and periodic screening, diagnosis, and treatment (EPSDT) supplemental specialty mental health services.

State: The state of California.

State Hearing: A California Department of Managed Care process for reviewing certain health care services disputes.

Sub-Acute Facility: A facility that provides a level of care needed by a person who does not need hospitalization but needs more care than is typically provided by a Skilled Nursing Facility.

Targeted Case Management: Services that assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services.

Telecommunications Device for the Deaf (TDD): A special device required at both ends of the conversation that enables people who are deaf, hard of hearing, or speech-impaired to use the telephone to communicate, and is also known as TeleType (TTY).

Telecommunications Relay Service (TRS): A telephone service that allows people with hearing or speech disabilities to place and receive telephone calls.

TeleType (TTY): A special device required at both ends of the conversation that enables people who are deaf, hard of hearing, or speech-impaired to use the telephone to communicate, and is also known as Telecommunication Device for the Deaf (TDD).

Third Party Liability: Responsibility of another person under the law.

Transitional Medi-Cal (TMC): Transitional Medi-Cal is health insurance coverage for families who no longer qualify for CalWORKs cash aid or Medi-Cal for low-income families because of earnings from work. All members of the family may still get no-cost Medi-Cal for up to 12 months.

UnitedHealthcare Community Plan of California, Inc. ID Card (also called a "Plan ID card"): The identification card given to you by UnitedHealthcare Community Plan of California, Inc. upon enrollment into the plan.

United States Department of Defense (DOD): The federal agency in charge of the United States military.

United States Department of Veterans Affairs (VA): The federal agency that is responsible for assisting veterans and their families.

United States Food and Drug Administration (FDA): A federal agency responsible for protecting the public health by assuring the safety, effectiveness, quality and security of human and veterinary drugs, vaccines and other biological products, medical devices, cosmetics, dietary supplements, products that give off radiation and most of the food supply of the United States, and regulating tobacco products.

Urgent Care: Services that are needed to prevent serious decline of health following an unforeseen medical condition or injury.

Utilization Management (UM): A method used to encourage the highest quality of care, in the most appropriate setting, and from the most appropriate provider.

Vaccines for Children Program: The federally funded program that provides free vaccines for eligible children, including Medi-Cal eligible children age eighteen (18) or younger, and distributes immunization updates and related information to participating providers.

Women, Infant and Children Program (WIC) Program: A state nutrition program that helps pregnant women, new mothers and young children eat well and stay healthy.

Workers' Compensation: Provides coverage for an employee who has been injured or become ill due to job-related duties.

Health Plan Notice of Privacy Practices

THIS NOTICE SAYS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED. IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. READ IT CAREFULLY.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Effective January 1, 2016.
We1 must by law protect the privacy of your health information ("HI"). We must send you this notice. It tells you:

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

We must by law follow the terms of this notice. "Health information" (or HI) in this notice means information related to your health or health care services that can be used to identify you. We have the right to change our privacy practices. If we change them, we will notify you by mail or e-mail, as permitted by law. If we maintain a website for your health plan, we will also post the new notice on **myuhc.com/CommunityPlan**. We have the right to make the changed notice apply to HI that we have now and to future information. We will follow the law and give you notice of a breach of your HI.

We collect and keep your HI so we can run our business. HI may be oral, written or electronic. We limit access to all types of your HI to our employees and service providers who manage your coverage and provide services. We have physical, electronic and procedural safeguards per federal standards to guard your HI.

How we use or share your information.
We must use and share your HI with:

- You or your legal representative.
- The Secretary of the Department of Health and Human Services.

We have the right to use and share your HI for certain purposes. This must be for your treatment, to pay for your care, and to run our business. For example, we may use and share your HI:

- **For Payment.** We may use or share your HI to process premium payments and claims. This also may include coordinating benefits. For example, we may tell a doctor if you are eligible for coverage and how much of the bill may be covered.
- **For Treatment or Managing Care.** We may share your HI with providers to help them give you care.
- **For Health Care Operations Related to Your Care.** We may suggest a disease management or wellness program. We may study data to see how we can improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.

- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer plan sponsor. We may give them other HI if they agree to limit its use as required by federal law.
- **For Underwriting Purposes.** We may use your HI to make underwriting decisions, but we will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may use your HI to send you information on your health benefits or care and doctor's appointment reminders.

We may use or share your HI as follows:

- **As Required by Law.**
- **To Persons Involved With Your Care.** This may be to a family member. This may happen if you are unable to agree or object. Examples are an emergency or when you agree or fail to object when asked. If you are not able to object, we will use our best judgment. If you pass away, we may share HI with family members or friends who helped with your care prior to your death unless doing so would go against wishes that you shared with us before your death.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability, as allowed by law.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) To give health care; (2) To protect your health and the health of others; (3) For the security of the institution.
- **To Our Business Associates** if needed to give you services. Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.
- **Other Restrictions.** Federal and state laws may limit the use and sharing of highly confidential HI. This may include state laws on:

  1. HIV/AIDS
  2. Mental health
  3. Genetic tests
  4. Alcohol and drug abuse
  5. Sexually transmitted diseases and reproductive health

6. Child or adult abuse or neglect or sexual assault

If stricter laws apply, we aim to meet those laws. The attached "Federal and State Amendments" document describes those laws in more detail.

Except as stated in this notice, we use your HI only with your written consent. This includes getting your written consent to share psychotherapy notes about you, to sell your HI to other people, or to use your HI in certain promotional mailings. If you allow us to share your HI, we do not promise that the person who gets it will not share it. You may take back your consent, unless we have acted on it. To find out how, call the phone number on your ID card.

Your rights.

You have a right:

- To ask us to limit use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others involved in your care or payment for it. We may allow your dependents to ask for limits. We will try to honor your request, but we do not have to do so.
- To ask to get confidential communications in a different way or place. (For example, at a P.O. Box instead of your home.) We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- To see or get a copy of certain HI that we use to make decisions about you. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you will have the right to ask for an electronic copy to be sent to you. You can ask to have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- To ask to amend. If you think your HI is wrong or incomplete, you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- To get an accounting of HI shared in the six years prior to your request. This will not include any HI shared: (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 require us to track.

- To get a paper copy of this notice. You may ask for a copy at any time. Even if you agreed to get this notice electronically, you have a right to a paper copy. If we maintain a website for your health plan, you may also get a copy at our website: **myuhc.com/CommunityPlan**.

Using your rights.

- To Contact your Health Plan. Call the phone number on your ID card. Or you may contact the UnitedHealth Group Call Center at **1-866-270-5785 or TTY 711**.
- To Submit a Written Request. Mail to:

  UnitedHealthcare Government Programs 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.

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

Effective January 1, 2016.
We protect your personal "financial information" ("FI"). This means non-health information about someone with health care coverage or someone applying for coverage. It is information that identifies the person and is generally not public.

Information we collect.
We get FI about you from:

- Applications or forms. This may be name, address, age and social security number.
- Your transactions with us or others. This may be premium payment data.

Sharing of FI.
We do not share FI about our members or former members, except as required or permitted by law.

To run our business, we may share FI without your consent to our affiliates. This is to tell them about your transactions, such as premium payment.

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To other companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To other companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and security.
We limit access to your FI to our employees and service providers who manage your coverage and provide services. We have physical, electronic and procedural safeguards per federal standards to guard your FI.

Questions about this notice.
If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at **1-866-270-5785 or TTY 711**.

Protected Information Release

Member's Name _____ ID # _____

Address _____

I hereby authorize _____

Address _____

to provide the following information to _____

Address _____

for health care coordination, care management, coordination of benefits and other health insurance purposes.

Social History	Authorized Services/Treatment Received
Psychiatric Evaluation	Diagnosis
Psychological Evaluation	Summary of CM Services
Service Coordination Plans	Other Referrals/Consultations
Other	HIV-related Information/Status

I have been informed and understand that I can revoke this authorization at any time by informing UnitedHealthcare Community Plan of California in writing. Revocation is not effective for disclosures of protected health information that have already occurred. I understand that UnitedHealthcare Community Plan of California may not condition the provision of treatment, payment, enrollment in the health plan or eligibility for benefits on the provision of an authorization. This authorization is effective beginning on _____. It does not expire until I notify UnitedHealthcare Community Plan of California in writing.

_____

Member or Personal Representative / Relationship to Member Date

_____

Witness Date

Member Services
UnitedHealthcare Community Plan of California
4365 Executive Drive, Suite 500, San Diego, CA 92121
1-866-270-5785, TTY 711

Grievance and Appeal Form

Member's Name _____ ID # _____

Address _____

Telephone Number: (Home) _____ (Work) _____

Please choose one of the following:

☐ GRIEVANCE — Are you unhappy about something other than a benefit or claims payment decision we made?

☐ APPEAL — Are you unhappy about a benefit or claims payment decision we made?

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

_____

_____

_____

_____

_____

_____

Name, Address and Phone number of your Authorized Representative, if any:

_____

_____

(Signature) (Date)

Member Services
UnitedHealthcare Community Plan of California
Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-866-270-5785, TTY 711** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired.

The department's internet website, http://www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

We're Here for You.

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-866-270-5785, TTY 711** Monday through Friday 7:00 a.m. – 7:00 p.m. You can also visit our website at **myuhc.com/CommunityPlan**.

UnitedHealthcare®
Community Plan