



Welcome to the
community.

Pennsylvania

UnitedHealthcare Community Plan for Kids
CHIP Member Handbook



Telephone Numbers

Member Services

Monday – Friday, 8:00 a.m. to 5:00 p.m. 1-800-414-9025, TTY/PA RELAY 711

Special Needs Services 1-877-844-8844, TTY/PA RELAY 711

Healthy First Steps 1-877-813-3417, TTY/PA RELAY 711

Fraud and Abuse Hotline 1-877-401-9430, TTY/PA RELAY 711



Website UHCCommunityPlan.com



Your Health Providers

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Emergency Room: _____ Phone: _____

Pharmacy: _____ Phone: _____

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Welcome to **UnitedHealthcare Community Plan.**

Welcome!

Thank you for enrolling your child in the Children's Health Insurance Program (CHIP) brought to you by UnitedHealthcare Community Plan for Kids. Our members have a wide range of benefits available to them through the CHIP program. These include:

- Doctor's visits
- Prescriptions
- Checkups
- Dental and Eye care
- Emergency room visits
- Behavioral health care
- Hospital stays
- Tests and X-rays

CHIP is a state and federally funded program that provides health insurance for uninsured children up to age 19, who are not eligible for Medical Assistance. UnitedHealthcare provides CHIP coverage through a contract with the Pennsylvania Insurance Department's Office of CHIP. Every CHIP member must renew benefits annually (subject to program funding availability and continued eligibility). The renewal process is simple and described in this handbook.

This handbook will help you understand your child's CHIP benefits, how to access care, and how to get in touch with us, if needed. It also provides information on members' rights and responsibilities.

If you haven't received your child's UnitedHealthcare member identification (ID) card in the mail, it will arrive shortly. Each child enrolled receives his or her own ID card. You will need to use this ID card when your child receives care. You will also need to take the card to the pharmacy when picking up prescriptions for your child.

Welcome

If you have any problems reading or understanding this information, have questions about your child's coverage or the care your child is receiving, or do not receive your child's ID card within the next two weeks, please contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

- No matter what language you speak, we can help. Call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and let them know what language you speak and that you will require special assistance.
- If you would like to request a Member Handbook or other CHIP information in Spanish, at no cost, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.
- If you are hearing impaired, and are calling from a **TTY** phone, please call **711**.
- If you are visually impaired, and would like to request a Member Handbook or other UnitedHealthcare information in an alternative format such as audio tape, Braille, or large print, at no cost, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

For your convenience, Member Services is available Monday – Friday, 8:00 a.m. to 5:00 p.m. You may also visit our website at **UHCommunityPlan.com** for additional information about your CHIP benefits, or you may write us at:

UnitedHealthcare Community Plan for Kids
2 Allegheny Center, Suite 600
Pittsburgh, PA 15212

Welcome to CHIP, brought to you by UnitedHealthcare Community Plan for Kids! We're glad you are a member and look forward to serving you.

Who Is Eligible for CHIP?

To qualify and be enrolled in the CHIP program, your child must be:

- Under the age of 19;
- A U.S. citizen, a U.S. National or a qualified alien;
- A resident of Pennsylvania;
- Uninsured and not eligible for Medical Assistance.

How Can I Check on the Enrollment or Eligibility Status of My Child?

You can check on your child's enrollment or eligibility status, the benefits they have available to them, and even find participating providers in your area by calling Member Services at **1-800-414-9025**, **TTY/PA RELAY 711**.

What CHIP Options Are Available?

Depending on your family size and income, your child may qualify for Free, Low-Cost, or Full-Cost CHIP coverage.

- Free coverage does not require any monthly premium payments or co-payments.
- Low-Cost and Full-Cost coverage requires a monthly premium payment and co-payments for certain services.
 - If your child qualifies for Low-Cost or Full-Cost coverage, you will receive detailed instructions and a monthly bill that must be returned with your payment in order for your child to remain enrolled in CHIP.
 - Your child will lose coverage if the monthly premium is not paid by the due date on the invoice.
 - If your child loses coverage due to non-payment or a late payment, your child may not be eligible again for CHIP for three months from the date that their coverage ended.

What Changes Do I Need to Report During the Benefit Period?

Please be sure to immediately report any and all changes in your family's circumstances after your child has been enrolled. If you do not report changes promptly, you may lose coverage. These changes may include:

- A change in family size;
- A change in address;
- A change in phone number; or
- A change in household income.

May I Transfer My Child's CHIP Coverage to a Different CHIP Insurance Company?

Yes. To transfer your child's CHIP coverage to a different CHIP insurance company, contact Member Services at **1-800-414-9025**, **TTY/PA RELAY 711**, and request the transfer. Before you request the transfer,

Eligibility and Enrollment

be sure to verify that the insurance company you would like to switch to participates in CHIP in your area and that your doctor participates with that insurance company. The change will take place shortly after you have contacted UnitedHealthcare, and there will be no lapse in CHIP coverage.

You will be told the effective date of change by your customer service representative and you will receive a letter confirming this information. Until that date, your child must continue to use their CHIP benefits through UnitedHealthcare.

May I Request a Re-Assessment of Eligibility During a CHIP Benefit Period?

At your request, UnitedHealthcare will do a re-assessment of your child's eligibility during the CHIP benefit period to see if they might qualify for a less expensive CHIP option. UnitedHealthcare will re-assess your child's eligibility based on any changes in the size of your family or income. You will be notified if the changes would or would not result in a change of CHIP options. You do not have to change options while in the middle of a benefit period.

How Can I Add Another Child to CHIP Coverage?

If your family already has one child enrolled in CHIP, you may add another child in the family by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**. No additional financial information is required. We will still need to verify that the child being added meets other eligibility requirements. Once eligibility is determined, the child will be enrolled.

Will a Pregnant CHIP Member Stay on CHIP?

A CHIP member who becomes pregnant during her 12-month term of CHIP eligibility will remain in CHIP for the duration of the 12-month term. If the member is still covered by CHIP when the baby is born, the CHIP member must contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**, immediately so UnitedHealthcare can screen the newborn for CHIP or Medical Assistance eligibility. UnitedHealthcare will determine which program the newborn is eligible for using the appropriate information on income and family size contained on the member's original application.

How Can a CHIP Member's Newborn Be Added to CHIP Coverage?

If a CHIP member has a newborn baby while enrolled in CHIP, the newborn is automatically covered by CHIP for the first 31 days of its life. You will need to call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, immediately **after** the child is born to start the enrollment process necessary to get the newborn their own health care coverage after the 31-day period ends. If the newborn is not eligible for CHIP, but appears to be eligible for Medical Assistance, the newborn's application will be automatically forwarded to the County Assistance Office for processing.

Is There a Waiting List for CHIP?

No.

How Long Does My Child's CHIP Coverage Last?

Your child's CHIP coverage will run for a full calendar year (12 months) from the first day of your child's enrollment unless eligibility changes due to non-financial reasons (e.g., move out of state, reach age 19, enroll in Medicaid, etc.). This time period is called the benefit period. At the end of the year, you must renew your child's CHIP coverage or his or her coverage will end.

How Do I Renew My Child's CHIP Coverage?

You will receive a letter and renewal form from UnitedHealthcare 90 days before the end of the benefit period. You will be told in your renewal letter and on your renewal form what information you will need to provide for the annual review.

You must either renew online at www.compass.state.pa.us, by phone at 1-800-986-KIDS or by paper by completing the renewal form and returning it and all required documentation to UnitedHealthcare **before** the deadline, or your child's CHIP coverage will end on the date stated in the letter.

It is possible that your child's health care coverage will change upon yearly renewal. UnitedHealthcare **must** review your family's income every year. Within 15 days of receiving your renewal form and any requested documents, you will be sent a letter telling you whether your child continues to be eligible for CHIP and explaining any changes in coverage for the new benefit period.

If your child is not eligible for CHIP, but appears to be eligible for Medical Assistance, your renewal application will be forwarded to the County Assistance Office for processing. If your child is not eligible for CHIP or Medical Assistance, you will receive a letter explaining why your renewal application was denied, along with information on how to appeal the decision if you disagree with it.

What May Cause My Child's CHIP Coverage to End?

You will receive written notice from UnitedHealthcare in the mail before your child's coverage ends.

The letter will include the date that your child's CHIP coverage will end and the reason why it is ending.

The following reasons will result in the termination of your child's CHIP coverage:

- **Your child is no longer eligible for CHIP due to your family income being too low.** Unless otherwise requested, if your child is no longer eligible for CHIP due to your family income being too low, your child's CHIP coverage will end **on the renewal date**. Your child's renewal application will be forwarded to the County Assistance Office for Medical Assistance eligibility determination. Your child will not have a lapse in coverage.
- **If you do not respond to any renewal notices.** If you do not respond to any renewal notices, then your child's coverage will end.

Eligibility and Enrollment

- **If you do not provide all the requested information needed for UnitedHealthcare to complete the renewal process.** Required information listed on your renewal form must be provided or the renewal cannot be completed and your child's CHIP coverage will end.
- **If your child is covered under a private health insurance policy or Medical Assistance.** Your child's CHIP coverage will end going back to the first day of the month the other coverage took effect. Your child will not suffer a lapse in coverage and any premiums paid to UnitedHealthcare after the termination date will be refunded to you.
- **Non-payment of the premium in Low-Cost or Full-Cost CHIP.** If your child is enrolled in either the Low-Cost or Full-Cost CHIP programs, and you don't pay the premium by the due date, you will receive a letter 30 days before the end date letting you know that you have 30 days to pay the premium or CHIP coverage will end for your child.
- **Voluntary termination.** You may end your child's CHIP coverage at any time by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and informing them that your child no longer needs CHIP coverage.
- **Your child turns 19 years of age.** A child is eligible for CHIP up to age 19. Coverage ends on the last day of the calendar month the child turns 19.
- **Your child moves out of state.** CHIP only covers Pennsylvania residents. Your child's coverage will end retroactive to the first of the month immediately following his or her relocation to a different state.
- **Your child is a prison inmate or a patient in a public institution for mental diseases.** Your child is not eligible to be covered by CHIP if he or she is a prison inmate or a patient in a public institution for mental diseases. Once your child is no longer in prison or a public mental institution, and meets the other eligibility requirements, he or she will become eligible for CHIP again.
- **Misinformation was provided at the time of application or renewal that would have resulted in a determination of ineligibility.** If it is determined that incorrect or fraudulent information was used in applying for or renewing CHIP coverage for your child, your child's coverage will be terminated.

What Can I Do if I Disagree With the Results of the Eligibility Determination or if My Child's CHIP Coverage Ends?

If you do not agree with the decision, you may request an impartial review of the determination made by UnitedHealthcare that your child is:

- Losing CHIP coverage;
- Ineligible for CHIP; or
- Eligible for a different CHIP option than you had before.

If a review is requested, it will be done with you and a representative from UnitedHealthcare. You may choose someone to act as your representative.

Eligibility and Enrollment

To request a review, you must send a letter and a copy of the notice sent to you by UnitedHealthcare explaining why you want a review. The request must be sent within 30 days of the date on the letter from UnitedHealthcare. The request for a review should be sent to:

UnitedHealthcare Community Plan for Kids
Attn: Xerox – Uniprise Project
3315 Central Avenue
Hot Springs, AR 71913-9940

If a formal interview is required, we will coordinate with the Pennsylvania Insurance Department. The Pennsylvania Insurance Department will contact you and provide more information including the time and date of the review. When possible, the review will be done by phone. You may request a face-to-face review.

Coverage of a child enrolled in Free CHIP should continue uninterrupted pending the outcome of the eligibility review. In the event that a child is terminated prior to the timely receipt of a request for review, coverage will be reinstated retroactively to the date of termination.

Coverage of a child enrolled in Low-Cost CHIP should continue uninterrupted pending the outcome of the eligibility review if you elect to continue paying the monthly premium until the review process is completed.

When a request for review is received for an enrollee in Low-Cost CHIP, you will be offered the option of paying the premium in order for coverage to continue pending the outcome of the review.

- If you elect to continue paying the premium, coverage will continue.
- If you elect not to pay, coverage will not continue.

Member Rights

As the parent or guardian of a CHIP member, you have the right to:

- Receive information about your child's rights and responsibilities;
- Receive information about all the benefits, services, and programs offered by CHIP, brought to you by UnitedHealthcare;
- Know about policies that can affect your child's membership;
- Basic information about doctors and other providers who participate with UnitedHealthcare;
- Choose from UnitedHealthcare's network of participating providers and to refuse care from specific doctors;
- Request a specialist serve as your child's primary care provider if your child has certain special medical needs or diagnoses;
- Be treated with respect and due consideration for your child's dignity and privacy;
- Expect that information you provide to UnitedHealthcare and anything you, or your child, discuss with your child's doctor will be treated confidentially, and will not be released to others without your permission;
- Have all records pertaining to your child's medical care treated as confidential unless sharing them is required to make coverage decisions or is otherwise required by law;
- See your child's medical records unless access is specifically restricted by reason of law or by the attending physician for medical reasons, to keep copies for yourself, and to ask to have corrections made if needed;
- Receive clear and complete information from your child's doctor about your child's health condition and treatment including what choices you have and what risks are involved;
- Receive information about available treatment options and alternatives regardless of cost or benefit coverage;
- Be a part of any decisions made about your child's health;
- Refuse to have your child receive any drugs, treatment, or other procedure offered by UnitedHealthcare or its providers to the extent permitted by law;
- Be informed by a physician about what may happen if drugs, treatments, or procedures are refused;
- Refuse to allow your child to participate in medical research projects;
- Give informed consent before the start of any procedure or treatment;
- Ensure your child receives timely care in the case of an emergency;
- Question decisions made by UnitedHealthcare or its participating providers, and to file a complaint or grievance regarding any medical or administrative decisions you disagree with;
- Make recommendations regarding UnitedHealthcare's members' "rights and responsibilities" policy;

Member Rights and Responsibilities

- Exercise your rights without adversely affecting the way UnitedHealthcare, its providers, and state agencies may treat you; and
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in other Federal regulations on the use of restraints and seclusion.

Member Responsibilities

As the parent or guardian of a CHIP member, you have a duty to:

- Understand how CHIP, brought to you by UnitedHealthcare, works by reading this handbook and other information made available to you;
- Follow the guidelines set forth in this handbook and in other information made available to you, and ask questions about how to access health care services appropriately;
- Inform UnitedHealthcare and your child's providers about any information that may affect your child's membership or right to program benefits, including other health insurance policies your child becomes covered under;
- Supply up-to-date medical information to UnitedHealthcare and its providers so they can provide your child with appropriate care;
- Be sure that your primary care provider has all of your child's medical records, including those from other doctors;
- **Contact your child's primary care provider first for all medical care except in the case of a true emergency;**
- Consent to the proper use of your child's health information;
- Treat your child's providers with dignity and respect, which includes being on time for appointments and calling ahead if you need to cancel an appointment;
- Provide a safe environment for services administered in your home;
- Learn about your child's health problems and work with providers to develop a plan for your child's care;
- Follow the instructions or guidelines you receive from the provider, such as taking prescriptions as directed and attending follow-up appointments;
- Take full responsibility for any consequences of your decision to refuse treatment on your child's behalf;
- Contact UnitedHealthcare if your child is admitted to the hospital or in an emergency room within 24 hours or as soon as possible;
- Use your child's member ID card to access care; and
- Pay any applicable fees.

Member Services

Member Services is ready and waiting to help you with any questions about your child's coverage or the care your child is receiving. The number for Member Services is printed on your child's ID card and is toll-free. You can reach Member Services by calling **1-800-414-9025, TTY/PA RELAY 711**. For your convenience, Member Services is available Monday – Friday, 8:00 a.m. to 5:00 p.m.

You may also visit our website at **UHCCCommunityPlan.com** for additional information about your child's CHIP benefits, or you may write us at:

UnitedHealthcare Community Plan for Kids
2 Allegheny Center, Suite 600
Pittsburgh, PA 15212

Can Member Services Help Me if I Speak a Foreign Language?

No matter what language you speak, we can help. Call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and let them know what language you speak and that you will require special assistance.

If you would like to request a Member Handbook or other UnitedHealthcare information in Spanish, at no cost, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

What Number Do I Call if I Am Hearing Impaired?

If you are hearing impaired, and are calling from a **TTY** phone, please call **711**.


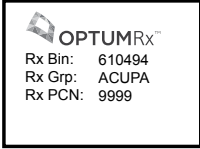
How Can Member Services Help Me if I Am Visually Impaired?


If you are visually impaired, and would like to request a Member Handbook or other UnitedHealthcare information in an alternative format such as audio tape, Braille, or large print, at no cost, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Identification Cards

You will receive your child's UnitedHealthcare identification (ID) card(s) in the mail within the next 10 days. The card(s) entitles your child to all of the CHIP benefits as explained in the benefit portion of this handbook (including medical, dental, vision, behavioral health, etc.). The card(s) will have your child's name, his or her member identification number, his or her PCP, and the number for Member Services for both UnitedHealthcare and United Behavioral Health on them.

Your child's ID card(s) is for his or her use only. Never let anyone else use your child's ID card(s).

 UnitedHealthcare Community Plan	
Health Plan (80840) 911-87726-04	
Member ID: 999999999	
<hr/>	
Member: Subscriber Brown	Payer ID: 87726
PCP Name: Provider Brown PCP Phone: (999) 999-9999	
Copay: OFFICE/SPEC/ER \$0/\$0/\$0	
0501	UnitedHealthcare Community Plan for Kids Administered by UnitedHealthcare of Pennsylvania, Inc.

In an emergency go to nearest emergency room or call 911. Printed: 09/28/11	
	
By using this card for services, you agree to the release of medical information, as stated in your member handbook. To verify benefits or to find a provider, visit the website www.myuhc.com/communityplan or call.	
For Members: 800-414-9025	TTY/PA RELAY 711
Mental Health:	866-261-7692
<hr/>	
For Providers: www.uhccommunityplan.com	800-600-9007
Medical Claims: PO Box 8207, Kingston, NY, 12402	
Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903	
For Pharmacists: 877-305-8952	

When Does My Child Need to Use an Identification Card?

You will need to show your child's ID card to providers whenever your child needs to receive any covered services.

What Do I Do if My Child's ID Card Is Lost?

If your child's ID card is lost, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, immediately. You will be sent a new ID card in the mail.

What Role Does a Primary Care Provider (PCP) Play in Your Child's Health Care?

A PCP is your child's regular doctor. Pediatricians, internists, and family medicine practitioners are examples of different types of PCPs you can choose from. If your child has special needs or has certain diagnoses, he or she may be better served by having a specialist serve as his or her PCP. This is possible only if the specialist agrees to act as your child's PCP and if UnitedHealthcare approves of the arrangement. An example of such an instance would be a pregnant member selecting an OB/GYN as her PCP.

PCPs provide well-child exams and preventive services and also see your child when he or she is sick. PCPs help coordinate care if tests are needed, if your child needs to see a specialist, or if he or she has to go to the hospital.

Your child's PCP will have someone available 24 hours a day, 7 days a week to assist with your child's health care. If your child requires care after your PCP's normal office hours, you may call your child's PCP. Either your PCP or another health care provider will instruct you where to take your child to receive care if the problem cannot wait until the PCP's normal office hours.

What if Your Child's Current PCP Is Not a Participating Provider?

If your child is a **new** UnitedHealthcare member, and your child is currently being treated by a PCP who does not participate with UnitedHealthcare, you must notify UnitedHealthcare immediately. In order to promote continuity of care, UnitedHealthcare will allow your child to continue seeing that provider for up to 60 days if the provider is willing to work with UnitedHealthcare on a non-participating basis. During this time, UnitedHealthcare will work with you to help you find a PCP who is a participating provider to take over the care of your child.

Under certain circumstances, UnitedHealthcare may not be able to honor your request for a particular provider. If a provider has been removed from the UnitedHealthcare network for quality issues, or if the federal or state government agency decides that a provider cannot participate in a government program, that provider's services cannot be covered by UnitedHealthcare.

How Do I Select My Child's PCP?

All enrolled children must have a PCP. You have 10 days from the receipt of your notice of enrollment letter to select a PCP. If you do not select a PCP, UnitedHealthcare will assign a PCP for your child.

You may use the Provider Directory to help you find a PCP that participates with UnitedHealthcare. If you choose a PCP who is not already treating your child, you will need to contact the PCP you have selected, and make sure they are taking new patients. You can reach the PCP at the telephone number listed in the Provider Directory. If the PCP agrees to take your child as a patient, notify UnitedHealthcare by phoning Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Primary Care Provider

You can find information about network doctors, such as name, address, phone number, professional qualifications, their specialty, board certification and any languages they speak at myuhc.com/CommunityPlan. For information about medical school and residency program details, contact Member Services. You can also call Member Services, to request a printed copy of the provider directory be sent to you in the mail.

If you are having difficulty locating a PCP who is accepting new patients, you may contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**, for assistance.

How Do I Change My Child's PCP?

You may choose a new PCP for your child at any time as long as you follow the established procedure for requesting a change in PCP.

- Select your new PCP from the list of participating providers in the Provider Directory.
- Make sure the PCP you select is taking new patients.
- Call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and tell the representative that you want to change your child's PCP.

In most cases, the change will become effective immediately. **The representative will tell you the date when your child may begin seeing his or her new PCP. Your child may not receive services from his or her new PCP until the date the change officially becomes effective.** If your child receives services from the new PCP before they are recognized as your child's official PCP by UnitedHealthcare, you may be responsible for paying bills for those services. Your child will receive a new ID card in the mail that lists the new PCP.

Specialist Providers

Specialists have training, education, and a board certification or license in a specialized area of health care. A specialist is usually not your PCP unless your child has special needs or certain diagnoses. If your PCP believes that your child has an illness or other type of condition that requires the services of a specialist, they will refer you to a specialist provider. You need to be sure that the specialist that your PCP refers you to is participating with UnitedHealthcare. You may find out by asking your PCP or calling the specialist's office and asking them if they participate with your plan.

What do I do if I think my child needs to see a specialist?

If you think your child has an illness or other type of condition that needs to be treated by a specialist, you should discuss this with your PCP. Your PCP will help you decide what type of specialist can best help your child and if necessary give you the appropriate referral. In many cases, a referral must be made by your PCP for services provided by a specialist.

Primary Care Provider

What specialists do not require a referral?

Not all specialists require a referral if they are participating with UnitedHealthcare. No matter what, you may make an appointment for your child to see the following specialists, as long as they are a participating provider, without a referral from your PCP:

- Dentists
- Ophthalmologists
- Optometrists
- Behavioral health providers
- OB/GYNs for services relating to annual exams or maternity care*

What is a referral?

A referral is written authorization from your PCP that gives your child permission to see a specialist or to receive other services outside of the PCP's scope of practice. Depending on your PCP's office practice, the referral may be faxed directly to the specialist, or you may be given a special form or prescription to take to your child's appointment. **A referral is good for 90 days or three visits (whichever comes first).** Unless otherwise specified in this handbook, your child may need to have a referral in order for services provided by a specialist. Call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, if you are unsure whether your child needs a referral to see a specialist.

What is a standing referral?

If your child has a life-threatening, degenerative, or disabling disease or condition, UnitedHealthcare may allow your child to have a standing referral to a specialist. A standing referral allows your child to see the specialist without getting additional referrals for the rest of the calendar year. Your child will need a new standing referral each calendar year.

Can a specialist serve as my child's PCP?

Members with special needs or certain diagnoses may request that an appropriate in-network specialist serve as his or her PCP. This is possible only if the specialist agrees to act as your child's PCP and if UnitedHealthcare approves of the arrangement. An example would be a pregnant member selecting an OB/GYN as her PCP. Call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, to determine if your child is eligible to have a specialist serve as his or her PCP.

* For Full-Cost CHIP, an OB/GYN never requires a referral.

What if my child is referred to a non-participating specialist?

If your child gets a PCP referral for a specialist who is a non-participating provider, you must get special permission from UnitedHealthcare to see the specialist. If the requested service can be provided by a specialist who is a participating provider, then you must go to the participating specialist in order for services to be covered.

What if your child's current specialist is a non-participating provider?

If your child is a **new** UnitedHealthcare member and is currently being treated by a specialist who does not participate with UnitedHealthcare, you must notify UnitedHealthcare immediately. In order to promote continuity of care, under most circumstances, UnitedHealthcare will allow your child to continue seeing that provider for up to 60 days if they are actively continuing a course of treatment and if the specialist is willing to work with UnitedHealthcare on a non-participating basis. During this time, UnitedHealthcare will work with you to help you find a specialist who is a participating provider to take over the care of your child.

What if My Child Is Pregnant and Her Current OB/GYN Is Not a Participating Provider?

If your child is a **new** UnitedHealthcare member and is in the second or third trimester of her pregnancy, and she is already under the care of an OB/GYN not in the UnitedHealthcare network, under most circumstances, she may continue to receive services from that specialist throughout her pregnancy, for the delivery of her baby, and for her postpartum-related care.

A member in her first trimester will be required to select a new OB/GYN provider that participates with UnitedHealthcare. If you need assistance finding a participating OB/GYN provider who is accepting new patients, you may contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

How Can My Child Get a Second Opinion?

Your child is entitled to a second opinion regarding the medical necessity of surgery or any other recommended medical treatment. You may need to contact your PCP and request a referral for the second opinion of a specialist provider.

If there are fewer than two specialists in UnitedHealthcare's network trained to provide a particular service, your PCP will need to send your child to an out-of-network specialist provider for the second opinion. Your PCP will need to contact UnitedHealthcare to receive special approval for your child to receive services from an out-of-network provider.

What Is Continuity of Care?

Continuity of care refers to the ongoing committed relationship between a member and his or her provider. Promoting continuity of care allows for providers to act as advisors and patient advocates as the member moves through various stages of the health care system.

How Does UnitedHealthcare Promote Continuity of Care for My Child?

If your provider ever leaves the UnitedHealthcare network, or if you are being treated by a non-participating provider when you join UnitedHealthcare, UnitedHealthcare is responsible for working with you to make sure that your child will be able to keep getting the health care that he or she needs.

Under most circumstances, if a provider you are seeing stops participating with UnitedHealthcare, a member may continue an ongoing course of treatment with that provider for a transitional period. This includes pregnant members in their second or third trimester who, except under certain circumstances, may continue to seek treatment from their OB/GYN for both their current pregnancy and postpartum care.

A new member may also continue a course of treatment with a non-participating provider for a transitional period under most circumstances. This includes both a member's primary care physician and specialists that are actively treating the member at the time CHIP coverage with UnitedHealthcare begins.

If you have questions about continuity of care, you may contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Under What Circumstances Would a Provider Not Be Allowed to Provide Care to My Child Under the Continuity of Care Policy?

Under certain circumstances, UnitedHealthcare may not be able to cover services provided by a certain provider. Some examples of these situations include, but are not limited to:

- Your current provider refuses to accept payment from UnitedHealthcare;
- Your current provider has been excluded from the UnitedHealthcare network for cause; or
- Your current provider is prohibited from receiving monies from a government-funded program.

Emergency Care

Emergency Care

Emergency care consists of services provided to a member after the sudden onset of a medical condition that is accompanied by rapidly progressing symptoms of sufficient severity or severe pain that the average person could reasonably expect that the absence of immediate medical attention would result in one or more of the following:

- The health of the member would be jeopardized;
- If the member is pregnant, the health of her unborn child would be jeopardized;
- The member would suffer serious impairment of bodily functions; or
- The member would suffer serious dysfunction of any body organ or part.

Emergency care also includes transportation and related emergency services provided by a licensed ambulance service if the condition meets the above criteria.

Where Should I Go to Receive Emergency Services?

In an emergency, you should seek medical care from the nearest hospital or health care provider. This sometimes means your child may need to be treated by a non-participating or out-of-plan hospital (especially if the emergency occurs out of the UnitedHealthcare service area). If this happens, your child might need to transfer to a participating hospital or provider. This transfer cannot take place until your child's condition has been stabilized. UnitedHealthcare will discuss your child's condition with the provider who is treating him or her, and the doctor will let UnitedHealthcare know when your child can be transferred.

What Should I Do if I Think My Child Needs Emergency Care?

In an emergency, get the care your child needs right away. If you are out of the service area, go immediately to the nearest emergency room. You will not be charged any additional amounts for using a non-participating provider or facility.

If you are not sure if your child's condition qualifies as an emergency, call your child's PCP for advice.

It is important to remember that an emergency services provider does not replace your child's PCP. Your child's PCP knows them best, and if your child does not require emergency services, taking your child for a sick visit to his or her PCP will provide your child with the best continuity of care.

If your child has a life-threatening situation, call 911 for help immediately. Some examples of life-threatening emergencies are:

- Poisoning
- Heavy bleeding
- Trouble breathing
- Serious cuts or burns
- Blackouts
- Choking
- Chest pain
- Sudden inability to move or talk
- Drug overdose
- Broken bones

Emergency Care

Call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, by the next business day to notify UnitedHealthcare of the emergency services provided to your child.

Call your child's PCP by the next business day to notify them of the emergency services provided to your child.

Any medically necessary **follow-up** care your child receives is **not** considered an emergency service. If the follow-up care is provided by a doctor other than your child's PCP, you should:

- Contact your child's PCP with the name of the provider who will be providing the follow-up care.
- If required, obtain prior authorization before taking your child to see the provider.
- If your child received emergency services from a non-participating specialist provider, your PCP and UnitedHealthcare will help you establish a relationship with a participating specialist provider who can provide your child's follow-up care.

Urgent Care

Urgent care is **not** intended for illnesses or conditions that require emergency care. Urgent care is any service provided to a member with a condition or injury that needs to be treated within 24 hours. Usually your child's PCP can provide urgent care services for your child. If you are not able to reach your child's PCP, or your PCP cannot see your child within 24 hours, you may also visit an Urgent Care Center.

If you are not sure if your child's condition qualifies as an urgent care situation, call your child's PCP for advice.

It is important to remember that an Urgent Care Center services provider does not replace your child's PCP. Your child's PCP knows them best, and if your child does not require urgent treatment, taking your child for a sick visit to his or her PCP will provide your child with the best continuity of care.

What is an Urgent Care Center?

Urgent Care Centers are facilities that provide basic medical care for walk-in patients with illnesses or injuries that do not require emergency care, such as sprains or cuts requiring stitches. If you need to find a participating Urgent Care Center in your service area, you can call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

If you are out of the service area, and your child needs urgent care, in order to be covered, the care must be in response to a sudden and unexpected condition or injury that needs care that cannot wait until you return to the service area.

What Is an Out-of-Network Provider?

An out-of-network provider is a provider that is a non-participating provider. They do not have an agreement with UnitedHealthcare to provide services to CHIP members.

What Is an Out-of-Network Facility?

An out-of-network facility is a facility (such as a hospital or a diagnostic test facility) that is a non-participating facility. They do not have an agreement with UnitedHealthcare to provide services to CHIP members.

How Can My Child Access Out-of-Network Services?

If medically necessary, your child's PCP can request that your child receive services from a provider or facility that is not part of UnitedHealthcare's network. If these services are available from providers within the network, your child will need to receive services from a participating provider or facility. Unless prior authorization is received, you may be responsible for payment of any out-of-network services your child receives.

Out-of-Area Services

If your child is traveling out of the service area and needs care, UnitedHealthcare Community Plan will work with your PCP to find the right care for your child. UnitedHealthcare Community Plan will cover the costs for any emergency care your child receives, even if the child is outside of the service area. Your child is also covered if he or she must be admitted to the hospital. Give the name and telephone number of your PCP to the Emergency Room staff. You must call your child's PCP or Member Services at **1-800-414-9025, TTY/PA RELAY 711**, within 24 hours of the emergency. However, your PCP must approve follow-up care or routine visits for UnitedHealthcare Community Plan to cover the visits.

If you are outside the United States and need medical care, any health care services your child receives will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services received by your child outside the United States.

How Are Claims Paid for Out-of-Network Services?

If your child receives a service from a non-participating provider or facility that was either authorized by UnitedHealthcare or was an emergency or urgent care service, the facility or provider may agree to bill UnitedHealthcare directly for your services. Some out-of-network providers may not be willing to do this. If you see an out-of-network provider who will not bill UnitedHealthcare for your services, you must submit the claim from the provider to UnitedHealthcare.

Out-of-Network Services

To file a claim, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and request that a claim form be mailed to you. Fill out the claim form and submit it along with the bill from the provider that lists all the services received to the following address:

UnitedHealthcare of Pennsylvania
P.O. Box 8207
Kingston NY, 12402

You have one year from the date of service to send the bill to UnitedHealthcare.

If UnitedHealthcare sends you a check to settle a claim you have submitted for payment, you will be responsible for ensuring that the provider's claim is paid in full.

Your Costs for Covered Services

Your family's size and income determine which CHIP coverage option is available for your child. You may be able to get Free CHIP coverage, Low-Cost coverage, or Full-Cost coverage. Depending on your child's type of coverage, you may be required to pay certain out-of-pocket costs in order for your child to receive services.

What Are Premiums and When Do I Pay Them?

Premiums are the regularly scheduled monthly payments that you pay to UnitedHealthcare for CHIP coverage. **There are no premiums for members with Free CHIP coverage.** If your child is enrolled in Low-Cost or Full-Cost CHIP, each month you will receive a bill for the following month. If the premium is not paid by the due date on the bill, or is paid after the due date, your child will lose CHIP coverage and may not be eligible again for CHIP coverage until three months from the date the coverage ends.

If a premium amount changes during the benefit period, you will receive notice from UnitedHealthcare of the change 30 days before the change takes place.

What Are Co-Payments and When Do I Pay Them?

Co-payments are out-of-pocket costs that you are required to pay at the time of service if your child is enrolled in Low-Cost or Full-Cost CHIP. **There are no co-payments for members with Free CHIP coverage.**

Co-payments are paid to the provider at the time of the appointment or when the service is rendered. You must pay the co-payment each time your child gets a service from a provider if the service is one which requires a co-payment.

- There are no co-payments for preventive or well-child visits. A preventive visit is one where your child receives a service to prevent a future disease or condition.
- There are no co-payments required for routine preventive or diagnostic dental or vision services.

When Can I Be Billed by a Provider?

Participating providers are not allowed to bill members except under certain circumstances. There are certain situations when you may get a bill from a provider that you will be responsible to pay. These situations are:

- If your child goes over a benefit limit on a service;
- If your child receives a medical service that is not a covered benefit;
- If your child receives a covered service from a health care provider who is not a UnitedHealthcare participating provider without first receiving prior authorization from UnitedHealthcare; and
- Unpaid co-pay amounts.

Your Costs for Covered Services

Participating providers are not allowed to bill members for services above and beyond UnitedHealthcare's agreed-upon reimbursement rate. This means that in other than the above circumstances, you should not receive a bill from a participating provider. If you do receive a bill from a participating provider, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, immediately so the situation can be resolved as soon as possible.

Coordination of Benefits

Coordination of benefits is a provision that is intended to help insurance companies avoid duplication of claims and delays in payments. It is often used in cases where two or more separate insurance companies are involved in the payment of services. It avoids claims payment problems by establishing the order in which insurance companies pay their claims and by providing the authority for the orderly transfer of information needed to pay claims properly.

CHIP members are not allowed to have any other medical insurance coverage in addition to CHIP, but occasionally there are times when some of your child's health care bills may be covered by a different policy other than CHIP. An example of when this might happen is when a member is involved in a motor vehicle accident and some of the cost of his or her medical care is covered by the automobile insurance policy.

If any of the benefits to which your child is entitled are also provided in full or in part by another agreement issued by another insurance plan or program, your child's CHIP insurance should be billed secondary to any such additional coverage(s).

If you have questions about coordination of benefits, you may contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Subrogation

Subrogation is the process of seeking recovery of health care expenses from other parties who may be responsible for an injury. The process saves health care dollars by making sure that the responsible party or his or her insurer pays the expenses.

For instance, when an injury occurs because of an accident in which someone other than your child is at fault, the insurance carrier of the other individual may be responsible for the payment of your child's medical treatment. In those cases, UnitedHealthcare may be entitled to recover from the other carrier payments for services it provided for your child. If you receive money from a lawsuit, settlement, or other third party or his or her insurer, you may be responsible, to the extent permitted by law, to reimburse UnitedHealthcare for expenses paid out relating to the injury.

If you have questions about subrogation, you may contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

CHIP Benefits Summary

Medical Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Autism-related services	None.	\$0	Co-payments based on the type of service	Co-payments based on the type of service
Diagnostic services	Some services may require prior authorization.	\$0	\$0	\$0
Durable medical equipment	Some services may require prior authorization.	\$0	\$0	\$0
Emergency services	None.	\$0	\$25*	\$50*
Emergency transportation	Transportation outside of the service area will only be covered if medically necessary.	\$0	\$0	\$0
Family planning services – OB/GYN	None.	\$0	\$0	\$0
Family planning services – PCP	None.	\$0	\$0	\$0
Hearing care services	<p>One routine hearing and audiometric examination per calendar year. One hearing aid or device per ear every two calendar years. Calendar year may change depending on decision for benefit plan year.</p> <p>No monetary limits for CHIP.</p> <p>*Co-payments apply only when services are rendered by a specialist provider.</p>	\$0	\$10*	\$25*
Home health services	Some services may require prior authorization.	\$0	\$0	\$0
Hospice services	Some services may require prior authorization.	\$0	\$0	\$0

* Waived if admitted to hospital.

CHIP Benefits Summary

Medical Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Inpatient hospital and skilled nursing facility stays	Some services may require prior authorization, or be subject to notification and concurrent reviews.	\$0	\$0	\$0
Inpatient rehabilitation stays	Some services may require prior authorization, or be subject to notification and concurrent reviews.	\$0	\$0	\$0
Maternity care services	None.	\$0	\$0	\$0
Medical foods	None.	\$0	\$0	\$0
Oral surgery	Some services may require prior authorization.	\$0	\$10	\$25
Outpatient medical therapy services (chemotherapy, dialysis, radiation treatments, and respiratory therapy)	None.	\$0	\$0	\$0
Outpatient therapies (occupational, physical, and speech therapy), including rehabilitative and habilitative	<p>Physical Therapy – limited to 30 visits per year combined rehabilitative and habilitative.</p> <p>Speech Therapy – limited to 30 visits per year combined rehabilitative and habilitative.</p> <p>Occupational Therapy – limited to 30 visits per year combined rehabilitative and habilitative.</p>	\$0	\$10	\$25
Outpatient surgical services	Some services may require prior authorization.	\$0	\$0	\$0

CHIP Benefits Summary

Medical Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
PCP office visits	*No co-payment is required for well-child visits.	\$0	\$5*	\$15*
Specialist office visits	None.	\$0	\$10	\$25
Spinal manipulation/ chiropractic care	Limited to 20 visits per year.	\$0	\$0	\$0
Urgent care services	None. *Co-pays may be higher depending on the facility where services are being provided.	\$0	\$10	\$25
Women's health services – OB/GYN	None.	\$0	\$0	\$0
Women's health services – PCP	None.	\$0	\$0	\$0
Pharmacy Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Brand name drug	None.	\$0	\$10	\$18
Generic drug	None.	\$0	\$6	\$9
Mental Health and Substance Abuse Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Mental health – inpatient stays	No referral needed. Some services may be subject to notification and concurrent reviews. No limit.	\$0	\$0	\$0
Mental health – outpatient services	None.	\$0	\$0	\$0
Substance abuse – inpatient detoxification stays	No referral needed. Some services may be subject to notification and concurrent reviews.	\$0	\$0	\$0

CHIP Benefits Summary

Mental Health and Substance Abuse Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Substance abuse – inpatient residential rehabilitation	None.	\$0	\$0	\$0
Substance abuse – outpatient rehabilitation	None.	\$0	\$0	\$0
Dental Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Comprehensive orthodontic services	No annual maximums. Some services will require prior authorization and proof of medical necessity in order to be covered. Some services may be limited based upon age or quantity.	\$0	\$0	\$0
Non-orthodontic services	No lifetime maximum. Requires prior authorization and proof of medical necessity in order to be covered.	\$0	\$0	\$0
Vision Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Vision care	<p>Frames and lenses: One set of eyeglass lenses that may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low-vision items.</p> <p>Frequency of eye exam: One routine examination and refraction every 12 months. Includes dilation, if professionally indicated. No cost to member In-Network. Out-of-Network – no coverage*.</p>	\$0	\$0	\$0

CHIP Benefits Summary

Vision Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Vision care <i>(continued)</i>	<p>Frequency of lens and frame replacement: One pair of eyeglasses every 12 months, when medically necessary for vision correction.</p> <p>Lenses: In-Network — One pair covered in full every 12 months. Out-of-Network — no coverage.*</p> <p>Frames: In-plan frames are available at no cost to member. Non-plan frames: Expenses in excess of \$130 allowance payable by member. Additionally, a discount of 20% is available for amounts over \$130.* *</p> <p>Out-of-Network — No coverage.*</p> <p>Replacement of lost, stolen, broken frames and lenses (one original and one replacement per calendar year, when deemed medically necessary).</p> <p>Contact lenses: One prescription every 12 months — in lieu of eyeglasses when medically necessary for vision correction.</p> <p>Additionally, a discount of 15% is available for amounts over \$130.* *</p>	\$0	\$0	\$0

* Out-of-Network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If child is unexpectedly out of the area, e.g., vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement.

** This discount is available from providers who have agreed to contract for the discount.

CHIP Benefits Summary

Vision Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Vision care <i>(continued)</i>	<p>In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, the difference up to the \$130 allowance may be applied toward the cost of evaluation, materials, fitting and follow-up care. You will be responsible for any amounts over \$130.</p> <p>Expenses in excess of \$600 for medically necessary contact lenses, with pre-approval. These conditions include:</p> <p>Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses.</p> <p>Low Vision: One comprehensive low-vision evaluation every five years, with a maximum charge of \$300; maximum low-vision aid allowance of \$600 with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care — four visits in any five-year period, with a maximum charge of \$100 per visit. Providers will obtain the necessary pre-authorization for these services.</p>	\$0	\$0	\$0

CHIP Medical Benefits

This section lists the medical services covered by your child's CHIP insurance. The services in this section are listed in alphabetical order. Under each covered service listing you will find a brief description of the benefit provided and any limits or restrictions that may apply. UnitedHealthcare reserves the right to restrict benefit coverage of medical equipment purchases to certain manufacturers and specific product types. For further information regarding medical equipment purchasing restrictions, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Except under very specific circumstances, such as in the case of an emergency, all services described in this section are covered only if provided by a participating provider. Except in the case of an emergency, preauthorization by UnitedHealthcare, or other specialized documentation or certifications required for a particular benefit must be obtained **before** your child receives the service in order for the claim to be covered.

Services are only covered up to the specified benefit limits. Once your child has reached the available benefit limit, your child will either need to stop receiving those particular services, or you will be responsible for paying for the services directly.

If you have any questions about your child's medical benefits, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**. Your Member Services representative can tell you if a particular service is covered, if there are any benefit limits, what providers your child may see for a service, and what you may need to pay out-of-pocket for a service. Your Member Services representative can also tell you how much money or how many visits you have remaining for any service that has a benefit limit.

UnitedHealthcare also offers additional services and care options as an added benefit to its members. These benefits are not sponsored by CHIP and are provided solely by UnitedHealthcare. These benefits are listed in the section titled "**Additional Medical Benefits Brought to You by UnitedHealthcare**" and may be found at the end of the standard medical benefit list. If you have questions relating to the additional benefits provided by UnitedHealthcare, you may call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

CHIP Medical Benefits

Autism Spectrum Disorder and Related Services¹

In accordance with the Pennsylvania Autism Insurance Act (Act 62), the following services, when medically necessary for the assessment, diagnosis, and treatment of Autism Spectrum Disorders are covered:

- Prescription drug coverage;
- Services of a psychiatrist and/or psychologist; and
- Rehabilitative and therapeutic care.

Benefit Limits: Coverage under this section is subject to co-payments as identified elsewhere in this handbook.

Treatment of autism spectrum disorders must be:

- Medically necessary;
- Identified in a treatment plan;
- Prescribed, ordered, or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker, or certified registered nurse practitioner; and
- Provided by an autism service provider or a person, entity, or group that works under the direction of an autism service provider.

Act 62 requires private insurance companies to permit expedited internal and external review processes to review grievances for a child who has been denied or partially denied autism treatment services. You may initiate this process by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**. Make certain that UnitedHealthcare has all of the information it needs from your child's treating professionals to support your service request.

If you have further questions regarding autism spectrum disorder benefits or need assistance finding participating providers specializing in the treatment of autism in your area, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

You may also visit the Department of Human Services Autism website at **www.PAutism.org** for more information about autism and Act 62.

Covered Preventative Medications:

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and covered at no cost to you when filled at a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

¹ In order to provide your child with the best care possible, if your child is diagnosed with autism, you should contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and request a consultation with a UnitedHealthcare case manager.

Diabetic Services²

Diabetic treatment, equipment, medications, and supplies as follows:

- Diabetic medical equipment, monitoring supplies, and prescription medications;
- Outpatient diabetic training and education;
- Diabetic eye examinations;
- Laboratory screening tests;
- Routine diabetic foot care and orthotics;
- UnitedHealthcare Diabetic Disease Management Program; and
- UnitedHealthcare Special Needs Unit care coordination and case management.

Benefit Limits: Payment is limited to one routine diabetic eye exam per calendar year. Batteries for diabetic medical equipment are not covered. Services identified above are subject to the same benefit limits noted elsewhere in this handbook.

You may learn more about Pennsylvania's Diabetes Prevention and Control Program by visiting www.health.state.pa.us/diabetes.

Diagnostic, Laboratory, and Radiology Services

Diagnostic tests, services, and materials related to the diagnosis and treatment of sickness and injury in both inpatient and outpatient settings.

Benefit Limits: Certain services may require prior authorization in order to be covered.

Durable Medical Equipment

Durable Medical Equipment (DME) coverage applies to equipment designed to serve a medical purpose which is not useful to a person unless they have an illness or an injury, is able to stand repeated use, is not disposable or for a single patient use, and is required for use in the home or school environment. This benefit covers the cost of DME rental (or purchase if purchase is cheaper than renting the DME over an extended period of time), delivery, and installation. Repair or replacement of DME is only covered as required with normal wear and tear when certified as being medically necessary due to a child's normal growth.

Benefit Limits: DME may require prior authorization.

² In order to provide your child with the best care possible, if your child has a diagnosis of diabetes, you should contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and request that your child be enrolled in the UnitedHealthcare diabetes disease management program.

CHIP Medical Benefits

Emergency Care Services

As described in the Emergency Care section of this handbook.

Benefit Limits: None.

Emergency Transportation Services

Transportation services by land, air, or water ambulance are covered only when medically necessary. Services must be rendered in response to an emergency, for the purpose of transporting an inpatient member between facilities, or when a homebound member is discharged from the hospital and for medical reasons cannot be transported by other means.

Benefit Limits: Transportation outside of the service area will only be covered if the services required by the member cannot be provided within the service area.

Family Planning Services

Family planning services cover the professional services provided by your child's PCP or OB/GYN provider related to the prescribing³, fitting, and/or insertion of a contraceptive. Food and Drug Administration-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost share to the member. Contraception drugs and devices are covered under the Prescription Drug benefit issued with the plan.

Benefit Limits: None.

Habilitative Services

- Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of outpatient settings. Covered services are limited to 30 visits per calendar year for Physical Therapy; 30 visits per calendar year for Occupational Therapy; and 30 visits per calendar year for Speech Therapy, for a combined visit limit of 90 days per calendar year. Visit limits under this benefit are combined with visit limits described under Outpatient Rehabilitation Therapy.
- Covered services also include inpatient therapy up to 45 visits per calendar year for treatment of CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain surgery.
- Chiropractic Care — limit 20 visits per year.
- Home Health Care.

³ Co-payments do not apply to prescription contraceptives.

CHIP Medical Benefits

Care provided to a CHIP member who is homebound by a home health care provider in the CHIP member's home, if within the service area. **This benefit is offered with no co-payments and no limitations.**

Hearing Care Services

Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary.

Benefit Limits: One routine hearing examination and one audiometric examination per 12 months. One hearing aid or device per ear every 24 months. Batteries for hearing aids and devices are not covered. **No monetary limits apply.**

Home Health Care Services

Home health care is only covered if your child is homebound. Your child is considered homebound when his or her medical condition prevents them from leaving home without a great deal of effort. Home health care services include medically necessary:

- Skilled nursing services;
- Home health aide services;
- Physician services;
- Physical, speech, and occupational therapy services;
- Medical and surgical supplies and equipment, including oxygen; and
- Home infusion therapy (not including blood or blood products).

Benefit Limits: Home health services may require prior authorization by UnitedHealthcare.

Hospice Services

Hospice is a special kind of care that is available to members who are suffering from a terminal illness. This care will be concurrent with care related to the treatment of the condition for which the diagnosis of terminal illness was made. Members receiving hospice and palliative care services may still receive UnitedHealthcare covered services for other illnesses or conditions as well.

Benefit Limits: Hospice services must be prior authorized by UnitedHealthcare and require a certification by a physician stating that the member has a terminal illness. UnitedHealthcare must be provided with a written request for hospice services by either the member, if they are of legal age, or by the member child's legal guardian.

CHIP Medical Benefits

Hospital Services: Inpatient, Outpatient, and Ambulatory Surgical Center Services

Hospital benefits may be provided by a participating facility on either an inpatient or outpatient basis. These services may be provided at participating facilities, such as an acute care hospital, skilled nursing facility, or an ambulatory surgical center.

Benefit Limits: Hospital-related services may require prior authorization except in the case of an emergency. Voluntary (planned) Admission must be prior authorized. Emergency or urgent admission will not require authorization, but will require notification to the health plan by the facility, and may be subject to concurrent reviews for verification that ongoing services are medically necessary and appropriate.

Immunizations

Coverage will be provided for pediatric immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric and adult immunization ACIP schedules may be found by accessing the following link: <http://www.cdc.gov/vaccines/recs/schedules/default.htm>.

Influenza Vaccines can be administered by a participating pharmacy for members starting at the age of 9 years old, with parental consent, according to PA Act 8 of 2015.

Mastectomy and Breast Cancer Reconstructive Surgery Services

Members who undergo a mastectomy are eligible for reconstructive surgical services, including surgery for symmetrical appearance, prostheses, and coverage for complications (such as lymphedemas).

Benefit Limits: Mastectomy services may require prior authorization.

Mastectomy and Breast Reconstruction:

Benefits are provided for a mastectomy performed on an inpatient or outpatient basis, and for the following:

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a mastectomy; and
- Physical complications of all stages of mastectomy, including lymphedemas.
- Coverage is also provided for one Home Health Care visit, as determined by the member's physician, received within forty-eight (48) hours after discharge.

CHIP Medical Benefits

Maternity Services

A female member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Except in the case of an emergency or in accordance with the UnitedHealthcare continuity of care policy, maternity services must be provided by participating providers and occur at participating facilities. Providers of maternity care services may include physicians, nurse practitioners, and certified nurse midwives. Facilities may include both acute care hospitals and free-standing birthing centers.

Hospital and physician care services relating to antepartum, intrapartum, and postpartum care, including complications resulting from the member's pregnancy or delivery, are covered.

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, after consultation with the provider, or in the case of a newborn, in consultation with the mother or the newborn's authorized representative, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames and if the treating or attending Physician determines that the mother and newborn meet medical criteria for safe discharge contained within guidelines developed by or in cooperation with treating Physicians which recognize treatment standards, including those of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, that determine appropriate length of stay based upon, but not limited to, the following:

- The evaluation of the antepartum, intrapartum and postpartum course of the mother and infant;
- The gestational stage, birth weight and clinical condition of the infant;
- The demonstrated ability of the mother to care for the infant post-discharge; and
- The availability of the post-discharge follow-up care to verify the condition of the infant and mother within 48 hours after discharge.

In the case of early discharge, Benefits will be provided for a Home Health Care visit within 48 hours of discharge. The Home Health Care visit will be made by a licensed health care provider whose scope of practice includes postpartum care. The Home Health Care visit will include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, the visit may occur at the facility of the provider. Home Health Care visits following an inpatient stay for maternity services are not subject to co-payments, deductibles or co-insurance, if otherwise applicable to this coverage.

CHIP Medical Benefits

Benefit Limits: Delivery at a facility outside the service area will only be covered in the case of an emergency.

Medical Foods

Medical foods such as specially formulated enteral feedings and supplements are covered only for the therapeutic treatment of certain genetic disorders. This benefit is not intended to cover normal food products used in the dietary management of rare genetic metabolic disorders.

Benefit Limits: Child must have a diagnosis of an aminoacidopathic hereditary metabolic disorder such as phenylketonuria, branched-chain ketonuria, galactosemia, or homocystinuria.

Newborn Coverage of Infants Born to CHIP Members

This benefit pertains to newborn children of CHIP members who are covered from the time of birth for the first 31 days of life. Services for these children are accessed using the member's CHIP identification card. To assure no lapse in access to health care for the newborn after the first 31 days, the member must contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**, immediately after the child is born to begin the process of getting the newborn his or her own health care coverage.

Benefit Limits: This service ends after the CHIP member's baby turns 31 days of age. Members with newborns should follow the guidelines set forth in this handbook to access their benefits. If you have questions about newborn care benefits or how to access them, or need help applying for coverage for your newborn, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Oral Surgery Services

Oral surgery services may be performed in either an inpatient or outpatient setting depending on the nature of the procedure. Examples of covered services include:

- Extraction of partially or totally bony impacted third molars (wisdom teeth);
- Baby bottle syndrome;
- Surgery to correct dislocation or complete degeneration of the temporomandibular joint; and
- Non-dental treatments of the mouth relating to medically diagnosed:
 - Congenital defects,
 - Birth abnormalities, and
 - Surgical removal of tumors.

Benefit Limits: May require prior authorization by UnitedHealthcare. UnitedHealthcare reserves the right to determine, based on medical necessity, what facility setting they deem most appropriate for the oral surgery services being provided. Anesthesia coverage varies based on the procedure and the type of facility where the service is provided.

CHIP Medical Benefits

Orthotic Devices

Orthotic devices are rigid appliances or apparatuses used to support, align, or correct bone and muscle injuries or deformities. This benefit covers the purchase, fitting, and necessary adjustments of covered orthotic devices and any repair that is required as a result of normal wear and tear on the device. Replacement of an orthotic device is only covered when it is deemed medically necessary and appropriate due to the normal growth of the child.

Benefit Limits: May require prior authorization. Must be deemed medically necessary and not be primarily intended for the child's convenience or personal comfort.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

Ostomy Supplies

Ostomy supplies are medical supplies necessary for the care and drainage of a stoma.

Benefit Limits: Benefit only available to members who have had a surgical procedure which resulted in the creation of a stoma.

Outpatient Medical Therapy Services

This benefit provides members with an unlimited number of outpatient visits for the following services:

- Dialysis treatments,
- Cancer chemotherapy and hormone treatments,
- Respiratory therapy, and
- Radiation therapy.

Benefit Limits: May require prior authorization. Member must have a documented diagnosis that indicates that the prescribed therapy is a medical necessity.

Outpatient Therapy Services: Rehabilitative or Habilitative

This benefit provides members with the following services:

- Physical therapy,
- Occupational therapy, and
- Speech therapy.

CHIP Medical Benefits

Benefit Limits: May require prior authorization. Member must have a documented diagnosis that indicates that the prescribed therapy is a medical necessity.

- Physical Therapy – Limited to 30 visits per year combined rehabilitative and habilitative.
- Occupational Therapy – Limited to 30 visits per year combined rehabilitative and habilitative.
- Speech Therapy – Limited to 30 visits per year combined rehabilitative and habilitative.

Pediatric Preventive Care

Pediatric Preventive Care includes the following, with no cost-sharing or co-pays:

- Physical Examination, Routine History, Routine Diagnostic Tests.
- Oral Health Risk Assessment, Fluoride Varnish – for children ages 5 months to 5 years old (U.S. Preventative Task Force Recommendation).
- Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling.
- Blood Lead Screening and Lead Testing. This blood test detects elevated lead levels in the blood.
- Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells.
- Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies.
- Urinalysis. This test detects numerous abnormalities.

Prescription Drug Benefits:

- Select Over-the-Counter (OTC) products may be covered if mandated by the Patient Protection and Affordable Care Act (PPACA). If the member has a prescription for the over-the-counter medication, the medication is listed in the formulary, and the member has been diagnosed with certain medical conditions, the medication may be covered. If you have questions about whether an over-the-counter medication is covered, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.
- When a Prescription Drug is available as a Generic, UnitedHealthcare will only provide benefits for that Prescription Drug at the Generic Drug level. If the prescribing Physician indicates that the Brand Name Drug is medically necessary and should be dispensed, the brand name drug is covered at the generic cost-share amount by the contractor.
- When clinically appropriate drugs are requested by the member, but are not covered by the health plan, the member shall call Customer Service at the telephone number on the back of the member's Identification Card to obtain information for the process required to obtain the prescription drugs.

Primary and Preventive Health Services

UnitedHealthcare periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force (USPSTF), (all items or services with a rate of A or B in the current recommendations). The American Cancer Society and the Health Resources and Services Administration (HRSA). Examples of covered "USPSTF A" recommendations are folic acid supplementation, chlamydial infection screening for non-pregnant women, and tobacco use counseling and interventions. Examples of covered "USPSTF B" recommendations are dental cavities prevention for preschool children, healthy diet counseling, oral fluoride supplementation/rinses and vitamins, BRCA risk assessment and genetic counseling and testing, prescribed Vitamin D, prescribed iron supplementation, mineral supplements, chlamydial infection screening for pregnant women, and sexually transmitted infections counseling. Examples of covered HRSA required benefits include all Food and Drug Administration approved contraceptive methods, sterilization procedures, breastfeeding equipment, and patient education and counseling for all women with reproductive capacity. All services required by HRSA are covered. Accordingly, the Preventive Services are provided at no cost to the member.

Primary Care Physician Office Services

Preventive and well-child services play a very important part in keeping your child healthy. Regular preventive and well-child visits can prevent your child from getting ill in the future and will also help your child's PCP find health conditions and/or developmental delays which may benefit from early treatment. It is important to schedule and keep appointments for preventive and well-child services based upon the schedule recommended by your child's PCP.

Remember that you may contact your child's PCP 24 hours a day, 7 days a week, if your child becomes ill and you need a doctor's advice. Your child's PCP can provide many of the health care services your child needs including:

- Preventive and well-child visits and services including immunizations;
- Sick and urgent care office visits including those that occur after normal office hours when medically necessary;
- Follow-up care after emergency services; and
- Woman's health services and family planning services (see benefit description for details).

Benefit Limits: Certain services may require proof of medical necessity and prior authorization in order to be covered for your child. Services rendered by your PCP must be within the scope of his or her practice in order to be covered.

CHIP Medical Benefits

Prosthetic Devices

Prosthetic devices replace all or part of a missing body part. They are also used to help a non-functioning organ to work again. This benefit covers the purchase, fitting, and necessary adjustments of covered prosthetic devices (including those related to post-mastectomy reconstruction) and any repair that is required as a result of normal wear and tear on the device. Replacement of a prosthetic device is only covered when it is deemed medically necessary and appropriate due to the normal growth of the child.

Benefit Limits: May require prior authorization.

Reconstructive Surgery

Reconstructive Surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy.

Restorative or Reconstructive Surgery Services (other than mastectomy-related services)

Covered services for restorative and reconstructive surgery include services relating to:

- Surgery to correct a deformity resulting from:
 - Disease
 - Trauma
 - Congenital or developmental anomalies (birth defects)
- Surgery to correct a bodily functional defect resulting from:
 - Accidental injury
 - Incidental to surgery
- Surgery in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment

Benefit Limits: May require prior authorization.

Routine Patient Costs Associated With Qualifying Clinical Trials:

Benefits are provided for routine patient costs associated with participation in a qualifying Clinical Trial. To ensure coverage and appropriate claims processing, UnitedHealthcare Community Plan must be notified in advance of the member's participation in a Qualifying Clinical Trial.

Benefits are payable if the Qualifying Clinical Trial is conducted by a Participating Professional Provider, and conducted in a Participating Facility Provider facility. If there is no comparable Qualifying Clinical Trial being performed by a Participating Professional Provider, and in a Participating Facility Provider facility, then UnitedHealthcare will consider the services by a Non-Participating Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial by UnitedHealthcare.

Qualifying Clinical Trials — A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following:

- A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - 1. The National Institutes of Health (NIH);
 - 2. The Centers for Disease Control and Prevention (CDC);
 - 3. The Agency for Healthcare Research and Quality (AHRQ);
 - 4. The Centers for Medicare and Medicaid Services (CMS);
 - 5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
 - 6. Any of the following, if the Conditions for Departments are met:
 - a. The Department of Veterans Affairs (VA);
 - b. The Department of Defense (DOD); or
 - c. The Department of Energy (DOE), if for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be (A) comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

CHIP Medical Benefits

- C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The citation for reference is 42 U.S.C. § 300gg-8. The statute requires the issuer to provide coverage for routine patient care costs for qualified individuals participating in approved clinical trials and issuer “may not deny the individual participation in the clinical trial.”

In the absence of meeting the criteria listed above, the clinical trial must be approved by UnitedHealthcare as a Qualifying Clinical Trial.

Routine Patient Costs Associated With Qualifying Clinical Trials — Routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

Skilled Nursing Inpatient Facility Services

Skilled nursing services are available if deemed medically necessary to children requiring around-the-clock skilled nursing services but not needing to be in a hospital.

Benefit Limits: May require proof of medical necessity and prior authorization.

Specialist Physician Services

Office visits, diagnostic testing and treatment by specialist physicians are covered if your child has an illness or other type of condition that requires treatment that is outside of your child’s PCP’s scope of practice.

Benefit Limits: Prior authorization may be required along with a determination of medical necessity before your child may access certain specialist services.

Transplant Services⁴

Transplant services that are medically necessary and not considered to be experimental or investigative by UnitedHealthcare are covered for your child.

Benefit Limits: Prior authorization is required. Medical necessity must be established. Covered services for patient selection criteria (testing required by the transplant facility to make sure your child meets the criteria for transplant) are covered at only one designated transplant facility except when the services are rendered as part of a second opinion that has been prior authorized by UnitedHealthcare. This benefit does not provide coverage for services related to the donation of organs to non-members.

⁴ In order to provide your child with the best care possible, if your child is in need of an organ transplant, you should contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and request a consultation with a UnitedHealthcare case manager.

CHIP Medical Benefits

Urgent Care Services

As described in the Urgent Care section of this handbook.

Benefit Limits: None.

Urological Supplies

Urological supplies required for medically necessary urinary catheterization are covered only if your child has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected for your child within three months.

Benefit Limits: None.

Well Woman Preventive Care

There is no cost sharing for preventive services under the services of Family Planning, Women's health, and Contraceptives.

Well Woman Preventive Care includes services and supplies as described under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act. Covered Services and Supplies include, but are not limited to, the following:

- **Routine Gynecological Exam, Pap Smear:** Female members are covered for one (1) routine gynecological exam each Benefit Period. This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female members have "direct access" to care by an Obstetrician or Gynecologist. This means there is no Primary Care Physician Referral needed.
- **Mammograms:** Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service Provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Co-payments, if any, do not apply to this benefit.
- **Breastfeeding:** Comprehensive support and counseling from trained Providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the member.
- **Contraception:** Food and Drug Administration-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost share to the member. Contraception drugs and devices are covered under the Prescription Drug benefit issued with the plan.

CHIP Medical Benefits

Woman's Health Services

Gynecological and woman's health services may be provided by your child's PCP or by a participating OB/GYN provider. Your child does not need a referral or prior authorization to receive a gynecological examination, family planning services, or maternity services from an OB/GYN.

Services covered under this benefit include:

- Annual gynecological examination and mammography screenings;
- Family Planning Services (refer to benefit described previously for further details and limitations);
- Maternity Services (refer to benefit described previously for further details and limitations); and
- Treatment of gynecological illness, including injury or complications that result from an elective abortion.

Benefit Limits: Except in cases of an emergency, abortion⁵ services may require prior authorization. Elective abortions are not covered.

⁵ Abortions will only be covered if a physician has certified the abortion is medically necessary to save the life of the mother or if the abortion is performed to terminate a pregnancy resulting from an act of rape or incest. The incident of rape or incest must have been reported to law enforcement authorities or child protective services, unless the treating physician certifies that in his or her professional judgment, the member is physically or psychologically unable to comply with the reporting requirement.

Pharmacy Benefits

UnitedHealthcare provides coverage for a broad range of prescription drugs. The UnitedHealthcare Pharmacy Benefits Formulary, sometimes called a “Preferred Drug List,” or “PDL,” explains which medications are covered. Typically, UnitedHealthcare will not pay for drugs not included in the Formulary.

- Some medications in the Formulary may require prior authorization.
- Some medications may only be covered if a member has met certain criteria. Examples include having the member or his or her health care provider submit documentation that the member has:
 - Certain medical conditions or diagnoses that indicate the medication is medically necessary;
 - Drug allergies that limit the use of other medications a member might be treated with; or
 - Unsuccessful treatment of a condition or illness with a different medication without success.
- You must present your ID card at the time of service in order to access your pharmacy benefits.
- More information on the pharmacy benefits, and a copy of the Formulary/PDL, can be found online at **UHCCommunityPlan.com**. You can also request a copy of the PDL by calling Member Services.

If you have questions about your pharmacy benefits or need help finding a participating pharmacy, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Are Brand-Name Medications Covered?

A generic drug will be substituted for a brand-name drug whenever a generic is available unless the physician indicates that the brand-name version of the drug is medically necessary. If the physician believes the brand-name version of the drug is medically necessary, a special request must be submitted to UnitedHealthcare for review before the brand-name version of the medication will be covered.

Are Over-the-Counter Medications Covered?

Most over-the-counter medications are not covered. However, if the member has a prescription for the over-the-counter medication, the medication is listed in the Formulary, and the member has been diagnosed with certain medical conditions, the medication may be covered. If you have questions about whether an over-the-counter medication is covered, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Mental Health Benefits

Some members diagnosed with severe mental health disorders or conditions that significantly impact a child's behavioral health (i.e., schizophrenia, autism, etc.) may be eligible for a broader range of services or different benefit limitations. Contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**, if you have questions regarding your child's eligibility for certain mental health services or benefit limits.

Who Can My Child Receive Mental Health Services From?

Except in the case of an emergency, mental health services must be provided by participating providers and facilities unless the use of a non-participating provider or facility is preauthorized by UnitedHealthcare.

Does My Child Need a Referral to Visit a Mental Health Specialist?

Your child does not need a referral from a PCP to see a participating mental health provider. A member (14 years of age or older) or a parent or guardian may self-refer.

If you need self-referral assistance, require help finding a participating provider in your area, are having difficulty getting an appointment scheduled with a participating provider, or have questions about behavioral health benefits, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**. For your convenience, this number is also located on your child's UnitedHealthcare ID card.

What if My Child Has a Mental Health Emergency?

A mental health emergency is the sudden onset of a potentially life-threatening condition where you believe that your child is at risk of injury to himself/herself or others if immediate medical attention is not given.

If you believe your child is in a mental health crisis or emergency situation, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**. You will be connected with a mental health professional who will help you assess the seriousness of the situation.

- If it is an emergency, the mental health professional will assist you in getting the treatment your child needs as quickly as possible.
- If the condition is not a life-threatening one that requires immediate inpatient admission, UnitedHealthcare will schedule your child for an urgent care appointment.

The **initial** treatment for a mental health emergency is covered even when provided by non-participating mental health providers or rendered at a non-participating facility if the symptoms are severe enough to need immediate attention.

Mental Health Benefits

What Do I Need to Know About Inpatient Mental Health Services?

- Except in the case of an emergency, if your child's mental health provider decides it is medically necessary for your child to receive mental health treatment in an inpatient setting, they may need to contact UnitedHealthcare and obtain prior authorization before your child may be admitted to the hospital. Prior authorization is done the very same day, so you do not have to worry about lengthy delays preventing your child from receiving timely treatment.
- Inpatient mental health services can only be provided by participating providers at participating facilities unless the admission occurred as a result of a psychiatric emergency. If your child is admitted to a non-participating facility, you must contact UnitedHealthcare within 24 hours to notify them of the admission. Once your child's condition is determined to be non-emergent, your child may be transferred to a participating facility. If you refuse to transfer your child to a participating facility after the psychiatric emergency has ended, the services your child receives at the non-participating facility may not be covered.

Voluntary (planned) Admission must be prior authorized. Emergency or urgent admission will not require authorization, but will require notification to the health plan by the facility, and may be subject to concurrent reviews for verification that ongoing services are medically necessary and appropriate.

Do Outpatient Mental Health Services Need to Be Prior Authorized?

Most outpatient mental health services do not require prior authorization from UnitedHealthcare.

Your child's mental health provider is responsible for obtaining necessary authorizations and should call the UnitedHealthcare Member Services to get the necessary approvals.

Substance Abuse Benefits

CHIP covers inpatient detoxification, non-hospital residential treatment, and outpatient treatment relating to drug⁶ and alcohol abuse for your child.

If you think your child has a drug or alcohol problem, don't delay getting them the help they need. The sooner a child begins treatment with a professional provider, the more likely they are to have a successful recovery.

Who Can My Child Receive Substance Abuse Services From?

Substance abuse services must be provided by participating providers and facilities unless the use of a non-participating provider or facility is preauthorized by UnitedHealthcare.

Does My Child Need a Referral to Visit a Substance Abuse Specialist?

Your child does not need a referral from a PCP to see a participating substance abuse provider. A member (14 years of age or older) or a parent or guardian may self-refer. If you need self-referral assistance, require help finding a participating provider in your area, are having difficulty getting an appointment scheduled with a participating provider, or have questions about substance abuse benefits, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**. For your convenience, this number is also located on your child's UnitedHealthcare ID card.

What if My Child Has a Substance Abuse Emergency or Crisis?

A substance abuse crisis is where your child is considered in imminent, potentially life-threatening physical danger with a need for immediate detoxification for chemical dependency. Other psychiatric emergencies are covered under your child's mental health benefit.

If you believe your child is in a psychiatric crisis or emergency situation, call Member Services at **1-800-414-9025, TTY/PA RELAY 711**. You will be connected with a mental health professional who will help you assess the seriousness of the situation.

- If it is an emergency, the mental health professional will assist you in getting the treatment your child needs as quickly as possible.
- Admission to a non-hospital residential treatment facility for rehabilitation treatment is **never** considered a part of emergency treatment.
- If the condition is not a life-threatening one that requires immediate inpatient admission, UnitedHealthcare will schedule your child for an urgent care appointment.

⁶ Substance abuse benefits do not cover tobacco abuse related services. However, smoking cessation counseling is a covered preventive service, and products to help stop smoking are included in your child's pharmacy benefits. Call UnitedHealthcare Member Services at **1-800-414-9025, TTY/PA RELAY 711**, for information or help accessing these benefits.

Substance Abuse Benefits

The **initial** treatment for psychiatric emergencies is covered even when provided by non-participating providers or rendered at non-participating facilities if the symptoms are severe enough to need immediate attention.

What Do I Need to Know About Inpatient Detoxification?

- Detoxification is the process by which a drug- or alcohol-intoxicated or dependent member is assisted through the period of time needed to eliminate the presence of the intoxicating substance(s) or the dependency factor(s), while keeping the physiological or psychological risk to the member at a minimum. Inpatient detoxification is used when a member's withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care with medical monitoring by medical and nursing professionals.
- Except in the case of an emergency, if your child's substance abuse provider decides it is medically necessary for your child to receive inpatient detoxification treatment, they may need to contact UnitedHealthcare and obtain prior authorization before your child can be admitted to the hospital. Voluntary (planned) Admission must be prior authorized. Emergency or urgent admission will not require authorization, but will require notification to the health plan by the facility, and may be subject to concurrent reviews for verification that ongoing services are medically necessary and appropriate. Prior authorization is done the very same day, so you do not have to worry about lengthy delays preventing your child from receiving timely treatment.
- Inpatient detoxification services may only be provided by participating providers at participating facilities unless the admission occurred as a result of a psychiatric emergency. If your child is admitted to a non-participating facility, you must contact UnitedHealthcare within 24 hours to notify them of the admission. Once your child's condition is determined to be non-emergent, your child may be transferred to a participating facility. If you refuse to transfer your child to a participating facility after the psychiatric emergency has ended, the services your child receives at the non-participating facility may not be covered.

Substance Abuse Benefits

What Do I Need to Know About Non-Hospital Residential Treatment?

- Non-hospital residential treatment refers to services that are administered at facilities where the member lives while participating in a comprehensive chemical dependency treatment program in a therapeutic environment that has met the minimum standards established by the Pennsylvania Department of Health.
- Members who do not require medical monitoring for withdrawal may receive detoxification-related services at these facilities as well.
- If your child's substance abuse provider decides it is medically necessary for your child to receive treatment in a non-hospital residential setting, the provider may need to contact UnitedHealthcare and obtain prior authorization before your child may be admitted to the facility.
- Admission to a non-hospital residential treatment facility for chemical dependency and rehabilitation treatment is **never** considered a part of emergency treatment.
- Non-hospital residential treatment services may only be rendered by participating providers at participating facilities unless UnitedHealthcare preauthorizes the use of a non-participating provider or facility **before** your child is admitted and begins receiving services. Non-hospital residential substance abuse services your child receives at a non-participating facility **will not** be covered by your child's insurance.

What Outpatient Substance Abuse Benefits Are Covered?

Your child is eligible for substance abuse outpatient visits. Covered services include psychological and laboratory testing, visits with substance abuse rehabilitation providers, partial hospitalization, intensive outpatient therapy, and medication management.

Dental Benefits

CHIP covers dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. There are no co-payments for dental services and no referrals are needed from your PCP to make an appointment, so making sure your child gets high-quality dental care couldn't be easier.

Tooth decay is the most common chronic childhood disease. Help prevent your child from suffering the effects of tooth decay by encouraging them to practice good oral hygiene daily and taking them to the see the dentist for regularly scheduled checkups even if their teeth appear to be healthy.

Who Can My Child See for Dental Care?

You may make an appointment with any participating UnitedHealthcare dentist. You may find a list of UnitedHealthcare providers on **UHCommunityPlan.com** or by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

If you need help finding a dental provider or getting an appointment, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and someone will assist you.

Can My Child Receive Services From a Non-Participating Dental Provider?

UnitedHealthcare will only cover services received from a non-participating dentist if the services are prior authorized. We may prior authorize services for continuity of care or if we cannot locate a participating provider to treat your child.

How Much Does Dental Care Cost?

Except in the case of an emergency, in order for a dental benefit to be completely covered by CHIP, dental care must be provided by a dentist who is a participating provider. Covered dental benefits provided by a participating provider and approved by UnitedHealthcare will have no out-of-pocket costs.

In a case involving a covered service in which the dentist, the member, or the member's parent selects a more expensive course of treatment than is customarily provided for the dental condition, payment under this benefit will be based on the charge allowance for the lesser procedure. In this case, the dentist may choose to balance bill you for the difference between the charge of the actual service rendered and the amount received from UnitedHealthcare.

Dental Benefits

What Dental Services Are Not Covered by CHIP?

Dental services performed for cosmetic purposes rather than medical necessity are not covered.

Additional treatment that is needed due to non-compliance with prescribed dental care is not covered.

What Dental Services Are Covered by CHIP?

Your child is eligible to have a routine examination and cleaning once every six months completely free of cost when provided by a participating dentist.

Your child is eligible for a number of other dental benefits as well. Some dental benefits are restricted to certain age groups, may be limited by how often your child may receive them, may be restricted to a particular facility setting, or may require prior authorization to determine whether the service is medically necessary for your child. We follow the recommendations of the American Dental Association when we make decisions about and how often or at what age we cover certain services.

Orthodontic Treatment (braces)

Orthodontic treatment (braces) is only covered if your child is diagnosed with a significant handicapping malocclusion or other severe condition (such as cleft palate) and orthodontic treatment is determined to be the only method capable of restoring your child's oral structure to health and function. Braces are not covered for cosmetic reasons.

Dental Benefits

This list outlines the scope of your benefits, but does not list every available dental service. Please talk with your dental provider about what is covered, and what treatments they recommend for your child. Some services require prior authorization and may only be available if they are determined to be medically necessary and age appropriate for your child. If you have questions about available services, please call UnitedHealthcare at **1-800-414-9025, TTY/PA RELAY 711**, for assistance.

Diagnostic Services

- Routine examinations
- Bitewing X-rays *2x each year*
- Panorex (Full Jaw) X-rays *every 36 months*

Preventive Services

- Routine cleanings *2x each year*
- Topical application of fluoride *2x each year*
- Topical fluoride varnish *2x each year*
- Sealants *for molars*
- Space maintainers *1 per quadrant*

Restorative Care

- Amalgam (silver) restorations (*fillings*)
- Resin based composite restorations (*fillings*)
- Crowns

Endodontic Services

- Pulpotomies
- Root canals

Periodontic Services

- Periodontal scaling and root planning
Once each quadrant per 24 months
- Periodontal maintenance
- Gingivectomy or gingivoplasty
- Full mouth debridement

Prosthodontic Services⁷

- Dentures *1 per arch every 5 years*
- Partial dentures *1 per arch every 5 years*
- Denture repairs/adjustments
- Crowns *1 per tooth per 60 months*
- Bridges *if medically necessary due to accident or injury*

Oral and Maxillofacial Surgery⁸

- Surgical extractions not covered by the member's medical oral surgery benefit including those involving wisdom teeth
- Brush biopsies
- Alveoloplasties
- Removal of cysts and tumors
- Incision and drainage of abscesses
- Frenulectomy

Orthodontic Services⁹

- Evaluation for braces
- Comprehensive orthodontic treatment
- Orthodontic retention

Adjunctive General Services

- General anesthesia
- Intravenous conscious sedation

Emergency Services

- Temporary crown for treatment of a fractured tooth
- Apicoectomy/periradicular surgery
- Palliative treatment of dental pain

⁷ Prior authorization mandatory.

⁸ Prior authorization mandatory.

⁹ Prior authorization mandatory.

Vision/Eye Care Benefits

Untreated eye problems can result in learning and behavioral problems that negatively affect a child's life. With proper attention to eye care, including regular checkups, many problems can be avoided.

Who Can My Child See for Vision Care?

You may make an appointment with any participating UnitedHealthcare optician, optometrist, or ophthalmologist. You may find a list of UnitedHealthcare providers at UHCommunityPlan.com or by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

You do not need to get a referral from your child's PCP in order to make an eye appointment.

If you are having difficulty finding a participating vision provider or getting an appointment, please call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, and someone will assist you.

How Much Does Vision Care Cost?

UnitedHealthcare participating providers will accept the allowance as payment in full for covered services. The participating provider will handle all of the paperwork for your child and payment will be made directly to them. When you use a participating provider, you will not have any out-of-pocket costs or be responsible for any portion of the bill.

UnitedHealthcare will only cover services provided by a non-participating vision provider if the services are prior authorized. We may prior authorize services for continuity of care or if we cannot locate a participating provider to treat your child.

In a case involving a covered service in which the vision provider, the member, or the member's parent selects a more expensive course of treatment or equipment than is customarily provided, payment under this benefit will be based on the charge allowance for the lesser procedure or equipment. In this case, the vision provider may choose to balance bill you for the difference between the charge of the actual service rendered or equipment provided and the amount received from UnitedHealthcare.

What Vision Benefits Are Covered?

UnitedHealthcare covers emergency, preventive and routine vision care services as outlined below.

Eye Examination and Refractive Services

- Limited to one routine examination and refraction test every 12 months. Additional exams are covered if medically necessary.

Vision/Eye Care Benefits

Post-Refractive Services

Frames and Lenses: One set of eyeglass lenses that may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low-vision items.

Frequency of eye exam: One routine examination and refraction every 12 months. Includes dilation, if professionally indicated. No cost to member in-network. Out-of-Network – no coverage*.

Frequency of lens and frame replacement: One pair of eyeglasses every 12 months, when medically necessary for vision correction.

Lenses: In-Network – One pair covered in full every 12 months. Out-of-Network – no coverage.*

Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters.

Note: Scratch-resistant coating is available for all lenses with no additional co-payment.

There may be co-payments for optional lens types and treatments:

Ultraviolet Protective Coating	No Co-Pay
Polycarbonate Lenses (if not child, monocular or prescription > +/-6.00 diopters)	\$30
Blended Segment Lenses	\$20
Intermediate Vision Lenses	\$30
Standard Progressives	\$50
Premium Progressives (Varilux®, etc.)	\$90
Photochromic Glass Lenses	\$20
Plastic Photosensitive Lenses (Transitions®)	\$65
Polarized Lenses	\$75
Standard Anti-Reflective (AR) Coating	\$35
Premium AR Coating	\$48
Ultra AR Coating	\$60
Hi-Index Lenses	\$55

Vision/Eye Care Benefits

Frames: In-plan frames are available at no cost to member. Non-plan frames: Expenses in excess of \$130 allowance payable by member. Additionally, a discount of 20% is available for amounts over \$130.** Out-of-network — No coverage.*

- Replacement of lost, stolen, broken frames and lenses (one original and one replacement per calendar year, when deemed medically necessary).

Contact Lenses: One prescription every 12 months — in lieu of eyeglasses when medically necessary for vision correction.

In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, the difference up to the \$130 allowance may be applied toward the cost of evaluation, materials, fitting and follow-up care. You will be responsible for any amounts over \$130. Additionally, a discount of 15% is available for amounts over \$130.* *

Expenses in excess of \$600 for medically necessary contact lenses, with pre-approval. These conditions include: Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses.

Low Vision:

One comprehensive low-vision evaluation every 5 years, with a maximum charge of \$300; maximum low-vision aid allowance of \$600 with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care — four visits in any five-year period, with a maximum charge of \$100 per visit. Providers will obtain the necessary pre-authorization for these services.

What Vision Benefits Are Not Covered?

- Vision exercise therapy and refractive surgery;
- Prescription lenses for sunglasses or industrial safety glasses.

* Out-of-Network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If child is unexpectedly out of the area; e.g., vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement.

** This discount is available from providers who have agreed to contract for the discount.

Routine Patient Costs Associated With Qualifying Clinical Trials:

Benefits are provided for routine patient costs associated with participation in a qualifying Clinical Trial. To ensure coverage and appropriate claims processing, UnitedHealthcare must be notified in advance of the member's participation in a Qualifying Clinical Trial.

Benefits are payable if the Qualifying Clinical Trial is conducted by a Participating Professional Provider, and conducted in a Participating Facility Provider facility. If there is no comparable Qualifying Clinical Trial being performed by a Participating Professional Provider, and in a Participating Facility Provider facility, then UnitedHealthcare will consider the services by a Non-Participating Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial by UnitedHealthcare.

Qualifying Clinical Trials — a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following:

- A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - 1. The National Institutes of Health (NIH);
 - 2. The Centers for Disease Control and Prevention (CDC);
 - 3. The Agency for Healthcare Research and Quality (AHRQ);
 - 4. The Centers for Medicare and Medicaid Services (CMS);
 - 5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
 - 6. Any of the following, if the Conditions for Departments are met:
 - a. The Department of Veterans Affairs (VA);
 - b. The Department of Defense (DOD); or
 - c. The Department of Energy (DOE), if for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be (A) comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Preventive Care

The citation for reference is 42 U.S.C. § 300gg-8. The statute requires the issuer to provide coverage for routine patient care costs for qualified individuals participating in approved clinical trials and issuer “may not deny the individual participation in the clinical trial.”

In the absence of meeting the criteria listed above, the clinical trial must be approved by UnitedHealthcare as a Qualifying Clinical Trial.

Routine Patient Costs Associated With Qualifying Clinical Trials – Routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

CHIP Exclusions

Not all services, supplies or charges are covered by CHIP. Except as specifically provided in the summary of CHIP benefits recognized in this handbook, or specifically identified in this handbook as a UnitedHealthcare enhanced benefit, **no benefits will be provided for the following services, supplies, and charges, including, but not limited to:**

Alternative Medicine

Including, but not limited to: acupuncture, acupressure, aromatherapy, aversion therapy, Ayurvedic medicine, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, dolphin therapy, electric aversion therapy for alcoholism, equestrian therapy, expressive therapies such as art or psychodrama, guided imagery, herbal medicine, homeopathy, hyperbaric therapy, massage therapy, narcotherapy, naturotherapy, orthomolecular therapy, primal therapy, relaxation therapy, transcendental meditation, and yoga.

Assisted Fertilization

None.

Behavioral Health Services for the following reasons

- Any service related to disorders that are not defined as treatable mental disorders according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).
- Services not expected to result in demonstrable improvement in the member's condition and/or level of functions, and chronic maintenance therapy, except in the case of serious mental illness/disorders.
- Inpatient or outpatient treatments related to mental retardation.
- Methadone maintenance for the treatment of chemical dependency.

Comfort and Convenience Items

None.

Corrective Appliances

Primarily intended for athletic purposes or those related to a sports medicine treatment plan.

CHIP Exclusions

Cosmetic Surgery or Other Procedures

Cosmetic surgery or other procedures to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons, and from which no improvement in physiological function can be expected, except for surgery or services which are required by law or as specified in the Covered Benefits section above.

Court Ordered

Court ordered services when not medically necessary for the member's medical or behavioral health condition as determined by the member's physician.

Custodial Care

None.

Dental Specific Exclusions

- Bridges unless required as a result of an accident or an injury.
- Claims involving covered services in which the dentist and the member select a more expensive course of treatment than is customarily provided by the dental profession and consistent with sound professional standards of dental practice for the dental condition concerned.
- Duplicate and temporary devices, appliances, and services.
- Gold foil restorations and restorations or prosthodontics using high noble or noble metals unless the use of such materials is determined to be medically necessary.
- Labial veneers.
- Laminates done for cosmetic purposes.
- Local anesthesia when billed for separately by a dentist.
- Oral surgery that is covered under the medical portion of the benefits.
- Plaque control programs, oral hygiene education and dietary instruction.
- Retainer replacement.

CHIP Exclusions

Drugs

- Drug Efficacy Study Implementation (DESI) drugs
- Experimental drugs
- Weight loss drugs
- Infertility agents
- Drugs used for cosmetic purposes
- Anabolic steroids
- Drugs labeled for investigational use
- Drugs used for hair growth
- Impotency drugs

Durable Medical Equipment

Medical equipment/supplies that are:

- Of an expendable nature.
- Dressings unless the level of care requires skilled nursing care in the home.
- Primarily used for non-medical purposes; e.g., air conditioners, humidifiers, or electric air cleaners.
- Basic comfort or convenience items or items primarily for the convenience of a person caring for a member.

Examinations

Physical examination or evaluation or any mental health or chemical dependency evaluation given primarily at the request of, for the protection or convenience of, or to meet a requirement of a third party, including, but not limited to, attorneys, employers, insurers, schools, camps, and driver's license bureaus.

Forms

Charges for completion of any specialized report, form, insurance form, or copying of medical records.

Genetic Counseling Studies

Genetic counseling and studies which are not medically necessary for the treatment of a defined medical condition.

Home Care

Home care for chronic conditions. No coverage is provided for dietary services, homemaker services, maintenance therapy, custodial care, and food or home-delivered meals.

CHIP Exclusions

Immunizations and Drugs	Immunizations and drugs used for prevention of disease when required solely for employment or traveling outside of the United States.
Long-Term Care	None.
Medically Unnecessary Services or Supplies	None.
Mental Retardation	Services for treatment of mental retardation except as otherwise provided herein.
Military Service	Care for military service related disabilities and conditions for which the member is legally entitled to receive services under other coverage.
Motor Vehicle Accident/Workers' Compensation	The cost of hospital, medical, or other health services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used – including such benefits mandated by law) of any automobile insurance policy unless otherwise prohibited by applicable law. Service for which coverage is required by federal, state, or local law to be purchased or provided through other arrangements, including, but not limited to, coverage required by workers' compensation, no-fault automobile insurance, or similar legislation.

CHIP Exclusions

Non-Covered Services

- Any service, supply, or treatment not specifically listed as a covered benefit, service, supply, or treatment under CHIP unless it is a basic health service. Any covered services related to or necessitated by an excluded item or non-covered service unless such services are considered basic health services.
- Charges for co-payments which are the member's responsibility.
- Charges for telephone conversations or failure to keep a scheduled appointment.
- Services or supplies which are not provided or arranged by a CHIP participating provider and authorized for payment in accordance with CHIP medical management policies and procedures.
- Services provided by a non-licensed provider or provider not recognized by CHIP.
- Services incurred after the date of termination of the member's coverage except as required by CHIP.
- Services provided before the member's effective date of coverage.
- Services rendered by a provider who is a member of the member's immediate family or household.
- Services for which the member would have no legal obligation to pay.
- Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
- Services related to purposes of obtaining or maintaining a license, employment, insurance, or for purposes related to judicial or administrative proceedings such as adjudication of marital, child support, or custody cases.
- Services requiring a prior authorization by CHIP for which the member or the treating provider did not obtain prior authorization.
- Services that are submitted by two different professional providers who provided the same services on the same date for the same member.
- Services which are primarily educational in nature, vocational rehabilitation, and recreational and educational therapy, except as required by law and when determined to be medically necessary.
- Treatment of sexual dysfunction not directly related to organic disease or injury.

CHIP Exclusions

Non-Medical Items	None.
Nutritional Supplements	<ul style="list-style-type: none">• Any formula, when used for the convenience of the member or the member's household.• Blenderized food, baby food, thickeners or regular shelf food when used with an enteral system.• Milk or soy-based infant formula with intact proteins.• Normal food products used in dietary management of rare hereditary genetic metabolic disorders.• Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance.• Oral semi-synthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates.• Regular food products or shelf products including oral nutritional supplements that are available over-the-counter.• Food supplements, lactose-free foods, vitamins and/or minerals used to replace intolerable foods, or certain infant formulas to supplement a deficient diet or to provide alternative nutrition.• Vitamins and/or minerals taken orally unless covered by the pharmacy benefit.• Enteral products and related supplies that are administered orally.
Oral Surgery	Services relating to the treatment of temporomandibular joint syndrome or temporomandibular joint disorders, with the exception of surgery for temporomandibular joint disease as noted in the covered benefits section.
Podiatry Services	Other than as necessary for the treatment of diabetes or medically necessary due to severe peripheral vascular disease.
Pregnancy Termination Services	Except those provided for under the Commonwealth of Pennsylvania laws.

CHIP Exclusions

**Public Facility/
Government** Care for conditions that federal, state, or local law requires to be treated in a public facility or services furnished by any level of government, unless coverage is legally required.

**Rehabilitative
Therapy for
Psychoneurotic
or Personality
Disorders**

None.

**Reversal of
Voluntary
Sterilization
Procedures**

None.

**Services
Provided without
the Required
Prior
Authorization**

None.

**Sex
Reassignment
Services and
Procedures**

None.

**Surrogate
Motherhood**

All services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to the conception and prenatal through postnatal care of a member acting as a surrogate mother.

CHIP Exclusions

Transplants/ Organ Donation

- Experimental or investigative transplants.
- Services required by a member related to organ donation when the member serves as the organ donor unless the recipient is covered by CHIP.
- Services required by a donor when benefits are available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits not available from another source, and provided to the donor, will be charged against the member's coverage.
- No payment will be made for human organs that are sold rather than donated.

Transportation for Routine or Non-Emergent Purposes

None.

Vision-Specific Exclusions

- Coverage for medical or surgical treatment, drugs or medications, nonprescription lenses, examinations, training procedures, or materials not listed as a CHIP benefit.
- Procedures that are special or unusual, such as, but not limited to: orthoptics, vision training, subnormal vision aids, and tonography.
- Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames, except at intervals specified in the CHIP Summary of Benefits.
- Services or materials provided by federal, state, or local government or workers' compensation.
- Sunglasses (plain or prescription), industrial (3mm) safety lenses, and safety frames with side shields.
- Surgery to correct myopia, hyperopia, astigmatism, and radial keratotomy.

Weight Reduction

Bariatric surgery, anti-obesity medication, including, but not limited to, appetite suppressants and lipase inhibitors.

Disease and Case Management Programs

Disease and Case Management programs that provide specific information and communications to members with certain health conditions. They are used to provide specialized support and education to assist members who are diagnosed with certain conditions that require specific self-care efforts. Disease management helps improve a member's quality of life by preventing or minimizing the effects of a disease or condition, and also helps to reduce health care costs. These programs are free of charge to CHIP members who are eligible.

What Disease Management Programs Are Available?

CHIP members are eligible to participate in any of the following disease management programs:

- Asthma
- Diabetes
- Obesity
- Tobacco Cessation

Call Member Services at **1-800-414-9025, TTY/PA RELAY 711**, to find out more about the disease management programs available to your child.

How Can I Enroll My Child in a Disease Management Program?

UnitedHealthcare may automatically enroll your child in a disease or case management program if your child has certain diagnoses. Your child's PCP may also enroll your child in one of UnitedHealthcare's programs.

If your child is not currently enrolled in a program and you think that he or she would benefit from disease or case management services, or you would like more information about these programs, you may contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**.

Utilization Management

Utilization management is a process that UnitedHealthcare uses to manage the use of medical services to ensure that your child receives necessary, appropriate, high-quality care in a cost-effective manner. Decisions are based only on appropriateness of care and existing coverage. No UnitedHealthcare Community Plan employee or provider is rewarded in any way for making decisions about the care your child should or should not get or that could result in not enough care being given. UnitedHealthcare Community Plan also makes sure our providers give great care. Your child's doctor can ask for our decision-making procedures by calling Provider Services at 1-800-600-9007.

You may get more information about the utilization process and decisions on authorization by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**. You will be referred to a member of the utilization management staff who will be able to discuss why a certain decision was made and provide you with the criteria used to make that decision.

Evaluation of New Treatments and Technology

Member access to safe and effective care is important to us. We routinely evaluate new health care services, procedures, devices, and drug treatments to determine if they should be included as a CHIP benefit for our members. To be considered for coverage, the new treatment or technology must:

- Have final approval from the appropriate government regulatory bodies such as the Food and Drug Administration (FDA);
- Be supported by published scientific evidence that the treatment or technology has therapeutic value;
- Have helpful effects on health outcomes or health risks; and
- Provide a benefit that is the same as or greater than any current alternative.

We are committed to evaluating all new treatments and technologies that are requested by your child's doctor for your child's care. UnitedHealthcare medical directors, who consider new medical and scientific information as well as any applicable government requirements, review these requests. Any medically necessary treatment that is not considered experimental will be reviewed upon request. Both you and your child's doctor will be notified of UnitedHealthcare's decision.

Quality Improvement Program

UnitedHealthcare has a program in place to monitor and improve the care your child receives as a CHIP member. This includes care your child receives from participating providers as well as services and other programs made available to you and your child.

UnitedHealthcare works with participating providers to follow the guidelines, standards, and regulations of regulatory agencies and accrediting bodies including the Pennsylvania Departments of Health, Insurance, and Human Services; the federal Centers for Medicare and Medicaid Services; and the National Committee for Quality Assurance.

Some of the areas we monitor as part of our quality improvement program include:

- Credentialing and recredentialing of doctors and other providers;
- Preventive health care and opportunities to improve member wellness;
- Access to and satisfaction with care; and
- Utilization management.

If you would like more information about the UnitedHealthcare quality improvement program, please contact Member Services at **1-800-414-9025, TTY/PA RELAY 711**. UnitedHealthcare can provide you with a description of the program and an update on how UnitedHealthcare is doing in meeting any established goals.

You may also visit www.chipcoverspakids.com to view CHIP annual performance reports.

Privacy and Confidentiality

What Privacy and Confidentiality Rights Does My Child Have?

Your child has the right to have all of his or her personal information and records safeguarded and kept private and confidential. This includes both existing and former members of UnitedHealthcare. CHIP and UnitedHealthcare follow all the regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This law protects the privacy of a person's medical records and health information. CHIP and UnitedHealthcare also follow all other state and federal regulations regarding the privacy of medical records and health information.

What Kind of Information Is Covered by the Privacy and Confidentiality Policies of UnitedHealthcare?

Protected health information includes items such as your child's:

- Name;
- Address;
- Social Security number;
- Birth date;
- Health care services received;
- Premiums paid; and
- Medical record.

Under What Circumstances May UnitedHealthcare Legally Release My Child's Protected Health Information?

UnitedHealthcare may release your child's protected health information under the following circumstances:

- As required by law or court order;
- When you provide written authorization to release the information;
- In connection with any of the following actions by UnitedHealthcare:
 - To verify a member's coverage;
 - To arrange for health care treatment and services for your child;
 - To provide payment for health care treatment and services your child received;
 - To coordinate benefits, care, and claims payments between two insurers;
 - To share information as required by law in connection with a member's complaint or grievance;
 - To gather demographic data and other statistical information for use in UnitedHealthcare's quality improvement and utilization management programs;
 - For internal and external audits; and
 - To perform routine business operations necessary to provide your child with quality health care coverage.

Privacy and Confidentiality

What Should I Do if I Think My Child's Privacy Rights Have Been Violated?

If you think that your child's privacy rights have been violated, you may file a written complaint directly with UnitedHealthcare's Privacy Officer at:

UnitedHealthcare Government Programs
Privacy Office
MN006-W800
P.O. Box 1459
Minneapolis, MN 55440

or by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711.**

If you prefer, you may file a formal written complaint with the Secretary of the U.S. Department of Health and Human Services at the address given below. Your complaint must be in written form and must include your name and your child's name. Anonymous complaints will not be accepted.

Office of Civil Rights
Secretary of the U.S. Department of Health and Human Services
150 South Independence Mall West
Suite 372
Philadelphia, PA 19106-3499

How May I Learn More About HIPAA and My Child's Privacy Rights?

If you'd like to know more about HIPAA and your child's privacy rights, you may contact Member Services at **1-800-414-9025, TTY/PA RELAY 711.**

You may also learn more by visiting any of the following websites:

- UHCCommunityPlan.com
- www.chipcoverspakids.com/chip-resources/resources-for-consumers/
- www.hhs.gov/ocr
- www.dsf.health.state.pa.us

Fraud and Abuse

UnitedHealthcare has a hotline number that may be used to report a medical provider, facility, or business for suspected fraud or abuse. The hotline number is 1-877-766-3844, TTY/PA RELAY 711. Some common examples of fraud and abuse are:

- Billing or charging you for services that were not provided to your child.
- Offering you gifts or money to receive treatment or services.
- Offering you free services, equipment, or supplies in exchange for your ID card number.
- Providing services that your child doesn't really need.
- Physical, mental, or sexual abuse by medical staff.

Complaints and Grievances

Your comments are important to us. We continually work to improve the quality of the care and service that your child receives. If at any point you are not satisfied with responses from UnitedHealthcare or the services that your child received, you may ask to file a complaint or grievance. Your child's CHIP coverage will not be canceled because you filed a complaint or grievance.

Each process has two levels of internal review and the opportunity to appeal the decision to state agencies through an external review process. There is also an "expedited" or faster grievance review for situations where a decision needs to be made quickly due to your child's medical condition.

At any time during the complaint or grievance process, you have the right to choose someone to help you by acting on your behalf. This person is called your "member representative." If you want to appoint someone to be your member representative, you must notify UnitedHealthcare in writing. You will be sent a form to complete and return to us so that we can formalize your request. You can request that someone stop being your member representative or change your member representative in a complaint or grievance at any time by notifying UnitedHealthcare in writing.

If your problem relates to a grievance, your child's health care provider can, with your written consent, file the grievance for you.

At any time during the complaint or grievance process, you have a right to request a UnitedHealthcare employee be appointed to help you or your member representative in preparing the complaint or grievance. **This will not cost you anything.** The employee that will be appointed will not have been involved in any decisions which are the subject of your complaint or grievance, and they will be committed to act fairly on your behalf. When you file your complaint or grievance, you have the right to send UnitedHealthcare any written comments, records, documents, or other information you have regarding your complaint or grievance. UnitedHealthcare is committed to fully and fairly consider any material they receive from you.

If, at any time during the complaint or grievance process, you believe that UnitedHealthcare has misclassified a complaint or grievance, you may contact the Pennsylvania Department of Health or the Pennsylvania Insurance Department for their opinion as to whether your issue is a complaint or grievance. UnitedHealthcare will follow their decision and use whichever process the Department of Health or the Insurance Department indicates is most appropriate.

If, at any time, you feel that UnitedHealthcare is using administrative requirements, time frames, or other tactics to directly or indirectly discourage you or your member representative from using the complaint or grievance process, you may contact the Pennsylvania Department of Health or the Pennsylvania Insurance Department to investigate your concerns. The investigation of such allegations will not delay the processing of your complaint or grievance.

Complaints and Grievances

The contact information for these departments is as follows:

Bureau of Managed Care

Pennsylvania Department of Health

Health & Welfare Building, Room 912
625 Forster Street
Harrisburg, PA 17120

Telephone Number: 1-717-787-5193 or 1-888-466-2787, TTY/PA RELAY 711
AT&T Relay Service: 1-800-654-5984 (TTY)
Fax Number: 1-717-705-0947

OR

Bureau of Consumer Services

Pennsylvania Insurance Department

1209 Strawberry Square
Harrisburg, PA 17120

Telephone Number: 1-717-787-2317 or 1-877-881-6388, TTY/PA RELAY 711
Fax Number: 1-717-787-8585

You can contact Member Services at one of the following toll-free telephone numbers for more information regarding the filing and status of a complaint or grievance:

- **1-800-414-9025**
- **TTY/PA RELAY 711**

What Is a Complaint?

A complaint is when you are unhappy with the care or services provided to your child by a participating provider, benefit issues including exclusions, limitations, and non-covered benefits, or the operations and management policies of UnitedHealthcare. A complaint does not include decisions based on medical necessity or the appropriateness of a health care service for your child. Member Services can help you decide if your problem is a complaint or a grievance if you are unsure.

What Do I Need to Know About Filing a First Level Complaint?

- You or your member representative can file a first level complaint by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**, or by sending a letter to:

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

Complaints and Grievances

- You or your member representative must file your complaint within **45 days** of the event or from the date of your receipt of notice of UnitedHealthcare's decision.
- UnitedHealthcare will provide written notice to you or your member representative confirming the receipt of your complaint.
- A first level complaint initial review committee will review and investigate your complaint. No one who was involved in making the decision related to the issue will be involved.
- You and your member representative are entitled to access all information relating to the matter being complained of. UnitedHealthcare may charge a reasonable fee for reproduction of documents.
- You and your member representative have a right to provide written data or other material in support of your complaint.
- UnitedHealthcare will complete its review and investigation of the complaint and will arrive at its decision within **30 days** of receipt of the complaint.
- UnitedHealthcare will notify you or your member representative in writing of the decision of the initial review committee within **5 business days** of the committee's decision. The letter will include what decision was made and why, and how to request a second level review if you are dissatisfied with the decision rendered.

What Do I Need to Know About Filing a Second Level Complaint?

- To file a second level complaint, your complaint must have gone through the first level complaint process first.
- You or your member representative can file a second level complaint by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**, or by sending a letter to:
Grievance and Appeals Department
UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364
- You or your member representative must file your second level complaint within **45 days** from the date of your receipt of notice of UnitedHealthcare's first level complaint decision.
- You and your member representative have the right to appear before the second level review committee. The date and time of the review will be provided to you and your representative in writing at least **15 days** in advance of the scheduled date. Efforts will be made to be reasonably flexible in terms of time and travel distance in order to allow you to attend. If you cannot attend in person, you have the right to request that you be allowed to participate by conference call, telephone, or other appropriate means.
- UnitedHealthcare will complete the second level review and arrive at a decision within **45 days** of their receipt of the request for a second level review.

Complaints and Grievances

- UnitedHealthcare will notify you or your member representative of the decision of the second level review committee in writing within **5 business days** after the committee's decision. The letter will tell you what decision was made and why, and how to file an appeal with the Department of Health or the Insurance Department if you are dissatisfied with the decision rendered.

What Do I Need to Know About Filing a Complaint Appeal With the Department of Health or the Insurance Department?

- To file a complaint appeal with the Department of Health or the Insurance Department, your complaint must have gone through both the UnitedHealthcare first and second level complaint processes first.
- You or your representative can file a complaint appeal by sending a letter to one of the addresses below. If you wish, you can request to file the appeal in an alternative format. Staff will be made available to transcribe an oral appeal.

Bureau of Managed Care

Pennsylvania Department of Health

Health & Welfare Building, Room 912

625 Forster Street

Harrisburg, PA 17120

Telephone Number: 1-717-787-5193 or 1-888-466-2787, TTY/PA RELAY 711

AT&T Relay Service: 1-800-654-5984 (TTY)

Fax Number: 1-717-705-0947

OR

Bureau of Consumer Services

Pennsylvania Insurance Department

1209 Strawberry Square

Harrisburg, PA 17120

Telephone Number: 1-717-787-2317 or 1-877-881-6388, TTY/PA RELAY 711

Fax Number: 1-717-787-8585

- Your appeal must include the following information:
 - Your name, address, and telephone number;
 - UnitedHealthcare's name and your child's member ID number;
 - A brief description of the issue being appealed; and
 - A copy of the second level denial letter.
- You or your member representative must file your complaint appeal within **15 days** from the date of your receipt of notice of UnitedHealthcare's second level complaint decision.

Complaints and Grievances

- UnitedHealthcare will forward your complaint file and all material considered as part of the first two reviews within **30 days** of being requested to do so by the Department. Both UnitedHealthcare and you or your member representative may provide additional information for review and consideration by the Department. You or your member representative will be provided copies of any additional information UnitedHealthcare sends to the Department. If you or your member representative sends additional information to the Department, you or your member representative will also need to provide copies to UnitedHealthcare.

What Is a Grievance?

A grievance is different from a complaint. A grievance is filed when you disagree with a decision that concerns the medical necessity and appropriateness of a health care service.

You, your member representative, or a health care provider involved in your child's care can file the grievance. If your child's health care provider chooses not to pursue a grievance they have been assisting you with, they have **10 days** from the receipt of any denials or decision letters to notify you or your representative, if you have one, of their decision.

First and second level grievances are always reviewed by a licensed physician or licensed psychologist that practices in the same or a similar specialty as the area of medicine that your grievance pertains to. You will be notified if the physician or psychologist will not be present or included by telephone or videoconference at the actual review. If the physician or psychologist will not be present, you have the right to request a copy of their report. UnitedHealthcare will provide the physician's or psychologist's report to you at least **7 days** prior to the review date.

What Do I Need to Know About Filing a First Level Grievance?

- You can file a first level grievance by sending a letter to:
Grievance and Appeals Department
UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364
- A grievance should be filed in written form unless you are unable to do so because of a disability or language barrier. If this is the case, you can request that a staff member record your verbal grievance by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**.
- You, your member representative, or your child's health care provider must file your grievance within **45 days** of the date of your receipt of notice of UnitedHealthcare's decision.
- UnitedHealthcare will provide written notice to you, your member representative, or your child's health care provider confirming the receipt of your grievance.

Complaints and Grievances

- A first level grievance review committee will review and investigate your grievance. No one who was involved in making the decision related to the issue will be involved.
- You, your member representative, and your child's health care provider, if they were involved with filing the grievance, are entitled to access all information relating to the matter being grieved. UnitedHealthcare may charge a reasonable fee for reproduction of documents.
- You, your member representative, and your child's health care provider have a right to provide written data or other material in support of your grievance.
- UnitedHealthcare will complete its review and investigation of the grievance and will arrive at its decision within **30 days** of receipt of the grievance.
- UnitedHealthcare will notify you, your member representative, or your child's health care provider in writing of the decision of the review committee within **5 business days** of the committee's decision. The letter will include what decision was made and why, and how to request a second level review if you are dissatisfied with the decision rendered.

What Do I Need to Know About Filing a Second Level Grievance?

- To file a second level grievance, your grievance must have gone through the first level grievance process first.
- You can file a second level grievance by sending a letter to:
Grievance and Appeals Department
UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364
- A request for a second level grievance should be filed in written form unless you are unable to do so because of a disability or language barrier. If this is the case, you can request that a staff member record your verbal request for a second level grievance to be filed by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**.
- You, your member representative, or your child's health care provider must file your grievance within **45 days** of the date of your receipt of notice of UnitedHealthcare's decision.
- You, your member representative, and your child's health care provider, if they were involved with filing the grievance, have the right to appear before the second level review committee. The date and time of the review will be provided to you, your member representative, or your child's health care provider in writing at least **15 days** in advance of the scheduled date. Efforts will be made to be reasonably flexible in terms of time and travel distance in order to facilitate your attendance. If you cannot attend in person, you have the right to request that you be allowed to participate by conference call, telephone, or other appropriate means.
- UnitedHealthcare will complete the second level review and arrive at a decision within **45 days** of their receipt of the request for a second level review.

Complaints and Grievances

- UnitedHealthcare will notify you, your member representative, or your child's health care provider of the decision of the second level review committee in writing within **5 business days** after the committee's decision. The letter will include what decision was made and why, and how to file an appeal with the Department of Health if you are dissatisfied with the decision rendered.

What Do I Need to Know About Filing an External Grievance With the Department of Health?

- To file a request for an external grievance, your grievance must have gone through both the UnitedHealthcare first and second level grievance processes first.
- You can file an external grievance by sending a letter to:
Grievance and Appeals Department
UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364
- A request for an external grievance should be filed in written form unless you are unable to do so because of a disability or language barrier. If this is the case, you can request that a staff member record your verbal request for an external grievance to be filed by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**.
- Your request for an external grievance must include the following information:
 - Your name, address, and telephone number.
 - UnitedHealthcare's name and your child's member ID number.
 - A brief description of the issue being grieved.
 - A copy of the second level denial letter.
- You, your member representative, or your child's health care provider must file your external grievance within **15 days** from the date of your receipt of notice of the UnitedHealthcare's second level grievance decision.
- Within **5 business days** of receiving your request for an external grievance review, UnitedHealthcare will notify the Department of Health of your request for an external grievance and request that a Certified Utilization Review Entity (CRE) be assigned to conduct a review.
- Within **2 business days** of receiving a request for an external grievance review, the Department of Health will assign a CRE to review your grievance. You, your member representative, or your child's health care provider will be notified of the CRE that has been assigned to review your grievance. You have the right to request information about your assigned CRE's accreditation from the Department of Health. If the Department of Health fails to select a CRE within **2 business days** of receipt of a request for an external grievance review, UnitedHealthcare may designate a CRE to conduct the review from a list of CREs already approved by the Department of Health.
- You have **7 days** from the date on the notice of the assignment of the CRE to object either orally or in writing to the Department of Health about the CRE assigned if you feel there is a conflict of interest between the CRE and UnitedHealthcare. A conflict of interest exists if the CRE has or is entering into a contract with UnitedHealthcare.

Complaints and Grievances

- Within **15 days** of receipt of the request for an external grievance review, UnitedHealthcare shall forward the grievance file and all material considered as part of the first two reviews. Within this same **15-day** period, you, your member representative, or your child's health care provider will be provided with the list of documents being forwarded to the CRE for external grievance review.
 - You, your member representative, or your child's health care provider will have **15 days** from receipt of notice that the request for an external review was officially filed, to supply additional information to the CRE for consideration in the external review. You, your member representative, or your child's health care provider will have to also provide copies of this same information to UnitedHealthcare at this time.
 - The assigned CRE will review and issue a written decision to you, your member representative, or your child's health care provider within **60 days** of the filing of the request for an external grievance review. If the CRE initially assigned was objected to, the **60 days** will begin from when the reviewing CRE body was agreed upon. The letter will include what decision was made and why, and inform you that you, your member representative, or your child's health care provider have **60 days** from the receipt of the decision to appeal to a court of competent jurisdiction if you are dissatisfied with the decision rendered.
-

What Is an Expedited Grievance Review?

An expedited review is a procedure that is available to you if your child's life, health, or ability to regain maximum function, would be placed in jeopardy by any delay that might be caused by following the normal review process. You, your member representative, or your child's health care provider can request an expedited grievance review at any stage in the grievance review process if you feel your child's situation meets the criteria necessary for an expedited grievance review.

What Do I Need to Know About Requesting an Internal Expedited Grievance Review?

- A request for an internal expedited grievance review can be filed by calling Member Services at **1-800-414-9025, TTY/PA RELAY 711**.
- You can also file a request for an internal expedited grievance review by sending a letter to:
Grievance and Appeals Department
UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364
- In order to obtain an internal expedited grievance review, you will need to provide UnitedHealthcare with a certification, in writing, from your child's physician that your child's life, health, or ability to regain maximum function would be placed in jeopardy by any delay that might be caused by following the normal review process. The certification needs to include the clinical reasoning and facts to support the physician's opinion. The certification can be mailed to:

Complaints and Grievances

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

- You, your member representative, and your child's health care provider, have the right to appear before the internal expedited grievance review committee.
- UnitedHealthcare will attempt to provide the physician's or psychologist's reports relating to your grievance prior to the hearing if possible. If they cannot, the reports will be read into the record at the hearing and you will be provided with a copy of them at that time.
- The hearing will take place within **48 hours** of their receipt of the request for an internal expedited grievance review accompanied by a physician's certification. Efforts will be made to be reasonably flexible in terms of time and travel distance in order to facilitate your attendance. If you cannot attend in person, UnitedHealthcare will hold the hearing telephonically and ensure that all information presented at the hearing is read into the record.
- UnitedHealthcare will complete the internal expedited grievance review and arrive at a decision within **48 hours** of their receipt of the request for an internal expedited grievance review accompanied by a physician's certification.
- UnitedHealthcare will notify you, your member representative, or your child's health care provider of the decision of the internal expedited grievance review committee. The notification will include what decision was made and why, and the procedure for obtaining an external expedited grievance review if you are dissatisfied with the decision rendered.

What Do I Need to Know About Requesting an External Expedited Grievance Review?

- You, your member representative, or your child's health care provider will have **2 business days** from the receipt of the internal expedited grievance review decision to contact UnitedHealthcare to request an external expedited grievance review.
- Within **24 hours** of the receipt of your request for an external expedited grievance review, UnitedHealthcare will submit a request for an external expedited grievance review to the Department of Health.
- The Department of Health will assign a CRE within **1 business day** of receiving the request for the external expedited grievance review.
- UnitedHealthcare will transfer a copy of the case file to the assigned CRE on the **next business day**.
- The CRE will have **2 business days** to issue a decision to you, your member representative, or your child's health care provider. The notification will include what decision was made and why, and inform you that you, your member representative, or your child's health care provider have **60 days** from the receipt of the decision to appeal to a court of competent jurisdiction if you are dissatisfied with the decision rendered.

Helpful Definitions

Authorization: An approval for a service.

Benefit Period: The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by UnitedHealthcare. A charge is considered incurred on the date the service or supply was provided to the member. Benefit limits may be calculated based on either a calendar year or a policy year, that is, the one-year period that begins with your child's enrollment in CHIP.

Benefits: Services, procedures, and medications UnitedHealthcare will cover.

Calendar Year: A one-year period that begins on January 1 and ends on December 31.

Case Management: One-on-one help made available by UnitedHealthcare to provide education and coordination of benefits tailored to your child's individual needs.

Concurrent Care: Services rendered in an inpatient setting by a provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions.

Cosmetic Procedure: A medical or surgical procedure which is performed to improve the appearance of any portion of the body and from which no improvement in physiologic function may be expected.

Covered Service: A service or supply specified in this handbook for which benefits will be provided.

Custodial Care: Services to assist an individual in the activities of daily living such as walking, bathing, dressing, and feeding. It typically involves personal care that does not require the continuing attention of skilled, trained medical personnel.

Disenrollment: To stop your membership in UnitedHealthcare CHIP.

Drug Formulary: A listing of preferred prescription drugs and supplies covered by UnitedHealthcare. The UnitedHealthcare drug formulary is available upon request.

Effective Date: The date a member's coverage begins as shown on the records of UnitedHealthcare.

Fraud: A dishonest; i.e., knowingly or intentionally false, misleading, or incomplete, statement or act.

Home Infusion Therapy: The administration of parenteral, enteral, and intravenous solutions which are provided in the home setting.

Informed Consent: Consent you give to allow medical treatment, made with complete knowledge of all relevant facts including any risks involved and any available alternatives.

Limitations: The maximum frequency or age restrictions or monetary caps associated with a covered service.

Helpful Definitions

Medical Necessity: A service or benefit is medically necessary if it meets any one of the following standards:

- The service or benefit will or is reasonably expected to prevent the onset of an illness, condition or disability,
- The service or benefit will or is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability, and
- The service or benefit will help the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review or exception basis, must be in writing. This determination is based upon medical information provided by the member, the member's family or caretaker and the PCP, as well as any other providers, programs or agencies that have evaluated the member. All such determinations will be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service.

Member: A child who meets eligibility requirements for CHIP and is enrolled in UnitedHealthcare.

Non-Participating Provider: A provider of covered services who has not entered into a contractual agreement with UnitedHealthcare. Except in the case of an emergency, prior authorization from UnitedHealthcare may be required before a member receives services from a non-participating provider regardless of the type of service rendered.

Palliative Care: Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms, rather than striving to halt, delay, or reverse progression of the disease itself or provide a cure. The goal is to prevent and relieve pain and suffering.

Partial Hospitalization: The provision of medical, nursing, counseling, or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility licensed as a mental health or alcohol and/or drug abuse treatment program by the Pennsylvania Department of Health, designed for a member who would benefit from more intensive services than are offered in outpatient treatment but does not require inpatient care.

Participating Provider: A provider of covered services who has entered into a contractual agreement with UnitedHealthcare in order to provide care or supplies to members.

PCP: Primary Care Physician.

Plan: UnitedHealthcare.

Helpful Definitions

Primary Care Physician: A physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner, or in some cases, as an internist or a pediatrician to a member. Under certain circumstances, a specialist may act as member's PCP if the member child has significant special needs or certain diagnoses.

Provider: A medical professional such as a doctor, nurse, counselor, or physical therapist.

Provider Directory: A list of providers who participate with UnitedHealthcare to help take care of members' health care needs.

Prior Authorization: The process by which services are approved by UnitedHealthcare prior to the member receiving a covered service or treatment by certain specialists or nonparticipating providers. If prior authorization is required, typically, except in the case of a medical or dental emergency, claims for these services will not be paid for unless the prior authorization is obtained before the date of service.

Reconstructive Procedure/Surgery: Procedures, including surgical procedures performed on a structure of the body to restore or establish satisfactory bodily function or correct a functionally significant deformity resulting from disease, trauma, or a previous therapeutic process.

Referral: A special form of prior authorization used to allow the member to seek services from a specialist.

Respite Care: Palliative care given in a setting outside the member's home in order to provide a brief interval of relief for the member's primary caregiver, which is usually a family member.

Self-Referred Services: Services not provided by a member's PCP, but that do not require prior authorization or a referral in order to receive them.

Service Area: The geographic region that a member must live in to be enrolled in CHIP with UnitedHealthcare.

Specialist: A doctor or other health care provider that has specific, detailed training in a specialized medical field.

Substance Abuse: Any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency as evidenced by physical tolerance or withdrawal.

Surgery: The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, and other procedures.

Terminally Ill: An incurable and irreversible medical condition in an advanced state that will, in the opinion of a physician, ultimately result in a member's death regardless of any medical treatments provided.

Treatment: The care a member receives from providers.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2018.

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

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

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

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

How We Use or Share Your Information

We must use and share your HI with:

- You or your legal representative.
- Government agencies.

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

- **For Payment.** We may use or share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.

Privacy Notices

- **For Underwriting Purposes.** We may use your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may use your HI to send you appointment reminders and information about your health benefits.

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

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- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below.
 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

We will follow stricter laws that apply. The attached “Federal and State Amendments” document describes those laws.

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

Your Rights

You have the following rights.

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

Privacy Notices

Using Your Rights

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

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

¹ This Medical Information Notice of Privacy Practices applies to 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.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

Financial Information Privacy Notice

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

Effective January 1, 2018.

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

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

Privacy Notices

Questions About This Notice

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

² For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women’s and Children’s Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connexions HCl, LLC; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, 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; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; 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 Services LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions.

Privacy Notices

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

Revised: January 1, 2018.

The first part of this Notice (pages 93 – 96) 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.	AR, CA, DE, NE, NY, PR, RI, UT, 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 disclose 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

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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

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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, AR, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI



UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

UnitedHealthcare Community Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

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

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

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

- Qualified interpreters
- Information written in other languages

If you need these services, contact UnitedHealthcare Community Plan at **1-800-414-9025, TTY/PA RELAY 711.**

If you believe that UnitedHealthcare Community Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

UnitedHealthcare Community Plan
P.O. Box 30608
Salt Lake City, UT 84131-0364

The Bureau of Equal Opportunity
Room 223, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675
Phone: **717-787-1127, TTY/PA Relay 711**
Fax: **717-772-4366**, or
Email: **RA-PWBEOAO@pa.gov**

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, UnitedHealthcare Community Plan and the Bureau of Equal Opportunity are available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

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



ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: **1-800-414-9025, TTY/PA RELAY: 711.**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-414-9025, TTY/PA RELAY: 711.**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните по телефону **1-800-414-9025, TTY/PA RELAY: 711.**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-414-9025, TTY/PA RELAY: 711**。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-414-9025, TTY/PA RELAY: 711.**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-414-9025, TTY/PA RELAY: 711**

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-800-414-9025, TTY/PA RELAY: 711** ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-414-9025, TTY/PA RELAY: 711** 번으로 전화해 주십시오.

សូមចាប់អារម្មណ៍ ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសាឥតគិតថ្លៃ គឺអាចមានសម្រាប់បំរើជូនអ្នក ។ ចូរទូរស័ព្ទទៅលេខ **1-800-414-9025, TTY/PA RELAY: 711** ។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-414-9025, TTY/PA RELAY: 711.**

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် **1-800-414-9025, TTY/PA RELAY: 711** သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-414-9025, TTY/PA RELAY: 711.**

ATENÇÃO: se fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para **1-800-414-9025, TTY/PA RELAY: 711.**

লক্ষ্য করুন: আপনি যদি বাংলায় কথা বলেন, তাহলে আপনার জন্য বিনা খরচে ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। **1-800-414-9025, TTY/PA RELAY: 711** নম্বরে ফোন করুন।

KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime falas të ndihmës gjuhësore. Telefononi në **1-800-414-9025, TTY/PA RELAY: 711.**

सूचना: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. કોલ કરો **1-800-414-9025, TTY/PA RELAY: 711.**

