Covered Benefits

Services	Coverage
Abortions	Covered. Must meet current federal and state guidelines.
Allergy Testing	Covered.
Audiology	Covered.
Birth Control Services	Covered.
Blood & Blood Plasma	Covered.
Bone Mass Measurement (bone density)	Covered.
Case Management	Covered.
Chemotherapy	Covered.
Chiropractor Services (manipulation/subluxation)	Covered. Prior authorization required. Maximum of 18 doctor visits combined per year, from July 1 through June 30.
Colorectal Screening Exams	Covered.
Cosmetic Services	Not covered. Depends on service.
Custodial Services	Not covered.
Dental Services (preventive and routine services, crowns, dentures, surgical extractions, orthodontia)	Covered. Prior authorization required for some services. Benefit limits may apply. Adult benefits may be dependent on category of assistance and geographic location. Please call member services for specific information about your dental coverage
Diabetic Education, Home Visits & Monitoring	Covered. Prior authorization required.
Diabetic Supplies and Equipment	Covered.
Diapers for Disabled Children (over age 3)	Covered. Prior authorization required if greater than $200 per month.
Durable Medical Equipment	Covered. Prior authorization required ifover $500.

Covered Benefits (cont.)

Services	Coverage
ESPDT Services & Immunizations (under age 21)	Covered.
Emergency Room Care	Covered.
Emergency Transportation (ambulance)	Covered.
Family Planning Basic Services	Covered.
Hearing Exams	Covered.
Hearing Aids & Batteries	Covered, if under age 21. Prior authorization required.
Hemodialysis	Covered.
HIV/AIDS Testing	Covered.
Home Assessment	Covered. Prior authorization required.
Home Adaptation	Not covered.
Home Delivered Meals	Not covered.
Home Health Care & Infusion Therapy	Covered. Prior authorization required.
Hospice Care	Covered. Prior authorization required.
Immunizations (pneumococcal, flu, hepatitis A & B)	Covered.
Infertility	Not covered.
Inpatient Hospitalization (semi-private, unless medically necessary)	Covered. Prior authorization required.
Lab Tests & X-rays	Covered.
Mammograms	Covered.
Nutrition	Covered. Prior authorization required.
Obstetrical (Maternity) Care	Covered.
Occupational Therapy	Covered. Prior authorization required after 12 visits.

Services	Coverage
Organ Transplant Evaluation	Covered. Prior authorization required.
Orthodontia	Covered under 21 years old. Prior authorization required.
Orthopedic Shoes	Covered. Prior authorization required.
Outpatient Surgery, Same-Day Surgery, Ambulatory Surgical Center	Covered. Prior authorization required.
Pain Clinic Services	Covered. Prior authorization required. Maximum of 18 doctor visits combined per year, from July 1 through June 30.
Pap Smears & Pelvic Exams	Covered.
Parenting & Child Birth Education	Covered.
Personal Emergency Response System	Not covered.
Physical Therapy	Covered. Prior authorization required after 12 visits.
Podiatry Care: Medically Necessary, Routine, Preventive (office-based, non-surgical)	Covered. Maximum of 18 doctor visits combined per year, from July 1 through June 30.
Prescription Drugs	Covered. Limits and copays may apply. See Preferred Drug List.
Preventive Services	Covered.
PCP Visits	Covered.
Private Duty or Skilled Nursing Care	Covered. Prior authorization required.
Prostate Cancer Screening Exams	Covered.
Prosthetics & Orthotics (less than $500)	Covered.
Prosthetics & Orthotics (more than $500)	Covered. Prior authorization required.
Radiation Therapy	Covered.

Covered Benefits (cont.)

Services	Coverage
Radiology Scans, MRI, MRA, PET	Covered. Prior authorization required.
Rehabilitation (occupational, physical & speech therapy; in-house therapy)	Covered. Prior authorization required after 12 visits.
Reproductive Health (procedures & devices)	Covered.
Second Opinions (Medical & Surgical)	Covered.
Skilled Nursing Facility	Covered up to 30 days. Prior authorization required.
Sleep Apnea Studies	Covered. Prior authorization required.
Smoking Cessation Products & Classes	Covered. Limits may apply. See drug formulary.
Specialty Physician Services (except OB/GYN)	Covered. Maximum of 18 doctor visits combined per year, from July 1 through June 30.
Speech Therapy	Covered. Prior authorization required after 12 visits.
Transportation: Non-Emergency Ambulance	Covered. Prior authorization required.
Transplants	Covered. Prior authorization required.
Urgent Care	Covered.
Behavioral Health (inpatient psychiatric, inpatient substance abuse, outpatient substance abuse and mental health, and partial hospitalization care, including testing)	Covered by HealthChoices behavioral health MCO.

Services	Coverage
Vision Care	Covered. Two exams per year. Daily-wear contacts or standard glasses (in-plan frames). Members under age 21 are covered for 4 lenses and 2 frames per year. Members age 21 and over are covered for 2 lenses and 1 frame per year. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20. Medically necessary exceptions can be made.

Benefit Limits

Most benefit limits do not apply if you are pregnant, under age 21 or in a nursing home.

Covered Benefit	Assistance
Outpatient Visits (ex. doctor, podiatrist, chiropractor)	Up to 18 visits per year
Inpatient Medical Rehabilitation Hospital	1 admission per year
Prescription Coverage	Adults can receive up to 6 prescriptions per month, including refills
Dental Coverage	Limited for adults over 21

Benefit Limits (cont.)

The yearly limits on your medical care refer to services received between July 1 and June 30 of following year. The yearly limits will start again on July 1 of every year. Your provider can ask UnitedHealthcare Community Plan to approve services above these limits for you. This is called an exception. An exception can be granted if:

- You have a serious chronic illness or health condition and without the additional service, your life would be in danger; or
- You have a serious chronic illness or health condition and without the additional service, your health would get much worse; or
- You would need more expensive services if the exception is not granted; or,
- It would be against federal law for UnitedHealthcare to deny the exception.

To have your provider ask for an exception, call UnitedHealthcare Community Plan at 1-800-414-9025, or send your request to:

Member Services
UnitedHealthcare Community Plan
1001 Brinton Road
Pittsburgh, PA 15221

We will let you know whether or not the exception is granted within the time listed below.

- If your provider asks for an exception before you receive the service, you will get a response within 21 days of the date we get the request.
- If your provider asks for an exception before you receive the service, and your provider tells us you have an urgent need for a quick response, you will get a response within 48 hours of the date and time we get the request.
- If your provider asks for an exception after you received the service, you will get a response within 30 days of the date we get the request.
- If you disagree with the response you get from UnitedHealthcare Community Plan, you can file a complaint or a grievance.

You can file a complaint with UnitedHealthcare Community Plan if you think you were charged the wrong copay or if a service is denied and you think you have not reached the limit. You can file an appeal if you or your provider asks for an exception and the exception is denied. You can also ask for a DPW fair hearing.

Non-Covered Services

There are some things that UnitedHealthcare Community Plan does not cover.
These include:

- Care for which you do not have a referral, except for self-referral services and emergency care.
- Care from out-of-network providers who are not prior-approved, except for emergency or family planning services.
- Services covered by other insurance, worker's compensation or programs like Veterans Administration.
- Boarding home expenses (residential care that is not medically necessary).
- Experimental procedures.
- Infertility services.
- Mental health or drug and alcohol treatment services (covered by your HealthChoices behavioral health plan).
- Skilled nursing or intermediate care facilities over 30 consecutive days. Members will be disenrolled from UnitedHealthcare Community Plan and placed into Fee-For-Service after 30 consecutive days in a skilled nursing facility.
- Personal convenience items (telephone, television, etc.) while in a hospital room, unless medically necessary.
- Plastic or cosmetic surgery, except in case of injury or surgery that causes disfigurement.
- Prescription drugs for members over age 21 who are eligible for only limited Medical Assistance benefits.
- Services that are not medically necessary.