



Welcome to the
community.

IA Health Link

- Home and Community Based Services (HCBS) Waiver and Long Term Services and Supports (LTSS)





Telephone Numbers

UnitedHealthcare Community Plan Member Services 1-800-464-9484
Monday – Friday, 7:30 a.m. – 6:00 p.m. Central Time TTY: 711



Emergencies.
In case of emergency, call 911



State Member Services.
Iowa Medicaid Member Services 1-515-256-4606 (local)
8:00 a.m. – 5:00 p.m. Monday – Friday Central Time 1-800-338-8366
Or email imemberservices@dhs.state.ia.us

Local DHS Office.
Please see the DHS office map at http://dhs.iowa.gov/dhs_office_locator
DHS Customer Service Center (income maintenance call center) 1-877-347-5678
Iowa Medicaid Member Services 1-800-338-8366

Fraud.
You can also report fraud directly to the Iowa Medicaid office
at either 1-800-831-1394 or 1-877-446-3787



Website offers 24/7 access to plan details.
Go to myuhc.com/CommunityPlan to sign up for Web access to your account. This secure website keeps all of your health information in one place.

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Your Doctors

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Emergency Room: _____ Phone: _____
Pharmacy: _____ Phone: _____

Getting started.

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 **1-800-464-9484, 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. See page 14 for details.

3

Get to know your health plan.

Member Handbook — This member handbook gives you general information about your health care coverage, special programs, and rights and responsibilities. Start with the Health Plan Highlights section on page 7 for a quick overview of your new plan. 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 web access to your account. This secure website keeps all of your health information in one place. Take your Health Assessment, find answers to your questions about plan benefits, network doctors and more. In addition to plan details, the site includes useful tools that can help you. You can even print a copy of your member ID card. Register today. See page 10.

5

Check your member ID card.

You should have received a member ID card in the mail. The card has the UnitedHealthcare 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.

Alternative formats.

If you need information in another language, call Member Services. You can also get information in formats for visually impaired.

For help to translate or understand this, call **1-800-464-9484 (TTY: 711)**.

Para recibir ayuda para traducir o comprender esto, llame al **1-800-464-9484 (TTY: 711)**.

ဤအရာကို ဘာသာပြန်ရန် သို့မဟုတ် နားလည်ရန် အကူအညီလိုအပ်ပါက **1-800-464-9484 (TTY: 711)**

သို့ ဖုန်းခေါ်ပါ။

Za pomoć u prevodenju ili za pomoć da ovo razumijete, molimo vas da pozovete **1-800-464-9484 (za lica sa oštećenim sluhom ili govorom TTY:711)**.

Welcome to

UnitedHealthcare Community Plan.

Thank you for choosing UnitedHealthcare Community Plan for your health plan.

Please take a few minutes to review this Member Handbook. We're ready to answer any questions you may have. You can find answers to most questions at myuhc.com/CommunityPlan.

We're happy to have you as a member. You've joined the millions of members who have health insurance with UnitedHealthcare Community Plan. You've made the right choice for you and your family.

UnitedHealthcare Community Plan gives you access to many health care providers — doctors, hospitals and pharmacies — so you have access to all the health services you need. Our service area includes all counties across the state. We cover preventive care, checkups and treatment services. We are dedicated to improving your health and well-being.

We're ready to answer any questions you may have. Just call Member Services at **1-800-464-9484**, **TTY: 711**, Monday – Friday 7:30 a.m. – 6:00 p.m. Central Time. You can also visit our website at myuhc.com/CommunityPlan.





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Health Plan Highlights

Introduction

IA Health Link is a program that gives you quality health coverage that is covered by a Managed Care Organization (MCO), also known as a health plan. You get to choose which MCO will manage your care. Thank you for choosing UnitedHealthcare Community Plan.

Home and Community Based Services (HCBS) are for people with disabilities and older Iowans who need services to allow them to maintain a good quality of life and stay in their home and community instead of going to an institution. You must be eligible for Medicaid and also meet the requirements of the HCBS program you are applying for and/or receiving. You will need to be certified as being in need of nursing facility level of care, skilled nursing facility level of care, hospital level of care, or being in need of care in an intermediate care facility for the intellectually disabled.

Before a member can access waiver services, the member must be awarded a funding slot. If no funding slot is available, then the member will be placed on a waiting list.

Iowa currently has seven Medicaid HCBS waivers:

- AIDS/HIV Waiver.
- Brain Injury Waiver.
- Children's Mental Health Waiver.
- Elderly Waiver.
- Health and Disability Waiver.
- Intellectual Disability Waiver.
- Physical Disability Waiver.

In addition, there is Habilitation Services – Iowa's 1915(i) State Plan HCBS Services Program for members with chronic mental illness. For more information about this program, please visit:

<http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/habilitation>.

Services are intended to help people reach the highest degree of independence possible. For more information about each HCBS Waiver program, please visit <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers>.

UnitedHealthcare Community Plan is offered statewide. We have a network of providers across the state of Iowa who you may see for care. We will also coordinate your care to help you stay healthy.

Most members who get coverage by Iowa Medicaid will be enrolled in an MCO.

Health Plan Highlights

There are some members who are excluded from Managed Health Care. They are listed below:

- Members who qualify for the Health Insurance Premium Payment program (HIPPP).
- Members who qualify for the Medicare Savings Program (MSP) only.
 - Qualified Medicare Beneficiary plan (QMB).
 - Specified Low-Income Medicare Beneficiary (SLMB).
- Expanded Low-Income Medicare Beneficiary (E-SLMB).
- Qualified Disabled and Working People (QWDP).
- Members who are on the 3-day emergency plan.
- Members who are on the Medically Needy program also known as the spenddown program.
- Presumptively eligible members.
- Members who receive eligibility retroactively for previous months.

Some members may choose to enroll in the Managed Health Care program:

- Members who are enrolled with the Program of All-Inclusive Care for the Elderly (PACE) program. If you are a member enrolled with PACE, you will need to be determined eligible under a new Medicaid coverage group in order to transition to an IA Health Link Managed Care program. Please contact your PACE provider for assistance in applying for a new coverage group before making any changes to your plan. Your PACE provider will assist you with disenrolling with PACE and enrolling with the IA Health Link Managed Care program if you are found to be eligible for another Medicaid coverage group.
- American Indian or Alaskan Native members may also choose to enroll in the Managed Care program. If you are a member who identifies as American Indian or Alaskan Native, contact Iowa Medicaid Member Services at 1-800-338-8366 to learn about enrolling in the IA Health Link Managed Care program.

Member ID Card

The image shows two sample Member ID cards. The left card is for a UnitedHealthcare Community Plan member. The right card is for an OptumRx pharmacy card. Callouts point to specific information on both cards:

- Your plan ID number:** Points to the Health Plan/Plan de salud number (911-87726-04) on the top left of the first card.
- Your member ID number:** Points to the Member ID/ID del Miembro (999999999) on the first card.
- Member Services phone number:** Points to the 800-464-9484 number on the second card.
- Name of your Primary Care Provider:** Points to the PCP Name/Nombre del PCP (DR. PROVIDER BROWN) on the first card.
- Information for your pharmacist:** Points to the Rx Bin, Rx Grp, and Rx PCN information on the second card.

Your member ID card holds a lot of important information. It gives you access to your covered benefits. You should have received your member ID card in the mail within 7 business days of joining UnitedHealthcare Community Plan. Each covered family member will have their own card. Check to make sure all the information is correct. If any information is wrong, call Member Services at **1-800-464-9484, TTY: 711.**

- Take your member ID card to your appointments.
- Show it when you fill a prescription.
- Have it ready when you call Member Services; this helps us serve you better.
- Do not let someone else use your card(s). It is against the law.

In addition to the UnitedHealthcare Community Plan ID card, you will receive a Medical Assistance Eligibility card from the State.

- Be sure to have **both** cards ready when you go to your provider.
- If you lose your Medicaid card, call Iowa Medicaid Member Services.

Lost your member ID card?

If you lose your ID card, you can print a new one at myuhc.com/CommunityPlan. Or call Member Services at **1-800-464-9484, TTY: 711.**



Discover Your Plan Online



Manage your health care information 24/7 on myuhc.com.

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

Great reasons to use myuhc.com/CommunityPlan.

- Look up your benefits.
- Find a doctor.
- Print an ID card.
- Find a hospital.
- Take your Health Assessment.
- Keep track of your medical history.
- View claims history.
- Learn how to stay healthy.

Register on myuhc.com/CommunityPlan today.

Registration is easy and fast. Sign up today! Just visit myuhc.com/CommunityPlan. Select "Register" on the Home Page. Follow the simple prompts. You're just a few clicks away from access to all types of information. Get more from your health care.

UnitedHealthcare Health4Me™.

UnitedHealthcare Community Plan has a new member app. It's called Health4Me. The app is available for Apple® or Android® tablets and smartphones. Health4Me makes it easy to:

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

Download the free Health4Me app today. Use it to connect with your health plan wherever you are, whenever you want. To download the app, go to the app store or scan this square with the QR reader on your smartphone.



Benefits at a Glance

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



Primary Care Services.

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



Behavioral Health and Substance Use Disorder.

Get help with personal problems that may affect you or your family. These include stress, depression, anxiety, a gambling problem, or using drugs or alcohol.



Long Term Services and Supports (LTSS).

Long Term Services and Support is for adults and children who need extra support and care to help them live safely at home.



Transportation services are available.

Emergencies and Hospitals — As a UnitedHealthcare Community Plan member, medical transport is available for some medical care. For details, see page 35.



Large Provider Network.

Our network also includes specialists, hospitals and pharmacies — giving you many options for your health care. Find a complete list of network providers at myuhc.com/CommunityPlan or call 1-800-464-9484, TTY: 711.



Home and Community Based Services.

As an HCBS member, your health care needs are unique. We will help you get access to the home and community services you need.



Checkups.

Stay in good health with regular checkups. As a new member, services like annual checkups are available to you. Taking care of your health today can keep little problems from turning into big ones down the road. Schedule an appointment to see your PCP today!



Immunizations.

Flu shots are recommended for all members. Your doctor will help you stay up to date with other recommended immunizations, based on your age.



Preventive Screenings for Children and Adults.

Ask your doctor about other tests or screenings you may need based on your gender or age.

Health Plan Highlights



Specialist Services.

Your coverage includes services from specialists. Specialists are doctors or nurses who are highly trained to treat certain conditions. Be sure to choose a specialist from the UnitedHealthcare Community Plan network.



Prescription Drugs.

Your plan covers prescription drugs and some over-the-counter drugs prescribed by your doctor. Find more information in the Pharmacy section.



Hospital Services.

You're covered for medically necessary hospital stays. You are also covered for outpatient services. These are services you get in the hospital without spending the night.



Laboratory Services.

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



Vision Care.

For your vision benefits see page 46.



Dental Care.

Routine dental services are available to Iowa Medicaid members through the Fee-for-Service program. For more information, call Iowa Medicaid Member Services at 1-800-338-8366. UnitedHealthcare does not cover routine dental services.



Urgent Care.

You are covered for urgent care. If you need medical care right away and your PCP is not available, visit a network urgent care center. Remember to always follow up with your PCP after you've been to an urgent care center.



Emergency Services.

Use the emergency room only if you have an emergency. The emergency room should **NOT** be used for problems like the flu, sore throats or ear infections. If you have any questions, call your PCP. You can also call NurseLine to assist with any medical questions you may have.



Hearing Services.

Hearing services include tests, checkups and hearing aids (for eligible members).



Maternity and Pregnancy Care.

You are covered for doctor visits before and after your baby is born. That includes hospital stays. You always have access to a prenatal program called Healthy First Steps. Call Member Services to learn more about our Healthy First Steps program.



NurseLineSM.

NurseLine gives you 24/7 telephone access to experienced registered nurses. They can give you information, support and education for any health-related question or concern.

Member Support

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



Website offers 24/7 access to plan details.

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

- Find a provider or pharmacy.
- Search for a medicine in the Preferred Drug List.
- Get benefit details.
- Download the Member Handbook.
- Print your member ID card.
- You may email us from our website. Select the “Contact Us” link.



Get information on-the-go with the UnitedHealthcare Health4Me™ mobile app.

Download the Health4Me mobile app to your Apple® or Android® smartphone or tablet and see how easy it is to find nearby doctors, view the member handbook, find help and support in your community, or view your ID card.



UnitedHealthcare Member Services.

When you call Member Services, you will be connected with a trained Advocate. They will help you get the most from your health plan. For example, your Advocate will answer your questions, resolve issues, help set up doctor appointments, and directly connect you with services available to you.

Call **1-800-464-9484**, TTY: 711, 7:30 a.m. to 6:00 p.m. Central Time Monday – Friday.

Our office is closed on these major holidays:

New Year's Day

Labor Day

Martin Luther King Jr. Day

Thanksgiving Day

Memorial Day

Day After Thanksgiving

Independence Day

Christmas Day

Health Plan Highlights



Your Health Assessment.

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

You may fill out the Health Assessment at myuhc.com/CommunityPlan. Click on the Health Assessment button on the right side of the page, after you register and/or log in. Or call Member Services at **1-800-464-9484, TTY: 711**, to complete it by phone. It only takes a few minutes.



In-Home and Community Long Term Services and Supports (LTSS).

Your case manager will work with you to determine which services best meet your care plan needs. The level of services you receive is based on your personal needs, which are determined by UnitedHealthcare Community Plan.



Transportation services are available.

As a UnitedHealthcare Community Plan member, medical transport is available for some medical care. For details, see page 35.



Special language needs.

We can help our non-English speaking members with their health care needs. To use this service, call **1-800-464-9484** and indicate the specific language you need. Our staff can also assist those members who are hearing impaired. Our **TTY** phone number is **711**. These services are available free of charge.



MyHealthLine.

A free cellphone program for eligible members. MyHealthLine lets us connect more with our members, especially those who are high-risk. MyHealthLine supports overall health, wellness and access to care. Members who qualify for this program can quickly and easily reach us to discuss health-related questions or concerns or to locate a PCP.

- A free phone and 350 monthly minutes.
- Unlimited text messages.
- Free calls to UnitedHealthcare Member Services that will not count toward your 350 minutes.
- Text messages with health tips and reminders.

Call Member Services to find out if you qualify.



Community Based Case Management and Role of the Case Manager

UnitedHealthcare Community Plan's Community Based Case Management Program is a holistic approach to helping our members live healthier lives.

Our focus is to work with you and your care providers to keep you healthy and independent in the community.

Our program encourages and promotes member involvement, active decision-making, and active participation in planning your health care needs.

As a member of the Iowa Long Term Services and Supports (LTSS) program, UnitedHealthcare Community Plan is responsible for managing all the services you receive to meet your physical health, mental health and long term care needs. UnitedHealthcare Community Plan does this through Community Based Case Management.

UnitedHealthcare Community Plan will assign you a Case Manager. You will receive a phone call that will let you know the name of your Case Manager and how to reach this person. Your Case Manager is your main contact person and is the first person you should go to if you have any questions about your services.

If there is any delay in assigning your Case Manager, UnitedHealthcare Community Plan will send a letter that tells you how to reach the Community Based Case Management department for help.

Your Case Manager will provide support and education and will assist you with coordinating services. They will work with you and your care providers to ensure you receive timely access to care with the right provider, at the right time, at the right place of service.

Contacting your Case Manager.

You can contact your Case Manager anytime you have a question or concern about your health care — you do not need to wait until a home visit or a phone call from the Case Manager. You should contact your Case Manager when you have a change in your health condition or other things that may affect the kind or amount of care you need.

Health Plan Highlights

Case Management.

- A copy of your Individual Service Plan (ISP) will be sent to your PCP.
- Your Case Manager works with your care providers to make sure you are involved in programs that can improve your health.

In addition, your Case Manager can help you with the following:

- If you do not have a Primary Care Provider (PCP), your Case Manager will help you find one.
- Your Case Manager can help make sure your PCP and other care providers are working with you.
- Your PCP is advised of any assessments and screenings you have had.
- Your Case Manager makes sure that your specialists share their findings with your PCP. In some cases your permission may be needed.
- Your Case Manager works with your PCP to make sure you get the services you need when you come out of the hospital.
- Your PCP can refer you to other doctors or specialists you may need, including behavioral health services.

If you have questions, call Member Services at 1-800-464-9484, TTY: 711.

Changing Case Managers.

If you are unhappy with your Case Manager, call UnitedHealthcare Community Plan at **1-800-464-9484, TTY: 711**. If we cannot resolve your concern, we may assign a new Case Manager to you.

There may be times when UnitedHealthcare Community Plan will have to change your Case Manager. If we need to do this, we will send you a letter.

Your Care Environment

As a member of the LTSS program, you may choose to get care:

- In your home,
- Or in another place in the community (such as an assisted living facility),
- Or in a facility.

If you are in a facility, you may be able to move from the nursing home to your own home and get health care. Talk with your Case Manager if you are interested in doing this.

To receive care in your home or in the community, UnitedHealthcare Community Plan will help.

To get care in your home or in the community, contact your Case Manager. You will not be forced to leave the facility if you do not want to do so, even if we think care in the community costs less, as long as you qualify for facility care.

Your Case Manager will work with you to discuss changes you want to consider and decide what setting is the best place to meet your needs and ensure your well-being.

You can also help choose the providers who will give your care. This could be any network provider that will provide care at home. You may also be able to hire your own workers for some kinds of care.

The provider you choose must be willing and able to give your care. Your Case Manager will help you arrange this. You can file an appeal only if you do not get the services you think you need.

If you receive care in a facility, your Case Manager will:

- Be part of the care planning process at the facility where you live.
- Perform any additional needs assessment that may be helpful in managing your health and long term care needs.
- Supplement (or add to) the facility's plan of care if there are things UnitedHealthcare Community Plan can do to help manage health problems or coordinate other kinds of physical and mental health care you need.
- Conduct face-to-face visits at least every 3 months.
- Coordinate with the facility when you need services the facility isn't responsible for providing.
- Determine if you are interested and able to move from the facility back to the community and if so, help make this happen.

Health Plan Highlights

If you receive care at home, your Case Manager will:

- Complete a comprehensive, individual assessment of your health and long term care needs. We will help to determine the best health care services for your needs.
- Help you develop your Individual Service Plan (ISP) of care.
- Make sure the right health care professionals are consulted during your plan of care process.
- Give you information to help you choose long term care providers contracted with UnitedHealthcare Community Plan.
- Conduct face-to-face visits at least once every 3 months.
- Help coordinate your plan of care so that it works like it should to meet your needs.
- Monitor your health care and make sure that you are getting the care you need. If you need additional care, the Case Manager will help you.
- Give you information about community resources that might be helpful to you.
- Make sure the services you receive at home are based on your needs and do not cost more than care in a nursing home.
- Help you coordinate your care and service needs.

Community transition.

What if I live in a nursing home and want to move out?

We want to help you live in the place that is right for you. Talk to your Case Manager about your options if you are thinking about moving.

Member Advocate

The Member Advocate is another person at UnitedHealthcare Community Plan to help you in addition to your Case Manager. The Member Advocate is available to:

- Help our staff and providers better understand the values and practices of all cultures we serve.
- Provide information about the LTSS plan.
- Help you figure out how things work at UnitedHealthcare Community Plan, such as filing a grievance, changing Case Managers or getting the care you need.
- Make referrals to the right UnitedHealthcare Community Plan staff.
- Help solve problems with your care.

To reach the UnitedHealthcare Community Plan Member Advocate, call UnitedHealthcare Community Plan at **1-800-464-9484, TTY: 711**. Ask to speak with the Member Advocate.

Self-Direction

Self-direction, also called Consumer Choices Option (CCO), means that you choose your personal caregiver. The Consumer Choices Option is an option that is available under the Home and Community-Based Services waivers, with the exception of the Children's Mental Health Waiver. This option gives you control over a targeted amount of Medicaid dollars so that you can develop a plan to meet your needs by directly hiring employees and/or purchasing other goods and services. The Consumer Choices Option offers more choice, control and flexibility over your services as well as more responsibility.

The Consumer Choices Option may be right for you if you answer yes to these questions:

Do you want more control over how waiver Medicaid dollars are spent on your needs?

Do you want to be the employer of the people that provide support to you?

Do you want to be responsible for recruiting, hiring and firing your workers and service providers?

Do you want to be responsible for training, managing and supervising your workers and service providers?

Do you want the flexibility to be able to purchase goods or services in order to meet your needs?

Additional help is available if you choose this option. You will choose an Independent Support Broker who will help you develop your individual budget and help you recruit employees. You will also work with a Financial Management Service that will manage your budget for you and pay your workers on your behalf.

If you feel the Consumer Choices Option is right for you, talk with your Case Manager for help getting this option.

Caregivers must be 18 years or older. You say how your care is given. Your caregiver works for you. The caregiver may do things like help with dressing or cleaning. They may fix meals or help with your care.

You will complete a self-assessment tool to determine if you are approved. Ask your Case Manager for more details.

You may choose to stop directing your own care at any time. Just talk with your Case Manager.

More information about the Consumer Choices Option is online at <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option>.



Pharmacy

You Can Start Using Your Pharmacy Benefit Right Away.

UnitedHealthcare Community Plan is required to use the state's list of covered drugs, called the Preferred Drug List (PDL). The PDL is a list of drugs covered under your plan. They must be ordered by a network provider and supplied by a network pharmacy. Your doctor uses this list to make sure the medicines you need are covered by your plan. You can find the PDL 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.

Do You Have a Prescription?

When you have a prescription from your doctor, or need to refill your prescription, go to a network pharmacy. Show the pharmacist your member ID card. You can find a list of network pharmacies in the Provider Directory online at myuhc.com/CommunityPlan, or you can call Member Services.

Prescription Drugs

Generic and brand name drugs.

Generic drugs have the same ingredients as brand name drugs — they often cost less, but they work the same.

In some cases, a limited number of brand name drugs are covered. These are limited to certain classes (or types) of drugs. Some of these may require prior authorization by UnitedHealthcare Community Plan. A pharmacy will not dispense more than a 31-day supply of each prescription or a 90-day supply for oral contraceptives.

Changes to the Preferred Drug List.

The list of covered drugs is reviewed on a regular basis and may change when new generic drugs are available. It is important that your doctor checks the PDL each time you need a prescription.

Pharmacy

Over-the-Counter (OTC) Medicines

UnitedHealthcare Community Plan also covers many over-the-counter (OTC) medications that are on the state's approved list. A provider must write you a prescription for the OTC medication you need. Then all you have to do is take your prescription and member ID card into any network pharmacy to fill the prescription. OTCs include:

- Pain relievers.
- Cough or cold medicine.
- First-aid cream.
- Acne medicine.

For a complete list of covered OTCs, go to myuhc.com/CommunityPlan or call Member Services at **1-800-464-9484**, TTY: 711.

Pharmacy Home

Some UnitedHealthcare Community Plan members will be assigned a pharmacy home. Having a pharmacy home helps us to better coordinate your care. This means members must fill prescriptions at a single pharmacy location for up to two years. This is based on prior medication use, including overuse of pharmacy benefit, narcotics, pharmacy locations and other information.

Members of this program will be sent a letter with the name of the pharmacy they are required to use. If you get this letter, you have 30 days from the date of the letter to request a change of pharmacy. To change pharmacies during this time, call Member Services at **1-800-464-9484**, TTY: 711. You can appeal our decision to place you in a pharmacy home by calling Member Services. For more information on the appeal process, refer to the appeal section of this member handbook.



Going to the Doctor

Medical Home

What is a medical home?

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

Why would I want a medical home?

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

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

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

Federally Qualified Health Centers

Some providers are Federally Qualified Health Centers (FQHCs). These clinics offer a wide variety of services at a single location. Some services could include the following: better understanding of ethnic culture and customs relating to health care, foreign language translation, transportation to the clinic and your home, health and wellness education and training, or pharmacy services.

Going to the Doctor

Your Primary Care Provider (PCP)

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

- Routine care, including yearly checkups.
- Help to get care from a specialist.
- Other health concerns.

You have options.

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

- Family doctor (also called a general practitioner) — cares for children and adults.
- 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.
- Physician Assistant (PA) — cares for children and adults.

Choosing a Primary Care Provider (PCP).

Your PCP will work with you to direct your health care. Your PCP will do your checkups and shots and treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital. You can reach your PCP by calling your PCP's office. Your PCP's name and telephone number are printed on your UnitedHealthcare Community Plan ID card.

Each member of UnitedHealthcare Community Plan must choose a Primary Care Provider (PCP) from UnitedHealthcare Community Plan's Provider Directory. Your PCP is an individual physician, or physician group practice, family medicine (general practice), internal medicine or pediatrics. You can find our most up-to-date listings of UnitedHealthcare Community Plan providers on our website at myuhc.com/CommunityPlan. If you do not have access to the internet, call Member Services at **1-800-464-9484, TTY: 711**.

Your PCP is an individual physician, physician group practice, advance practice nurse or advance practice nurse group practice trained in pediatrics, family medicine (general practice), internal medicine or pediatrics. If you are pregnant, you can choose a PCP trained in obstetrics/gynecology (OB/GYN).

Some Primary Care Provider offices may have medical residents, nurse practitioners and provider assistants who will provide care to you under the supervision of your PCP. If your Primary Care Provider stops working with UnitedHealthcare Community Plan, we will let you know. We will help you pick a new provider.

What is a Network Provider?

Network Providers have contracted with UnitedHealthcare Community Plan to care for our members. You don't need to call us before seeing one of these providers. There may be times when you need to get services outside of our network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to you than if provided in-network. Call Member Services to learn if they are covered in full. You may have to pay for those services.

Learn more about network doctors.

You can learn information about network doctors, such as name, address, telephone numbers, professional qualifications, specialty, medical school, residency program, board certification, and languages they speak, at myuhc.com/CommunityPlan, or by calling Member Services.

Out-of-network providers.

A provider who is not in the UnitedHealthcare Community Plan network is an out-of-network provider. If you go to an out-of-network provider, UnitedHealthcare will usually not pay for the care unless it is a family planning covered service, an emergency or you have an approved prior authorization from us. Call Member Services if you need help finding a network provider. Read the prior authorization process on page 33.

Availability of services.

You can see a specialist, and get routine and preventive care services in addition to services provided by your PCP.

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

1. Use the Find-a-Doctor search tool at myuhc.com/CommunityPlan.
2. Call Member Services at **1-800-464-9484, TTY: 711**. We can answer your questions and help you find a PCP close to you.
3. Look through our printed Provider Directory, available upon request.

Once you choose a PCP, call Member Services and let us know. We will make sure your records are updated. We can help you choose a PCP that is near you.

Changing your PCP.

It's important that you like and trust your PCP. You can change PCPs at any time up to three (3) times per year. . Call Member Services and we can help you make the change. When you change your PCP, we will send you a new member ID card. Also, if a provider leaves our network, we will send you a letter telling you of the change.

Yearly Checkups

The importance of your annual checkup.

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

Recommended health screenings.

We use preventive care guidelines from the U.S. Preventive Services Task Force. Coverage and reimbursement may vary depending on state or federal law. It may vary depending on your coverage plan. Call Member Services at **1-800-464-9484**, TTY: **711** if you have any questions.

Guidelines for Maintaining Your Health

Well-child visits.

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

- Eating.
- Sleeping.
- Behavior.
- Physical activity.

Checkup schedule.

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

3 to 5 days	15 months
1 month	18 months
2 months	24 months
4 months	30 months
6 months	3 years
9 months	4 years
12 months	Once a year after age 5

Recommended Health Screenings

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

Health Screenings – Children

Screening: Children ages 0 to 18 years.

Age	Screening test	Frequency
Newborn	Newborn screening (PKU, sickle cell, hemoglobinopathies, hypothyroidism)	During newborn period
Birth – 2 months	Head circumference	At each well-child visit
Birth – 2 years	Length and weight	At each well-child visit
2 – 18 years	Height and weight	At each well-child visit
3 – 4 years	Eye screening	Once
Younger than 5 years	Dental health	At each well-child visit

Health Screenings – Adults

Preventive care guidelines: Adults over age 18.

Range of recommended ages

Years of age	18	25	30	35	40	45	50	55	60	65	70	75	
Screening													
Blood Pressure, Height and Weight	At each preventive visit												
Obesity	At each visit												
Cholesterol				Men: Every 5 years									
						Women: Every 5 years							
Cervical Cancer Screening	Annually beginning at age 18 or age of sexual activity, and every three years after three consecutive normal tests												
Chlamydia/Gonorrhea													
Mammography					Women: Every one to two years								
Prostate Cancer							Men: As directed by your doctor						
Colorectal Cancer* (Colonoscopy)							Every 5 years						
Osteoporosis										At age 65			
Alcohol Use, Depression	Periodically												

Immunizations – Children

Immunization schedule: Children ages 0 to 6 years.*

	Range of recommended ages			Catch-up immunization				Certain high-risk groups				
Vaccine	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19 – 23 months	2 – 3 years	4 – 6 years	
Hepatitis B	HepB	HepB							HepB Series			
Rotavirus			Rota	Rota	Rota							
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP				DTaP	
Haemophilus influenzae type b			Hib	Hib	Hib	Hib		Hib				
Pneumococcal			PCV	PCV	PCV	PCV				PCV		
										PCV		
Inactivated Poliovirus			IPV	IPV	IPV						IPV	
Influenza					Influenza (yearly)							
Measles, Mumps, Rubella						MMR					MMR	
Varicella						Varicella					Varicella	
Hepatitis A						HepA (2 doses)				HepA Series		
Meningococcal										MPSV4		

* SOURCE: Recommended Childhood and Adolescent Immunization Schedule – United States, 2006, MMWR™, Morbidity and Mortality Weekly Report, Vol 54, No MM51;0, Centers for Disease Control and Prevention, Department of Health and Human Services.

Immunization schedule: Children ages 7 to 18 years.*

Range of recommended ages	Catch-up immunization		Certain high-risk groups		
Vaccine	7 – 10 years	11 – 12 year assessment	13 – 14 years	15 years	16 – 18 years
Tetanus, Diphtheria, Pertussis		Tdap	Tdap		
Human Papillomavirus		HPV (3 doses)	HPV Series		
Meningococcal	MCV4	MCV4		MCV4	
Pneumococcal	PPV				
Influenza	Influenza (yearly)				
Hepatitis A	HepA Series				
Hepatitis B	HepB Series				
Inactivated Poliovirus	IPV Series				
Measles, Mumps, Rubella	MMR Series				
Varicella	Varicella Series				
* SOURCE: Recommended Childhood and Adolescent Immunization Schedule – United States, 2006, MMWR™, Morbidity and Mortality Weekly Report, Vol 54, No MM51;0, Centers for Disease Control and Prevention, Department of Health and Human Services.					

Immunizations – Adults

Immunization schedule: Adults over age 18.

Range of recommended ages

Years of age	18	25	30	35	40	45	50	55	60	65	70	75
Immunization												
Tetanus-Diphtheria (Td/Tdap)	Every 10 years											
Varicella (VZV)	Susceptibles only – two doses											
Shingles (Herpes Zoster)										One dose after age 60		
Measles, Mumps, Rubella (MMR)	Persons not already immune											
Pneumococcal										One dose		
Influenza	Yearly											
Hepatitis B/Hepatitis A	Persons at risk											
Meningococcal	For certain high-risk groups**											
Human Papillomavirus (HPV)	One dose											

Upper age limits should be individualized for each patient.

* See www.ahrq.gov for U.S. Preventive Services Task Force recommendations on colorectal cancer screening and other clinical preventive services.

** High risk is defined as adults who have terminal complement deficiencies, had their spleen removed, their spleen does not function or they have medical, occupation, lifestyle or other indications such as college freshmen living in dormitory or other group living conditions.

Individual health plans vary in preventive coverage. Generally, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and published by the Centers for Disease Control and Prevention are covered. For complete immunization guidelines, visit www.cdc.gov/.

Making an Appointment With Your Doctor

Call your doctor's office directly. When you call to make an appointment, be sure to tell the office what you're coming in for. This will help make sure you get the care you need, when you need it. This is how quickly you can expect to be seen:

How long it should take to see your doctor:	
Emergency	Call 911 or go to nearest emergency room
Urgent (but not an emergency)	Same day
Routine	Within 14 days
Preventive, Well-Child and Regular	Within 4 weeks

If you need to cancel an appointment, be sure to call the doctor at least 48 hours (2 days) before your scheduled visit. UnitedHealthcare will not pay for any charges for missed appointments.

Preparing for Your Appointment

Before the visit.

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

During the visit.

When you are with the doctor, feel free to:

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

Wait times.

You will wait a few minutes after you check-in for your appointment. You will then wait a few minutes in the exam room. A normal wait time is 30 minutes. Sometimes wait times may be longer if the doctor has an emergency. Wait times are also longer at walk-in clinics.



NurseLineSM Services – Your 24-Hour Health Information Resource

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

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

- Minor injuries.
- Common illnesses.
- Self-care tips and treatment options.
- Recent diagnoses and chronic conditions.
- Choosing appropriate medical care.
- Illness prevention.
- Nutrition and fitness.
- Questions to ask your doctor.
- How to take medication safely.
- Children’s health.

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

Simply call the toll-free number **1-800-464-9484** or **TTY: 711** for the hearing impaired. You can call the toll-free number anytime, 24 hours a day, 7 days a week. And, there’s no limit to the number of times you can call.

If You Need Care and Your Doctor’s Office Is Closed

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

You may be told to:

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

Call NurseLine.

1-800-464-9484 or TTY: 711

Getting a Second Opinion

A second opinion is when you want to see a second doctor for the same health concern. You can get a second opinion from a network provider for any of your covered benefits. This is your choice. You are not required to get a second opinion. If the type of doctor needed is not available in-network for a second opinion, we will arrange for a second opinion out-of-network at no more cost to you than if the service was provided in-network.

Medical Care When You Are Away From Home

If you are away from home and you have a medical emergency, get help right away from the nearest hospital emergency room. After you have seen a provider for the medical emergency, call your network provider for any follow-up care. UnitedHealthcare will pay for any medical emergency you have while you are away from home. Follow-up care must be from a network doctor.

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

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

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

Prior Authorizations

As a member of UnitedHealthcare Community Plan, you agree to go to network doctors for your health care. If you have a medical problem that is not an emergency and cannot be treated by a network doctor, you will need an approved prior authorization before you can see an out-of-network doctor. If you seek care from an out-of-network doctor when it is not an emergency without first getting an approved prior authorization, then UnitedHealthcare will not pay for that care. You would be responsible for paying the doctor bills. There are also some covered services that require prior authorization from a network doctor. Refer to the Benefits section of this member handbook for information on services that require prior authorization.

A complete list of services requiring prior authorization is available online at UHCCommunityPlan.com.

Going to the Doctor

These are the steps you should follow to get a prior authorization:

- 1 See your network doctor who will make a request for prior authorization to UnitedHealthcare Community Plan.
- 2 A medical professional will review the request. If there is a network doctor who can help you, your request will probably not be approved. You will get an approval if there are no network doctors who can treat your medical problem.
- 3 You and your network doctor will be notified in writing when your prior authorization request is approved or denied. Requests generally take two working days to be processed. If your network doctor feels care is needed quickly, the prior authorization review can be done in less time.
- 4 If you get an approved prior authorization, you may only see the doctor you have been approved to and only during the time noted in the request. Be sure to take a copy of the written approval with you.

The only time you do not need a prior authorization to see an out-of-network provider is in the case of a medical emergency. If your prior authorization is denied, then you have the right to appeal. Please refer to the appeal section of this member handbook or call Member Services.

Transition of Care and Continuity of Care

The Transition of Care plan gives new members a transition period to switch from an out-of-network doctor to an in-network doctor when you join the health plan. If you are in a period of active treatment with an out-of-network doctor when you enroll with UnitedHealthcare, we will work with you to ensure you continue to get the needed care and help you find an in-network doctor to meet your needs.

The Continuity of Care plan gives current members a transition period when the participating treating doctor leaves our network. If your treating doctor leaves our network, we will work with you to ensure you continue to get the needed care and help you find an in-network doctor to meet your needs.

Your benefits will remain the same. When you enroll with UnitedHealthcare Community Plan of Iowa starting April 1, 2016, you should continue to see your doctor as you normally would.



Transportation

Medical transport is covered for some medical care. If you have no other way to get to the doctor, live in an area with no public transport or cannot use public transportation due to a health condition or disability, call our UnitedHealthcare Member Services at **1-800-464-9484**, TTY: 711, Monday through Friday from 7:30 a.m. to 6:00 p.m. Central Time. Your ride will be comfortable and safe. Refer to the Benefits section of this member handbook for benefit details.

You can get a ride to a medical appointment if:

- The service is covered.
- You are seen by a network provider.
- The appointment is to a network provider near where you live. If the provider is far away, you may need further approval.
- Pharmacy trips are covered unless there is mail-in prescription filling service available through the pharmacy.

How do I get a ride?

Call us at least 2 business days before your appointment. Rides can be scheduled up to 30 days in advance. We will ask you for:

- Your full name, current address and phone number.
- Member ID number.
- The date you want to ride.
- The name, address and phone number of where you are going.
- The reason for your transportation request.
- The type of appointment.
- The type of assistance or mobility aid(s), if any, you require.

Please have this information ready when you call.

What do I do after I schedule my trip?

- The transportation provider will call you and tell you the time of your pickup and give you their telephone number. Keep this number handy.
- Be ready 60 minutes before your pickup time. The driver can come to your door to help you if you need it, but cannot come into your home.
- If you have a scheduled ride back, your ride should pick you up within less than 30 minutes after your appointment is over.
- If you must call your transportation provider for pick up after your appointment, your ride should arrive in less than 60 minutes.
- If you have to wait longer than 60 minutes, call the number the transportation provider gave you.

If you have a complaint.

If you have a complaint about the transportation service, call Member Services at **1-800-464-9484**, TTY: 711. If you need help, you may bring someone to the appointment to help you.



Emergencies and Hospital Services

Emergency Care

Hospital emergency rooms are there to offer emergency treatment for trauma, serious injury and life-threatening symptoms. Reasons to go to the ER include:

- Serious illness.
- Broken bones.
- Serious breathing problems.
- Poisoning.
- Severe cuts or burns.

Don't wait.

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

UnitedHealthcare Community Plan covers any emergency care you need throughout the United States and its territories. You should call your PCP and let them know about your visit so they can provide follow-up care if needed. Follow-up care in the ER is not covered.

Emergency Ambulance

You can get medical transportation for emergencies.

Medically necessary ambulance services are covered when you meet the following conditions:

- Your sickness or injury is serious enough that you can only go to the hospital in an ambulance.
- If you go in an ambulance, you must be taken to the closest hospital with the right equipment to help.
- If you are going from one hospital to another, to a skilled nursing facility, or to a licensed nursing home.

UnitedHealthcare will not pay for the following non-emergency (routine) transportation services:

- Transportation from your home to your doctor's office.
- Transportation to the outpatient area of a hospital, unless a network provider or UnitedHealthcare decides that your sickness or injury requires it.
- Transportation from one private home to another.

Emergencies and Hospital Services

Post-Stabilization Care Services

Post-stabilization services are covered by a network doctor without prior authorization. These are services related to an emergency medical condition that are provided after you are stabilized in order to maintain, improve or resolve your condition.

Post-stabilization care is covered when:

1. You have an approved prior authorization from a network provider, or
2. UnitedHealthcare does not respond within one (1) hour to a request for prior authorization from an out-of-network provider, or
3. UnitedHealthcare could not be reached during normal business hours for prior authorization, or
4. UnitedHealthcare and the treating physician cannot reach an agreement about your care and a network doctor is not available to review.

Post-stabilization care services with an out-of-network provider are covered until one of the following:

1. You are discharged, or
2. A network provider with privileges at the treating hospital assumes responsibility for the your care, or
3. The out-of-network provider and UnitedHealthcare reach an agreement concerning your care, or
4. A network provider assumes responsibility for your care until you are transferred to a network facility.

You will not pay more than any applicable co-payment or cost sharing for post-stabilization services. Any cost sharing for post-stabilization services begins on the date of inpatient admission.

Non-Emergency Care

If you have a sickness or injury that does not put your health or life in danger, you need non-emergency care. In these cases, you should call your PCP first. Do not go to the emergency room or you may be responsible for a co-payment. Your PCP will help you get the best care. Examples of conditions needing non-emergency care are:

- Cold.
- Headache.
- Sore throat.
- Minor cuts or burns.
- Earache.
- Bruises.
- Sprains.

Urgent Care

Urgent care clinics are there for you when you need to see a doctor for a non-life-threatening condition but your PCP isn't available or the office is closed. Common health issues for urgent care include:

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

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

Hospital Services

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

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

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

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

Going to the hospital.

If you need to know what hospital is nearest you, you can find network hospitals at myuhc.com/CommunityPlan. Or you can call Member Services at **1-800-464-9484**, TTY: 711.

No Medical Coverage Outside of United States

If you are outside of the United States and need medical care, any health care services you receive will not be covered by UnitedHealthcare Community Plan. Medical services you get outside of the United States are not covered.



Benefits

Benefits Covered by UnitedHealthcare Community Plan

As a member of UnitedHealthcare Community Plan, you are covered for the following services. (Remember to always show your current member ID card when getting services. It confirms your coverage.) If a provider tells you a service is not covered by UnitedHealthcare and you still want these services, you may be responsible for payment.

You should get services from a UnitedHealthcare network provider. Some services require prior authorization. Limits and exclusions may apply. Always talk with your PCP or doctor about your care.

For a comparison summary of the benefits by eligibility category please refer to the Benefits at a Glance document located at uhcommunityplan.com/content/communityplan/homepage/ia/medicaid/community-plan-health-link.html.

Co-Payments

The following members will be charged a co-payment for each visit to the emergency room that is not considered an emergency. See page 36 for the definition of emergency.

Iowa Medicaid members (unless under the age of 21)	\$3.00 co-payment
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You may have costs for facility services and waiver services. This is called “Client Participation.” Iowa Medicaid will mail a notice of decision to you if you must pay in order to receive these services.

You can always call Member Services at **1-800-464-9484**, TTY: 711, to ask questions about benefits.

Benefits

Service	Description
CHILDREN'S CARE	
Newborn Care	Newborn screenings are covered. Circumcisions performed on male newborns before leaving the hospital are covered.
Immunizations and Vaccines (shots)	You can get these at the doctor's office or the local health department. The <i>Vaccines for Children</i> is available for children under age 19. Immunizations and vaccines are covered according to the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics vaccination schedule.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (under 21 years old)	<p>Covered services include:</p> <ul style="list-style-type: none">• Well-child visits.• Developmental screening.• Vision testing.• Behavioral screening.• Immunizations.• Hearing testing. <p>For more information on EPSDT, refer to the EPSDT section of this member handbook.</p>
Lead Screening	Lead screenings can be done at the doctor's office or local health department.
Office Visits	Well-child visits, routine visits and sick visits are covered.

Service	Description
WOMEN'S CARE	
Family Planning	<p>Family planning offers counseling, supplies, routine care and treatment for sexually transmitted infections (STIs). This care is private. You can go to any provider that offers these services. Also includes family planning drugs, supplies and devices. These include, but are not limited to, generic birth control pills, shots, IUDs and diaphragms. <u>Men who are under 55 years of age and who are capable of fathering children are also eligible for family planning services.</u></p> <p>There are two ways members receive family planning services under Iowa Medicaid:</p> <ol style="list-style-type: none"> 1. Members who are eligible for full Medicaid, where family planning is one of many different types of services available to members. 2. Members who are only eligible for family planning and family planning related services under the Iowa Family Planning Network (IFPN), where only these services are covered. For members only eligible for IFPN, no other Medicaid services are covered.
Obstetric and Maternity Care	<p>You are covered for:</p> <ul style="list-style-type: none"> • Doctor and hospital care before your baby is born (prenatal care). • Delivery. • Care after birth (postpartum care). • Certified midwife care. • Birthing and parenting classes. <p>You may go to your OB/GYN for care without a referral.</p> <p>You can stay in the hospital up to 2 days after a normal vaginal delivery and up to 4 days after a cesarean delivery.</p>

Benefits

Service	Description
WOMEN'S CARE <i>(continued)</i>	
Well-Care for Women	You are covered for routine office visits, mammograms, pap tests and family planning services. No referral is needed.
Sterilization	Both women and men may receive sterilizations. Your health care provider performing the sterilization must complete the 'sterilization consent form', which is required under both state and federal Medicaid law and rules.
Abortions	Abortion services are limited to coverage based on federal and state laws and regulations. No services associated with an abortion will be covered unless criteria are met. The appropriate Certification of Medical Necessity for Abortion form must be completed and submitted with the claim by your provider, along with supporting documentation.
EMERGENCY AND URGENT HOSPITAL CARE	
Ambulance Services	Emergent and non-emergent transportation by an ambulance is covered.
Emergency Room Care (Co-payments apply, refer to page 39 for details)	<p>Emergency care is for a medical issue that is a threat to your life or that can badly harm your health if you do not get care right away. Here are some examples of emergencies:</p> <ul style="list-style-type: none">• Convulsions.• Chest pain.• High fever.• Serious breathing problems.• Broken bones.• Loss of consciousness (fainting or blackout). <p>Emergency care does not need prior authorization and you can get care anywhere in the USA. This includes post-stabilization care. Post-stabilization care includes the care you get after an emergency to make you stable or to maintain, improve or resolve your health condition.</p>

Service	Description
EMERGENCY AND URGENT HOSPITAL CARE (continued)	
Medical Inpatient Care	Hospital inpatient care is covered when medically necessary. Includes medical, surgical, post-stabilization, acute and rehabilitative services. The hospital must notify UnitedHealthcare.
Urgent Care Visits	<p>Urgent care is for problems that need prompt medical attention, but are not life threatening. Here are some examples of urgent care:</p> <ul style="list-style-type: none"> • Sore throat or cough. • Back pain. • Earache. • Flu or cold symptoms. • Minor injury. <p>Visits to an urgent care center are covered.</p>
OUTPATIENT CARE	
Doctor Visits	Routine and preventive care services including doctor visits, preventive services, clinic visits and outpatient doctor care are covered.
Cardiac and Pulmonary Rehab	Covered when medically necessary. Prior authorization is required.
Home Health Services	<p>Services in the home include visits by nurses, home health aides, and therapists. Home health services are provided by home health agencies in a plan of care approved by your PCP.</p> <p>NOTE: Private duty nursing and personal cares are not included in the home health services program. These services are covered under the EPSDT authority for children up to 21. Both of the services require prior authorization.</p>
Rehabilitative Therapy (including physical, occupational and speech therapy)	This type of care is given after serious illness or injury to restore function. Covered therapy includes physical, occupational and speech. These are covered when medically necessary. Prior authorization may be required and limitations may apply.

Benefits

Service	Description
OUTPATIENT CARE (continued)	
Specialty Care (Office Visits and Clinics)	Care with a specialist is covered. Talk to your doctor to see if you need specialty care. But you do not need a referral to go to a network specialist.
Diagnostic Testing	Diagnostic lab tests are covered. Cardiology and radiology services may require prior authorization.
SURGERY	
Outpatient Surgery	Medically necessary outpatient surgeries may be performed in a hospital or in an ambulatory surgery center. Some surgeries may require prior authorization. Talk with your PCP.
HOSPICE	
Hospice Care	Hospice care is for people with a terminal illness with a life expectancy of six months or less. Hospice is intended to be provided to members who live in their own homes. However, routine hospice can be provided to a member who lives in a nursing facility. Hospice requires prior authorization in coordination with your physician or a hospice physician.
OTHER COVERED CARE AND PROGRAMS	
Asthma Care	Covered equipment, supplies and services include: <ul style="list-style-type: none">• Peak flow meters.• Spacers.• Nebulizers and masks.• Regular doctor visits.• Specialist visits.• Other supplies needed to manage asthma.

Service	Description
OTHER COVERED CARE AND PROGRAMS <i>(continued)</i>	
Chiropractic Services	<p>Chiropractic manipulative therapy eligible for reimbursement is specifically limited to the manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae.</p> <p>X-rays are limited to one per condition. Additional X-rays are not covered.</p> <p>Chiropractic adjustments which are not related to a diagnosed/covered condition are not covered.</p> <p>Services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing are not covered.</p>
Diabetic Supplies	<p>All diabetic supplies including, but not limited to, alcohol swabs, syringes, test strips and lancets are covered. Diabetic supplies can be obtained from a network pharmacy.</p>
Durable Medical Equipment (DME) and Supplies	<p>Equipment and supplies for medical purpose. May include, but are not limited to: oxygen tanks, ventilators, wheelchairs, crutches, orthotic devices, prosthetic devices, pacemakers and medical supplies. Items with a retail or total rental cost of more than \$500 require prior authorization.</p> <p>Some DME is available in nursing facilities and ICF/IDs.</p>

Service	Description
OTHER COVERED CARE AND PROGRAMS (continued)	
Vision Services	<p>Medicaid</p> <p>Vision exams, prescription lenses, eyeglasses, cataract removal, and prosthetic eyes, if prescribed.</p> <p>Routine eye exams are covered once per year. Non-routine eye exams are covered when the exam is the result of a complaint or symptom of an eye disease or injury.</p> <p>New eyeglasses are covered as follows:</p> <ul style="list-style-type: none"> • Up to 3 times for children up to 1 year of age. • Up to 4 times per year for children 1 through 3 years of age. • Once per year for children 4 through 7 years of age. • Once per 24 months after 8 years of age. • Safety frames are allowed for children through 7 years of age. <p>Repairs and replacement frames, lenses, or component parts are covered. Replacement of lost or damaged glasses for adults age 21 and over is limited to once every 12 months, except in certain circumstances. Replacement of lost or damaged glasses for children under 21 years of age is not limited.</p> <p>Gas permeable contact lenses are limited as follow: up to 16 lenses for children up to 1 year of age, up to 8 lenses every 12 months for children 1 – 3 years of age, up to 6 lenses every 12 months for children 4 – 7 years of age, two lenses every 24 months for members 8 years of age and over.</p> <p>Artificial eyes are covered.</p> <p>hawk-i</p> <p>Routine eye exams are covered once per year. Non-routine eye exams are covered when the exam is the result of a complaint or symptom of an eye disease or injury.</p> <p>New eyeglasses are covered as follows:</p> <p>Up to \$100 retail allowance which may be applied to one set of eyewear (frames and lenses or contact lenses) per calendar year.</p> <p>Replacement eyewear is not covered.</p>

Service	Description
OTHER COVERED CARE AND PROGRAMS <i>(continued)</i>	
Vision Services <i>(continued)</i>	Wellness Plan and Family Planning Network Eyeglasses are not covered for Iowa Wellness Plan non-medically exempt members. Eyeglasses, repairs and exams are not covered for Iowa Family Planning Network members.
Hearing Services	Includes diagnostic screening, preventive visits and hearing aids. One routine visit every 12 months. Hearing aids, both analog and digital, are covered. Lost, broken or destroyed hearing aids will be replaced one time during a four-year time period with a prior authorization. Binaural hearing aids are covered. (One hearing aid per ear every 4 years.) Requires specific medical necessity documents. Hearing aid repairs are covered. Hearing aid batteries are covered, but limited to 30 batteries per hearing aid in a 90-day period.
Nutritional Classes/Counseling	Nutritional services/counseling must be given by a licensed dietician. It is covered for certain medical conditions, like diabetes.
Podiatry (Foot) Care	Covered when medically necessary for conditions, like diabetes. Routine foot care, such as toenail trimming, is not covered.
Mental Health and Substance Use Disorder Services	Mental health and substance use disorder services are covered. This includes: <ul style="list-style-type: none"> • Inpatient and outpatient services. • Individual and group therapy with physicians, psychologists, social workers, counselors or psychiatric nurses. • Prescription drugs for therapeutic purposes. • Partial hospitalization and day treatment services. Some services have limitations and require prior authorization.

Benefits

Service	Description
OTHER COVERED CARE AND PROGRAMS <i>(continued)</i>	
Prescription and Over-the-Counter (OTC) Drugs	Prescriptions are covered according to the State's Preferred Drug List (PDL). See page 20 for more information about your prescription benefits.
Non-Emergency Transportation	Transportation to and from medical appointments are covered if you qualify and have no other way to get there. Must be medically necessary appointments or to go to the pharmacy. Prior authorization may be required. See page 35 for details.

UnitedHealthcare reviews new procedures, devices and drugs to decide if they are safe and effective for members. If they are found to be safe and effective, they may become covered. If new technology becomes a covered service, it will follow plan rules, including medical necessity. Any applicable member co-payments apply.

In addition to your Medicaid benefits, as an HCBS Waiver member you also receive some of the following services. The benefit chart shows what waivers cover each service. You may have costs for waiver services. This is called “client participation.” Iowa Medicaid will mail a notice of decision to you if you must pay in order to receive HCBS waiver services.

Prior Authorization is required for all of the following services. Some limitations may apply.

Call Member Services or your Case Manager for benefit details.

Service	Description	Home and Community-Based Services (HCBS) Waivers
Adult Day Care	Program of support care in a group environment with supervision and assistance on a regular or intermittent basis in a day care center.	<ul style="list-style-type: none"> • AIDS/HIV. • Brain Injury. • Elderly. • Health and Disability. • Intellectual Disability.
Assisted Living	The assisted living service provides staff on call 24 hours per day to meet your needs. Staff will help you in a way that promotes maximum dignity and independence and provides safety and security.	<ul style="list-style-type: none"> • Elderly.
Assistive Devices	Equipment to assist members with activities of daily living to allow the member more independence. Devices include, but are not limited to: <ul style="list-style-type: none"> • Long-reach brush. • Extra-long shoe horn. • Non-slip grippers to pick up and reach items. • Dressing aids. • Transfer boards. • Shampoo rinse tray and inflatable shampoo tray. • Double-handled cup and sipper lid. 	<ul style="list-style-type: none"> • Elderly.

Benefits

Service	Description	Home and Community-Based Services (HCBS) Waivers
Behavioral Programming	Individually designed programs to increase the member’s appropriate behaviors and decrease the member’s maladaptive behaviors that have interfered with the member’s ability to remain in the community.	<ul style="list-style-type: none"> • Brain Injury.
Chore	Assist with the household maintenance activities as necessary to allow a member to remain in their own home safely and independently	<ul style="list-style-type: none"> • Elderly.
Community-based neurobehavioral rehabilitation services	These intensive services are available for members with a traumatic brain injury. This is for members who have challenges living in the community with the effects of a traumatic brain injury and the behavioral health conditions that may exist. Intensive services are offered in order to assist the member in returning to community living with services and supports.	<ul style="list-style-type: none"> • Brain Injury.
Consumer-Directed Attendant Care (CDAC)	Activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. CDAC services must be cost-effective and necessary to prevent institutionalization.	<ul style="list-style-type: none"> • AIDS/HIV. • Brain Injury. • Elderly. • Health and Disability. • Intellectual Disability. • Physical Disability.

Service	Description	Home and Community-Based Services (HCBS) Waivers
Counseling	<p>Face-to-face non-psychiatric mental health services necessary to:</p> <ul style="list-style-type: none"> • Manage depression, • Assist with the grief process, • Alleviate psychosocial isolation, and • Provide support to cope with a disability or illness, including terminal illness. 	<ul style="list-style-type: none"> • AIDS/HIV. • Health and Disability.
Day Habilitation	<p>Regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as:</p> <ul style="list-style-type: none"> • Assist with acquisition, retention or improvement in self-help; • Socialization and adaptive skills that enhance social development; and • Develop skills in performing activities of daily living and community living. 	<ul style="list-style-type: none"> • Intellectual Disability.
Environmental Modifications and Adaptive Devices	<p>Items installed or used within the member's home that address specific, documented health, mental health or safety concerns.</p>	<ul style="list-style-type: none"> • Children's Mental Health.
Family and Community Support	<p>Support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression, and will increase the member's and the family's social and emotional strength.</p>	<ul style="list-style-type: none"> • Children's Mental Health.

Benefits

Service	Description	Home and Community-Based Services (HCBS) Waivers
Family Counseling and Training	Services are face-to-face mental health services provided to the member and the family with whom the member lives (or who routinely provides care to the member) to increase the member’s or family members’ capabilities to maintain and care for the member in the community.	<ul style="list-style-type: none"> • Brain Injury.
Habilitation Services	Program to help members acquire, retain, and improve the self-help, socialization and adaptive skills needed to live successfully in home- and community-based settings. Services include: <ul style="list-style-type: none"> • Home-based habilitation. • Day Habilitation. • Prevocational. • Supported Employment. 	Habilitation Services – Iowa’s 1915(i) State Plan HCBS Services Program
Home-Delivered Meals	Each meal shall ensure the member receives a minimum of one-third of the daily-recommended dietary allowance, as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard. A maximum of 2 meals per day or 14 meals per week is allowed.	<ul style="list-style-type: none"> • AIDS/HIV. • Elderly. • Health and Disability.
Home Health Aide	Unskilled medical services that provide direct personal care.	<ul style="list-style-type: none"> • AIDS/HIV. • Elderly. • Health and Disability. • Intellectual Disability.

Service	Description	Home and Community-Based Services (HCBS) Waivers
Homemaker	Provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions.	<ul style="list-style-type: none"> • AIDS/HIV. • Elderly. • Health and Disability.
Home/Vehicle Modifications	Physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare or safety of the member and enable the member to function with greater independence in the home or vehicle.	<ul style="list-style-type: none"> • Brain Injury. • Elderly. • Health and Disability. • Intellectual Disability. • Physical Disability.
In-Home Family Therapy	Skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.	<ul style="list-style-type: none"> • Children's Mental Health.
Interim Medical Monitoring and Treatment (IMMT)	Services are monitoring and treatment of a medical nature requiring specially trained caregivers.	<ul style="list-style-type: none"> • Brain Injury. • Health and Disability. • Intellectual Disability.
Mental Health Outreach	Services provided in a member's home to identify, evaluate and provide treatment and psychosocial support. The services can be provided only on the basis of a referral from the member's interdisciplinary team.	<ul style="list-style-type: none"> • Elderly.

Benefits

Service	Description	Home and Community-Based Services (HCBS) Waivers
Nursing	<p>Services provided to a member by licensed agency nurses in the home. Must be included in the plan of treatment established by the physician. The services must be reasonable and necessary to the treatment of an illness or injury. Services should be based on medical necessity of the member.</p>	<ul style="list-style-type: none"> • AIDS/HIV. • Elderly. • Health and Disability. • Intellectual Disability.
Nutritional Counseling	<p>Services provided for a nutritional problem or condition of such severity that nutritional counseling beyond that normally expected as part of the standard medical management is needed.</p>	<ul style="list-style-type: none"> • Elderly. • Health and Disability.
Personal Emergency Response System	<p>A call button so the member can get help in an emergency. Use it when the caregiver is not around.</p>	<ul style="list-style-type: none"> • Brain Injury. • Elderly. • Health and Disability. • Intellectual Disability. • Physical Disability.
Prevocational Services	<p>Services that provide learning and work experiences, including volunteer work, where the member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the member and the member's service and supports planning team through an ongoing person-centered planning process.</p>	<ul style="list-style-type: none"> • Brain Injury. • Intellectual Disability.

Service	Description	Home and Community-Based Services (HCBS) Waivers
Respite: Basic Individual	<p>Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation.</p> <p>Individual respite is provided on a ratio of one staff to one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.</p>	<ul style="list-style-type: none"> • AIDS/HIV. • Brain Injury. • Children’s Mental Health. • Elderly. • Health and Disability. • Intellectual Disability.
Respite: Group	<p>Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation.</p> <p>Group respite provided on a ratio of one staff to two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.</p>	<ul style="list-style-type: none"> • AIDS/HIV. • Brain Injury. • Children’s Mental Health. • Elderly. • Health and Disability. • Intellectual Disability.

Benefits

Service	Description	Home and Community-Based Services (HCBS) Waivers
Respite: Specialized	<p>Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation.</p> <p>Respite provided on a staff-to-member ratio of one-to-one or higher to members with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.</p>	<ul style="list-style-type: none"> • AIDS/HIV. • Brain Injury. • Children’s Mental Health. • Elderly. • Health and Disability. • Intellectual Disability.
Senior Companion	<p>Include nonmedical care supervision, oversight and respite services. Companions may assist with meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care.</p>	<ul style="list-style-type: none"> • Elderly.
Specialized Medical Equipment	<p>Medically necessary items for personal use by a member for the member’s health and safety, such as:</p> <ul style="list-style-type: none"> • Electronic aids and organizers. • Medicine dispensing devices. • Communication devices. • Bath aids. • Environmental control units. • Repair and maintenance of items purchased through the waiver. 	<ul style="list-style-type: none"> • Brain Injury. • Physical Disability.



Service	Description	Home and Community-Based Services (HCBS) Waivers
Supported Community Living (SCL)	Services provided within the member's home and community, according to the individualized member's needs as identified in the approved service plan.	<ul style="list-style-type: none"> • Brain Injury. • Intellectual Disability.
Supported Community Living: Residential-Based (RBSCCL)	Medical or remedial services provided to children under the age of 18 while living outside their family home. The residential-based living environment is furnished by the residential-based supported community living service provider. The services remove barriers to family reunification or develop self-help skills for maximum independence.	<ul style="list-style-type: none"> • Intellectual Disability.
Supported Employment (SE)	Individual employment support services for members who, due to disabilities, need ongoing support to obtain and maintain an individual job.	<ul style="list-style-type: none"> • Brain Injury. • Intellectual Disability.
Transportation	<p>Transportation services may be provided for members:</p> <ul style="list-style-type: none"> • To conduct business errands and essential shopping, • To receive medical services not reimbursed through medical transportation, • To travel to and from work or day programs (BI, ID and PD), or • To reduce social isolation. 	<ul style="list-style-type: none"> • Brain Injury. • Elderly. • Intellectual Disability. • Physical Disability.

Iowa Family Planning Network Services



Iowa Family Planning Network (IFPN) Services are available for men and women ages 12 through 54. Services available to those who are eligible include:

- Birth control exams and advice.
- Limited testing and treatment for sexually transmitted diseases (STDs).
- Pap tests.
- Birth control supplies for men and women.
- Voluntary sterilization for men and women who are over the age of 21 and have signed a valid sterilization consent form.

Value-Added Benefits

Value-Added Benefit	Benefit Details	Eligibility
 <p>Baby Blocks™</p>	<p>If you are pregnant, you can earn rewards with Baby Blocks. When you join, you get a gift card or gear for your baby. Then earn up to seven more rewards with doctor visits during pregnancy and your baby's first 15 months. You earn great rewards while both you and your baby get the care you need to stay healthy. It's easy to get started.</p> <ol style="list-style-type: none"> 1. Enroll at UHCBabyBlocks.com. Get appointment reminders by text or email. 2. Go to your appointments and record them at UHCBabyBlocks.com. 3. Choose your rewards for going to the doctor. 	<p>Pregnant women and mothers of children under 15 months of age</p>
 <p>Community Rewards™</p>	<p>Make good health fun and rewarding. As a UnitedHealthcare Community Plan member, you may be eligible to join our Community Rewards program. It's an easy way to keep track of the healthy activities you may already be doing – or help build new healthy habits.</p> <p>You can earn points for healthy habits like:</p> <ul style="list-style-type: none"> • Daily activities: brushing teeth, eating healthy and getting a good night's sleep. • Insurance activities: Using NurseLine, reading the welcome kit. • Regular checkups: Annual well visits, flu shots, dental visits. • Use your computer or smartphone to record healthy activities. • Do something every day; points can really add up. • Use your points to collect rewards. Choose from movie tickets, electronics, kitchen tools, exercise equipment and more. <p>It's that easy. The rewards are great. But creating healthy habits is the best reason of all to start today.</p> <p>Enroll at UHCommunityRewards.com/IA.</p> <p>Rules and restrictions may apply. Rewards are based on participation.</p>	<p>Eligible for all members</p>

Benefits

Value-Added Benefit	Benefit Details	Eligibility
 <p>Weight Watchers</p>	<p>We offer enrollment in the Weight Watchers program for qualified members. Members will receive vouchers to attend official Weight Watchers meetings where they will learn valuable skills about healthy eating and weight loss.</p>	<p>Eligible for all members 12 years and older.</p> <p><i>A parent or guardian must sign the health notice portion of the Weight Watchers registration form for members ages 12 – 16.</i></p>
 <p>School/Camp/ Sports Physicals</p>	<p>We offer one sports/school/camp physical every 12 months. The exam helps determine whether it is safe for children to participate in a particular sport or daytime camp. Services must be received from a network provider.</p> <p>Note: This does not replace routine medical examinations. This benefit is limited to one visit per calendar year for children ages 4 – 19.</p>	<p>Eligible for Medicaid members.</p>

For Moms-to-Be and Children

Healthy First Steps™.

Our Healthy First Steps program makes sure that both mom and baby get good medical attention.

We will help you:

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

Having a baby?

When you think you are pregnant, call the Iowa Department of Human Services (DHS) at **1-877-347-5678**. This will help ensure you get all the services available to you.

Call us toll-free at **1-800-464-9484**, TTY: **711**, Monday – Friday, from 7:30 a.m. – 6:00 p.m. Central Standard Time.

Follow us on Twitter [@UHCPregnantCare](https://twitter.com/UHCPregnantCare).

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

Pregnant women.

Women may see any UnitedHealthcare Community Plan OB/GYN for obstetrical care without being sent by their PCP. (Maternity-prenatal, delivery and postpartum.)

- If you think you may be pregnant, see your PCP or a UnitedHealthcare Community Plan OB/GYN right away. It is important to start prenatal care as soon as you become pregnant.
- See your PCP or UnitedHealthcare Community Plan OB/GYN throughout your pregnancy.
- Make sure you go to all your visits when your PCP or UnitedHealthcare Community Plan OB/GYN tells you to.
- Make sure you go to your provider right after you have your baby for follow-up care (between 21 and 56 days after your baby is born).

You may be able to get free formula, milk and food from the Women, Infants and Children (WIC) program. Talk to your provider or call your local Health Department about these services.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

UnitedHealthcare Community Plan will pay for children under 21 to see the doctor regularly. These visits are part of the EPSDT program. EPSDT is covered for Iowa Medicaid members. These visits make sure your child is growing normally and check for problems and conditions. These exams include screenings and are recommended by the American Academy of Pediatrics (AAP) periodic schedule. These screenings will include many things:

- Health history.
- Complete physical exam.
- Lab tests (as appropriate).
- Immunizations.
- Vision, hearing and dental screenings.
- Developmental and behavioral screenings.
- Advice on how to keep your child healthy.

You also get other services, such as:

- Treatment, including rehabilitation for any physical, developmental or mental health conditions discovered during a screening.
- Regular visits to a dentist for checkups and treatment (this benefit is offered through your dental plan).
- Immunizations (shots).
- Regular tests of and treatment for the child's hearing and eyesight.
- Routine lab tests, as well as tests for lead in the blood and sickle cell anemia, if the child is at-risk.
- Lead investigations, if your child has a high level of lead in his or her blood.
- Private duty nursing and personal cares services if medically necessary and prior authorized.
- Transportation: If you cannot get your child to his or her visits, you may be able to get a ride. Read more on page 35.
- Other tests and services needed to correct or prevent defects, physical conditions and mental illnesses discovered by the screenings.

Making and keeping your child's EPSDT appointments can help your child stay healthy. The best time to prevent serious health problems is before they develop.

Sesame Street.

A is for Asthma — A program from Sesame Street. It teaches kids and parents about the best ways to live with asthma.

Sesame Street Food for Thought Program — A program to help families eat better. The program teaches families with children between ages 2 and 8 how to buy healthy food.

Sesame Street Healthy Habits — Learn from Sesame Street friends about going to your doctor. Learn about asthma and lead tests.

Visit the website at www.UHCCommunityPlan.com/community-partners/ia.html.

Text4baby.

Text4baby is a free mobile information service that will help you through your pregnancy and baby's first year of life. Get free text messages on your cellphone each week. The text4baby messages will give you tips about:

- Keeping healthy.
- Labor and delivery.
- Breastfeeding.
- The importance of immunizations.
- Exercise and healthy eating.
- And much more.

To sign up for text4baby, simply text the word BABY to 511411. You will be asked for a participant code after you sign up. The participant code is HFS. This code will let text4baby know that you are a member of our health plan. It will also let us know you signed up for the service.

Give your baby the best possible start in life. Sign up for text4baby.

Newborns' and Mothers' Health Protection Act.

UnitedHealthcare follows federal guidelines that require certain benefits for mothers and infants after childbirth. Our benefit plans cover 48 hours in the hospital after a vaginal delivery. We also cover 96 hours in the hospital after a delivery by cesarean section. (You can choose to stay less time in the hospital if your provider says it's okay.)

Women, Infants and Children (WIC).

WIC is the special nutrition program for women, infants and children enrolled in Medicaid. The WIC program provides healthy food at no cost, breastfeeding support, nutrition education and health care referrals. If you are pregnant, ask your doctor to fill out a WIC application during your next visit. If you have an infant or child, ask their doctor to fill out a WIC application or contact your local WIC office.

Family planning services.

UnitedHealthcare Community Plan covers family planning services, including contraceptive care and pregnancy tests. You do not need to get our approval before using these services. There is no limit to how often you can use them.

Dr. Health E. Hound® program.

We are proud of our mascot — Dr. Health E. Hound. His goal is to teach your children about fun ways to stay fit and healthy. Dr. Health E. Hound loves to travel around the state and meet children of all ages. He hands out flyers, posters, stickers and coloring books about healthy foods and exercise. He helps kids understand that going to the doctor is an important way to stay healthy. You and your family can meet Dr. Health E. Hound at some of our events. Come to an event and learn about healthy eating and exercise. Visit the website at www.UHCCommunityPlan.com/community-partners/ia.html.

JOIN for MESM Childhood Weight Management Program.

JOIN for ME is a unique program to help kids reach a healthier weight. This program will be piloted in the State of Iowa. It is available to members ages 6 through 17 who are above the 85th percentile for body mass index (weight-to-height ratio). Members must also be in general good health. A doctor's signature is necessary to attest to the fact that the member meets BMI criteria. The required referral form is online at UHCCommunityPlan.com.

You and your child meet as a small group with other families and an expert coach. Parents also have the opportunity to lose weight.

Your child is eligible for a \$50 gift card upon completion of JOIN for ME, to be handed out during the final class. We will also give children ages 6 and up Nerf Energy bands and Nerf balls to promote physical activity.

Health Home and Integrated Health Home

Health Homes.

A health home is an approach to care coordination for individuals with multiple chronic conditions, including mental health and substance use disorders. The health home provides a team based clinical approach that includes the member, their medical providers, and family members (when appropriate). The health home model builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of our members with multiple chronic illnesses.

Health homes focus on providing the following six core services for our members:

1. Comprehensive Care Management.
2. Care Coordination.
3. Health Promotion.
4. Comprehensive Transitional Care.
5. Individual and Family Support.
6. Referral to Community and Social Support Services.

For Iowa HealthLink members, there are two health homes programs, Health Home and Integrated Health Home, differentiated by the member's conditions.

Health Home (chronic condition).

Members must have two or more of the following criteria to be eligible for Health Homes:

- Mental health condition.
- Substance abuse disorder.
- Asthma.
- Diabetes.
- Heart Disease.
- BMI over 25.
- Hypertension.
- BMI over 85 percentile for pediatric population.
- Meet one of the above criteria and at risk for developing another.

Integrated Health Home.

Members are eligible for Integrated Health Homes if they have been diagnosed with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).

SMI is defined as:

- Psychotic disorders.
- Schizophrenia.
- Schizoaffective disorder.
- Major depression.
- Bipolar disorder.
- Delusional disorder.
- Obsessive Compulsive Disorder.

SED is a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders published by the American Psychiatric Association or its most recent International Classification of Diseases equivalent that result in functional impairment. SED may co-occur with substance use disorders, learning disorders, or intellectual disorders that may be a focus of clinical attention.

For additional information on eligibility and participation in the Health Home or Integrated Health Home programs, please talk with your Primary Care Physician (PCP), MCO Care Coordinator (CBCM), or behavioral health specialist to learn more.



Other Plan Details

When to Call the State of Iowa

Call the Iowa Medicaid Member Services at 1-800-338-8366, 8:00 a.m. – 5:00 p.m. Central Time, Monday – Friday if you have questions about your eligibility or premium payments. You should also call if you:

- Get other health insurance.
- Have a change in eligibility.
- Are pregnant.

If you move to a new address, call the DHS call center at 1-877-347-5678.

Help with Insurance Premium Payments

The Health Insurance Premium Payment (HIPP) program is available from the State of Iowa. HIPP helps people get or keep health insurance through their employer by reimbursing the cost of the health insurance premium. The HIPP program is a way for the State of Iowa to save money.

To complete an application over the phone or for questions, call 1-888-346-9562. Paper applications are online at www.dhs.state.ia.us/hipp. Applications may be returned by fax at 1-515-725-0725 or email at hipp@dhs.state.ia.us.

Changing Your Health Plan

If you have a complaint, please call us. We can help. If you still want to change your health plan, you may at any time during the first 90 days after your initial enrollment in a health plan. You can also change your health plan during the open enrollment period. To change your health plan, call the Iowa Medicaid Member Services at 1-800-338-8366, 8:00 a.m. – 5:00 p.m. Central Time, Monday – Friday.

How Do I Disenroll From My Plan?

Disenrollment.

Call Member Services first if you have concerns with your plan. We can help answer your questions. If you still want to disenroll, you can at the following times. UnitedHealthcare Community Plan will not disenroll any member until the State sends it to us.

You may request disenrollment **without cause**:

- During your initial 90-day enrollment period.
- During annual open enrollment.
- Upon automatic re-enrollment of Medicaid eligibility for a period of 2 months or less, if the temporary loss of Medicaid eligibility caused you to miss the annual open enrollment period.
- If the State grants an intermediate sanction according to federal law. The State will notify you of your right to disenroll without cause.

You may disenroll at any time throughout the year for reasons of **good cause**. **Good cause** reasons can include:

- Your provider is not in the network and that impacts your health outcomes.
- If there is a change in eligibility (for example PACE).
- You need related services to be performed concurrently, but not all related services are available through our network, or your PCP has determined that receiving the services separately would subject you to unnecessary risk.
- The managed care plan does not, because of moral or religious objection, cover the service you seek.
- Other state-approved reasons, including, but not limited to poor quality of care, lack of access to covered services, inappropriate changes of PCPs, changes to where you can get services that result in difficulty getting those services, an unreasonable delay or denial of service, lack of access to providers experienced in dealing with your health care needs, when a provider disenrolls and results in disruption to the member's residence or employment, or fraudulent enrollment.

To make a change:

- Call the Iowa Medicaid Member Services at 1-800-338-8366, 8:00 a.m. – 5:00 p.m. Central Time, Monday – Friday to request disenrollment for good cause.
- Tell the Iowa Medicaid Member Services which MCO you want to switch to.
- If you have a question about whether you have a “good cause,” call the Iowa Medicaid Member Services for more information.

Other Health Insurance Coordination of Benefits (COB)

If you have other insurance, UnitedHealthcare Community Plan and your other plan will share the cost of your care. This is called Coordination of Benefits. Together, both plans will pay no more than 100% of the bill, excluding any co-payments. If you or anyone in your family has other health insurance, you must call Member Services and tell us about it. For example, if you have a health plan at work or if your children have insurance with their other parent, call Member Services.

If we pay the full bill and another party should pay part, we will contact the other plan. For example, if you are hurt in a car accident, auto insurance may pay some of your bills. You will not get a bill for covered services. We get the bill. If you get the bill by mistake, call Member Services at **1-800-464-9484, TTY: 711**.

Estate Recovery Program

Estate Recovery legal reference: 441 IAC 75.28(7)

If you received Medicaid benefits, which includes capitation fees paid to a Managed Care Organization (MCO), the state of Iowa has the right to ask for money back from your estate after your death. Members affected by the estate recovery policy are those who:

- Are 55 years of age or older, regardless of where they are living; or
- Are under age 55 and:
 - Reside in a nursing facility, an intermediate care facility for persons with an intellectually disability, or a mental health institute, and
 - Cannot reasonably be expected to be discharged and return home.

For more information, please call IME Member Services:

1-800-338-8366 Toll Free, 515-256-4606 (Des Moines area)
8:00 a.m. – 5:00 p.m., Monday – Friday

Advance Directive

You have the right to make care decisions even when you can't speak for yourself. You can do this by making an Advance Directive. This is a written or oral statement that is made and witnessed in advance of illness or injury. It tells others how you want health care decisions made when you are not able to make them yourself.

Iowa law allows two types of Advance Directive:

1. Living Will.
2. Durable Power of Attorney for Health Care Decisions.

You can find information and forms on Advance Directive on our website. Visit <http://www.UHCCCommunityPlan.com/ia/medicaid/community-plan-health-link/member-information.html>. Click on Advance Directive/Power of Attorney Forms, where you will find a link to the State of Iowa website where the information can be found.

Living Wills.

A Living Will states the kind of health care you want or do not want if you are not able to make your own decisions. It is called a Living Will because it takes effect while you are still living. You may wish to talk to a lawyer or provider to be sure your Living Will makes your wishes clear.

Adults have the right to control decisions for their own medical care. This includes the right to withhold life-sustaining treatment in case of a terminal condition. Any adult may make a Living Will. A Living Will must be:

1. In writing.
2. Dated and signed by the adult making the declaration.
3. Signed by two adult witnesses or notarized.

The law says that relatives by blood or marriage, heirs or people who are responsible for paying for the medical care may not serve as witnesses. It says the Living Will has no effect during pregnancy.

The declaration may be revoked in three ways:

1. By destroying the declaration.
2. By signing and dating a written revocation.
3. By speaking an intent to revoke in front of an adult witness. The witness must sign and date a written statement that the declaration was revoked.

Before the Living Will becomes effective, two doctors must diagnose that the patient has a terminal condition. The Natural Death Act specifies doctor duties. It provides penalties for violations of these laws.

Durable Power of Attorney.

A Durable Power of Attorney for Health Care lets you name someone to make medical decisions if you cannot speak for yourself. This can include decisions about life support. The person you appoint is called an agent. He or she can speak for you at any time you are unable to make your own medical decisions, not just at the end of your life. The Power only takes effect when the adult is disabled unless it specifies that it should take effect earlier. The document can include instructions about any treatment you want or wish to avoid.

You can access forms for Durable Power of Attorney in Iowa by visiting:

<http://dhs.iowa.gov/ime/providers/forms>.

The Durable Power of Attorney may give the agent any or all of these rights:

1. To consent or to refuse consent to medical treatment.
2. To make decisions about donating organs, autopsies and disposition of the body.
3. To arrange for hospital, nursing home or hospice care.
4. To hire or fire doctors and other health care providers.
5. To sign releases and get information about the patient.

The Power may not give the agent the power to revoke the adult's Living Will under the Iowa Natural Death Act. A health care provider treating an adult may not be that person's agent, except in limited cases.

The Durable Power of Attorney should be:

1. In writing.
2. Signed by the adult making the declaration.
3. Dated.
4. Signed by two adult witnesses or notarized.

Relatives by blood or marriage, heirs or people who are responsible for paying for the medical care may not serve as witnesses.

The adult, at the time the Power is written, should state how the Power may be revoked.

Questions About Advance Directive

Can I change my mind after I write a Living Will or a Durable Power of Attorney?

Yes, you may change or cancel these documents at any time. The desires of a patient always supersede the declaration. A competent patient can revoke his or her Living Will at any time. If a patient is incompetent, the declaration will be presumed to be valid.

Other Plan Details

What should I do with my Advance Directive?

Make sure that someone such as a provider, attorney or relative knows that you have an Advance Directive. Tell them where it is located. Consider:

- If you have made a Durable Power of Attorney, give a copy of it to that person.
- Give a copy of your Advance Directive to your provider.
- Keep a copy of your Advance Directive in a place where it can easily be found.
- Keep a card in your purse or wallet stating that you have an Advance Directive and where it is located.
- If you change your Advance Directive, make sure your provider, attorney and/or relative has the latest copy.

How can I make an Advance Directive?

You can talk with your doctor, attorney or go to myuhc.com/CommunityPlan. Our website has Advance Directive forms you can download.

Does my doctor have to follow my Advance Directive?

Yes. You have a right to choose a new provider if the one you have cannot honor your Advance Directive wishes due to objections of conscience. For more information, ask those in charge of your care or call Member Services.

If you believe your provider is not following Advance Directive laws and rules, you may file a complaint. You can send a letter of complaint to:

Iowa Department of Human Services
Administrator, Diversity Program Unit
1305 E. Walnut
Des Moines, IA 50319-0114
Phone: 1-800-972-2017, Fax: 515-281-4243

Do I have to write an Advance Directive under Iowa law?

No. However, if you have not made an Advance Directive, health care decisions may be made for you.

Iowa Long Term Care Ombudsman Program

Call Member Services for help with your issue. If you still need help and receive long term care services or home and community based waiver services, interdependent advocacy services are available.

The Long Term Care Ombudsman can assist you with:

- Education and information.
- Advocacy.
- Outreach.
- Complaint resolution.
- Grievances, appeals and state fair hearings.

Assistance is available to Iowa Medicaid members who wish to have a complaint about their services researched.

For members receiving long term care services or home and community based waiver services, independent advocacy services are available. You may contact:

Office of the State Long-Term Care Ombudsman
 510 East 12th Street
 Des Moines, IA 50319
 515-725-3333, or 1-866-236-1430 (toll-free nationwide)

Member Survey

Every year, UnitedHealthcare asks some of our members how they feel about UnitedHealthcare Community Plan. This survey helps us to decide which areas we should work on to make improvements and what we are doing well.

If you get a survey, please answer it. An outside firm takes the survey and we do not ever see your answers. Your privacy is guarded. Your responses will never be used to make decisions about you or your family's health care. Your answers, along with the answers of many other members, are combined to let us know how we are doing. It's your chance to "give us a grade." We want to hear from you.

Nondiscrimination Policy

UnitedHealthcare Community Plan members have the right to receive services from the plan without discrimination due to age, sex, color, race, religion or national origin. We encourage any member who feels unfair discrimination has occurred to file a complaint in accordance with the complaint and appeals procedure. We are committed to making sure our members are treated fairly.

Fraud and Abuse

Fraud and abuse takes many forms. It is a criminal act if anyone deliberately gets Medicaid coverage based on false information. It is also against the law:

- For another person to help someone get Medicaid coverage based on false information.
- To misrepresent, impersonate or conceal any fact that would cause Medicaid to provide coverage when a person is not eligible.
- To get or help someone get more benefits or benefits at a higher level than they should get.
- For any person or business to make a false statement about a person's health status or eligibility for health insurance.

If found guilty, penalties range from paying back Medicaid and UnitedHealthcare Community Plan for payments made for a person's health care to jail time.

Health care providers found to commit fraud and abuse can be banned from taking part in the Medicaid program, as well as other penalties.

Some additional examples of fraud and abuse are:

- Billing or charging you for services your health plan covers.
- Offering you free services, equipment or supplies in exchange for your Medicaid number.
- Giving you treatment or services you don't need.
- Physical, mental or sexual abuse by medical staff.
- Someone using another person's Medicaid or UnitedHealthcare Community Plan identification card.

If you suspect anyone is committing fraud and abuse, including providers, call UnitedHealthcare Community Plan's Member Services line at **1-800-464-9484**, **TTY: 711**. You can remain anonymous.

If you do give your name, the provider will not be told you called.

You can also report fraud directly to the Iowa Medicaid office at either 1-800-831-1394 or 1-877-446-3787.

Member Rights and Responsibilities

UnitedHealthcare Community Plan Statement of Rights and Responsibilities

As a UnitedHealthcare Community Plan member, you have rights and responsibilities. It is important that you understand them. They do not change your health care coverage in any way. If you have any questions, call our Member Services at **1-800-464-9484**, TTY: 711.

Members have a right:

- To get information about UnitedHealthcare Community Plan. This includes its services, its providers and member rights and responsibilities.
- To be treated with respect, dignity and the right to privacy.
- To take part in making decisions about their health care.
- To discuss treatment options, regardless of cost or coverage.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To voice complaints or appeals about UnitedHealthcare or the care it provides.
- To make recommendations to the rights and responsibilities policy.
- To ask for and receive a copy of his or her medical records, and request that they be corrected, if needed.
- To receive treatment in the least restrictive setting.
- To be involved in the community and to work, live and learn to the best of their ability.

Members have a responsibility:

- To supply the information UnitedHealthcare and its providers need to provide care.
- To follow plans for care that they have agreed to.
- To understand their health problems. To take part in setting treatment goals.

Grievances, Appeals and State Fair Hearings

If you have a complaint about a service or care you received from UnitedHealthcare or a network doctor, call Member Services or talk to the doctor. If your issue cannot be resolved on an informal basis, then you have the right to file a formal grievance or appeal. **If you have any questions about grievances, appeals or State Fair Hearings, call us at 1-800-464-9484, TTY: 711.** The appeal form can be found online at UHCCommunityPlan.com/ia. We can help if you need help filling out the form.

What Is a Grievance?

A grievance is an expression of dissatisfaction about any matter other than an Action, as defined in the Appeal section. You, your representative or a provider who is acting on your behalf and has your written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the action occurred. You have the right to file a grievance if you disagree with a decision made by UnitedHealthcare.

Examples include, but are not limited to:

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

What should I do if I have a Grievance?

You or someone acting for you can file a grievance by calling UnitedHealthcare Member Services at **1-800-464-9484**. Or write to UnitedHealthcare Community Plan at:

Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

If someone else is going to file for you, we need your written permission. We will send you a letter within 3 working days confirming we received your grievance. We will review your grievance and send our decision in writing within 30 calendar days of getting your grievance. Sometimes we might need more time to review the information; if so, the decision may be extended up to 14 calendar days. If we do need more time, we will send you a letter telling you.

You may not appeal a grievance decision.

What Is an Appeal?

An appeal is your request for a review of an Adverse Action. An Action is when we:

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

How do I file an Appeal with UnitedHealthcare Community Plan?

You or someone acting for you can file an appeal by calling or writing to UnitedHealthcare Community Plan. Call **1-800-464-9484**, **TTY: 711** or write to:

Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

You must file your appeal within 30 days from the date of the Notice of Action. If you need help writing or filing an appeal, call us. The appeal form is on [UHCCommunityPlan.com](https://www.uhc.com/CommunityPlan).

If someone else, such as your provider or family member is going to file for you, we need your written permission.

If you file an appeal, we will send you a letter within 3 business days telling you that we got your appeal.

We will review your appeal and send you a decision within 30 business days of getting the appeal. The letter will tell the reason for our decision. We will tell you what to do if you do not agree with the decision. This letter will be a Notice of Action.

What can I do if I need a decision faster?

If you or your doctor wants a fast decision because your health is at risk, call Member Services for an expedited appeal. UnitedHealthcare Community Plan will review the request for an expedited appeal. We will call you within 2 working days if the appeal is denied for expedited review and being reviewed through the standard appeal process instead. This time may be extended up to 14 days if you ask for this or if we need more information and the delay is in your interest. You will receive written notice of the reason for the extension.

You will get a letter with our decision and the reason for our decision. We will tell you what to do if you do not agree with the decision.

Other Plan Details

For full details about the grievance and appeals process, please call Member Services. You can also file your grievance or appeal in person at:

UnitedHealthcare Community Plan
1089 Jordan Creek Parkway
West Des Moines, IA 50266

How Do I File a State Fair Hearing Request?

If you do not agree with the appeal decision, you, your representative or a provider who is acting on your behalf and has your written consent can ask for a State Fair Hearing.

Be sure to request a State Fair Hearing within 90 days after the date of the UnitedHealthcare Community Plan's appeal decision. If the final decision is to uphold the denial, you may have to pay the cost of services received while the appeal was pending.

You can appeal in person, by telephone or in writing. To appeal in writing, do one of the following:

- Complete an appeal electronically at <http://dhs.iowa.gov/node/966>, or
- Write a letter telling us why you think a decision is wrong, or
- Fill out the Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, please ask your county DHS office or contact the DHS Appeals Section at 515-281-3094.

You are not required to have a lawyer. You are allowed to attend your appeal hearing without legal representation. If you do have a lawyer, write your lawyer's name on the Appeal and Request for Hearing form or call the Appeals Section at 515-281-3094. You will need to tell the Appeals Section the name and address of your lawyer. Your lawyer will receive a copy of everything that you get, including the Notice of Hearing, the Proposed Decision and the Final Decision. For more information about your right to appeal, go to the Iowa Administrative Code Section 441 Chapter 7 at <http://dhs.iowa.gov/appeals>.

Continuation of benefits

Your benefits may continue while the appeal or state fair hearing is pending, if all of the following apply:

- The appeal or state fair hearing request is filed:
 - Within 10 calendar days from the date we mailed the notice of action, or
 - Before the effective date of this notice.
- The appeal or state fair hearing request is related to reduced or suspended services or to services that were previously authorized for you.
- The services were ordered by an authorized provider.
- The authorization period for the services has not ended.
- You asked that the service continue.

Your benefits will continue until one of the following occurs:

- You withdraw the appeal request.
- You do not request a state fair hearing within 10 days from the date we mailed the notice of action.
- The authorization for services expires or service authorization limits are met.
- A hearing decision is issued in the state fair hearing that is adverse to the member.

Any benefits you get while your appeal is being decided may have to be paid back if UnitedHealthCare's actions are correct.

Other Plan Details

HEALTH PLAN NOTICES OF PRIVACY PRACTICES.

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

Effective January 1, 2016.

We¹ must by law protect the privacy of your health information (“HI”). We must send you this notice.

It tells you:

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

We must by law follow the terms of this notice.

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

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

How we use or share your information.

We must use and share your HI with:

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

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

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

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

We may use or share your HI as follows:

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

Other Plan Details

- **Other Restrictions.** Federal and state laws may limit the use and sharing of highly confidential HI. This may include state laws on:
 1. HIV/AIDS
 2. Mental health
 3. Genetic tests
 4. Alcohol and drug abuse
 5. Sexually transmitted diseases and reproductive health
 6. Child or adult abuse or neglect or sexual assault

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

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

Your rights.

You have a right:

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

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

Using your rights.

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-800-464-9484** or **TTY: 711**.
- **To Submit a Written Request.** Mail to:
UnitedHealthcare Government Programs Privacy Office
MN017-E300
P.O. Box 1459
Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

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

Effective January 1, 2016.

We² protect your “personal financial information” (“FI”). This means non-health information about someone with health care coverage or someone applying for coverage. It is information that identifies the person and is generally not public.

Information we collect.

We get FI about you from:

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

Sharing of FI.

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

Other Plan Details

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

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

Confidentiality and security.

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

Questions about this notice.

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-800-464-9484** or **TTY: 711**.

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.; Health Plan of Nevada, Inc.; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare 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.; UnitedHealthcare Plan of the River Valley, Inc.

² For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1 on this page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women’s and Children’s Health, LLC; AmeriChoice Health Services, Inc.; Connexions HCI, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, 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 healthplans in states that provide exceptions.

UNITEDHEALTH GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2016.

The first part of this Notice (pages 80 – 84) says how we may use and share your health information (“HI”) under federal privacy rules. Other laws may limit these rights. The charts below:

1. Show the categories subject to stricter laws.
2. Give you a summary of when we can use and share your HI without your consent.

Your written consent, if needed, must meet the rules of the federal or state law that applies.

SUMMARY OF FEDERAL LAWS

Alcohol and Drug Abuse Information

We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.

Genetic Information

We are not allowed to use genetic information for underwriting purposes.

SUMMARY OF STATE LAWS

General Health Information

We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclosure information regarding certain public assistance programs except for certain purposes	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

Other Plan Details

Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID,NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, IL, MD, MA, ME, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT

HIV/AIDS

We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR

Mental Health

We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Child or Adult Abuse

We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI
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We're here for you.

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-464-9484**, TTY: 711. You can also visit our website at myuhc.com/CommunityPlan.



