



Virginia

Welcome to the community

Commonwealth of Virginia

Department of Medical Assistance Services (DMAS)

Cardinal Care Member Handbook

November 1, 2023

CSVA23MD0089375_000

United
Healthcare
Community Plan



Table of contents

1. Let's get started	<u>6</u>
Welcome to Cardinal Care	<u>6</u>
Other languages and formats	<u>6</u>
Notice of nondiscrimination	<u>10</u>
Important contact information	<u>11</u>
Staying connected	<u>13</u>
2. Cardinal Care managed care overview	<u>14</u>
Health plan enrollment	<u>14</u>
Welcome packet	<u>16</u>
Other insurance	<u>18</u>
3. Providers and getting care	<u>19</u>
UnitedHealthcare Community Plan's provider network	<u>19</u>
Primary Care Providers (PCPs)	<u>20</u>
Specialists	<u>22</u>
Out-of-state providers	<u>22</u>
When a provider leaves the network	<u>23</u>
Getting care outside of UnitedHealthcare Community Plan's network	<u>23</u>
Choices for nursing facility members	<u>24</u>
Making appointments with providers	<u>25</u>
Telehealth	<u>25</u>
Getting care from the right place when you need it quickly	<u>26</u>
Getting care after hours	<u>29</u>
Transportation to care	<u>29</u>

Questions? Visit uhccommunityplan.com/Virginia, or call Member Services 3
at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

4. Care coordination and care management.	<u>31</u>
Care coordination	<u>31</u>
What is care management?	<u>32</u>
How to get a care manager.	<u>32</u>
Health Risk Assessment	<u>35</u>
Your care plan.	<u>35</u>
Your care team	<u>35</u>
Coordination with Medicare or other health plans.	<u>36</u>
Additional care management services.	<u>36</u>
5. Your benefits.	<u>37</u>
Overview of covered benefits	<u>37</u>
Benefits for all members	<u>38</u>
Benefits for Home and Community Based Services (HCBS) waiver enrollees	<u>46</u>
Benefits for children/youth under age 21.	<u>48</u>
Benefits for family planning and pregnant/postpartum people.	<u>50</u>
Newborn coverage	<u>51</u>
Added benefits for UnitedHealthcare Community Plan members.	<u>51</u>
6. Your prescription drugs.	<u>53</u>
Understanding your prescription drug coverage	<u>53</u>
Getting your drugs from a network pharmacy.	<u>56</u>
Getting your drugs mailed to your home	<u>57</u>
Patient Utilization Management and Safety Program.	<u>57</u>
7. Getting approval for your services, treatments, and drugs.	<u>58</u>
Second opinions.	<u>58</u>
Service authorization.	<u>58</u>
Adverse benefit determinations	<u>61</u>

4 **Questions?** Visit uhccommunityplan.com/Virginia, or call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

8. Appeals and complaints	<u>62</u>
Appeals	<u>62</u>
Complaints	<u>67</u>
9. Cost sharing	<u>70</u>
Copayments.	<u>70</u>
Patient pay	<u>70</u>
Premiums	<u>71</u>
10. Your rights	<u>72</u>
General rights.	<u>72</u>
Advance Directives	<u>73</u>
Member Advisory Committee.	<u>74</u>
11. Your responsibilities	<u>75</u>
General responsibilities.	<u>75</u>
Reporting fraud, waste, and abuse	<u>76</u>
12. Key words and definitions in this handbook	<u>79</u>
Health Plan Notices of Privacy Practices	<u>89</u>

1. Let's get started

Welcome to Cardinal Care

Medicaid and Family Access to Medical Insurance Security (FAMIS) Plan are health insurance programs funded by the state and the federal government. They are run by the Virginia Department of Medical Assistance Services (DMAS or “the Department”). For more information, visit dmas.virginia.gov and dmas.virginia.gov/for-members/cardinal-care. Monthly income limits for eligibility vary by program. For more information on eligibility, visit coverva.org. Both programs have full benefits as described below.

This Member Handbook explains benefits and how to access services for Cardinal Care, Virginia’s Medicaid/FAMIS program. For questions, call UnitedHealthcare Community Plan’s Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday, visit our website at uhcommunityplan.com/Virginia or call your care manager.

Other languages and formats

If you need this handbook in large print, in other formats or languages, read aloud, or if you need a paper copy, call UnitedHealthcare Community Plan’s Member Services at **1-844-752-9434**, TTY **711**. You can get what you need for free. Members with alternative hearing or speech communication needs can dial 711 to reach a Telecommunications Relay Services (TRS) operator who can help you. Auxiliary aids and services are available upon request at no cost. Visit us online anytime at uhcommunityplan.com/Virginia or dmas.virginia.gov.

English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Please call **1-844-752-9434, TTY 711.**

Spanish

ATENCIÓN: si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-752-9434, TTY 711.**

Korean

참고: 한국어(Korean)를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-844-752-9434, TTY 711** 로 전화하십시오.

Vietnamese

LƯU Ý: Nếu quý vị nói Tiếng Việt (Vietnamese), chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **1-844-752-9434, TTY 711.**

Chinese

注意:如果您說中文(Chinese), 您可獲得免費語言協助服務。請致電 **1-844-752-9434, 或聽障專線(TTY)711。**

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية (Arabic) ، تتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل بالرقم **1-844-752-9434، الهاتف النصي 711.**

1. Let's get started

Tagalog

ATENSYON: Kung nagsasalita ka ng Tagalog (Tagalog), may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa 1-844-752-9434, TTY 711.

Persian (Farsi)

توجه: اگر به فارسی (Farsi) صحبت می کنید، خدمات ترجمه به صورت رایگان در اختیارتان قرار می گیرد. با 1-844-752-9434 (TTY 711) تماس بگیرید.

Amharic

የሚናገሩት ቋንቋ አማርኛ (Amharic) ከሆነ የቋንቋ እርዳታ አገልግሎት ከክፍያ ነጻ አለልዎት። ወደ 1-844-752-9434, TTY 711 ይደውሉ።

Urdu

توجه فرمائیں: اگر آپ کی زبان اردو (Urdu) ہے تو آپ کے لیے لسانی خدمات مفت دستیاب ہیں۔ 1-844-752-9434 (TTY 711) پر کال کریں۔

French

ATTENTION: Si vous parlez français (French), vous pouvez obtenir une assistance linguistique gratuite. Appelez le 1-844-752-9434, TTY 711.

Russian

ВНИМАНИЕ: Если вы говорите по-русски (Russian), вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел 1-844-752-9434, TTY 711.

Hindi

ध्यान दे: यदि आप **हिंदी (Hindi)** भाषा बोलते हैं तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **1-844-752-9434**, TTY 711.

German

HINWEIS: Wenn Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Wählen Sie: **1-844-752-9434**, TTY 711.

Bengali

আপনি যদি **বাংলায় কথা (Bengali)** বলেন, তাহলে ভাষা সহায়তা পরিষেবাগুলি, আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-844-752-9434**, TTY 711 নম্বরে ফোন করুন।

Kru (Bassa)

TÒ ÌDÙŪ NÒ MÒ DYÍIN CÁO: À bédé gbo-kpá-kpá **bó wuḍu (Kru (Bassa))**-dù kò-kò po-nyò bě bìlì nō à gbo bó pídyi. M̄ dyi gbo-kpá-kpá m̄ ó ín, d̄á nò bà nià k̄e: **1-844-752-9434**, TTY 711.

Igbo

Ọ bụrụ na ị na asụ **Igbo (Igbo)**, ọrụ enyemaka asụsụ, n'efu dijiri gi. Kpọọ **1-844-752-9434**, TTY 711.

Yoruba

Tí ó bá ń s **Yorùbá (Yoruba)**, ìrànṣíwọ́ ìtum èdè, wà fún ní ọfẹ́. Pe **1-844-752-9434**, TTY 711.

1. Let's get started

Notice of nondiscrimination

UnitedHealthcare does not discriminate (or treat you differently) based on race, color, national origin, age, disability, or sex. UnitedHealthcare Community Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

UnitedHealthcare Community Plan provides:

- Free aids and services to people with disabilities to communicate effectively, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact UnitedHealthcare Community Plan's Member Services at **1-844-752-9434**, TTY **711**. This call is free.

If you think UnitedHealthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at:

Civil Rights Coordinator, DMAS
600 E. Broad St.
Richmond, VA 23219
Telephone: 804-786-7933, TTY 1-800-343-0634

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at

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

UHC_Civil_Rights@uhc.com

1-800-368-1019, TTY **800-537-7697**

Complaint forms are available at <https://hhs.gov/ocr/office/file/index.html>.

10 **Questions?** Visit uhccommunityplan.com/Virginia, or call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

Important contact information

Below is a list of important phone numbers you may need. If you are not sure who to call, contact UnitedHealthcare Community Plan's Member Services for help. This call is free. Free interpreter services are available in all languages for people who do not speak English.

Entity name	Contact information
United Healthcare Community Plan Member Services	<p>1-844-752-9434, TTY 711 8:00 a.m.–8:00 p.m., Monday–Friday uhccommunityplan.com/Virginia Including information on alternative technologies for afterhours.</p> <p>Download the UnitedHealthcare Community Plan Health4Me App. It's designed for people on the go, and includes many of the same features as the member website. Find it at the App Store or Google Play.</p> <p>If you would like to contact our Care Management program, please call Member Services at 1-844-752-9434 and ask for a Care Manager.</p> <p>You can also call 1-800-842-3014, TTY 711, 24 hours a day, seven days a week to talk to an on-call nurse or other licensed health professional.</p>
UnitedHealthcare Community Plan's Medical Advice Line	<p>1-800-842-3014, TTY 711 24 hours a day, seven days a week</p>
UnitedHealthcare Community Plan Behavioral Health Crisis Line	<p>1-800-842-3014, TTY 711 24 hours a day, seven days a week</p>

Questions? Visit uhccommunityplan.com/Virginia, or call Member Services 11 at **1-844-752-9434, TTY 711, 8:00 a.m.–8:00 p.m., Monday–Friday.**

1. Let's get started

Entity name	Contact information
Addiction and Recovery Treatment Services (ARTS) Medical Advice Line	1-800-842-3014, TTY 711 24 hours a day, seven days a week
Department of Behavioral Health and Developmental Services (DBHDS) for DD Waiver Services	My Life My Community Helpline 1-844-603-9248, TTY 804-371-8977 9:00 a.m.–4:30 p.m., Monday–Friday mylifemycommunityvirginia.org/
Cardinal Care Dental Benefits Administrator	1-888-912-3456, TTY 1-800-466-7566 8:00 a.m.–6:00 p.m., Monday–Friday dentaquest.com/state-plans/regions/virginia/
UnitedHealthcare Community Plan's Vision Services	1-844-752-9434, TTY 711
UnitedHealthcare Community Plan's Transportation Services	833-215-3884, TTY 844-488-9724 7:00 a.m.–7:00 p.m., Monday–Friday To check on the status of a scheduled ride, please call Ride Assist at 1-833-215-3885 .
Cardinal Care Transportation for Developmental Disability Waiver Services	1-866-386-8331, TTY 1-866-288-3133 Dial 711 to reach a TRS operator 24 hours a day, seven days a week.
Cardinal Care Managed Care Enrollment Helpline	1-800-643-2273, TTY 1-800-817-6608 8:30 a.m.–6:00 p.m., Monday–Friday
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019, TTY 1-800-537-7697 hhs.gov/ocr
Office of the State Long-Term Care Ombudsman	1-800-552-5019, TTY 1-800-464-9950 elderrightsva.org

12 **Questions?** Visit uhccommunityplan.com/Virginia, or call Member Services at **1-844-752-9434, TTY 711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

Staying connected

Have you moved, changed phone numbers, or gotten a new email address? It is important to let us know so that you keep getting high quality health insurance. The Department and UnitedHealthcare Community Plan need your current mailing address, phone number, and email address so that you do not miss any important updates and you receive information about changes to your health insurance.

You can update your contact information today:

- By calling Cover Virginia at 1-833-5CALLVA
- Online at commonhelp.virginia.gov
- By calling UnitedHealthcare Community Plan's Member Services
- By calling your local Department of Social Services (DSS)

Make sure to get the latest news about your Medicaid health insurance.

Update your contact info today.

2. Cardinal Care managed care overview

Health plan enrollment

You are successfully enrolled in UnitedHealthcare Community Plan. UnitedHealthcare Community Plan, a Cardinal Care Medicaid/FAMIS managed care plan (a “health plan”), covers your health care and provides care management. A health plan is an organization that contracts with doctors, hospitals, and other providers to work together to get you the health care you (the member) need. In Virginia, there are six Cardinal Care health plans that operate statewide.

If you move out-of-state you will no longer be eligible for Cardinal Care in Virginia, but you may be eligible for the Medicaid program in the state where you live. If you have questions about your eligibility for Cardinal Care, contact your local DSS or call Cover Virginia at 1-833-5CALLVA, TTY 1-888-221-1590. This call is free.

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

1. Call your doctor and schedule a checkup

Regular checkups are important for good health. If you don't know your Primary Care Provider (PCP) number, or if you need help finding a network doctor near you, call Member Services at **1-844-752-9434**, TTY **711**. We're here to help.

2. Take your Health Assessment

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

3. Get to know your health plan

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

4. Discover your plan online

Go to myuhc.com/CommunityPlan to sign up for our members only website to get tools that help you use your plan. You can view your member ID card, get help with using your benefits, take your Health Assessment, find answers to your questions about plan benefits, network doctors and sign-up for text and email communication. It just takes just a few minutes to register. Then you can log in anytime.

5. Check your member ID card

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

UnitedHealthcare Community Plan's Member Services is available to help if you have any questions or concerns. Call at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday, or visit us at uhcommunityplan.com/Virginia.

You can change your health plan:

- For any reason during the first 90 calendar days of enrollment
- For any reason once a year during your open enrollment period
- For “good cause” reasons determined by the Department. Examples include poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care. This includes OB care. If you are pregnant and your OB provider does not participate with UnitedHealthcare Community Plan and does participate with Medicaid fee-for-service (FFS), you can ask to get coverage through Medicaid FFS until after the delivery of your baby.

2. Cardinal Care managed care overview

Call the Cardinal Care Managed Care Enrollment Helpline at 1-800-643-2273, TTY 1-800-817-6608, 8:30 a.m. to 6:00 p.m., Monday through Friday, for information about your open enrollment period, or “good cause,” or to help you choose or change your health plan. Cardinal Care Managed Care Enrollment Helpline services are free. FAMIS members can call Cover Virginia at 1-833-5CALLVA to change health plans.

Welcome packet

You should have received a welcome packet that includes your member ID card, information on UnitedHealthcare Community Plan’s Provider Directory, and the Preferred Drug List. If you did not receive your welcome packet, call UnitedHealthcare Community Plan’s Member Services. This information is also listed on our member website, uhcommunityplan.com/Virginia.

UnitedHealthcare Community Plan member ID card

You must show your UnitedHealthcare Community Plan member ID card to get services or prescription drugs covered by your plan (see sample member ID card below) when you go to your provider or pharmacy. If you have not received your card, or if your card is damaged, lost, or stolen, call UnitedHealthcare Community Plan’s Member Services right away to get a new one.

	
Health Plan (80840) 911-87726-04	CardinalCare
Member ID: 001500001	Group Number: VACCCP
Member: NEW M ENGLISH Medicaid ID: 9999999991 PCP Name: DOUGLAS GETWELL PCP Phone: (717)851-6816	Payer ID: 87726  Rx Bin: 610494 Rx GRP: ACUVA Rx PCN: 4900
0501	UnitedHealthcare Community Plan Administered by UnitedHealthcare Insurance Company

In case of emergency call 911 or go to nearest emergency room. <small>Printed: 07/27/22</small>	
This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myUHC.com/CommunityPlan or call. Member Customer Service Hours 8:00 am-8:00 pm local time.	
Member Services/Behavioral: 844-752-9434	TTY 711
Dental: 888-912-3456	TTY 711
NurseLine: 800-842-3014	TTY 711
Transportation: 833-215-3884	TTY 711
For Providers: UHCprovider.com	844-284-0146
Claims: PO Box 5270, Kingston, NY 12402-5270	
Preauthorization: 844-284-0146	
Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334 For Pharmacists: 1-855-873-3493	

16 **Questions?** Visit uhcommunityplan.com/Virginia, or call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

2. Cardinal Care managed care overview

You may have more than one health insurance card. In addition to your UnitedHealthcare Community Plan member ID card, you should also have your Commonwealth of Virginia Medicaid/FAMIS ID card. Keep this card to access services that are covered by the Department under Medicaid. If you have Medicare and Medicaid, show your Medicare card and UnitedHealthcare Community Plan member ID card when you receive services. If you have coverage with a private (non-Medicaid) insurance company, show your private insurance ID card and your UnitedHealthcare Community Plan member ID card when you receive services.

UnitedHealthcare Community Plan's Provider Directory

The provider directory lists providers and pharmacies that participate in UnitedHealthcare Community Plan's network of contracted providers. It also includes information on the accommodations each provider has for members with disabilities or who do not speak English. You may ask for a paper copy of the Provider and Pharmacy Directory by calling Member Services at **1-844-752-9434**, TTY **711**. You can also see or download the Provider and Pharmacy Directory at www.uhccommunityplan.com/va.html. The provider directory will include name, address, phone numbers, professional qualifications, medical school attended (education), residency completion, board certification and specialty. While you are a member of our plan, and in most cases, you must use one of our network providers to get covered services.

Preferred Drug List

This list tells you which prescription drugs are covered by UnitedHealthcare Community Plan and the Department. It also tells you if there are any rules or restrictions on the drugs, like a limit on the amount you can get (see **Section 6 – Your prescription drugs**). Call UnitedHealthcare Community Plan's Member Services to find out if your drugs are on the list or check online at uhccommunityplan.com/Virginia. UnitedHealthcare Community Plan can also mail you a paper copy at your request.

2. Cardinal Care managed care overview

Other insurance

If you have more than one health insurance plan, then Medicaid pays for services after your other insurance plans have paid your provider. This means that if you have other insurance, are in a car accident, or if you are injured at work, then your other insurance or workers compensation must pay for your services first. Let UnitedHealthcare Community Plan's Member Services know if you have other insurance so that UnitedHealthcare Community Plan can coordinate your benefits. The Virginia Insurance Counseling and Assistance Program (VICAP) can also help. Call 1-800-552-3402, TTY 711 for health insurance counseling available to people with Medicare. This call is free.

3. Providers and getting care

UnitedHealthcare Community Plan's provider network

It is important that the providers you choose accept Cardinal Care members and participate in UnitedHealthcare Community Plan's network. UnitedHealthcare Community Plan's network includes access to care 24 hours a day, seven days a week.

UnitedHealthcare Community Plan provides you with a choice of providers that are located near you. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, you should not have to travel more than 60 miles or 75 minutes to receive services. To find providers, such as Primary Care Providers (PCPs), specialists, and hospitals, you can:

- Search for providers in the Provider Directory (see **Section 2 – Cardinal Care managed care overview**)
- Call UnitedHealthcare Community Plan's Member Services at **1-844-752-9434**, TTY **711** or visit us at uhcommunityplan.com/Virginia. You may ask for a paper copy.

You will usually see your Primary Care Provider (PCP) for most of your routine health care needs. Your Primary Care Provider will work with you to coordinate most of the services you get as a member of our plan. Coordinating your services or supplies includes checking or consulting with other plan providers about your care. If you need to see a doctor other than your PCP you may need a referral (authorization) from your PCP. You may also need to get approval in advance from your PCP before receiving certain types of covered services or supplies. In some cases, your PCP will need to get authorization (prior approval) from us.

3. Providers and getting care

You do not need a referral or service authorization to get:

- Care from your Primary Care Provider (PCP)
- Family planning services and supplies
- Routine women's health care services like breast exams, screening mammograms, pap tests, and pelvic exams, as long as you get them from a network provider
- Emergency or urgently needed services
- Routine dental services
- Services from Indian health providers, if you are eligible
- Other services for members with special health care needs as determined by UnitedHealthcare Community Plan

See below for more information about when a provider leaves the network and times when you can get care from out-of-network providers.

Primary Care Providers (PCPs)

Your PCP is a doctor or nurse practitioner who helps you get and stay healthy. Your PCP will provide and coordinate your health care services. You should see your PCP:

- For physical exams and routine checkups
- For preventive care services
- When you have questions or concerns about your health
- When you are not feeling well and need medical help

To help your PCP get to know you and your medical history, you should have your past medical records sent to your PCP's office. UnitedHealthcare Community Plan's Member Services or your care manager can help.

Choosing your PCP

You have the right to choose a PCP that is in UnitedHealthcare Community Plan's network. Review your Provider Directory to find a PCP in your community who can best meet your health care needs. You can also call UnitedHealthcare Community Plan's Member Services or your care manager for help. If you do not choose a PCP by the 25th day of the month before your health coverage begins, UnitedHealthcare Community Plan will assign you a PCP. UnitedHealthcare Community Plan will notify you in writing of your assigned PCP.

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

- Family doctor (also called a general practitioner) — Cares for children and adults
- Gynecologist (GYN) — Cares for women
- Internal medicine doctor (also called an internist) — Cares for adults
- Nurse Practitioner (NP) — Cares for children and adults
- Obstetrician (OB) — Cares for pregnant women
- Pediatrician — Cares for children

If you already have a PCP who is not in UnitedHealthcare Community Plan's network, you can continue seeing them for up to 30 days after enrolling in UnitedHealthcare Community Plan. For individuals who are pregnant or have significant health or social needs, you can continue seeing your PCP for up to 60 days after enrolling. If you do not choose a PCP in UnitedHealthcare Community Plan's network after the 30 day or 60 day period, UnitedHealthcare Community Plan will assign you a PCP. If you have a Medicare assigned PCP, you do not have to choose a PCP in UnitedHealthcare Community Plan's network. Call UnitedHealthcare Community Plan's Member Services or your care manager for help with selecting your PCP and coordinating your care.

3. Providers and getting care

Changing your PCP

You can change your PCP at any time. Call UnitedHealthcare Community Plan's Member Services to choose another PCP in UnitedHealthcare Community Plan's network. When you change your PCP, we will send you a new member ID card. The PCP is effective immediately.

Specialists

If you need care that your PCP cannot provide, UnitedHealthcare Community Plan or your PCP may refer you to a specialist. A specialist is a provider who has additional training on services in a specific area of medicine, like a surgeon. The care you receive from a specialist is called specialty care. If you need ongoing specialty care, your PCP may be able to refer you for a specified number of visits or length of time.

Out-of-state providers

The care you can get from out-of-state providers is limited to:

- Necessary emergency, crisis, or post-stabilization services
- Special cases in which it is common practice for those living in your locality to use medical resources in another state
- Medically necessary and required services that are not available in-network and within the state of Virginia
- Periods of transition (until you can get timely services from a network provider in the state)
- Out-of-state ambulances for facility-to-facility transfers

UnitedHealthcare Community Plan may need to give you authorization to see a provider who is out-of-state. UnitedHealthcare Community Plan does not cover any health care services outside of the U.S.

When a provider leaves the network

If your PCP leaves UnitedHealthcare Community Plan's network, UnitedHealthcare Community Plan will let you know and help you find a new PCP. If one of your other providers is leaving UnitedHealthcare Community Plan's network, contact UnitedHealthcare Community Plan's Member Services or your care manager for help finding a new provider and managing your care. You have the right to:

- Ask that medically necessary treatment you get is not interrupted and UnitedHealthcare Community Plan will work with you to ensure that it continues
- Get help selecting a new qualified provider
- File a complaint (see **Section 8 – Appeals and complaints**) or request a new provider if you feel UnitedHealthcare Community Plan's has not replaced your previous provider with a qualified provider or that your care is not being appropriately managed

Getting care outside of UnitedHealthcare Community Plan's network

You can get the care you need from a provider outside of UnitedHealthcare Community Plan's network in any of the following circumstances:

- If UnitedHealthcare Community Plan does not have a network provider to give you the care you need
- If a specialist you need is not located close enough to you (within 30 miles in urban areas or 60 miles in rural areas)
- If a provider does not provide the care you need because of moral or religious objections
- If UnitedHealthcare Community Plan approves an out-of-network provider
- If you are in a nursing facility when you enroll with UnitedHealthcare Community Plan, and the nursing facility is out-of-network
- If you get emergency care or family planning services from a provider or facility that is out-of-network. You can receive emergency treatment and family planning services from any provider, even if the provider is not in UnitedHealthcare Community Plan's network. This care is free.

Questions? Visit uhcommunityplan.com/Virginia, or call Member Services 23 at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

3. Providers and getting care

You will be allowed to continue seeing your out-of-network providers with reimbursement provided at the Medicaid Fee For Service rate for the duration of the continuity of care period for the first thirty (30) or sixty (60) days of your enrollment, depending on your medical need.

United Healthcare will make reasonable efforts to contact out-of-network providers who are providing services to you, and provide them with information on becoming credentialed, in-network providers.

If the provider does not join the network, or you do not select a new in-network provider, United Healthcare will facilitate a transition to a participating provider.

You also have the right to see your old providers and access prescription drugs or other needed medical supplies for up to 30 days (or 60 days, if you are pregnant or have significant health or social needs) if you were previously enrolled in Virginia's Medicaid program but are new to UnitedHealthcare Community Plan. After 30 days (or 60 days), you will need to see providers in UnitedHealthcare Community Plan's network unless UnitedHealthcare Community Plan extends this timeframe for you. You can call UnitedHealthcare Community Plan's Member Services or your care manager, if you have one, for help finding a network provider (see **Section 4 – Care coordination and care management** for more information about your care manager).

Choices for nursing facility members

If you are in a nursing facility at the time you enroll in UnitedHealthcare Community Plan, you may choose to:

- Remain in the facility as long as you remain eligible for nursing facility care
- Move to a different nursing facility
- Receive services in your home or other community-based settings

Making appointments with providers

Call your provider's office to make an appointment. For help with making an appointment, call UnitedHealthcare Community Plan's Member Services. If you need a ride to your appointment, call UnitedHealthcare Community Plan's transportation provider at 1-833-215-3884 TTY 1-844-488-9724.

If you call after hours, leave a message explaining how to reach you. Your PCP or other provider will call you back as quickly as possible. If you have difficulty getting an appointment with a provider, contact UnitedHealthcare Community Plan's Member Services. Remember to tell UnitedHealthcare Community Plan when you plan to be out of town so UnitedHealthcare Community Plan can help you arrange your services.

Telehealth

Telehealth lets you get care from your provider without an in-person office visit. Telehealth is usually done online with internet access on your computer, tablet, or smartphone. Sometimes it can be done over the phone. While telehealth is not appropriate for every condition or situation, you can often use telehealth to:

- Talk to your provider over the phone or through video chat
- Send and receive electronic messages with your provider
- Participate in remote monitoring so that your provider can track how you are doing at home
- Get medically necessary medical and behavioral health care

To make a telehealth appointment, contact your provider to see what services they provide through telehealth.

3. Providers and getting care

Getting care from the right place when you need it quickly

It is important to choose the right place to get care based on your health needs, especially when you need care quickly or unexpectedly. Below is a guide to help you decide whether your usual care team, like your PCP, can help you or whether you should go to an urgent care center or the emergency room. If you are not sure of what type of care you need, call your PCP or UnitedHealthcare Community Plan’s Medical Advice Line at 1-800-842-3014, TTY 711, 24 hours a day, seven days a week. This call is free.

Type of care	How to get care	Examples of when to get this type of care	Need a referral?
PCPs can provide care for when you get sick or injured and preventive care that keeps you healthy.	Contact your PCP’s office or UnitedHealthcare Community Plan to schedule an appointment.	<ul style="list-style-type: none">• Minor illness/injury• Flu/fever• Vomiting/diarrhea• Sore throat, earache, or eye infection• Sprains/strains• Possible broken bones	No

3. Providers and getting care

Type of care	How to get care	Examples of when to get this type of care	Need a referral?
<p>Urgent care is care you get for a sickness or an injury that needs medical care quickly and could turn into an emergency.</p>	<p>Check the Provider Directory at uhcommunityplan.com/Virginia to find an urgent care clinic.</p>	<p>Urgent care can manage similar things as your PCP, but is available when other offices are unavailable.</p>	<p>No, but make sure to go to an urgent care clinic that is in UnitedHealthcare Community Plan’s network if you can. An authorization is required for care that is not available from UnitedHealthcare Community Plan Community Plan’s network of providers.</p>

3. Providers and getting care

Type of care	How to get care	Examples of when to get this type of care	Need a referral?
<p>Emergency care (or care for an emergency medical condition) is care you get when an illness or injury is so serious that your (or, as applicable, your unborn baby’s) health, bodily functions, body organs or body parts may be in danger if you do not get medical care right away.</p>	<p>Call 911 and go to the nearest hospital. You have the right to get emergency care 24 hours a day, seven days a week from any hospital or other setting, even if you are in another city or state. UnitedHealthcare Community Plan will provide follow-up care after the emergency.</p>	<ul style="list-style-type: none"> • Unconsciousness • Difficulty breathing • Serious head, neck, or back injury • Chest pain/pressure • Severe bleeding • Severe burns • Convulsions/seizures • Broken bones • Fear you might hurt yourself or someone else (“behavioral health emergency”) • Sexual assault 	<p>No.</p> <p>You can get emergency care from network providers or out-of-network providers. You do not need a referral or service authorization.</p>

Getting care after hours

If you need non-emergency care after normal business hours, call UnitedHealthcare Community Plan's 24/7 medical advice line at: **1-800-842-3014**.

A nurse or behavioral health professional can:

- Answer medical questions and give you advice for free
- Help you decide if you should see a provider right away
- Help with medical conditions
- You can video chat with a doctor 24/7 with UHC Doctor Chat at no cost to you. Download the UHC Doctor Chat app or go to [UHCDoctorChat.com](https://www.uhcdoctorchat.com).

Transportation to care

Non-emergency medical transportation

If you need transportation to receive covered benefits such as medical, behavioral, dental, vision and pharmacy services, call UnitedHealthcare Community Plan's Transportation Reservation line. UnitedHealthcare Community Plan covers non-emergency transportation for covered services, if you have trouble getting an appointment, call UnitedHealthcare Community Plan's Transportation Where's My Ride/Ride Assist, Member Services or your care manager.

If you have your own ride to your appointment, your driver may be eligible to receive mileage reimbursement for the trip. Depending on your health plan, members, family, friends, and caregivers can receive mileage reimbursement at the current Business IRS reimbursement rate. To receive reimbursement, the trip must first be scheduled with the Transportation Reservation Line at 1-833-215-3885. A Mileage Reimbursement Trip Log, which can be found at www.mymodivcare.com/members/va, must be completed with all appropriate trip information and signed by a "Physician/Clinician." Once complete, the form can be submitted via email, fax, and mail. Additional information related to the mileage reimbursement program can be found at www.mymodivcare.com/mileage-reimbursement.

3. Providers and getting care

FAMIS children are not eligible for Non-Emergency Medical Transportation.

If you need transportation to developmental disability waiver services, contact the Cardinal Care Transportation for Developmental Disability Waiver Services Contractor at 1-866-386-8331, TTY 1-866-288-3133, or visit transportation.dmas.virginia.gov/. If you have problems getting transportation to your developmental disability waiver services, call Where's My Ride at 1-866-246-9979 or your developmental disability waiver Case Manager.

Emergency medical transportation

If you are experiencing an emergency medical condition and need transportation to the hospital, call **911** for an ambulance. UnitedHealthcare Community Plan will cover an ambulance if you need it.

4. Care coordination and care management

Care coordination

All members can get help finding the right health care or community resources by calling UnitedHealthcare Community Plan Member Services at **1-844-752-9434**. Shortly after you become a UnitedHealthcare Community Plan member, a member of the care management team will call you to set up your initial in-person comprehensive health assessment.

Shortly after you become a UnitedHealthcare Community Plan member, a member of the Care Management team will reach out to you for a welcome call and a health screening. Once your health screening is complete, a UnitedHealthcare Community Plan Care Manager or Care Coordinator will be assigned to you, and you will be given the contact information to reach this person.

Once your health assessment is complete, a UnitedHealthcare Community Plan Care Manager is assigned to you, and you are given contact information to reach this person. If you wish to speak to a member of the UnitedHealthcare Community Plan team before completing your initial health assessment, you may call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week. A member of your care management team can also help you reach your UnitedHealthcare Community Plan Care Manager.

You can also call 1-800-842-3014, TTY 711 24 hours a day, seven days a week to talk to an on-call nurse or other licensed health professional.

4. Care coordination and care management

What is care management?

If you have significant health care needs, you will receive care management. Care management helps to improve the coordination between your different providers and the services you receive. If you get care management, UnitedHealthcare Community Plan will assign you a care manager. Your care manager is someone from UnitedHealthcare Community Plan with special health care expertise who works closely with you, your PCP and treating providers, family members, and other people in your life to understand and support your needs and goals.

How to get a care manager

During the first three months after you enroll, UnitedHealthcare Community Plan will contact you or someone you trust (your “authorized representative”) to conduct a Health Screening. During the Health Screening, you will be asked to answer some questions about your health needs (such as medical care) and social needs (such as housing, food, and transportation). The Health Screening includes questions about your health conditions, your ability to do everyday things, and your living conditions. Your answers will help UnitedHealthcare Community Plan understand your needs and decide whether to assign you to a care manager. If you are not assigned a care manager, you can ask UnitedHealthcare Community Plan to consider giving you one if you need help getting care now or in the future.

If you have questions or need help with the Health Screening, contact Member Services at **1-844-752-9434**, TTY **711**. This call is free.

4. Care coordination and care management

How your care manager can help you

Your care manager is someone from UnitedHealthcare Community Plan with special health care expertise who can help you manage your health and social needs. Your care manager can:

- Assess your health and social needs
- Answer questions about your benefits, like physical health services, behavioral health services, and long-term services and supports (LTSS) (see **Section 5 – Your benefits**)
- Help connect you to community resources (for example, programs that can support your housing and food needs)
- Support you in making informed decisions about your care and what you prefer
- Assist you with scheduling appointments when needed and find available providers in UnitedHealthcare Community Plan’s network, and make referrals to other providers, as needed
- Help you get transportation to your appointments (see **Section 3 – Providers and getting care**)
- Make sure you get your prescription drugs and help if you feel side effects
- Share your test results and other health care information with your providers so your care team knows your health status
- Help with moving between health care settings (like from a hospital or nursing facility to home or another facility)
- Make sure your needs are met once you leave a hospital or nursing facility and on an ongoing basis

4. Care coordination and care management

How to contact your care manager

- Call Member Services toll-free at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m. ET, Monday–Friday when you want to speak with your care manager
- Member Services will forward your call to your Care Manager during business hours
- You can also request a care manager change by contacting Member Services during business hours

Free interpreter services are available in all languages for people who do not speak English.

Contact method	Contact information
Call	1-844-752-9434 , TTY 711 8:00 a.m.–8:00 p.m., 7 days a week
Fax	855-770-7088
Write	UnitedHealthcare Community Plan 9020 Stony Point Parkway, Suite 350 Richmond, VA 23235
Email	VA_CAC@UHC.com
Website	uhccommunityplan.com/Virginia

Your care manager will regularly check in with you and can help with any questions or concerns you may have. You have the right at any time to ask your care manager to contact you more or less often. You decide how you want your care manager to contact you (by phone, videoconference, or visit you in-person). If you meet your care manager in-person, you can suggest the time and place. You are encouraged to work with your care manager and to have open communication with them.

Health Risk Assessment

After UnitedHealthcare Community Plan assigns you a care manager and conducts the Health Screening, UnitedHealthcare Community Plan will contact you to conduct a more in-depth Health Risk Assessment. During the Health Risk Assessment, your care manager or another health care professional will ask you more questions about your physical health, behavioral health, social needs, and your goals and preferences. The Health Risk Assessment helps your care manager to understand your needs and get you the right care. You can choose to do the Health Risk Assessment in-person, over the phone, or by videoconference. Over time, your care manager will check-in with you to repeat the Health Risk Assessment questions to find out if your needs are changing.

Your care plan

Based on your Health Risk Assessment, your care manager will work with you to develop your personalized Care Plan. Your Care Plan will include the health care, social services, and other supports that you will get and explains how you will get them, how often and by what provider. Your care manager will update your Care Plan once a year. Your care manager may make changes more often than once a year if your needs change. It is important to keep your Care Plan updated.

Your care team

Your care team includes your providers, nurses, counselors, or other health professionals. You and your family members or caregivers are important members of your care team. Your care manager may organize a meeting with your care team depending on your needs, or you can ask to meet with your care team. You have the choice of whether to participate in care team meetings. Communication among your care team members helps ensure your needs are met.

4. Care coordination and care management

Coordination with Medicare or other health plans

If you have Medicaid and Medicare, UnitedHealthcare Community Plan is responsible for coordinating your Cardinal Care benefits with your Medicare health plan and any other health plan(s) you have. Call UnitedHealthcare Community Plan's Member Services or your care manager if you have questions about how your different health plans work together and make sure your services are paid for correctly.

Additional care management services

You may be able to get additional care management services if you:

- Are in foster care or were in foster care
- Are pregnant and are at higher risk for complications during and after pregnancy
- Receive services in your home or the community, such as a home health, personal care, or respite services
- Have a substance use disorder
- Use a ventilator
- Are homeless

If you need a care manager, call UnitedHealthcare Community Plan's Member Services for assistance.

5. Your benefits

Overview of covered benefits

Covered benefits are services provided by UnitedHealthcare Community Plan, the Department, or its contractor. In order to get covered benefits, the service must be medically necessary. A medically necessary service is a service you need to prevent, diagnose, or treat a medical condition or its symptoms.

You can also access the full list of covered benefits at: uhcommunityplan.com/Virginia. Call UnitedHealthcare Community Plan’s Member Services at 1-844-752-9434, TTY 711 or your care manager, if you have one, for more information about your services and how to get them.

Generally, you must get services from a provider that participates in UnitedHealthcare Community Plan’s network. In some cases, you may need to get approval (a “service authorization”) from UnitedHealthcare Community Plan or your PCP before getting a service. The services marked in this section with an asterisk (*) require service authorization. See **Section 3 – Providers and getting care**, for more information on what to do if you need services from an out-of-network provider. See **Section 7 – Getting approval for your services, treatments, and drugs**, for more information if a service you need requires approval.

5. Your benefits

Benefits for all members

Physical health services

UnitedHealthcare Community Plan and the Department cover physical health services (including dental and vision) for Cardinal Care members:

- Adult Day Health Care*
- Cancer screenings and services* (colorectal cancer screening, mammograms, pap smears, prostate specific antigen and digital rectal exams, reconstructive breast surgery)
- Care management and care coordination services (see **Section 4 – Care coordination and care management**)
- Clinic services
- Clinical trials (routine patient costs related to participation in a qualifying trial)
- Court-ordered services, emergency custody orders (ECO), and temporary detention orders (TDO)
- Dental services (more on this below)
- Durable Medical Equipment (DME)* (respiratory, oxygen, and ventilator equipment and supplies; wheelchairs and accessories; hospital beds; diabetic equipment and supplies; incontinence products; assistive technology; communication devices; rehabilitative equipment and devices)
- Early and Periodic Screening Diagnostic and Treatment (EPSDT) (more on this below)
- Early Intervention (EI) services (more on this below)
- Emergency and post-stabilization services
- Gender dysphoria treatment services*
- Glucose test strips
- Hearing services
- Home and community-based waiver services (more on this below)*
- Home health*
- Hospice

38 **Questions?** Visit uhccommunityplan.com/Virginia, or call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

- Hospital care (inpatient and outpatient) *
- Human Immunodeficiency Virus (HIV) services (testing and treatment counseling)
- Immunizations (adult and child)
- Laboratory, radiology, and anesthesia services *
- Lead Investigations
- Oral services (hospitalizations, surgeries, services billed by a medical provider) *
- Organ transplants (for all children and for adults who are in intensive rehabilitation) *
- Orthotics (children under age 21) *
- Nutritional counseling for chronic disease
- Podiatry services (foot care)
- Prenatal and maternal services (pregnancy/postpartum care) (more on this below)
- Prescription drugs (see **Section 6 – Your prescription drugs**)
- Preventive care (regular check-ups, screenings, well-baby/child visits)
- Prosthetics (arms/legs and supportive attachments, breasts, and eye prostheses) *
- Regular medical care (PCP office visits, referrals to specialists, exams)
- Radiology services *
- Rehabilitation services (inpatient and outpatient, including physical/occupational therapy and speech pathology/audiology services) *
- Renal services (dialysis, End Stage Renal Disease services) *
- School health services (more on this below)
- Surgery services *
- Telehealth services (more on this below)
- Tobacco cessation services
- Transportation services (see **Section 3 – Providers and getting care**)
- Tribal clinical provider type services
- Vision services (eye exams/treatment/glasses to replace those lost, damaged, or stolen for children under age 21 (under EPSDT))

Questions? Visit uhccommunityplan.com/Virginia, or call Member Services 39 at 1-844-752-9434, TTY 711, 8:00 a.m.–8:00 p.m., Monday–Friday.

5. Your benefits

- Well visits
 - A comprehensive review of your child’s physical and mental growth
 - An unclothed physical exam that includes a vision and hearing screening, a dental check and a nutritional assessment
 - Immunizations (shots) for your child that will help protect him or her from illnesses
 - Laboratory tests, such as blood or urine screening tests
 - Health education/help with preventive care
 - Referrals for more medically needed healthcare*
 - Height and weight/Body Mass Index (BMI)

Remember, services marked with an asterisk (*) may require service authorization.

Physical health services	Service authorization review timeframes
Inpatient Hospital Services (Standard or expedited review process)	Within 14 calendar days or as quickly as your condition requires.
Outpatient Services (Standard review process)	Within 14 calendar days or as quickly as your condition requires.
Outpatient Services (Expedited review process)	Within 72 hours from receipt of your request; or, as quickly as your condition requires.

The Department contracts with a Dental Benefits Administrator, DentaQuest, to provide dental services to all Medicaid/FAMIS members. See the table below for dental services available to you. You are not responsible for the cost of dental services received from a participating dental provider. Some dental services will require prior approval. UnitedHealthcare Community Plan will work with the Department’s Dental Administrator to authorize some services, including anesthesia when medically necessary. For questions about your dental benefits or to find a participating dentist near you, call DentaQuest Member Services at 1-888-912-3456, TTY 1-800-466-7566, or visit dmas.virginia.gov/dental.

40 **Questions?** Visit uhccommunityplan.com/Virginia, or call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

5. Your benefits

Dental service	Children/youth under age 21	Pregnant/postpartum people	Adults age 21 and older
Braces	Covered	Not covered	Not covered
Cleanings	Covered (including fluoride)	Covered	Covered
Crowns	Covered	Covered	Limited coverage
Dentures	Covered (including partials)	Covered (including partials)	Covered
Exams	Covered (including regular check-ups)	Covered	Covered
Extractions and oral surgeries	Covered	Covered	Covered
Fillings	Covered	Covered	Covered
Gum treatment	Covered	Covered	Covered
Root canals	Covered (including treatment)	Covered	Covered
Sealants	Covered	Not covered	Not covered
Space maintainers	Covered	Not covered	Not covered
X-rays	Covered	Covered	Covered

Questions? Visit uhccommunityplan.com/Virginia, or call Member Services 41 at 1-844-752-9434, TTY 711, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

5. Your benefits

Behavioral health services

UnitedHealthcare Community Plan, the Department or its contractor covers the behavioral health treatment services in the table below for UnitedHealthcare Community Plan members. Behavioral health refers to mental health and addiction services. In Virginia, treatment for addiction is called “Addiction and Recovery Treatment Services” (ARTS). UnitedHealthcare Community Plan’s Member Services, your PCP, and your care manager can help you get the behavioral health services you need.

Mental health services	
<ul style="list-style-type: none">• 23-hour observation• Applied behavior analysis• Assertive community treatment• Community stabilization• Functional family therapy• Intensive in-home• Mental health case management• Mental health intensive outpatient• Mental health partial hospitalization program• Mental health peer recovery supports services	<ul style="list-style-type: none">• Mental health skill-building services• Mobile crisis• Multisystemic therapy• Psychiatric residential treatment facility• Psychosocial rehabilitation• Residential crisis stabilization• Therapeutic day treatment• Therapeutic group home• Inpatient psychiatric services• Outpatient psychiatric services
<p>Services that are managed by the Department’s behavioral health administrator contractor. Your care manager will work with the Department’s behavioral health administrator contractor to help you get these services if you need them.</p>	

Addiction and Recovery Treatment Services (ARTS)

- Screening, brief intervention and referral to treatment
- Substance use case management services
- Outpatient services
- Intensive outpatient services
- Partial hospitalization
- Substance use residential treatment
 - ASAM 3.1
 - ASAM 3.3
 - ASAM 3.5
 - ASAM 4.0
- Medication assisted treatment
- Peer recovery support services
- Opioid treatment services
- Office based addiction treatment

UnitedHealthcare Community Plan has a review team to be sure you receive medically necessary services. Doctors, nurses and licensed clinicians are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards. The standards we use to determine what is medically necessary are not allowed to be more restrictive than those that are used by DMAS. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination (decision). These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a medical or behavioral health professional, who may be a doctor or other health care professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity. United Healthcare adheres to Mental Health Parity and Addiction Equity Act (MHPAEA).

Questions? Visit uhcommunityplan.com/Virginia, or call Member Services 43 at 1-844-752-9434, TTY 711, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

5. Your benefits

Timeframes for service authorization review

UnitedHealthcare Community Plan follows National Committee for Quality Assurance service authorization standards and timeframes. UnitedHealthcare Community Plan Community Plan is responsible for deciding how quickly the authorization is needed depending on the urgency and type of service requested. For standard authorization decisions, UnitedHealthcare Community Plan Community Plan will provide written notice as quickly as needed, and within fourteen (14) calendar days. For urgent decisions, UnitedHealthcare Community Plan will provide written notice within three (3) calendar days. Urgent requests include requests for medical or behavioral health care or services where waiting 14 days could seriously harm your health or ability to function in the future. Care or services to help with transitions from inpatient hospital or institutional setting to home are also urgent requests. You or your doctor can ask for an urgent request if you believe that a delay will cause serious harm to your health. For standard or urgent decisions, if UnitedHealthcare Community Plan, you or your provider request an extension, or more information is needed, an extension of up to fourteen (14) additional calendar days is allowed.

Contact UnitedHealthcare Community Plan Community Plan if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call **1-800-842-3014**, TTY **711**. If you have thoughts about harming yourself or someone else, you should:

- Get help right away by calling **988** or **911**
- Go to the closest hospital for emergency care

For questions about addiction and recovery services, call the ARTS Medical Advice Line at **1-800-842-3014**, TTY **711** 24 hours a day, seven days a week. This call is free. Call this number if you need help identifying the kind of healthcare you need or getting the care you need.

If you are thinking of harming yourself or someone else, call the Behavioral Health Crisis Line **1-800-842-3014**, TTY **711**, 24 hours a day, seven days a week. This call is free. Remember, if you need help right away, call **911**.

Long-Term Services and Supports (LTSS)

UnitedHealthcare Community Plan and the Department cover LTSS such as private duty nursing, personal care, and adult-day health care services to help people meet their daily needs and maintain independence living in the community or a facility. Before receiving LTSS, a community-based or hospital team will conduct a screening to see if you meet “level of care” criteria – in other words, whether you qualify for and need LTSS. Contact your care manager to learn about the screening process to receive LTSS.

You can get LTSS in the setting that is right for you: your home, the community, or a nursing facility. Members who are interested in moving from the nursing facility into their home or the community should talk with their care manager. However, it is important to know that receiving certain types of care will end your enrollment with managed care and UnitedHealthcare Community Plan, but you will still have Medicaid. These types of care include:

- Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Care from one of the following nursing facilities:
 - Bedford County Nursing Home
 - Birmingham Green
 - Dogwood Village of Orange County Health
 - Lake Taylor Transitional Care Hospital
 - Lucy Corr Nursing Home
 - The Virginia Home Nursing Facility
 - Virginia Veterans Care Center
 - Sitter and Barfoot Veterans Care Center
 - Braintree Manor Nursing Facility and Rehabilitation Center
- Care from Piedmont, Hiram Davis, or Hancock state operated long term care facility
- Program of All Inclusive Care for the Elderly (PACE) care

5. Your benefits

If you get LTSS, you may need to pay for part of your care (see **Section 9 – Cost sharing**). If you have Medicare, UnitedHealthcare Community Plan will cover nursing facility care after you have used all of the skilled nursing care that was available to you. Most LTSS services require prior authorization. You may contact Member Services or your care manager to answer your questions and learn more about how to request a service authorization. If you want to request a specific service that requires a service authorization, your care manager can help you find the right provider who can help figure out if you need the service.

Benefits for Home and Community Based Services (HCBS) waiver enrollees

Some members may qualify for HCBS waiver services (see table below). To learn more or to find out if you are eligible, contact UnitedHealthcare Community Plan or your care manager. Developmental Disability waiver services are managed through the Department of Behavioral Health and Developmental Services (DBHDS). You can also find more information about Developmental Disability waiver services on the DBHDS website mylifemycommunityvirginia.org or by calling 1-844-603-9248.

Waiver	Description	Examples of covered benefits
Commonwealth Coordinated Care (CCC) Plus Waiver	<p>Provides care in your home and community instead of a nursing facility.</p> <p>You can choose to receive agency-directed or consumer-directed services, or both.</p>	<ul style="list-style-type: none">• Adult day health care• Assistive technology• Environmental modifications• Personal care• Personal Emergency Response System• Private duty nursing• Respite• Transition services

Waiver	Description	Examples of covered benefits
<p>Developmental Disability Waivers:</p> <p>Building Independence (BI)</p> <p>Community Living (CL)</p> <p>Family and Individual Supports (FIS)</p>	<p>Provides supports and services to members with developmental disabilities to help with successful living, learning, physical and behavioral health, employment, recreation, and community inclusion. Waivers may have a waiting list.</p> <p>You should put your name on the waiting list if you need to so that when space opens up you can start receiving these services.</p>	<ul style="list-style-type: none"> • Assistive technology • Benefits planning services • Electronic home-based services • Employment and day supports • Environmental modifications • Personal emergency response system • Crisis supports • Residential options

Most HCBS services require prior authorization. You may contact Member Services or your care manager to answer your questions and learn more about how to request a service authorization. If you want to request a specific service that requires a service authorization, your care manager can help you find the right provider who can help figure out if you need the service.

5. Your benefits

Benefits for children/youth under age 21

Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT)

Benefits are not the same for all Cardinal Care members. Medicaid children and youth under age 21 are entitled to EPSDT, a federally-required benefit. EPSDT provides comprehensive services to identify a child's condition, treat it, and make it better or prevent it from getting worse. Covered services include any medically necessary health care, even if the service is not normally available to adults or other Medicaid members. EPSDT services are available at no cost. Examples of EPSDT services include:

- Screenings/well-child visits and immunizations
- Periodic screening services (vision, hearing and dental)
- COVID-19 counseling visits
- Developmental services
- Eyeglasses (including a replacement for glasses that are lost, broken, or stolen) and other vision services
- Orthotics (braces, splints, supports)
- Personal care or personal assistance services (for example, help with bathing, dressing and feeding)
- Private duty nursing
- Treatment foster care case management

Clinical trials may be considered on a case-by-case basis

FAMIS children are eligible for well-child visits and immunizations, but not all EPSDT services. For more information on accessing EPSDT services, contact UnitedHealthcare Community Plan's Member Services or your care manager.

Early Intervention (EI) services

If you have a baby under the age of three that is not learning or developing like other babies, your child may qualify for EI services. EI services include, for example:

- Speech therapy
- Physical therapy
- Occupational therapy
- Service coordination
- Developmental services to support the child's learning and development

EI services do not require service authorization from UnitedHealthcare Community Plan. There is no cost to you for EI services. Contact UnitedHealthcare Community Plan's Member Services for a list of EI providers, specialists, and case managers. Your care manager can connect you to your local Infant and Toddler Connection program to help you access these services. You can also call the Infant and Toddler Connection program directly at 1-800-234-1448, TTY 711 or visit [itcva.online](https://www.ithcva.com).

School health services

The Department covers the cost of some health care or health-related services provided to Cardinal Care-enrolled children at their school. School health services can include certain medical, behavioral health, hearing, personal care, or rehabilitation therapy services, such as occupational therapy, speech therapy, and physical therapy services and are based on your child's individualized education plan (IEP), as determined by the school. Your child's school will arrange for these services and your child can get them for free. Children may also receive covered EPSDT services while they are at school (see **Section 5 – Your benefits**). Contact your child's school administrator if you have questions about school health services.

5. Your benefits

Benefits for family planning and pregnant/postpartum people

You can get free health care services to help you have a healthy pregnancy and a healthy baby. This includes health care services for up to 12 months after you give birth. UnitedHealthcare Community Plan and the Department cover the following services:

- Labor and delivery services
- Doula services
- Family planning (services, devices, drugs — including long acting reversible contraception — and supplies for the delay or prevention of pregnancy)
- Lactation consultation and breast pumps
- Nurse midwife/provider services
- Pregnancy-related services
- Prenatal/infant services and programs. (There are opportunities to earn rewards for attending prenatal visits and making healthy choices for you and your baby. Please contact the plan for more information.)
- Postpartum services (including postpartum depression screening)
- Services to treat any medical condition that could complicate pregnancy
- Smoking cessation services
- Substance Use Treatment Services
- Abortion services (only if a doctor certifies in writing that there is a substantial danger to the mother's life)

Remember, you do not need a service authorization or a referral for family planning services. You can get family planning services from any provider, even if they are not in UnitedHealthcare Community Plan's network. If you are interested in our services for Pregnant Women, please call our Healthy First Steps program to enroll at 1-800-599-5985.

Newborn coverage

If you have a baby, report the birth to the Department as quickly as possible so that your child can get health insurance. Do this by calling Cover Virginia at 1-833-5CALLVA or by contacting your local DSS.

Added benefits for UnitedHealthcare Community Plan members

UnitedHealthcare Community Plan provides some added benefits for members. These include:

- Vaccine incentives up to \$100 at Footlocker for members up to age 18
- Free access to 300+ gyms and local YMCAs for members age 18+
- Free access to over 14,000 virtual fitness options for members age 18+
- Extracurricular sports physical covered by the health plan
- Free Boys & Girls Club membership
- Sanvello — Interactive phone application to help manage stress, anxiety, and depression. For enrollment information please visit [Sanvello.com](https://www.sanvello.com).
- Routine vision — Eye exam and glasses are covered for members age 21 and older once every 2 years.
- Assistance for members with asthma — Receive free mattress cover and pillowcase that help eliminate dust mites for people with asthma.
- Free cellphone program — Free smartphone with unlimited minutes and texts. The service is non-transferable. Only eligible members may enroll in the program. The program is limited to one discount per household. Phone is subject to location and eligibility. To apply and to choose the program best for you, please visit www.lifelinesupport.org.
- Healthy First Steps — There are opportunities to earn rewards for attending prenatal visits and making healthy choices for you and your baby. Please contact the plan for more information.

Questions? Visit uhcommunityplan.com/Virginia, or call Member Services 51 at 1-844-752-9434, TTY 711, 8:00 a.m.–8:00 p.m., Monday–Friday.

5. Your benefits

- Non-Emergency Medical Transportation (NEMT) — NEMT provides crucial support for helping individuals take personal responsibility and improving overall health. This benefit will improve your access to care, particularly in rural areas where transportation needs affect a member’s ability to pursue a healthier lifestyle. Our enhanced benefit includes up to 6 trips per 6 months to destinations that were not otherwise covered by Medicaid. This includes round trips to places of worship, gyms, Department of Motor Vehicles, grocery stores, and Medicaid eligibility offices. No limits on rides to food banks, farmer’s markets or Women Infants and Children appointments.
- Weight Watchers — We will provide 13 Weight Watchers meeting vouchers annually to qualified Members who are 10 years of age and older.
- On My Way (OMW) — Interactive website to educate and support young adults and help prepare them for real world situations. For enrollment information, please visit www.uhcOMW.com.

If you have any questions about these benefits, please call our Member Services Department.

6. Your prescription drugs

Understanding your prescription drug coverage

Prescription drugs are medicine your provider orders (“prescribes”) for you. Usually, UnitedHealthcare Community Plan will cover (“pay for”) your drugs if your PCP or another provider writes you a prescription and your prescription is on the Preferred Drug List. If you are new to UnitedHealthcare Community Plan, you can keep getting the drugs you are already taking for a minimum of 30 days. If a prescription you need is not on the Preferred Drug List, you can still get it if it is medically necessary.

To know which prescriptions are covered by UnitedHealthcare Community Plan and the Department, see the Preferred Drug List at uhcommunityplan.com/Virginia. The Preferred Drug List can change during the year, but UnitedHealthcare Community Plan will always have the most up-to-date information. Information on how to contact Plan for the current Preferred Drug Lists. Description of how members are notified of changes to the Preferred Drug List, including if a drug a member is taking is removed from the list.

You can find the Preferred Drug List online at myuhc.com/CommunityPlan. You can also search by a medicine name on the website. It’s easy to start getting your prescriptions filled. Here’s how:

Are your medicines included on the Preferred Drug List?

Yes.

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

6. Your prescription drugs

No.

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

Not sure.

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

By law there are some drugs that cannot be covered. Drugs that cannot be covered include experimental drugs, drugs for weight loss or weight gain, drugs used to promote fertility or for the treatment of sexual or erectile dysfunction, and drugs used for cosmetic purposes.

Prescription drugs for FAMIS members

Generic outpatient prescription drugs are covered. If you choose a brand drug you are responsible for 100% of the difference between the allowable charge of the generic drug and the brand drug.

Drugs that require you or your provider to take extra steps

Some drugs have rules or restrictions on them that limit how and when you can get them. For example, a drug may have a quantity limit, which means you can only get a certain amount of the drug each time you fill your prescription. For drugs with special rules, you may need a service authorization from UnitedHealthcare Community Plan before you can get your prescription filled (see **Section 7 – Getting approval for your services, treatments, and drugs**). If you do not get approval, UnitedHealthcare Community Plan may not cover the drug. To find out if the drug you need has a special rule, check the Preferred Drug List. If UnitedHealthcare Community Plan denies or limits your coverage for a drug and you disagree with the decision, you have the right to appeal (see **Section 8 – Appeals and complaints**).

In some cases, UnitedHealthcare Community Plan may require “step therapy.” This is when you try a drug (usually one that is less expensive) before UnitedHealthcare Community Plan will cover another drug (usually one that is more expensive) for your medical condition. If the first drug does not work, then you can try the second drug.

Emergency supply of drugs

If you ever need a drug and you cannot get a service authorization quickly enough (like over the weekend or a holiday), you can get a short-term supply of your drug by getting UnitedHealthcare Community Plan approval. You can get UnitedHealthcare Community Plan approval if a pharmacist believes that your health would be at-risk without the benefit of the drug. When this happens, UnitedHealthcare Community Plan may authorize a 72-hour emergency supply.

This process provides you with a short-term supply of the medications you need and gives time for your physician to submit a service authorization request for the prescribed medication. The pharmacist will call United Healthcare Community Plan to help with the emergency supply request.

Dispensing three-day supply emergency prescriptions

If the medication is needed immediately and prior authorization is not available, you may dispense medications as an emergency three-day supply by following these policies:

- Dispense only one three-day supply per member, per drug
- For medications that cannot be dispensed as an exact three-day supply, such as metered dose inhalers, nasal sprays, topical preparations and powders for reconstitution, dispense the minimum quantity as a three-day supply
- Complete the claim form fields as follows:
 - “Prior Authorization Type code” (Field 461-EU) = 8
 - “Prior Authorization Number Submitted” (Field 462-EV) = 3
 - “Day Supply” in the claim segment of the billing transaction (Field 405-D5) = 3
- To help reduce processing errors, please confirm the information on each member’s ID card before submitting prescriptions

6. Your prescription drugs

If you have questions, please call the OptumRx Help Desk 24/7 at the number for pharmacists found on the back of the member's ID card.

Long-term supply of drugs

Members may receive up to a one-month supply (34 days) of medication per prescription order or prescription refill. Members may reorder or refill a medication after using 85 percent of the medication.

If you have a long-term supply need for a specific prescription, contact Member Services at **1-844-952-7434**, TTY **711** or call your Care Coordinator.

Getting your drugs from a network pharmacy

Once your provider orders a prescription for you, you will need to get your prescription drugs filled at a network pharmacy (except during an emergency). A network pharmacy is a drug store that agrees to fill drugs for UnitedHealthcare Community Plan's members. To find a network pharmacy, use your Provider Directory available at www.uhccommunityplan.com/va.html. You can use any of UnitedHealthcare Community Plan's network pharmacies.

If you need to change pharmacies, you can ask your pharmacy to transfer your prescription to another network pharmacy. If your pharmacy leaves UnitedHealthcare Community Plan's network, you can find a new pharmacy in the Provider Directory or by calling UnitedHealthcare Community Plan's Member Services at **1-844-752-9434**, TTY **711**.

When you go to the network pharmacy to drop off a prescription or pick up your drugs, show your UnitedHealthcare Community Plan member ID card. If you have Medicare, show both your Medicare Card and UnitedHealthcare Community Plan member ID card. Call UnitedHealthcare Community Plan's Member Services or your care manager if you have questions or need help getting a prescription filled or finding a network pharmacy.

Getting your drugs mailed to your home

Sometimes you may need a drug that is not available at a pharmacy near you, such as a drug used to treat a complex condition or one that requires special handling and care. If this happens, a specialized pharmacy will ship these drugs to your home or your provider's office.

You may use mail-order services to get up to a 31-day supply. Contact Member Services at **1-844-752-9434**, TTY **711** for more information.

Patient Utilization Management and Safety Program

Some members who need additional support with their medication management may be enrolled in the Patient Utilization Management and Safety Program. The program helps coordinate your drugs and services so that they work together in a way that will not harm your health. Members in the Patient Utilization Management and Safety Program may be restricted (or locked in) to only using one pharmacy to get their drugs.

UnitedHealthcare Community Plan will send you a letter with more information if you are in the Patient Utilization Management and Safety Program. If you are placed in the program but do not think you should have been, you can appeal within 60 days of receiving the letter (see **Section 8 – Appeals and complaints**).

7. Getting approval for your services, treatments, and drugs

Second opinions

If you disagree with your provider's opinion about the services you need, you have the right to a second opinion. You can get a free second opinion from a network provider without a referral. When network providers are not accessible or when they cannot meet your needs, your Primary Care Provider can refer you to an out-of-network provider for a second opinion at no cost.

Service authorization

There are some services, treatments, and drugs that require service authorization before you receive them or to continue receiving them. A service authorization helps to figure out if certain services are medically necessary and if UnitedHealthcare Community Plan can cover them for you. After assessing your needs and making a care recommendation, your provider must submit a request for a service authorization to UnitedHealthcare Community Plan with information that explains why you need the service. This helps make sure that they can be paid for the services they provide to you. Requests to cover new medical procedures, devices or drugs are reviewed by the UnitedHealthcare Community Plan Community Plan Technology Assessment Committee. This group includes doctors and other health care experts. The team uses national guidelines and scientific evidence from medical studies to help decide whether UnitedHealthcare Community Plan Community Plan should approve such equipment, procedures or drugs. They are reviewed by a committee of UnitedHealthcare Community Plan Community Plan doctors, nurses, pharmacists and guest experts. They make the final decision about coverage. If you want more information, call us at **1-844-752-9434**, TTY **711**.

7. Getting approval for your services, treatments, and drugs

If you are new to UnitedHealthcare Community Plan, UnitedHealthcare Community Plan will honor any service authorizations made by the Department or another health plan for up to 30 days (or until the authorization ends if that is sooner) or up to 60 days if you are pregnant or have significant health or social needs.

Decisions are based on what is right for each member and on the type of care and services that are needed. We look at standards of care based on:

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

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

- Deny care or services that you need
- Support decisions that approve less than what you need
- Say you do not have coverage

You can request your doctor's incentive plans. See **Section 5 – Your benefits** for the specific services that require service authorization.

Service authorization is never required for primary care services, emergency care, preventive services, EI services, family planning services, basic prenatal care, or Medicare-covered services.

How to get a service authorization

To submit a Service Authorization Request, please call **1-844-752-9434**, TTY **711**, 8:00 a.m. to 8:00 p.m., 7 days a week. UnitedHealthcare Community Plan's Member Services or your care manager can answer your questions and share more about how to request a service authorization. If you want to request a specific service that requires a service authorization, your care manager can help you find the right provider who can help figure out if you need the service.

7. Getting approval for your services, treatments, and drugs

Timeframe for service authorization review

After receiving your service authorization request, UnitedHealthcare Community Plan will make a decision whether to approve or deny a request. Normally, UnitedHealthcare Community Plan will give written notice as quickly as needed, and within 14 calendar days (for physical and behavioral health services). If waiting that long could seriously harm your health or ability to function, UnitedHealthcare Community Plan will decide more quickly. UnitedHealthcare Community Plan will instead give written notice within three calendar days. Post service authorization requests are reviewed in 30 calendar days with a possible 14 calendar day extension.

UnitedHealthcare Community Plan will make any decisions about pharmacy services within 24 hours. On weekends or a holiday, UnitedHealthcare Community Plan may authorize a 72-hour emergency supply of your prescribed drugs. This gives your provider time to submit a service authorization request and for you to potentially receive an additional supply of your prescribed drug after the 72-hour emergency supply is done.

UnitedHealthcare Community Plan will contact your provider if UnitedHealthcare Community Plan needs more information or time to make a decision about your service authorization. You will be informed of the communication to your requesting provider. If you disagree with UnitedHealthcare Community Plan taking more time to review your request or if you do not like the way UnitedHealthcare Community Plan handled your request, see **Section 8 – Appeals and complaints**, on how to file a complaint. You can talk to your care manager about your concerns, or you may call the Cardinal Care Managed Care Enrollment Helpline at 1-800-643-2273, TTY 1-800-817-6608. If you have more information to share with UnitedHealthcare Community Plan to help decide your case, then you, or your provider can ask UnitedHealthcare Community Plan to take more time to make a decision in order to include the additional information.

Adverse benefit determinations

If UnitedHealthcare Community Plan denies a service authorization request, this is called an adverse benefit determination. An adverse benefit determination can also occur when UnitedHealthcare Community Plan approves only part of the care request or a service amount that is less than what your provider requested. Examples of adverse benefit determinations include when UnitedHealthcare Community Plan:

- Denies or limits a request for health care or services your provider or you think you should be able to get, including services outside of your provider's network
- Reduces, pauses, or stops health care or services you were already receiving
- Fails to provide services in a timely manner
- Fails to act in a timely manner to address grievances and appeals
- Denies your request to reconsider a financial liability
- Does not pay for all or part of your health care or services

If UnitedHealthcare Community Plan makes an adverse benefit determination, UnitedHealthcare Community Plan will usually notify your provider and you in writing at least 10 days before making changes to your service. But, if you do not hear from UnitedHealthcare Community Plan, contact UnitedHealthcare Community Plan Member Services or the provider who would be providing you the service to follow up. When UnitedHealthcare Community Plan tells you the decision in writing, UnitedHealthcare Community Plan will tell you what the decision was, why the decision was made, and how to appeal if you disagree. You should share a copy of the decision with your provider. If you disagree with the decision, you can request an appeal. See **Section 8 – Appeals and complaints**, for more information on the appeal process.

8. Appeals and complaints

Appeals

When to file an appeal with UnitedHealthcare Community Plan

You have the right to file an appeal if you disagree with an adverse benefit determination (see **Section 7 – Getting approval for your services, treatments, and drugs**) that UnitedHealthcare Community Plan makes about your health coverage or covered services. You must appeal within 60 calendar days from the date on the adverse benefit determination letter. You can allow an authorized representative (provider, family member, etc.) or your attorney act on your behalf. If you choose to let someone file the appeal on your behalf, you must call UnitedHealthcare Community Plan’s Member Services at **1-844-752-9434**, TTY **711** to let UnitedHealthcare Community Plan know. See **Section 7 – Getting approval for your services, treatments, and drugs**, for more information on service authorizations and adverse benefit determinations. If you need assistance with an appeal, you may talk to your care manager.

You will not lose coverage if you file an appeal. In some cases, you may be able to keep getting services that were denied while you wait for a decision on your appeal. Contact UnitedHealthcare Community Plan’s Member Services if your appeal is about a service you get that is scheduled to end or be reduced. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

How to submit your appeal to UnitedHealthcare Community Plan

You can file your appeal by phone or in writing. You can submit either a standard (regular) or an expedited (fast) appeal request. You might decide to submit an expedited appeal if you or your provider believe your health condition or need for the services requires urgent review. You or your doctor can ask for an expedited review if you believe that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your case will be handled under the standard review process.

Phone requests	1-844-752-9434, TTY 711
Written requests	Mail: P.O. Box 31364 Salt Lake City, UT 84131-0364 Fax: 1-801-994-1082
Electronic requests (Provider online submission only)	Go to https://csprovideranddg.optum.com and submit for pre-service and expedited pre-service appeal request. Phone: 1-844-752-9434, TTY 711

Timeframe for appeal to UnitedHealthcare Community Plan

When you file an appeal, be sure to let UnitedHealthcare Community Plan know of any new or additional information that you want to be used in making the appeal decision.

You may submit information in writing to:

UnitedHealthcare Community Plan
Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131-0364
Fax: 1-801-994-1082

8. Appeals and complaints

You can also call UnitedHealthcare Community Plan's Member Services if you need help. United Healthcare Community Plan will send you a letter to let you know that UnitedHealthcare Community Plan received your appeal.

If UnitedHealthcare Community Plan needs more information to help make an appeal decision, UnitedHealthcare Community Plan will send you a written notice within two calendar days of receiving your appeal to tell you what information is needed. For expedited appeals (meaning appeals that need to happen on a faster than normal timeline), UnitedHealthcare Community Plan will also call you right away. If UnitedHealthcare Community Plan needs more information, the decision about your standard or expedited appeal could be delayed by up to 14 days from the respective timeframes.

If UnitedHealthcare Community Plan has all the information needed from you:

- Within 72 hours of receiving your **expedited** appeal request, UnitedHealthcare Community Plan will send you a written notice and try to provide verbal notice to tell you the decision
- Within 30 days of receiving your **standard** appeal request, UnitedHealthcare Community Plan will send you a written notice to tell you the decision

If you are unhappy with UnitedHealthcare Community Plan's appeal decision

You can file an appeal to the Department through what is called the State Fair Hearing process after filing an appeal with UnitedHealthcare Community Plan if:

- You disagree with the final appeal decision you receive from UnitedHealthcare Community Plan

Or

- UnitedHealthcare Community Plan does not respond to your appeal in a timely manner

Like UnitedHealthcare Community Plan's appeals process, you may be able to keep getting services that were denied while you wait for a decision on your State Fair Hearing appeal (but may ultimately have to pay for these services if your State Fair Hearing appeal is denied).

How to submit your State Fair Hearing appeal

You (or your authorized representative) must appeal to the state within 120 calendar days from date when UnitedHealthcare Community Plan issued its final appeal decision letter notice. You can appeal by phone, in writing, or electronically. If you appeal in writing, you can write your own letter or use the Department’s appeal request form. Be sure to include a full copy of the final written notice showing UnitedHealthcare Community Plan’s appeal decision and any documents you want the Department to review. If you have chosen an authorized representative, you must provide documents that show that individual can act on your behalf.

If you want your State Fair Hearing to be handled quickly, you must clearly state “EXPEDITED REQUEST” on your State Fair Hearing request. You must also ask your provider to send a letter to the Department that explains why you need an expedited State Fair Hearing request.

Phone requests	1-804-371-8488, TTY 1-800-828-1120
Written requests	Mail: Appeals Division, DMAS 600 E. Broad Street Richmond, VA 23219 Fax: 804-452-5454
Electronic requests	Website: dmas.virginia.gov/appeals Email: appeals@dmas.virginia.gov

8. Appeals and complaints

Timeframe for State Fair Hearing appeal

After you file your State Fair Hearing appeal, the Department will tell you the date, time, and location of the scheduled hearing. Most hearings can be done by phone. You may also request an in-person hearing.

If you qualify for an **expedited** State Fair Hearing appeal, the hearing will usually take place within one to two days of the Department receiving the expedited request letter from your provider. The Department will issue a written appeal decision within 72 hours of receiving the expedited request letter from your provider.

For **standard** State Fair Hearing appeals, the Department will usually issue a written appeal decision within 90 days of you filing your appeal with UnitedHealthcare Community Plan. The 90-day timeframe does not include the number of days between UnitedHealthcare Community Plan's decision on your appeal and the date you sent your State Fair Hearing request to the Department. You will have the chance to participate in a hearing and present your position.

State Fair Hearing outcome

If the State Fair Hearing reverses UnitedHealthcare Community Plan's appeal decision, UnitedHealthcare Community Plan must authorize or provide the services as quickly as your condition requires and no later than 72 hours from the date the Department gives notice to UnitedHealthcare Community Plan. If you continued to get services while you waited for a decision on your State Fair Hearing appeal, UnitedHealthcare Community Plan must pay for those services. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed. The State Fair Hearing decision is the Department's final decision. If you disagree, you may appeal to your local circuit court.

How FAMIS members ask for an external review

FAMIS members can request an external review instead of a State Fair Hearing. You or your authorized representative must submit a written request for external review within 30 calendar days of receipt of the UnitedHealthcare Community Plan's final appeal decision. Please mail external review requests to:

FAMIS External Review
c/o Kepro
2810 N. Parham Road, Suite 305
Henrico, VA 23294

Or submit online at www.DMAS.Kepto.com

Please include: your name, your child's name and ID number, your phone number with area code, and copies of any relevant notices or information.

Complaints

When to file a complaint

You have the right to file a complaint (a "grievance") at any time. You will not lose your coverage for filing a complaint.

You can complain about anything except a decision about your health coverage or covered services. (For those types of issues, you will need to submit an appeal — see above). You can file a complaint to either UnitedHealthcare Community Plan or an outside organization if you are unhappy. You can make complaints about:

- Accessibility: For example, if you cannot physically access your provider's office/facilities or you need language assistance and did not get it
- Quality: For example, if you are unhappy with the quality of care you got in the hospital
- Customer Services: For example, if your provider or health care staff was rude to you

8. Appeals and complaints

- Wait times: For example, if you have trouble getting an appointment or have to wait a long time to see your provider
- Privacy: For example, if someone did not respect your right to privacy or shared your confidential information

Did you receive a medical bill from an in-network provider?

If so, follow these steps:

- Do not ignore a bill from your doctor. This can result in a collections notice. United Healthcare Community Plan of Virginia maybe able to assist you find a solution.
- Contact Member Services at **1-844-752-9434**, TTY **711**. Have your bill and/or letter with you when you call. Also, be prepared to give your most current phone number and address to the Member Services Representative.
- Your request will be received by the United Healthcare Community Plan of Virginia grievance department. A grievance team member will contact you by letter and/or phone to help you with your billing question or concern.

How to file a complaint with UnitedHealthcare Community Plan

To file a complaint with UnitedHealthcare Community Plan, call UnitedHealthcare Community Plan's Member Services at **1-844-752-9434**, TTY **711** or file a complaint in writing by mailing it to: P.O. Box 31364, Salt Lake City, UT 84131-0364, or faxing it to 1-801-994-1082. Be sure to include details on what the complaint is about so that UnitedHealthcare Community Plan can help.

UnitedHealthcare Community Plan will tell you our decision within 90 calendar days after getting your complaint. If your complaint is about your request for an expedited appeal (see above), UnitedHealthcare Community Plan will respond within 24 hours of getting your complaint.

How to file a complaint with an outside organization

To file a complaint with an outside organization that is not affiliated with UnitedHealthcare Community Plan, you can:

- Call the Cardinal Care Managed Care Enrollment Helpline at 1-800-643-2273, TTY 1-800-817-6608
- Contact the U.S. Department of Health and Human Services' Office for Civil Rights:
 - Phone requests: 1-800-368-1019, TTY 800-537-7697
 - Written requests: Office of Civil Rights – Region III, Department of Health and Human Services, 150 S Independence Mall West Suite 372, Public Ledger Building, Philadelphia, PA 19106; or fax to 215-861-4431
- Contact the Virginia Long-Term Care Ombudsman (for complaints, concerns or assistance with nursing facility care or long-term services and supports in the community):
 - Phone requests: 1-800-552-5019, TTY 1-800-464-9950
 - Written requests: Virginia Office of the State Long-Term Care Ombudsman, Virginia Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive Henrico, Virginia 23229
- Contact the Office of Licensure and Certification at the Virginia Department of Health (for complaints specific to nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and health plans):
 - Phone requests: 1-800-955-1819, TTY 711
 - Written requests: Virginia Department of Health, Office of Licensure and Certification, 9960 Maryland Drive, Suite 401, Richmond, Virginia 23233-1463
 - or email: mchip@vdh.virginia.gov

9. Cost sharing

Copayments

Copayments are when you pay a fixed amount for certain services covered by UnitedHealthcare Community Plan or the Department. Most UnitedHealthcare Community Plan members will not owe copayments for covered services. However, there are some exceptions (see below). If you receive a bill for a covered service, contact UnitedHealthcare Community Plan's Member Services for help at **1-844-752-9434**, TTY **711**. Remember, if you get services that are not covered through UnitedHealthcare Community Plan or the Department, you must pay the full cost yourself.

If you have Medicare, you may have copayments for prescription drugs covered under Medicare Part D.

Patient pay

If you get LTSS, you may need to pay for part of your care. This is called your patient pay amount. If you have Medicare, you may also have a patient pay responsibility towards skilled nursing facility care. Your local DSS will notify you if you have a patient pay responsibility and can answer questions about your patient pay amount.

Premiums

You do not need to pay a premium for your coverage. However, the Department pays UnitedHealthcare Community Plan a monthly premium for your coverage. If you are enrolled in UnitedHealthcare Community Plan but do not actually qualify for coverage because information you provided to the Department or to UnitedHealthcare Community Plan was false or because you did not report a change (like an increase in your income, which may impact whether you qualify for Medicaid/FAMIS), you may have to pay the Department back the cost of the monthly premiums. You will have to pay the Department even if you did not get services during those months.

10. Your rights

General rights

As a Cardinal Care member, you have the right to:

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status, or disability
- Be treated with respect and consideration for your privacy and dignity
- Get information (including through this handbook) about your health plan, provider, coverage, and benefits
- Get information in a way you can easily understand. Remember: interpretation, written translation, and auxiliary aids are available free of charge.
- Access health care and services in a timely, coordinated, and culturally competent way
- Get information from your provider and health plan about treatment choices
- Participate in all decisions about your health care, including the right to say “no” to any treatment offered
- Ask your health plan for help if your provider does not offer a service because of moral or religious reasons
- Get a copy of your medical records and ask that they be changed or corrected in accordance with State and Federal Law
- Have your medical records and treatment be confidential and private. UnitedHealthcare Community Plan will only release your information if it is allowed under federal or state law, or if it is required to monitor quality of care or protect against fraud, waste, and abuse.
- Live safely in the setting of your choice. If you or someone you know is being abused, neglected, or financially taken advantage of, call your local DSS or Virginia DSS at 1-888-832-3858. This call is free.

- Receive information on your rights and responsibilities and exercise your rights without being treated poorly by your providers, UnitedHealthcare Community Plan, or the Department
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- File appeals and complaints and ask for a State Fair Hearing (see **Section 8 – Appeals and complaints**)
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example)

Advance Directives

Advance directives are written instructions to those caring for you that tell them what to do if you are unable to make health care decisions for yourself. Your Advance Directive lists the type of care you do or do not want if you become so ill or injured that you cannot speak for yourself. It is your right and choice about whether to fill out an Advance Directive. UnitedHealthcare Community Plan is responsible for providing you with written information about Advance Directives and your right to create an Advance Directive under Virginia law. UnitedHealthcare Community Plan must also help you understand why UnitedHealthcare Community Plan may not be able to follow your Advance Directive.

If you want an Advance Directive, you can fill out an Advance Directive form. You can get an Advance Directive form from:

- Virginiaadvancedirectives.org
- Your care manager, if you have one
- Your provider, a lawyer, a legal services agency, a social worker, the hospital
- UnitedHealthcare Community Plan’s Member Services, if applicable

10. Your rights

You can cancel or change your Advance Directive or power of attorney if your decisions or preferences about your health care decisions or authorized representative change. If your provider is not following your Advance Directive, complaints can be filed with the Enforcement Division at the Virginia Department of Health Professions:

- 1-800-533-1560, TTY 711
- Email: enfcomplaints@dhp.virginia.gov
- Write: Virginia Department of Health Professions
Enforcement Division
9960 Maryland Drive, Suite 300
Henrico, Virginia 23233-146

If you believe UnitedHealthcare Community Plan has not provided you with the information you need about Advance Directives, or you are concerned that UnitedHealthcare Community Plan is not following your Advance Directive, you can contact the Department to file a complaint:

- 1-800-643-2273, TTY 711
- Email: DMAS-Info@dmas.virginia.gov, or
- Write to the Department at:
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

Member Advisory Committee

You have the right to let us know how the Department and UnitedHealthcare Community Plan can better serve you. UnitedHealthcare Community Plan invites you to join the Member Advisory Committee. As a member of the committee, you can participate in educational meetings that happen once every three months. You can attend in-person or virtually. Attending committee meetings will give you and your caregiver or family member the chance to provide input on Cardinal Care and meet other members. If you would like more information or want to attend, contact UnitedHealthcare Community Plan's Member Services.

74 **Questions?** Visit uhccommunityplan.com/Virginia, or call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

11. Your responsibilities

General responsibilities

As a Cardinal Care member, you have some responsibilities. This includes the responsibility to:

- Follow this handbook, understand your rights, and ask questions when you do not understand or want to learn more
- Treat your providers, UnitedHealthcare Community Plan staff, and other members with respect and dignity
- Choose your PCP and, if needed, change your PCP (see **Section 3 – Providers and getting care**)
- Be on time for appointments and call your provider’s office as soon as possible if you need to cancel or if you are going to be late
- Show your member ID card whenever you get care and services (see **Section 2 – Cardinal Care managed care overview**)
- Provide (to the best of your ability) complete and accurate information about your medical history and your symptoms
- Understand your health problems and talk to your providers about treatment goals, when possible
- Work with your care manager and care team to create and follow a care plan that is best for you (see **Section 4 – Care Coordination and care management**)
- Invite people to your care team who will be helpful and supportive to be included in your treatment
- Tell UnitedHealthcare Community Plan when you need to change your care plan
- Get covered services from UnitedHealthcare Community Plan’s network when possible (see **Section 3 – Providers and getting care**)
- Get approval from UnitedHealthcare Community Plan for services that require a service authorization (see **Section 7 – Getting approval for your services, treatments, and drugs**)

Questions? Visit uhcommunityplan.com/Virginia, or call Member Services 75 at 1-844-752-9434, TTY 711, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

11. Your responsibilities

- Use the emergency room for emergencies only
- Pay for services you get that are not covered by UnitedHealthcare Community Plan or the Department
- Report suspected fraud, waste, and abuse (see below)

Call UnitedHealthcare Community Plan’s Member Services at 1-844-752-9434, TTY 711 to let them know if:

- Your name, address, phone number, or email have changed (see **Section 1 – Let’s get started**)
- Your health insurance changes in any way (from your employer or workers’ compensation, for example) or you have liability claims, like from a car accident
- Your member ID card is damaged, lost, or stolen
- You have problems with health care providers or staff
- You are admitted to a nursing facility or the hospital
- Your caregiver or anyone responsible for you changes
- You join a clinical trial or research study

Reporting fraud, waste, and abuse

As a Cardinal Care member, you are responsible for reporting suspected fraud, waste, and abuse concerns and making sure you do not participate in or create fraud, waste, and abuse. Fraud is an intentional deception or misrepresentation by a person who knows the action could result in an unauthorized benefit to themselves or someone else. Waste is overusing, underusing, or misusing Medicaid resources. Abuse is the practice of causing unnecessary cost to the Medicaid program or payment for services that are not medically necessary or that do not meet certain health care standards.

Examples of member fraud, waste, and abuse include:

- Falsely reporting income and/or assets to qualify for Medicaid
- Permanently living in a state other than Virginia while receiving Cardinal Care benefits
- Using another person's member ID card to get services

Examples of provider fraud, waste, and abuse include:

- Providing services that are not medically necessary
- Billing for services that were not provided
- Changing medical records to cover up illegal activity

Information on how to report suspected fraud, waste, or abuse is included in the table below.

The Department's fraud and abuse hotline

Phone	1-804-786-1066, TTY 711 Toll free: 1-866-486-1971
Email	RecipientFraud@DMAS.virginia.gov
Mail	Department of Medical Assistance Services Recipient Audit Unit 600 East Broad Street, Suite 1300 Richmond, VA 23219

11. Your responsibilities

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

Phone	1-804-371-0779, TTY 711 Toll free: 1-800-371-0824
Fax	804-786-3509
Email	MFCU_mail@oag.state.va.us
Mail	Office of the Attorney General Medicaid Fraud Control Unit 202 North Ninth Street Richmond, VA 23219

Virginia Office of the State Inspector General Fraud, waste, and abuse hotline

Phone	1-800-723-1615, TTY 711
Email	covhotline@osig.virginia.gov
Mail	State Fraud, Waste, and Abuse Hotline 101 N. 14th Street The James Monroe Building, 7th Floor Richmond, VA 23219

12. Key words and definitions in this handbook

Just Plain Clear® Tools

UnitedHealthcare Community Plan offers an online tool for health literacy called Just Plain Clear® Tool. This tool contains glossary of commonly used medical and insurance terms, in easy-to understand language to help you make informed decisions. The tool is available in English, Spanish and Portuguese. To access the tool visit <https://www.justplainclear.com/en>.

Addiction and Recovery Treatment Services (ARTS): A substance use disorder treatment benefit for members with addiction. Members can access a comprehensive continuum of addiction treatment services, such as inpatient services, residential treatment services, partial hospitalization, intensive outpatient treatment, Medication Assisted Treatment (MAT), substance and opioid use services, and peer recovery support services.

Adverse Benefit Determination: Any decision by the health plan to deny a service or a service authorization request for a member. This includes an approval for a service amount that is less than requested.

Appeal: A request by an individual (or someone they trust acting on their behalf) for the health plan to review a service request again and consider changing an adverse benefit determination made by the health plan about health coverage or covered services.

Authorized Representative: A person who can make decisions and act on a member's behalf. Members can select a trusted family member, guardian, or friend to be their authorized representative.

Brand Name Drug: A medication that is made and sold by a single company. Generic versions of these drugs are sometimes available with the same ingredients but made by a different company.

12. Key words and definitions in this handbook

Cardinal Care Managed Care Enrollment Helpline: Assistance provided by an organization that contracts with the Department to help individuals with enrollment activities and choosing a health plan. Cardinal Care Managed Care Enrollment Helpline services are free and may be provided by phone or online.

Cardinal Care: Virginia's Medicaid/FAMIS program, which includes the state's two prior Medicaid managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus), fee-for-service (FFS) Medicaid members, FAMIS Children, FAMIS MOMS and FAMIS Prenatal Coverage.

Care Coordination: Help that the health plan provides to members so that members understand what services are available and how to get the health care or social services that they need. Care coordination is available to all members, including those who are not assigned a care manager and do not need or want care management.

Care Management: Ongoing support provided to members with significant health, social, and other needs by a health plan's care manager. Care management services include a careful review a member's needs, development of a Care Plan, regular communication with a care manager and the member's care team and help with getting health care and social services transitions between different health care settings.

Care Manager: A health professional that works for the health plan with special health care expertise that is assigned to and works closely with certain members with more significant needs. The Care Manager works with the member, the member's providers, and their family members/caregivers to understand what health care and social services the member needs, help them get the services that they need and to support them making decisions about their care.

Care Plan: A plan that is developed and updated regularly by a member and their care manager that describes a member's health care and social needs, the services the member will get to meet their needs, how they will get these services, by whom, and in some cases, how frequently.

Care Team: A group of health care providers, including a member's doctors, nurses, and counselors, as selected by the member, who help the member get the care they need. The member and their caregivers are part of the Care Team.

80 **Questions?** Visit uhccommunityplan.com/Virginia, or call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

12. Key words and definitions in this handbook

CCC Plus Waiver: A home and community-based services (HCBS) waiver program in Virginia that provides care in the home and community instead of a nursing facility to members who qualify.

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

Copayment: A fixed dollar amount that a member may be required to pay for certain services. Most Cardinal Care members will not have to pay copayments for covered services.

Cover Virginia: Virginia's statewide support center. Individuals can call 1-833-5CALLVA, TTY 1-888-221-1590, for free or visit coverva.org/en to learn about and apply for health insurance, renew their coverage, update information, and ask questions.

Covered Benefits: Health care services and prescription drugs covered by the health plan or the Department, including medically necessary physical health services, behavioral health services, and LTSS.

Doulas: A trained individual in the community who provides support to members and their families throughout pregnancy, during labor and birth, and up to one year after giving birth.

Dual Eligible Member: A person who has Medicare and full Medicaid coverage.

Durable Medical Equipment (DME): Medical equipment and appliances, such as walkers, wheelchairs, or hospital beds, that members can get and use at home when medically necessary.

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT):

A federally-required benefit that Medicaid members under age 21 are entitled to get. EPSDT provides comprehensive services to identify a child's condition, treat it, and make it better or prevent it from getting worse. EPSDT makes sure children and youth get needed preventive, dental, mental health, developmental, and specialty services.

12. Key words and definitions in this handbook

Early Intervention (EI): Services for babies under the age of three who are not learning or developing like other babies. Services may include speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to support learning and development.

Eligible: Meeting conditions or requirements for a program.

Emergency Care (or Emergency Services): Treatment or services an individual gets for an emergency medical condition.

Emergency Medical Condition: When an illness or injury is so serious that an individual (or, as applicable, their unborn baby's) health, bodily functions, body organs, or body parts may be in danger if they do not get medical care right away.

Emergency Medical Transportation: Transportation in an ambulance or emergency vehicle to an emergency room to receive medical care. Members can get emergency medical transportation by calling **911**.

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

Excluded Services: Services that are not covered under Cardinal Care by the health plan or the Department.

Family Access to Medical Insurance Security (FAMIS) Plan or FAMIS Children: A comprehensive health insurance program run by the federal and state government for uninsured children from birth through age 18 not eligible for Medicaid with income less than 200% of the federal poverty level.

FAMIS MOMS: A health insurance program run by the federal and state government for uninsured pregnant individuals with income eligibility the same as FAMIS children.

FAMIS Prenatal Care (FAMIS PC): A health insurance program run by the federal and state government for pregnant individuals who do not meet eligibility for Medicaid or FAMIS MOMS because of their citizenship or immigration status. Coverage begins during pregnancy and lasts through two months after the baby is born.

12. Key words and definitions in this handbook

Fraud, Waste, and Abuse: Fraud is an intentional deception or misrepresentation by a person who knows the action could result in an unauthorized benefit to themselves or someone else. Waste is overusing, underusing, or misusing Medicaid resources. Abuse is member or provider practice of causing unnecessary cost to the Medicaid program or payment for services that are not medically necessary or that do not meet certain health care standards.

Generic Drug: A medication that is approved by the federal government to use in place of a brand name medication because they have the same ingredients and work equally.

Good Cause Reasons: Acceptable reasons to change health coverage. Examples of good cause reasons are: (1) an individual moves out of the state, or (2) the health plan is not able to provide the required medical services.

Grievance (or Complaint): A written or verbal complaint that an individual makes to their health plan or an outside organization. Complaints can be concerns about accessibility, the quality of care, customer service, wait times, and privacy.

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

Health Assessment: An in-depth assessment completed by the care manager to help identify a member's health, social, and other needs, goals, and preferences. The Health Assessment helps guide the development of the Care Plan for members receiving care management.

Health Insurance: A type of insurance coverage that pays for some or all of the member's health care costs. A company or government agency makes the rules for when and how much to pay.

Health Plan (or Plan): A Cardinal Care Medicaid/FAMIS managed care organization that contracts with a group of doctors, hospitals, pharmacies, other providers, and care managers. They all work together to get members the care and care coordination they need.

12. Key words and definitions in this handbook

Health Screening: A screening administered to all members by the health plan to help understand if the member would benefit from Care Management. The screening asks members about their health needs, social needs, medical conditions, ability to do everyday things, and living conditions.

Home Health Aide: Short term services provided to Medicaid members to support them with personal care. Home health aides do not have a nursing license or provide therapy.

Home Health Care: Health care services a member receives at home, including nursing care, home health aide services, physical/occupational therapy and other services.

Hospice Services: Care to provide comfort and support for members (and their families) with a terminal prognosis — meaning the individual is expected to have six months or less to live. A member with a terminal prognosis has the right to choose to stay in hospice. In hospice, a specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

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

Hospitalization: When an individual is admitted to a hospital as a patient to receive care. This is also known as inpatient hospital care.

Long-Term Services and Supports (LTSS): Services and supports that help elderly individuals and children or adults with disabilities meet their daily needs and maintain independence. Examples include assistance with bathing, dressing, eating, and other basic activities of daily life and self-care, as well as support for everyday activities such as laundry, shopping, and transportation. Members can get LTSS in the setting that is right for them: the home, the community, or a nursing facility.

Medicaid or FAMIS Fee-for-Service (FFS): The way in which the Department pays providers for Medicaid or FAMIS services. Cardinal Care members who are not enrolled in managed care are enrolled in FFS.

12. Key words and definitions in this handbook

Medicaid/FAMIS Managed Care: When the Department contracts with a health plan to provide Medicaid/FAMIS benefits to members.

Medicaid: A health insurance program run by the federal and state government that provides free or low-cost health coverage and care to low-income individuals. In Virginia, Medicaid is called Cardinal Care.

Medically Necessary: Services, supplies, or drugs needed to prevent, diagnose, or treat a medical condition or its symptoms. Medically necessary also means that services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

Medicare: The federal health insurance program for individuals 65 years of age or older, some individuals under age 65 with certain disabilities, and individuals with end-stage renal disease (generally meaning those with permanent kidney failure who need dialysis or a kidney transplant) or Amyotrophic Lateral Sclerosis (ALS).

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

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

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

Medicare Part D: The Medicare prescription drug benefit program. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A, Medicare Part B, or Medicaid.

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

12. Key words and definitions in this handbook

Member Services: A department at the health plan responsible for answering questions about membership, benefits, appeals, and complaints.

Network: A group of doctors, clinics, hospitals, pharmacies, and other providers contracted with the health plan to provide care to members.

Network Provider (or Participating Provider): A provider or facility that contracts with the health plan to provide covered health care services to members.

Network Pharmacy: A drugstore that has agreed to fill prescription drugs for the health plan's members. In most cases, prescription drugs are covered only if they are filled at one of the health plan's network pharmacies.

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

Out-of-Network Provider (or Non-Participating Provider): A provider or facility that is not employed, owned, or operated by the health plan and is not under contract to provide covered health care services to members.

Patient Pay: The amount a member may have to pay for LTSS based on their income. The local DSS calculates the member's patient pay amount if they live in a nursing facility or receive CCC Plus waiver services and have an obligation to pay a portion of care.

Personal Care Aide Services: Services provided by a Personal Care Aide that help members with personal care (bathing, using the toilet, dressing, or carrying out exercises) on an ongoing or long-term basis.

Premium: The monthly amount a member may be required to pay for their health insurance every month. Cardinal Care Medicaid managed care members do not need to pay any premiums for coverage. If a member is enrolled in a health plan but does not qualify for coverage because information they reported to the Department or the health plan was false or because they did not report a change, the member may have to pay the Department back the cost of the monthly premiums. The member will have to repay the Department even if they did not get services during those months.

12. Key words and definitions in this handbook

Prescription Drug Coverage (or Covered Drugs): Prescription medications covered (paid for) by the health plan. The health plan also covers some over-the-counter medications.

Prescription Drugs: Medications that by law, members can only obtain through a provider prescription.

Primary Care Provider (PCP) (or Primary Care Physician): A doctor or nurse practitioner who helps members get and stay healthy by taking care of their needs. PCPs provide and coordinate health care services.

Private Duty Nursing Services: Skilled in-home nursing services provided by a licensed registered nurse (RN), or by licensed practical nurse under the supervision of an RN, to CCC Plus waiver members who have serious medical conditions or complex health care needs. Medicaid children and youth under age 21 can also get private duty nursing services under the EPSDT benefit.

Prosthetics and Orthotics: Medical devices ordered by a member's provider. Covered items include, but are not limited to arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.

Provider: Doctors, nurse practitioners, specialists, and other individuals who are authorized to provide health care or services to members. Many kinds of providers participate in each health plan's network.

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

Referral: Approval from a PCP to use other providers in the health plan's network. A PCP's referral is required before a member can see other network providers.

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

Service Authorization (or Preauthorization): Approval that may be needed before a member can get certain services, treatments, or prescription drugs. Service authorizations are requested by providers to the health plan to help make sure that the provider can be paid for the services they provide to the member.

12. Key words and definitions in this handbook

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

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

Specialist: A provider who has additional training on services in a specific area of medicine, like a surgeon. The care members receive from a specialist is called specialty care.

State Fair Hearing: The process where a member appeals to the state about a decision made by the health plan. Individuals can file a State Fair Hearing appeal if the health plan does not respond to or provide a decision on an individual's appeal on time, or if the individual does not agree with the plan's appeal decision.

Urgent Care: Care an individual gets for a sickness or an injury that needs medical care quickly and could turn into an emergency.

Health Plan Notices of Privacy Practices

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

Effective January 1, 2023

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

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

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

HI is information about your health or health care services. We have the right to change our privacy practices for handling HI. If we change them, we will notify you by mail or e-mail. We will also post the new notice at this website (**www.uhccommunityplan.com**). We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

How we collect, use, and share your information

We collect, use, and share your HI with:

- You or your legal representative.
- Government agencies.

We have the right to collect, use and share your HI for certain purposes. This must be for your treatment, to pay for your care, or to run our business. We may use and share your HI as follows.

- **For Payment.** We may collect, use, and share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may collect, use, and share your HI with your providers to help with your care.

Questions? Visit uhccommunityplan.com/Virginia, or call Member Services 89 at 1-844-752-9434, TTY 711, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

- **For Health Care Operations.** We may suggest a disease management or wellness program. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** We may collect, use, and share your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may collect, use and share your HI to send you appointment reminders and information about your health benefits.
- **For Communications to You.** We may use the phone number or email you gave us to contact you about your benefits, healthcare or payments.

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

- **As Required by Law.**
- **To Persons Involved with Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.

- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates** if needed to give you services. Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.
- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
 1. Alcohol and Substance Abuse
 2. Biometric Information
 3. Child or Adult Abuse or Neglect, including Sexual Assault
 4. Communicable Diseases
 5. Genetic Information
 6. HIV/AIDS
 7. Mental Health
 8. Minors' Information
 9. Prescriptions
 10. Reproductive Health
 11. Sexually Transmitted Diseases

We will only use your HI as described here or with your written consent. We will get your written consent to share psychotherapy notes about you. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain promotional mailings. If you let us share your HI, the recipient may further share it. You may take back your consent. To find out how, call the phone number on your ID card.

Questions? Visit uhccommunityplan.com/Virginia, or call Member Services 91 at 1-844-752-9434, TTY 711, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

Your rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request as allowed by state and federal law. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. You can have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website (www.uhccommunityplan.com).
- **To ask that we correct or amend** your HI. Depending on where you live, you can also ask us to delete your HI. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

Using your rights

- **To Contact your Health Plan. Call the phone number on your ID card.**
Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or TTY/RTT **711**.
- **To Submit a Written Request.** Mail to:
UnitedHealthcare Privacy Office
MN017-E300, P.O. Box 1459, Minneapolis MN 55440
- **Timing.** We will respond to your phone or written request within 30 days.
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

¹ This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; and UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to <https://www.uhc.com/privacy/entities-fn-v2>.

Questions? Visit uhccommunityplan.com/Virginia, or call Member Services 93 at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

Financial Information Privacy Notice

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

Effective January 1, 2023

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

Information we collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and security

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

Questions about this notice

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

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



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

UnitedHealthcare Community Plan:

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

If you need these services, contact UnitedHealthcare Community Plan at **1-844-752-9434**, TTY **711**, 8 a.m.–8 p.m. ET, Monday–Friday.

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

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

UHC_Civil_Rights@uhc.com

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

Mail:

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

Phone:

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

Complaint forms are available at

<http://www.hhs.gov/ocr/office/file/index.html>

English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Please call **1-844-752-9434, TTY 711.**

Spanish

ATENCIÓN: si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-752-9434, TTY 711.**

Korean

참고: 한국어(Korean)를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-844-752-9434, TTY 711** 로 전화하십시오.

Vietnamese

LƯU Ý: Nếu quý vị nói Tiếng Việt (Vietnamese), chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **1-844-752-9434, TTY 711.**

Chinese

注意:如果您說中文(Chinese), 您可獲得免費語言協助服務。請致電 **1-844-752-9434, 或聽障專線(TTY)711。**

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية (Arabic) ، تتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل بالرقم **1-844-752-9434، الهاتف النصي 711.**

Tagalog

ATENSYON: Kung nagsasalita ka ng Tagalog (Tagalog), may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa 1-844-752-9434, TTY 711.

Persian (Farsi)

توجه: اگر به فارسی (Farsi) صحبت می کنید، خدمات ترجمه به صورت رایگان در اختیارتان قرار می گیرد. با 1-844-752-9434 (TTY 711) تماس بگیرید.

Amharic

የሚናገሩት ቋንቋ አማርኛ (Amharic) ከሆነ የቋንቋ እርዳታ አገልግሎት ከክፍያ ነጻ አለልዎት። ወደ 1-844-752-9434, TTY 711 ይደውሉ።

Urdu

توجه فرمائیں: اگر آپ کی زبان اردو (Urdu) ہے تو آپ کے لیے لسانی خدمات مفت دستیاب ہیں۔ 1-844-752-9434 (TTY 711) پر کال کریں۔

French

ATTENTION: Si vous parlez français (French), vous pouvez obtenir une assistance linguistique gratuite. Appelez le 1-844-752-9434, TTY 711.

Russian

ВНИМАНИЕ: Если вы говорите по-русски (Russian), вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел 1-844-752-9434, TTY 711.

Hindi

ध्यान दे: यदि आप **हिंदी (Hindi)** भाषा बोलते हैं तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **1-844-752-9434**, TTY 711.

German

HINWEIS: Wenn Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Wählen Sie: **1-844-752-9434**, TTY 711.

Bengali

আপনি যদি **বাংলায় কথা (Bengali)** বলেন, তাহলে ভাষা সহায়তা পরিষেবাগুলি, আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-844-752-9434**, TTY 711 নম্বরে ফোন করুন।

Kru (Bassa)

TÒ ÌDÙŪ NÒ MÒ DYÍIN CÁO: À bédé gbo-kpá-kpá **bó wuḍu (Kru (Bassa))**-dù kò-kò po-nyò bě bìlì nō à gbo bó pídyi. M̄ dyi gbo-kpá-kpá mó ín, dǎ nò bà nià kẹ: **1-844-752-9434**, TTY 711.

Igbo

Ọ bụrụ na ị na asụ **Igbo (Igbo)**, ọrụ enyemaka asụsụ, n'efu dijiri gi. Kpọọ **1-844-752-9434**, TTY 711.

Yoruba

Tí ó bá ń s **Yorùbá (Yoruba)**, ìrànṣẹ́wọ́ ìtum èdè, wà fún ní ọ̀fẹ́. Pe **1-844-752-9434**, TTY 711.



We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m. ET, Monday–Friday. You can also visit our website at uhcommunityplan.com/Virginia.

UnitedHealthcare Community Plan
12018 Sunrise Valley Drive
Reston, VA 20191

**United
Healthcare
Community Plan**

Questions? Visit uhcommunityplan.com/Virginia, or call Member Services 101 at **1-844-752-9434**, TTY **711**, 8:00 a.m.–8:00 p.m., Monday–Friday.

[Table of contents](#)

