Welcome to the community.

Pennsylvania
Medicaid Member Handbook

1-800-414-9025, TTY: 711
MyUHC.com/CommunityPlan
Important Telephone Numbers

Member Services:
(8 a.m. to 5 p.m. Monday, Tuesday, Thursday and Friday, and 8 a.m. to 8 p.m. on Wednesday) 1-800-414-9025
TTY (Hard-of-hearing) 711

Special Needs Services 1-877-844-8844

Healthy First Steps 1-877-813-3417

Fraud and Abuse Hotline 1-877-401-9430

Website MyUHC.com/CommunityPlan

Address UnitedHealthcare Community Plan
1001 Brinton Road, Pittsburgh, PA 15221

Your Health Providers

Name: ____________________________ Phone: ____________________________
Name: ____________________________ Phone: ____________________________
Name: ____________________________ Phone: ____________________________
Emergency Room: __________________ Phone: ____________________________
Pharmacy: _________________________ Phone: ____________________________

If you have questions about your health plan, please call us. Our toll-free Member Services number is 1-800-414-9025, TTY: 711.
New Member Checklist

Getting started.
Welcome to UnitedHealthcare Community Plan. We are happy to have you as a member. As a new member, it’s important that you complete this checklist. It will help you get the most from your health plan right away.

Review member ID card.
A few days ago you should have received a member ID card in the mail. The card has the UnitedHealthcare Community Plan logo on it. You should have a separate ID card for each member of your family who is in our plan. If you did not get an ID card, or if the information on it isn’t right, call Member Services.

Take your UnitedHealthcare Community Plan ID Card with you when you go to the doctor or get a prescription. Keep this card with you at all times. This card is only for the person whose name is on the card. Never give your card to anyone else to use, not even your family.

Confirm or choose Primary Care Provider (PCP).
Your ID should have the name of a doctor on it. If you have seen this doctor and want to keep seeing this doctor, you don’t need to do anything. This will be your main doctor for all of your health needs.

If there isn’t a PCP’s name on your card, or if you want to change the doctor listed, call Member Services. We will help you pick a doctor in your area. If you already have a doctor, tell us your doctor’s name. If the doctor is in our network, you can keep seeing him or her.

Complete a health survey.
We will be calling you soon to welcome you to the plan and to explain your benefits. We will also help you take a survey about your health. This short survey helps us understand your health needs so that we can serve you better.

Schedule a first appointment with your doctor.
For good health, it’s important to have regular checkups with your doctor. Make an appointment to see your doctor within the next 30 days. Do not wait until you are sick.

Read your Member Handbook.
Read this Member Handbook and keep it handy. It tells about your health plan and programs to keep you healthy.
### 7 Health Plan Highlights
- Welcome to UnitedHealthcare Community Plan
- Your Primary Care Provider (PCP)
- More Information for Members
- Clinical Sentinel Hotline
- Language Help
- Member ID Cards
- ACCESS ID Card
- UnitedHealthcare Community Plan Member ID Card
- Eligibility and Enrollment
- Choosing a Health Plan
- Changing Plans
- Losing Coverage
- Single Provider and Pharmacy Lock-In
- Lock-In Appeal Process

### 15 Going to the Doctor
- Getting Care
- Choosing a PCP
- Changing Your PCP
- Continuity of Care
- Visiting Your PCP
- Referrals and Specialists
- Self-Referral Services
- Specialist as PCP
- Second Opinions
- Out-of-Plan Specialty Services
- Out-of-Area Services
- No Medical Coverage Outside of the United States
- Home Health Services
- Making Appointments
22 Benefits and Services
22 Covered Benefits
31 Benefit Limits
32 Non-Covered Services
33 Emergencies and Urgent Care
33 Emergency Care
34 Urgent Care
34 Hospital Care
35 Prescription Drugs
37 Dental
40 Vision
41 Women’s Health
41 Family Planning/Birth Control Services
41 Women, Infants and Children
42 Transportation
43 Making Health Decisions
43 Advance Directives
43 Living Will
44 Durable Power of Attorney for Health Care
44 Medical Necessity
45 Utilization Review Policies
45 New Procedures
45 Quality Improvement Program
46 Be the Driver of Your Health Care
46 Member Satisfaction – Make Your Voice Heard
46 Coordination of Benefits
47 Healthy Living
47 Preventive Services
47 Tobacco Cessation – to Help You Quit
47 Physical Exam
47 Pregnancy
48 The Baby Blues
48 Healthy First Steps
50 Mental Health/Drug and Alcohol Treatment
52 Children’s Health Services
52 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
53 Lead Screening Blood Test
53 Early Intervention Program
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>Other Plan Details</td>
</tr>
<tr>
<td></td>
<td>54  Additional Services</td>
</tr>
<tr>
<td></td>
<td>54  COMPASS Community Partner</td>
</tr>
<tr>
<td></td>
<td>54  Health Education Programs</td>
</tr>
<tr>
<td></td>
<td>54  Domestic Violence</td>
</tr>
<tr>
<td></td>
<td>54  Legal/Advocacy Help</td>
</tr>
<tr>
<td></td>
<td>55  Disease and Case Management Programs</td>
</tr>
<tr>
<td></td>
<td>55  Special Needs Services</td>
</tr>
<tr>
<td></td>
<td>55  Asthma</td>
</tr>
<tr>
<td></td>
<td>55  Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td></td>
<td>55  Congestive Heart Failure</td>
</tr>
<tr>
<td></td>
<td>56  Coronary Artery Disease</td>
</tr>
<tr>
<td></td>
<td>56  Diabetes</td>
</tr>
<tr>
<td></td>
<td>56  HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>57  Copayments and Billing</td>
</tr>
<tr>
<td></td>
<td>57  Copayments</td>
</tr>
<tr>
<td></td>
<td>59  If You Get a Bill</td>
</tr>
<tr>
<td></td>
<td>59  Complaints and Grievances</td>
</tr>
<tr>
<td></td>
<td>59  Complaints</td>
</tr>
<tr>
<td></td>
<td>63  Grievances</td>
</tr>
<tr>
<td></td>
<td>67  Expedited Complaints</td>
</tr>
<tr>
<td></td>
<td>68  Help With the Complaint and Grievance Processes</td>
</tr>
<tr>
<td></td>
<td>69  Department of Human Services Fair Hearings</td>
</tr>
<tr>
<td></td>
<td>72  Rights and Responsibilities</td>
</tr>
<tr>
<td></td>
<td>74  Fraud and Abuse</td>
</tr>
<tr>
<td></td>
<td>75  Important Terms</td>
</tr>
<tr>
<td></td>
<td>77  Privacy Notices</td>
</tr>
<tr>
<td></td>
<td>77  Medical Information</td>
</tr>
<tr>
<td></td>
<td>80  Financial Information</td>
</tr>
<tr>
<td></td>
<td>85  Personal Representative Authorization</td>
</tr>
</tbody>
</table>
Welcome to UnitedHealthcare Community Plan

Welcome.
Welcome to the community. UnitedHealthcare Community Plan is a health care plan for people eligible for Medical Assistance. UnitedHealthcare has offered quality health care to Philadelphia residents since 1989 through the HealthPASS program. Today, as a licensed health maintenance organization (HMO), UnitedHealthcare Community Plan works to improve the health and well-being of our members and their communities. With UnitedHealthcare Community Plan, you get all of your regular Medicaid benefits plus more services.

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

You may have a question before you get our call. Our Member Services can help you. We can answer your questions and help you get care. You can call Member Services toll-free at 1-800-414-9025, TTY: 711.

Our Member Services hours are from 8 a.m. to 5 p.m. Monday, Tuesday, Thursday and Friday, and 8 a.m. to 8 p.m. on Wednesday. If you call after hours, your call will be answered by voicemail. A representative will call you back in one business day.

Your Primary Care Provider (PCP).
You have a choice of a doctor. He or she will make sure you get the care you need to stay healthy. This doctor is called your primary care provider (PCP). Your PCP delivers main and preventive care and acts as your advocate when providing, recommending and arranging for care. You should see your PCP for all your medical needs. There are no limits on the number of times you may see your doctor. If your doctor thinks you need to see a specialist, he or she can help you find one in our network.

Inside the front cover of this book is a space to write down the names and phone numbers of your doctors.

If you have an emergency, call 911 for help, or go to the nearest emergency room so that you can be seen.
Helping you along the way.
You can call us any time, any day. Our toll-free Member Services phone is 1-800-414-9025, TTY: 711.
They will help you with anything related to your plan. They can:

• Explain your plan, options and choices.
• Answer questions about how to get care.
• Help you with any problems you have with your health care.
• Help you with PCP changes if you need a new PCP for any reason.
• Help you file a grievance or ask for a State Fair Hearing.

More Information for Members

Our website at MyUHC.com/CommunityPlan has more information. You can ask for this information by writing to us:

• Information on our board of directors.
• Confidentiality procedures.
• Description of the provider credentialing process.
• List of participating providers affiliated with participating hospitals.
• Coverage for a specifically identified drug.
• Prescription procedures including off-label use and non-formulary drugs.
• Copy of the formulary.
• Summary of reimbursement methods, excluding specific contract or provider financial arrangement information.
• Description of the quality management program.
• Other information required by Centers for Medicare and Medicaid Services, Department of Health or Pennsylvania Insurance Department to be disclosed.

To request this information, write to:
Member Services
UnitedHealthcare Community Plan
1001 Brinton Road
Pittsburgh, PA 15221
Clinical Sentinel Hotline

The Clinical Sentinel Hotline (CSH) is operated by The Department of Human Services (DHS) to make sure that your requests for medically necessary care and services sent to UnitedHealthcare Community Plan and your behavioral health MCO are responded to in a timely manner. The CSH helps all Medical Assistance consumers who are enrolled in the HealthChoices Program.

The CSH allows members to speak to nurses who work for the Department of Human Services (DHS). If you or your health care provider request medical care or services, and UnitedHealthcare Community Plan or your behavioral health managed care organization (MCO) has not responded in time to meet your needs, call the CSH. You can also call the CSH if UnitedHealthcare Community Plan or your behavioral health plan has denied you medically necessary care or services and will not accept your request to file a grievance. You can also call the CSH if you are having trouble getting shift home health services that have been authorized by UnitedHealthcare Community Plan.

You can call the CSH Monday through Friday between 9 a.m. and 5 p.m. To reach the CSH, call 1-800-426-2090. The CSH cannot provide or approve urgent or emergency medical care. If you believe you need urgent or emergency care, you should call your PCP or go to your local hospital.
Language Help

We can get you materials in a language or format that is easier for you. We have interpreters if your doctor does not speak your language. This is free when you speak to us or your doctors. If you do not speak English, call Member Services at 1-800-414-9025, TTY: 711. They will connect you with an interpreter.

If you have trouble hearing, the Telecommunications Relay Service (TRS) can help. This lets people with hearing or speech issues make phone calls. The service is free. Call 711 and give them the Member Services phone number: 1-800-414-9025. They will connect you to us.

If you need information in another language, call Member Services. You can also get information in large print, Braille or audio tapes.

For help to translate or understand this, call 1-800-414-9025, TTY: 711.

Spanish (español):
Si necesita ayuda para traducir o entender este texto, por favor llame al telefono 1-800-414-9025, TTY: 711.

Vietnamese (Tiếng Việt):
Để được giúp đỡ phiên dịch hoặc dễ hiểu rõ vấn đề này, xin gọi số 1-800-414-9025 (TTY: 711).

Russian (Русский):
Для помощи с переводом или разъяснением текста звоните 1-800-414-9025 (TTY: 711).

Chinese (中文):
如需翻译或了解此服务的协助，请拨打 1-800-414-9025 (聽障專線 [TTY]: 711)。

Cambodian (តាព្រ័ន្ធតូគឺកែត្រាគំរីប្រាកដ់ប្រាកដ់ករណីពលីប្រវត្តិប៉ះពង្ការនៃប្រជាជន 1-800-414-9025 (តារាវាសអងេះនោះរវាងក្តី [TTY]: 711)។

Member Services.
1-800-414-9025, TTY: 711
(available 24 hours a day, 7 days a week)
## Member ID Cards

### Your ACCESS ID card.
After you sign up for medical benefits, the Department of Human Services will send you a Pennsylvania ACCESS ID card. Check your ACCESS card as soon as it comes in the mail. If the information on this card is wrong, call your case worker at the County Assistance Office.

Your ACCESS card has a recipient number on it. This is the same number that UnitedHealthcare Community Plan uses to identify members. Providers must use the ACCESS card to see which benefits and services you can get. Carry this card at all times and use it when you get care. If you don’t have an ACCESS card, see or call your case worker at the County Assistance Office.

### Your UnitedHealthcare Community Plan member ID card.
Every UnitedHealthcare Community Plan member will get a UnitedHealthcare Community Plan member ID card. Show this ID card, your Pennsylvania ACCESS card and any other insurance cards every time you get health care or pharmacy services. Your member ID card will have your name, member number, your PCP's name and phone number. If you do not have a member ID card or need a new one, call Member Services at **1-800-414-9025**, **TTY: 711**. You can also call if the information on your card is wrong. Call your case worker at the County Assistance Office if your name, family size, address or phone number changes.

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### Member Information Card

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<td>Health Plan (80840)</td>
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<td>Member ID: 9999999999</td>
<td>PAPHCPC</td>
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<td>Subscriber Brown</td>
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<td>Medicaid ID: 9999999999</td>
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<td>PCP Name:</td>
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<td>Provider Brown</td>
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<td>PCP Phone: (999) 999-999999</td>
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| OPTUMRx                         |  |
| Rx Bin: 610494                  |  |
| Rx Grp: ACUPA                   |  |
| Rx PCN: 9999                    |  |

Copays and Limits May Apply to Some Services

UnitedHealthcare Community Plan for Families

Administered by UnitedHealthcare of Pennsylvania, Inc.

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<th>In an emergency go to nearest emergency room or call 911.</th>
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<tr>
<td>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 <a href="http://www.myuhc.com/communityplan">www.myuhc.com/communityplan</a> or call.</td>
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<tr>
<td>For Members: <strong>800-414-9025</strong> TTY <strong>711</strong></td>
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<td>For Providers: <a href="http://www.uhccommunityplan.com">www.uhccommunityplan.com</a> <strong>800-600-9007</strong></td>
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<td>Medical Claims: PO Box 6207, Kingston, NY, 12402</td>
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<td>Pharmacy Claims: OptumRx, PO Box 2904, Hot Springs, AR 71903</td>
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<td>For Pharmacists: <strong>877-305-8952</strong></td>
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Printed: 09/28/11
Eligibility and Enrollment

Choosing a health plan.
If you are choosing a health plan now, please read this handbook to learn more about UnitedHealthcare Community Plan. Benefit consultants at the HealthChoices Hotline can help you choose a health plan. They can answer your questions and help you enroll in UnitedHealthcare Community Plan. You can call the HealthChoices Hotline at 1-800-440-3989, TTY: 711.

Changing plans.
You may decide to voluntarily leave UnitedHealthcare Community Plan without giving a specific reason. If you are thinking of disenrolling because of a concern, we want you to give us a chance to resolve the problem. Just call Member Services at 1-800-414-9025, TTY: 711, and explain your concern. We will do everything we can to help.

If you still wish to disenroll from UnitedHealthcare Community Plan, you must call the HealthChoices Hotline at 1-800-440-3989. The benefit consultant will help you complete the disenrollment and tell you when your last day as a member of UnitedHealthcare Community Plan will be. This process can take 4 to 6 weeks.

 Losing coverage.
Your UnitedHealthcare Community Plan benefits cannot be canceled if you become sick. But you can be disenrolled from UnitedHealthcare Community Plan for other reasons.

You will be disenrolled if you lose your Medical Assistance benefits. If your Medical Assistance eligibility is restored within 6 months, you will automatically be re-enrolled with UnitedHealthcare Community Plan unless you call a benefit consultant to make another choice. You will also be disenrolled if you move out of the UnitedHealthcare Community Plan service area. Call your case worker or visit your County Assistance Office to find out what to do if you move.

If you have any questions about UnitedHealthcare Community Plan’s services and special programs, call Member Services at 1-800-414-9025, TTY: 711.
The Department of Human Services can also disenroll you for other reasons that may include:
- Placement in a nursing home facility for more than 30 days in a row.
- Change in status to a recipient group that is exempt from the HealthChoices program.
- Admittance into a juvenile detention center for more than 35 days in a row.
- Pennsylvania Department of Aging (PDA) waiver eligibility beyond 30 days in a row.
- Admission to a state facility, with the exception of public intermediate care offices and mental retardation.
- The recipient is in jail or placed in a youth development center.
- Admission to a state-operated psychiatric facility.

**Single provider and pharmacy lock-in.**
UnitedHealthcare Community Plan may limit how many pharmacies or doctors you can use. This is called a “lock-in.” Members in this program are given 1 pharmacy or PCP that they can use to get all of their prescriptions. If you are in this program and would like to change your assigned pharmacy or PCP, you can call Member Services at 1-800-414-9025, TTY: 711. UnitedHealthcare Community Plan may lock in members who, in a 6-month period:
- Allegedly altered a prescription,
- Reported their card used by another person,
- Used more than 3 pharmacies or 3 physicians (same provider type),
- Received several prescriptions from several doctors or have documented evidence of early fills and refills, or
- Frequently visited the ER without evidence of provider involvement.

Some situations in which a member may be enrolled in the lock-in program are:
- Pharmacy lock-in: A member has visited 7 different pharmacies in the past 2 months of a 6-month period.
- Pharmacy and PCP lock-in: A member visited 8 physicians and 5 pharmacies in a 6-month period.
- Voluntary lock-in: A member agrees to a voluntary lock-in because someone else filled prescriptions with his/her card.
Lock-in appeal process.
You may appeal your enrollment in the pharmacy or PCP lock-in programs by writing to DHS and asking for a fair hearing. You will need to ask this within 30 days of receiving our letter telling you about your lock-in. In your letter, please list your phone number. If you need help filing an appeal, call your local legal aid office. You can mail the appeal to:

Department of Human Services
Office of Medical Assistance Programs
Bureau of Program Integrity
Recipient Restriction Section
P.O. Box 2675
Harrisburg, PA 17105-2675

If DHS receives your appeal within 10 days of the date of our notice, the proposed restrictions will not apply until your appeal is decided. If your appeal is received more than 10 days but less than 31 days from the date of this letter, the restrictions will be in effect until the outcome of your appeal. The Bureau of Hearings and Appeals will let you know, in writing, of the date, time and location of your hearing. You may not file a grievance or complaint through UnitedHealthcare Community Plan.
Getting Care

Choosing a PCP.
There are several kinds of doctors who may be PCPs:
- Family practice and general practice doctors who take care of adults and children.
- Internal medicine doctors who take care of adults.
- Pediatricians who treat children and teens.
- Nurse practitioners who take care of adults and children.

You can choose one doctor for the whole family, or you can pick a doctor for yourself and a pediatrician for your children. If you want more information about a doctor, call Member Services at **1-800-414-9025, TTY: 711**.

If you choose a group practice as your PCP, you may not always see the same PCP every time you visit. You may be scheduled with another doctor with that group practice. If this happens, your medical record will not change. This new doctor will have all of your medical records. Some clinics and doctor offices also have medical residents, nurse practitioners or physician assistants who care for members under the supervision of the PCP. The selection of certain group practice sites may result in medical residents, nurse practitioners and physician assistants providing care.

The provider directory lists all of the doctors who are in the UnitedHealthcare Community Plan provider network. If you need a provider directory, or information in another language, call Member Services at **1-800-414-9025, TTY: 711**. The provider directory is also on our website at [MyUHC.com/CommunityPlan](http://MyUHC.com/CommunityPlan). If you already have a PCP, call Member Services or visit the UnitedHealthcare Community Plan website to see if your doctor is in the UnitedHealthcare Community Plan network.

Changing your PCP.
We want you to be happy with your PCP choice. You should stay with the same doctor so your PCP gets to know you and your health. But, you can change your PCP at any time. To change your PCP, call Member Services at **1-800-414-9025, TTY: 711**. Member Services can also tell you how UnitedHealthcare Community Plan chooses network providers and checks their credentials.

If you need a provider directory, call Member Services at **1-800-414-9025, TTY: 711**. The provider directory is also on our website at [MyUHC.com/CommunityPlan](http://MyUHC.com/CommunityPlan). You can learn information about network doctors, such as board certifications, medical school and residency program attended, and languages they speak, at [MyUHC.com/CommunityPlan](http://MyUHC.com/CommunityPlan), or by calling Member Services.
Go to the Doctor

If your PCP leaves the UnitedHealthcare Community Plan network, we will let you know so that you can choose a new PCP. You will have at least 10 days to choose a new UnitedHealthcare Community Plan PCP. If you do not choose a new PCP in 10 days, we will choose a PCP for you. We will send you a letter with the name of your PCP. If you want a different PCP, you can change your PCP at any time by calling Member Services.

After you choose a new PCP, we will mail you a new ID card. This ID card will list your new PCP’s name and phone number. Remember to have your medical records transferred to your new Doctor’s offices.

Continuity of care.
UnitedHealthcare Community Plan wants to make sure all members undergoing a course of treatment can complete their treatments. New UnitedHealthcare Community Plan members can see their old doctor for up to 60 days, even if that doctor is not part of our network. We may extend the 60-day period if the treatment is clinically appropriate. UnitedHealthcare Community Plan will make arrangements with the treating physician and you can continue treatment if:

- You are a new member and have an ongoing course of treatment with a non-participating provider.
- UnitedHealthcare terminates a contract with a participating provider for reasons other than cause.

If you are already pregnant when you join UnitedHealthcare Community Plan, you can see the same obstetrics/gynecology (OB/GYN) specialist for all your pregnancy and postpartum care, even if that doctor is not in our network.

Visiting your PCP.
UnitedHealthcare Community Plan wants to help you stay healthy. As a new member, you should see your PCP as soon as possible. You and your PCP need to get to know each other. This way, when you get sick, your PCP will be able to give you better care. UnitedHealthcare Community Plan recommends that adults see the doctor at least once a year for a check-up. To make an appointment with a PCP, just call the phone number printed on your UnitedHealthcare Community Plan ID card and ask for an appointment.

Here are some things your doctor may do during your visit:
- Check your blood pressure, height and weight.
- Listen to your heart.
- Give you a physical exam.
- Check your body mass index (BMI) and talk to you about healthy eating habits.
- Complete health screenings based on your age and gender.
- Order lab tests to check your blood sugar and cholesterol levels.
Women.
- Perform a breast exam or Pap test.
- Give you a prescription for a mammogram (age 50 – 74).
- Tell you how to do self-breast exam (starting at age 20).

Men.
- Give you a prostate exam.
- Tell you how to do a self-testicular exam.

Your PCP may also:
- Review the medicines you are taking.
- Recommend follow-up and specialist care.
- Review your immunizations.
- Talk to you about your family medical history.
- Recommend an exercise program.
- Remind you about vision screenings and dental exams.
- Talk to you about domestic violence.
- Discuss sun exposure.
- Give you tips to reduce stress.
- Discuss the use of seat belts.
- Give you information on family planning and sexually transmitted diseases.
- Advise you about substance abuse and mental health.
- Talk to you about quitting smoking.

Write down all your questions before your appointment. Follow all of the directions that your PCP gives you. It is your responsibility to follow the treatment plan that you and your PCP agree on.

If you are sick or hurt, see your PCP as soon as possible. If you think you may be pregnant, see your PCP or an OB/GYN right away. If you have diabetes, asthma, heart disease, sickle cell disease or high blood pressure, you should see your doctor as often as he/she recommends. Your children also need to see the doctor regularly, too.

You may call your PCP’s office any time. Your PCP can give you general health information and tell you if you need medical care. If you feel very sick, call right away. If it cannot wait, you may call your doctor 24 hours a day. If no one answers, leave a message and he/she will call you back quickly.
Referrals and specialists.
Sometimes, your PCP may think that your health needs special medical care. Your PCP may send you to a specialist. A specialist is a doctor who has advanced training for certain illnesses or conditions. UnitedHealthcare Community Plan covers treatments by specialists as long as your PCP approves the care.

When your PCP sends you to see a specialist, it is called a referral. Your PCP will suggest a specialist and help you make an appointment with that specialist. There are some specialist services that your PCP does not need to give you a referral for, called self-referral services. If you think you need to see a specialist, talk to your PCP about it. If you think your PCP is not referring you to the specialist you need, call Member Services.

The specialists in the UnitedHealthcare Community Plan network are listed in our provider directory. If you need a provider directory, call Member Services at 1-800-414-9025, TTY: 711. The provider directory is also on our website at MyUHC.com/CommunityPlan.

Self-referral services.
Most of the time, you must call your PCP for medical care. But there are some kinds of care that you can get without seeing your PCP. These are called self-referral services.

If you have any questions about these self-referral services, call Member Services at 1-800-414-9025, TTY: 711. UnitedHealthcare Community Plan self-referral services are listed below:

- AIDS waiver services.
- Case management.
- Dental exams and services.
- Emergency care.
- Emergency ambulance transportation.
- EPSDT screenings and services.
- Family planning services.
- Healthy Beginnings Plus (first prenatal visit).
- Obstetrician/gynecologist visits.
- PCP office visits.
- Vision exams.

You can use your Pennsylvania ACCESS card for family planning and birth control services. Call a self-referral provider who accepts Medical Assistance for an appointment. You must get all other self-referral services from UnitedHealthcare Community Plan providers who are listed in the provider directory.
Specialist as PCP.
Some members with very specialized health care needs can ask for their specialist to be their PCP. Members can ask for this by calling Member Services at 1-800-414-9025, TTY: 711, or their case manager. UnitedHealthcare Community Plan will get written confirmation from the specialist that they will accept all of the responsibilities of a PCP for you. Once this is approved, UnitedHealthcare Community Plan will send you a new ID card with your new PCP’s name and phone number on it.

Second opinions.
At UnitedHealthcare Community Plan, you have the right to a second opinion about any medical service or non-emergency surgery you choose to have. To arrange for a second opinion, call your PCP. Through a second opinion, you may get the facts you need to make treatment decisions. This may give you the chance to learn about other options and possible problems if you do not get treatment.

Out-of-plan specialty services.
Sometimes you will need to be referred for very specialized care. If UnitedHealthcare Community Plan cannot give you a choice of two specialists in our network, we may allow you to see an out-of-network provider, and if approved this out-of-network service may continue for as long as we are unable to provide the service in-network. Authorized out-of-network services are available to you at no greater cost to you than if they were provided in-network.

Your doctor must ask for a prior authorization by calling 1-800-366-7304. If an out-of-network authorization is denied, you may file a complaint or grievance.

Out-of-area services.
If you are traveling out of the service area and need specialist care, UnitedHealthcare Community Plan will work with your PCP to find the right care for you. UnitedHealthcare Community Plan will cover the costs for any emergency care you get, even if you are out of the service area. You are also covered if you must be admitted to a hospital. Give the name and telephone number of your PCP to the emergency room staff. You must call your PCP or Member Services at 1-800-414-9025, TTY: 711, within 24 hours of the emergency. However, your PCP must approve follow-up care or any routine visits for UnitedHealthcare Community Plan to cover the visits.

No medical coverage outside of the United States.
If you are outside of the United States and need medical care, any health care services you receive will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services you receive outside of the United States.

Home health services.
For some illnesses, you may need to get treatment at home after going to the hospital. This way, you can stay in the comfort of your own home and still get the medical care you need. If you need home health services, ask your PCP about home health care from UnitedHealthcare Community Plan.
## Making Appointments

Your PCP does not know how long it will take to see each person, so be patient if you have to wait. If you feel you have to wait too long at your PCP’s office or to get an appointment, call Member Services at **1-800-414-9025, TTY: 711.** For a regular check-up, you may have to wait two to three weeks. If you have a problem that cannot wait, your doctor will see you within 24 hours. When you call, tell the doctor why you need to see him or her. Your doctor will decide how quickly he/she needs to see you.

It is very important to arrive on time for your appointments. If you will be late or cannot make your appointment, call the doctor’s office so you can set a new time or day. Some PCPs allow walk-in visits without appointments. Walk-ins may have to wait longer to see the PCP. Call your PCP to learn if s/he allows walk-ins.

<table>
<thead>
<tr>
<th>We will make an appointment for you:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members with HIV/AIDS</strong></td>
</tr>
<tr>
<td>with a PCP or specialist no later than 7 days after you become a member of UnitedHealthcare Community Plan, unless you are already being treated by a PCP or specialist.</td>
</tr>
<tr>
<td><strong>Members who receive supplemental security income (SSI)</strong></td>
</tr>
<tr>
<td>with a PCP or specialist no later than 45 days after you become a member of UnitedHealthcare Community Plan, unless you are already being treated by a PCP or specialist.</td>
</tr>
<tr>
<td><strong>Members under age 21</strong></td>
</tr>
<tr>
<td>with a PCP for an EPSDT screen no later than 45 days after you become a member of UnitedHealthcare Community Plan, unless you are already being treated by a PCP or specialist.</td>
</tr>
<tr>
<td><strong>All other members</strong></td>
</tr>
<tr>
<td>with a PCP, no later than 3 weeks after you become a member of UnitedHealthcare Community Plan.</td>
</tr>
<tr>
<td>Appointment with:</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td>PCP – urgent medical condition</td>
</tr>
<tr>
<td>PCP – routine appointment</td>
</tr>
<tr>
<td>PCP – health assessment or general physical exam</td>
</tr>
<tr>
<td>Specialist – urgent medical condition</td>
</tr>
<tr>
<td>Specialist – routine appointment</td>
</tr>
<tr>
<td>If you are pregnant, during:</td>
</tr>
<tr>
<td>First trimester</td>
</tr>
<tr>
<td>Second trimester</td>
</tr>
<tr>
<td>Third trimester</td>
</tr>
<tr>
<td>High-risk pregnancies</td>
</tr>
</tbody>
</table>

Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.
# Covered Benefits

<table>
<thead>
<tr>
<th>Services</th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Must meet current federal and state guidelines and be medically necessary.</td>
<td>Must meet current federal and state guidelines and be medically necessary.</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Audiology</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Autism Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers (ASCs)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>May require prior authorization. Depends on service.</td>
<td>May require prior authorization. Depends on service.</td>
</tr>
<tr>
<td>Birth Control Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Bone Mass Measurement (Bone Density)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>CRNP</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Crisis Support</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Colorectal Screening Exams</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Services</td>
<td>Children</td>
<td>Adults</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed for some services.</td>
<td>Prior authorization needed for some services.</td>
</tr>
<tr>
<td><strong>Diabetic Education, Home Visits and Monitoring</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Diabetic Supplies and Equipment</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed if over $500.</td>
<td>Prior authorization needed if over $500.</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>EPSDT Services and Immunizations (Under Age 21)</strong></td>
<td>Covered.</td>
<td>Not Covered.</td>
</tr>
</tbody>
</table>

Key Limitations:
- Dentures 1 per lifetime;
- Exams/prophylaxis 1 per 180 days;
- Crowns, periodontics and endodontics only via approved benefit limit exception.
<table>
<thead>
<tr>
<th>Services</th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eyeglasses/Contact Lenses</strong></td>
<td>Daily-wear contacts or standard glasses (in-plan frames):</td>
<td>Daily-wear contacts or standard glasses (in-plan frames):</td>
</tr>
<tr>
<td></td>
<td>Members under age 21 are covered for 4 lenses and 2 frames per year.</td>
<td>Members age 21 and over are covered for 2 lenses and 1 frame per year.</td>
</tr>
<tr>
<td></td>
<td>Regular single vision, bifocal or trifocal lenses.</td>
<td>Regular single vision, bifocal or trifocal lenses.</td>
</tr>
<tr>
<td></td>
<td>Polycarbonate lenses:</td>
<td>Polycarbonate lenses:</td>
</tr>
<tr>
<td></td>
<td>Covered.</td>
<td>Covered for adults who are blind in one eye and +/-6.00 prescription.</td>
</tr>
<tr>
<td></td>
<td>In-plan frames are covered in full. Out-of-plan frames are covered up to</td>
<td>In-plan frames are covered in full. Out-of-plan frames are covered up to</td>
</tr>
<tr>
<td></td>
<td>$20; member must pay cost over $20.*</td>
<td>$20; member must pay cost over $20.*</td>
</tr>
<tr>
<td></td>
<td>One pair soft daily wear contacts or medically necessary contact covered</td>
<td>One pair soft daily wear contacts or medically necessary contact covered</td>
</tr>
<tr>
<td></td>
<td>in lieu of glasses, including contact lens exam/evaluation.</td>
<td>in lieu of glasses, including contact lens exam/evaluation.</td>
</tr>
<tr>
<td></td>
<td>Medically necessary contact lenses are covered when such lenses provide</td>
<td>Medically necessary contact lenses are covered when such lenses provide</td>
</tr>
<tr>
<td></td>
<td>better management of a visual or ocular condition than can be achieved</td>
<td>better management of a visual or ocular condition than can be achieved</td>
</tr>
<tr>
<td></td>
<td>with spectacle lenses, including, but not limited to the diagnosis of:</td>
<td>with spectacle lenses, including, but not limited to the diagnosis of:</td>
</tr>
<tr>
<td></td>
<td>Unilateral Aphakia; or Keratoconus when vision with glasses is less than</td>
<td>Unilateral Aphakia; or Keratoconus when vision with glasses is less than</td>
</tr>
<tr>
<td></td>
<td>20/40; or Corneal transplant when vision with glasses is less than 20/40;</td>
<td>20/40; or Corneal transplant when vision with glasses is less than 20/40;</td>
</tr>
<tr>
<td></td>
<td>or Anisometropia that is greater than or equal to 4.00 diopter.</td>
<td>or Anisometropia that is greater than or equal to 4.00 diopter.</td>
</tr>
<tr>
<td></td>
<td>Medically necessary exceptions can be made for children under 21.</td>
<td></td>
</tr>
</tbody>
</table>

*This allowance applies at retail locations such as Walmart, and may not be available at independent provider locations.*
<table>
<thead>
<tr>
<th>Services</th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center/Rural Health Clinic</td>
<td>Covered.</td>
<td>Covered (except for dental services as defined above).</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Hearing Aids and Batteries</td>
<td>Covered.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Hearing Aids and Batteries Prior authorization needed.</td>
<td>Prior authorization needed.</td>
<td>Prior authorization needed.</td>
</tr>
<tr>
<td>Home Assessment</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Home Health Care and Infusion Therapy</td>
<td>Covered.</td>
<td>Unlimited first 28 days; 15 days per month following.</td>
</tr>
<tr>
<td>Home Health Care and Infusion Therapy Prior authorization needed.</td>
<td>Prior authorization needed.</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Hospice Care Respite care may not exceed a total of 5 days in a 60-day certification period.</td>
<td>Covered.</td>
<td>Respite care may not exceed a total of 5 days in a 60-day certification period.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Incontinence Supplies</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Independent Clinic</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Inpatient Drug and Alcohol Please contact your Behavioral Health MCO (see page 50).</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
<td></td>
</tr>
<tr>
<td>Inpatient Acute Hospital</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed for non-emergent admission.</td>
<td>Prior authorization needed for non-emergent admission.</td>
</tr>
<tr>
<td>Services</td>
<td>Children</td>
<td>Adults</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Hospital</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed.</td>
<td>Prior authorization needed.</td>
</tr>
<tr>
<td>Inpatient Psychiatric Hospital</td>
<td>Please contact your Behavioral</td>
<td>Please contact your Behavioral</td>
</tr>
<tr>
<td></td>
<td>Health MCO (see page 50).</td>
<td>Health MCO (see page 50).</td>
</tr>
<tr>
<td>Intermediate Care Facility (IID/ORC)</td>
<td>Please contact your Behavioral</td>
<td>Please contact your Behavioral</td>
</tr>
<tr>
<td></td>
<td>Health MCO (see page 50).</td>
<td>Health MCO (see page 50).</td>
</tr>
<tr>
<td>Lab Tests and X-rays</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Mammograms</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Mobile Mental Health Treatment</td>
<td>Please contact your Behavioral</td>
<td>Please contact your Behavioral</td>
</tr>
<tr>
<td></td>
<td>Health MCO (see page 50).</td>
<td>Health MCO (see page 50).</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Methadone Maintenance</td>
<td>Please contact your Behavioral</td>
<td>Please contact your Behavioral</td>
</tr>
<tr>
<td></td>
<td>Health MCO (see page 50).</td>
<td>Health MCO (see page 50).</td>
</tr>
<tr>
<td>Non-Emergency Medical Transport</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Some services provided by</td>
<td>Some services provided by</td>
</tr>
<tr>
<td></td>
<td>MATP. Please see page 42.</td>
<td>MATP. Please see page 42.</td>
</tr>
<tr>
<td>Nutritional Supplements</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Optometrist Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Eyeglass or contact lens exams:</td>
<td>Eyeglass or contact lens exams:</td>
</tr>
<tr>
<td></td>
<td>two each year.</td>
<td>two each year.</td>
</tr>
<tr>
<td>Outpatient Drug and Alcohol Services</td>
<td>Please contact your Behavioral</td>
<td>Please contact your Behavioral</td>
</tr>
<tr>
<td></td>
<td>Health MCO (see page 50).</td>
<td>Health MCO (see page 50).</td>
</tr>
<tr>
<td>Outpatient Hospital Clinic</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Services</td>
<td>Children</td>
<td>Adults</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Psychiatric Clinic</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
</tr>
<tr>
<td>Organ Transplant Evaluation</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed.</td>
<td>Prior authorization needed.</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Covered.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed.</td>
<td></td>
</tr>
<tr>
<td>Orthopedic Shoes</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Pain Clinic Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>May require prior authorization. Depends on service.</td>
<td>May require prior authorization. Depends on service.</td>
</tr>
<tr>
<td>Pap Smears and Pelvic Exams</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
</tr>
<tr>
<td>Physician Office Visits (Including Medical/Surgical Services Provided by a Dentist)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Podiatrist Services: Medically Necessary, Routine and Preventive</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>May require prior authorization. Depends on service.</td>
<td>May require prior authorization. Depends on service.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Services</td>
<td>Children</td>
<td>Adults</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed.</td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer Screenings</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed for</td>
<td>Prior authorization needed for</td>
</tr>
<tr>
<td></td>
<td>items with a value greater than</td>
<td>items with a value greater than</td>
</tr>
<tr>
<td></td>
<td>$500.00.</td>
<td>$500.00.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Orthopedic Shoes and Hearing Aids are not covered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coverage for low vision aids is limited to 1 per 2 calendar years.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coverage for an eye ocular is limited to 1 per calendar year.</td>
</tr>
<tr>
<td>Psychiatric Partial Hospital</td>
<td>Please contact your Behavioral</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
</tr>
<tr>
<td></td>
<td>Health MCO (see page 50).</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Radiology Scans (PET, MRI, MRA, CT)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed.</td>
<td>Prior authorization needed.</td>
</tr>
<tr>
<td>Renal Dialysis (Kidney Treatment)</td>
<td>Covered.</td>
<td>Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.</td>
</tr>
<tr>
<td>Reproductive Health (Procedures and Devices)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Services</td>
<td>Children</td>
<td>Adults</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
</tr>
<tr>
<td>(Non-Hospital Residential D&amp;A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Opinions (Medical and Surgical)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Short Procedure Unit (SPU)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>May require prior authorization.</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Depends on service.</td>
<td>Depends on service.</td>
</tr>
<tr>
<td>Skilled Nursing Care (Home Visits)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed.</td>
<td>Prior authorization needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limits may apply.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization needed.</td>
<td>Prior authorization needed.</td>
</tr>
<tr>
<td>Targeted Case Management – Behavioral Health</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
<td>Please contact your Behavioral Health MCO (see page 50).</td>
</tr>
<tr>
<td></td>
<td>Limited to individuals identified in the target group.</td>
<td>Limited to individuals identified in the target group.</td>
</tr>
<tr>
<td></td>
<td>Limited to individuals identified in the target group.</td>
<td>Limited to individuals identified in the target group.</td>
</tr>
<tr>
<td>Transportation Help</td>
<td>Available to and from MA Covered services.</td>
<td>Available to and from MA Covered services.</td>
</tr>
<tr>
<td></td>
<td>See information under MATP.</td>
<td>See information under MATP.</td>
</tr>
</tbody>
</table>
# Benefits and Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco Cessation Counseling</strong></td>
<td>Covered.</td>
<td>70 visits per calendar year.</td>
</tr>
<tr>
<td><strong>Therapy</strong>&lt;br&gt;(Physical, Occupational, Speech (PT, OT, ST))&lt;br&gt;Includes Rehabilitative and Habilitative</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
</tbody>
</table>
Benefit Limits

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

<table>
<thead>
<tr>
<th>Covered benefit</th>
<th>Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Coverage</td>
<td>Limited for all adults over 21.</td>
</tr>
</tbody>
</table>

Your provider can ask UnitedHealthcare Community Plan to approve services above these limits for you. This is called an exception. An exception can be granted if:

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

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

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

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

You will find more information about Dental Benefit Limits on page 37 of this Handbook.
Non-Covered Services

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

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

Emergency Care

If you have an emergency, go to an Emergency Room (ER). If you need help getting to the ER fast, call 911. You do not need a referral from your PCP to use the ER.

You can get emergency care 24 hours a day, 7 days a week. You should be seen within an hour to see the extent of your illness or injury. Call your PCP as soon as you can after getting emergency care.

What is an emergency?

Emergency means a condition with sudden acute symptoms of such severity that lack of fast care could result in:

- Placing the patient’s health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, jeopardy to the health of a woman or her unborn child.

If you have an emergency, call 911 or go to the nearest ER.

Examples of emergencies:

- Severe pain.
- Convulsions.
- Unconsciousness.
- Severe or unusual bleeding.
- A serious accident.
- A suspected heart attack or stroke.
- For a pregnant woman, having contractions.

If you have an emergency, call 911 for help, or go to the nearest emergency room so that you can be seen. You can get emergency care 24 hours a day, 7 days a week.
Here are some examples of what is NOT generally an emergency:

- Colds and flu.
- Headaches.
- Sore throats.
- Bruises or minor cuts.
- Rashes.

Urgent Care

Urgent Care is not emergency care. It is care that is needed sooner than a normal appointment. Call your PCP if you have a medical issue that is not an emergency.

For the following conditions, contact your PCP:

- Fever.
- Infections.
- Symptoms of cold or flu.

Hospital Care

Unless you are admitted to the hospital directly from the emergency room, your PCP or specialist will decide if you need to go to the hospital. If you do, your PCP will arrange it for you. All covered services will be provided.
**Prescription Drugs**

**Prescription drugs.**
If you have prescription drug coverage through the Medical Assistance (MA) program, your UnitedHealthcare coverage will follow the same rules as your MA. If you have copays or benefit limits under MA, you will have the same copays or limits.

**Drug formulary.**
UnitedHealthcare Community Plan uses a list of medications called a preferred drug list (PDL), also called a drug formulary, for your prescription coverage. A formulary is a list of medicines that UnitedHealthcare Community Plan will pay for when the medicine is prescribed by your provider. The formulary helps your doctor prescribe medicines for you. New drugs and forms of medication are added every year. UnitedHealthcare Community Plan will add drugs to its formulary as needed. You can ask for a copy of the formulary by calling Member Services at **1-800-414-9025**, TTY: 711, or visiting [MyUHC.com/CommunityPlan](http://MyUHC.com/CommunityPlan).

Most medicines used by UnitedHealthcare Community Plan members are on our formulary. If you do not see your medicine on the list, have your doctor call the UnitedHealthcare Community Plan Pharmacy Department. You can call your doctor, pharmacist or Member Services to see if your medicine is covered. The formulary has brand name and generic drugs. Generic drugs are medications sold without a brand name. For example, the generic name for Advil is ibuprofen. Generic drugs will be used when possible.

If a drug is not listed on the formulary, your doctor may ask for a prior authorization for you to get it. UnitedHealthcare Community Plan has 24 hours from the time a request is received to approve or deny the non-formulary drug. If a request for an exception to the PDL is denied, you and your doctor will be informed of the decision in writing. The written decision notice will explain how and when to file a complaint or grievance with UnitedHealthcare Community Plan, or ask for a Fair Hearing with the Department of Human Services (DHS).

If you have questions about the drug formulary, call your doctor, pharmacist or Member Services at **1-800-414-9025**, TTY: 711.

**Temporary supplies.**
You can get up to a 5 day temporary supply of a medicine that is not on our formulary, as long as it is covered by Pennsylvania Medical Assistance. If you have already been taking the medicine, you may receive up to a 15-day temporary supply of the medicine as long as it is covered by Pennsylvania Medical Assistance. Your doctor will have to request a prior authorization for the drug as soon as possible, though.
Prescription drug copays.
The table below lists the copays that you may be charged. If you are under 18 years of age, pregnant or in a nursing home, you do not have copays.

<table>
<thead>
<tr>
<th>Program/Category</th>
<th>Copays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Assistance</td>
<td>$1 Generic; $3 Brand</td>
</tr>
</tbody>
</table>

The following classes of drugs do not have copays. If you are not sure whether you have a copay, call Member Services at **1-800-414-9025, TTY: 711**.

- AIDS drugs.
- Anticonvulsants.
- Antidiabetics.
- Antiglaucoma drugs.
- Antihypertensives.
- Antineoplastics.
- Antiparkison drugs.
- Antipsychotics.
- Cardiovascular preparations.

You need a written prescription from your PCP or specialist to have your prescription filled. Many generic over-the-counter medicines are covered as long as you have a prescription. Just take your prescription to a UnitedHealthcare Community Plan participating pharmacy. Call Member Services at **1-800-414-9025, TTY: 711**, and someone will help you find a participating pharmacy near you. If you take your prescription to a health care provider who is not a UnitedHealthcare Community Plan participating pharmacy, you will be responsible to pay for that medicine, except when:

- UnitedHealthcare Community Plan approved ahead of time for you to get that prescription filled and pre-approval (prior authorization requirements were not met, or
- The provider writing the prescription and the pharmacy are your Medicare providers, or
- The provider writing the prescription and the pharmacy are your providers for other insurance you have.
Dental

Dental services for members under 21.
Children under age 21 can get all medically needed dental services. Your child can go to any dentist in the UnitedHealthcare Community Plan network. You can find a dentist in your area by using our online provider directory at [MyUHC.com/CommunityPlan](http://MyUHC.com/CommunityPlan), or by calling Member Services **1-800-414-9025, TTY: 711.** Your child does not need a referral for a dental visit.

Dental services covered for children under age 21 include the following, when medically needed:

- Anesthesia.
- Check-ups.
- Cleanings.
- Crowns.
- Dental emergencies.
- Dental surgical procedures.
- Dentures.
- Extractions (tooth removals).
- Fillings.
- Fluoride treatments.
- Orthodontics (braces)*.
- Periodontal services.
- Root canals.
- Sealants.
- X-rays.

*If braces were placed before age 21, the care will be covered until it is done, or until age 23, whichever comes first, as long as the member remains eligible for Medical Assistance and remains a member of UnitedHealthcare Community Plan. If the member changes to another HealthChoices healthplan, coverage will be provided by that HealthChoices plan.*

Your children's PCP may refer them to a dental home as part of their EPSDT well-child screenings. A dental home is a dental office where you have an ongoing relationship with a dentist who provides all aspects of oral health care.

UnitedHealthcare will be offering an opportunity for children to use the services of a dental van for check-ups at several schools. Look for our dental flyer in the mail announcing these events.

For more information on your child's dental benefits, please call Member Services at **1-800-414-9025, TTY: 711.**
Benefits and Services

Dental services for members 21 years of age and older.
Members age 21 and over may be eligible for dental benefits. The dental services you may get as an adult member are based on your eligibility category and need. All adult members are eligible for emergency services related to treatment symptoms and pain. Some are also eligible for these dental services:

- Anesthesia (may require prior authorization).
- Surgical procedures (requires prior authorization).
- Extractions (impacted tooth removal) (requires prior authorization).
- Extractions (simple tooth removals).
- Fillings (restorations).
- Palliative Care (Emergencies).
- X-rays.
- Inpatient, Short Procedure Unit (SPU) or Ambulatory Surgical Center (ASC).
- One dental exam and one cleaning every 180 days (6 months).
- Pulpotomies (removal of pulp) for pain relief.
- Re-cementing of crowns (re-gluing the crown).
- In your lifetime, you can get:
  - One partial upper denture or one full upper denture. If you got a partial or full upper denture paid by the Medical Assistance program since March 1, 2004, you must get special approval, called a benefit limit exception, to get another one.
  - One partial lower denture or one full lower denture. If you got a partial or full lower denture paid by the Medical Assistance program since March 1, 2004, you must get special approval, called a benefit limit exception, to get another one.
- The services below are available only if a benefit exception is approved:
  - Crowns and related services.
  - Root canals and other endodontic services.
  - Periodontal services.
  - Additional cleanings and exams.
**Dental benefit limit exceptions.**

Your dentist can ask UnitedHealthcare Community Plan for a benefit limit exception. Exceptions are allowed if:

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

Providers may submit a Benefit Limit Exception (BLE) request to:

UnitedHealthcare Community Plan for Families
Benefit Limit Exception
P.O. Box 1091
Milwaukee, WI 53201

- Providers can call 1-800-508-4876 if they need a copy of the BLE request form, or have any questions about required documents.

- If your dentist asks for the BLE before your dental care, UnitedHealthcare will respond within 21 days from when we receive it. If we receive the request after your dental services, we will respond within 30 days from when we receive it.

- For new members who had BLE requests approved by the MA program or another PH-MCO, UnitedHealthcare can honor those approvals if the provider sends us:
  - A copy of the prior BLE approval.
  - A Completed BLE request form.
  - A completed claim form.

- If a request for a benefit limit exception is denied, the Provider and Member will receive written notice of the denial. The written notice will explain how you can make a Complaint, Grievance, or ask for a DHS Fair Hearing if you disagree with our decision.

- If the request is approved before your dental care begins, you and your dentist will receive a written notice of the approval.

- If the request is approved after your dental care, the dentist’s claim for payment will be adjusted to show the approval.

Your dentist must ask for the exception. This can happen before the services start or after they are finished. Your dentist can ask for an exception up to 60 day after your dental services are finished.

If you have any questions about your dental benefits or benefit limits exceptions, please call us anytime at **1-800-414-9025, TTY: 711.**
Vision

Vision services.

Regular eye exams are important. Members are eligible for 2 routine eye exams per year. Call your doctor to schedule a routine eye exam. You can schedule an appointment with any participating vision care provider. If you need help finding an eye doctor, call Member Services.

The following vision services are covered for members under age 21:

- All medically necessary eye care is covered, including routine vision exams — no referral is necessary.
- Two pairs of prescription eyeglasses (2 frames, 4 lenses), or two pairs of contact lenses, or one of each, every twelve months or more often if medically necessary.
- Replacement of glasses if broken or lost or if a prescription changes, if medically necessary.

The following vision services are covered for members age 21 and over:

- Routine vision exams — no referral is necessary.
- UnitedHealthcare Community Plan covers prescription eyeglasses or daily wear contacts (in-plan frames, 2 lenses/1 frame per year).
- There are special provisions for members with aphakia. To learn more, call Member Services at 1-800-414-9025, TTY: 711.
Women’s Health

Women’s health.
The specialists who take care of women’s health care are known as obstetricians/gynecologists (OB/GYNs). These doctors, as well as nurse midwives, are trained in prenatal care, childbirth and women’s health care needs. Members do not need a referral or prior authorization to visit participating OB/GYNs or midwives. These health care providers will give you:

- Prenatal care, including office visits and delivery.
- Postpartum care visit between the 21st and 56th day after delivery.
- Birth control services and counseling.
- Annual Pap test beginning at age 21 or earlier if sexually active (discuss frequency with your provider).
- Annual pelvic exam beginning at age 18 or earlier if sexually active (discuss frequency with your provider).
- STD testing beginning at age 16 or earlier if sexually active (discuss frequency with your provider).
- A referral for an annual mammogram (discuss frequency with your provider).

Family planning/birth control services.
UnitedHealthcare Community Plan provides family planning services and supplies, including counseling and birth control. You can choose to get this care from your PCP or a participating OB/GYN or family planning provider or any doctor or clinic that accepts Medical Assistance. You do not need a referral to get these services.

Women, infants and children.
Women, Infants and Children (WIC) is a special program from the Pennsylvania Department of Health that helps you and your baby eat well. The program starts when you are pregnant and lasts for 12 months if you breastfeed or 6 months if you bottle-feed your baby. Your baby can receive WIC until age 5. Babies and young children must eat nutritious food so they grow up healthy and strong. WIC can teach you about good nutrition and provide you with food vouchers to use at grocery stores. For more information about WIC, see your case worker, ask your PCP, or call the WIC hotline at 1-800-942-9467.
Transportation

UnitedHealthcare Community Plan will cover transportation if you are having a medical emergency. Call 911 if you are not able to go to the emergency room. If you need a ride to your doctor’s appointment, your county Medical Assistance Transportation Program (MATP) can help arrange for and provide transportation. Just call the telephone number of the county MATP where you live. If you need assistance with this, or your county is not listed on this page, just call Member Services at 1-800-414-9025, TTY: 711.

<table>
<thead>
<tr>
<th>County</th>
<th>Toll-Free Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>1-800-830-6473</td>
</tr>
<tr>
<td>Allegheny</td>
<td>1-888-547-6287</td>
</tr>
<tr>
<td>Armstrong</td>
<td>1-800-468-7771</td>
</tr>
<tr>
<td>Beaver</td>
<td>1-800-262-0343</td>
</tr>
<tr>
<td>Bedford</td>
<td>1-800-323-9997</td>
</tr>
<tr>
<td>Berks</td>
<td>1-800-383-2278</td>
</tr>
<tr>
<td>Blair</td>
<td>1-800-245-3282</td>
</tr>
<tr>
<td>Bucks</td>
<td>1-888-795-0740</td>
</tr>
<tr>
<td>Butler</td>
<td>1-866-638-0598</td>
</tr>
<tr>
<td>Cambria</td>
<td>1-888-647-4814</td>
</tr>
<tr>
<td>Chester</td>
<td>1-877-873-8415</td>
</tr>
<tr>
<td>Cumberland</td>
<td>1-800-315-2546</td>
</tr>
<tr>
<td>Dauphin</td>
<td>1-800-309-8905</td>
</tr>
<tr>
<td>Delaware</td>
<td>1-866-450-3766</td>
</tr>
<tr>
<td>Fayette</td>
<td>1-800-321-7433</td>
</tr>
<tr>
<td>Franklin</td>
<td>1-800-548-5600</td>
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</tbody>
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<thead>
<tr>
<th>County</th>
<th>Toll-Free Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fulton</td>
<td>1-888-329-2376</td>
</tr>
<tr>
<td>Greene</td>
<td>1-877-360-7433</td>
</tr>
<tr>
<td>Huntingdon</td>
<td>1-800-817-3383</td>
</tr>
<tr>
<td>Indiana</td>
<td>1-888-526-6060</td>
</tr>
<tr>
<td>Lancaster</td>
<td>1-800-892-1122</td>
</tr>
<tr>
<td>Lawrence</td>
<td>1-888-252-5104</td>
</tr>
<tr>
<td>Lebanon</td>
<td>1-717-273-9328</td>
</tr>
<tr>
<td>Lehigh</td>
<td>1-888-253-8333</td>
</tr>
<tr>
<td>Montgomery</td>
<td>1-215-542-7433</td>
</tr>
<tr>
<td>Perry</td>
<td>1-877-800-7433</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>1-877-835-7412</td>
</tr>
<tr>
<td>Somerset</td>
<td>1-800-452-0241</td>
</tr>
<tr>
<td>Washington</td>
<td>1-800-331-5058</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>1-800-242-2706</td>
</tr>
<tr>
<td>York</td>
<td>1-800-632-9063</td>
</tr>
</tbody>
</table>

Sometimes, when you have a severe injury or illness, you will need special transportation to get to your medical treatments. If this is necessary, your PCP will work with UnitedHealthcare Community Plan to arrange transportation. UnitedHealthcare Community Plan also covers ambulance transportation when you have an emergency and need immediate medical attention. Please call Member Services at 1-800-414-9025, TTY: 711, if you have any questions or concerns about getting to your scheduled appointments.
Making Health Decisions

Advance directives.
An advance directive is a written statement that states the types of health care you want to get. In case of serious illness when you can’t make decisions, such as a coma, an advance directive will tell your doctor and your family what you want done. You can make your wishes known in two ways: a living will and a durable power of attorney for health care. You have the right to make an advance directive. UnitedHealthcare Community Plan will let you know, by letter, of any changes in Pennsylvania law within 90 days of the change.

For written information on advance directive policies you may request a copy of “Advance Directives Form and Information” by writing to:

   Pennsylvania Department of Aging
   Office of the Chief Counsel
   555 Walnut Street, 5th Floor
   Harrisburg, PA 17101
   717-783-1609

Living will.
A living will usually tell the type of care you want or do not want. For example, if you have a terminal disease and you need an operation, a living will can instruct the doctor not to go to any extremes to keep you alive. Examples of extreme treatments are machines that help you breathe or tubes that feed you. The living will or advance directive for health care declaration becomes operative when:

• Your doctor has a copy of it, and
• Your doctor has concluded that you are incompetent and you have a terminal condition or are in a state of permanent unconsciousness.

Pennsylvania’s living will law states that you may revoke a living will at any time and in any manner. All that you must do is tell your doctor that you are revoking it. Someone who saw or heard you revoke your declaration may also tell your doctor.

Your doctor must let you know if they cannot, in good conscience, follow your wishes or if their policies prevent them from honoring your wishes. This is one reason why you should give a copy of your living will to your doctor or to those in charge of your medical care. The doctor who cannot honor your wishes must help transfer you to another health care provider willing to carry out your directions if they are the kind of directions that Pennsylvania recognizes as valid. A living will may not order a doctor to cut off your food supply.
**Benefits and Services**

**Durable power of attorney for health care.**
A durable power of attorney for health care is a written statement naming a person you trust (husband, wife, parent, adult child, sibling or friend) to make medical decisions if you are not physically or mentally able to make decisions.

To get a durable power of attorney, you need legal help. You can get help from a group called Legal Aid at 1-800-322-7572. If you are over age 60, you can call your Area Agency for Aging, or you can call the Senior Law Center (formerly Judicare) at 1-215-988-1244 (general information) or 1-215-988-1242 (intake line operates 9 a.m. to 1 p.m.) to ask for help. Your PCP also can give you information on your options. For more information go to [www.caringinfo.org](http://www.caringinfo.org) or call 1-800-658-8898.

You can also combine a living will and a durable power of attorney into one statement. This statement would name someone to make health decisions for you AND say what type of care you should or should not receive.

If you are concerned that your doctor or hospital has not followed the directions in your advanced directive, you can file a complaint or grievance with UnitedHealthcare Community Plan. You can also file a complaint with the Department of Health by calling 1-800-254-5164.

**Medical necessity.**
A service or benefit is Medically Necessary if it is compensable under the MA Program and 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.
- The service or benefit will assist 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, retrospective-review or exception basis, must be in writing. This determination is based on 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.
Utilization review process.
UnitedHealthcare Community Plan reviews the health care you get to make sure it is the right care for you and that it is covered by UnitedHealthcare Community Plan and Medicaid. UnitedHealthcare Community Plan has policies we follow when making decisions about which medical services you need. Our goal is to make sure you get the medical help you need and services in the right setting. Decisions about care 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 what care you should or should not receive, or that could result in not enough care. UnitedHealthcare Community Plan also makes sure our providers give you great care. Your doctor can ask for our decision-making procedures by calling Provider Services. You can also request decision-making procedures or reach utilization review staff during normal business hours by calling Member Services at 1-800-414-9025, TTY: 711. Language assistance is available.

New procedures.
Requests for coverage for newly developed medical equipment or procedures are reviewed by the UnitedHealthcare Community Plan Technology Assessment Committee. This committee includes physicians and other health care professionals. The committee uses national guidelines and scientific proof from medical papers to help decide whether UnitedHealthcare Community Plan should approve this equipment or these procedures.

Quality Improvement program.
Our Quality Improvement (QI) program makes sure that we offer the best health care that we can. The Pennsylvania Department of Health (DOH), DHS and the National Committee for Quality Assurance (NCQA) set guidelines that we use to guide our QI program. We pay special attention to:

- Quality management and improvement.
- How we make sure our providers have the right education and qualifications.
- The types of services members are using.
- Member rights and responsibilities.
- Preventive health care.

If you would like more information about our practice guidelines, quality improvement goals, activities or outcomes, please write to:

UnitedHealthcare Community Plan
Quality Improvement Department
1001 Brinton Rd.
Pittsburgh, PA 15221
Benefits and Services

Be the driver of your health care.
Help improve your safety, take responsibility when it comes to your medical care:

• Tell your doctor all your health history.
• Be part of every decision about your health care — talk with your doctor, ask questions.
• Don’t wait to hear — call your doctor, ask for test results.
• Tell your doctor about any changes in your health.
• Take your doctors advice and follow instructions you both agreed to.
• If you don’t understand — ask again.

Be an active part of your health care. Know how you can make a difference!

Member satisfaction – Make your voice heard.
As a United Healthcare Community Plan member, you may be asked to complete an adult survey for yourself or a child’s version for a child you care for. We do not receive the names of the members included in the survey. All member comments are kept confidential and member names are not given.

The results of this survey will help to improve our services so we can serve our members better. We value your opinion so please tell us what you think.

Coordination of benefits.
You do not have to fill out any forms with UnitedHealthcare Community Plan unless you have another health plan and UnitedHealthcare. You need to tell us if you have another health plan. If you have two health plans, UnitedHealthcare and another plan will both share the cost of your health care needs. When both share the cost, it is called coordination of benefits (COB). Together, both plans will pay your bill up to 100%. If UnitedHealthcare Community Plan pays the whole bill and another party then pays a part, we will contact the other health plan. You need to tell us if you get money from another health plan. You aren’t responsible for paying for covered services provided by a participating provider. UnitedHealthcare Community Plan gets the bill. You won’t get a bill even if the provider doesn’t receive payment from us. If you get a bill by mistake, call Member Services at 1-800-414-9025, TTY: 711.

If you have Medicare.
If you have Medicare, you need to make sure your County Assistance Office knows that you do. You should also let UnitedHealthcare know. You can continue to see your Medicare doctor, and that doctor can coordinate your benefits, using the process described above, by billing Medicare, and then billing UnitedHealthcare second.
Healthy Living

**Preventive services.**
Preventive services can help keep you well. Preventive services include more than just seeing your PCP once a year for a check-up. They also include immunizations (shots), lab tests and other tests that tell your PCP if you have any health problems. Visit your PCP for preventive services. Women can also go to a participating OB/GYN for their yearly Pap test, pelvic exam and mammogram.

**Tobacco cessation – To help you quit.**
Cigarette smoking or using other tobacco products (cigars, pipes or chew) can lead to health problems such as asthma and other lung problems, heart attacks, strokes, and cancer. Mothers who smoke while they are pregnant may have a baby born with health problems. Breathing secondhand smoke is also not healthy for infants and young children. If you smoke and are ready to quit, UnitedHealthcare Community Plan can help you.

There are medicines that are available to help you quit smoking and using tobacco products. Medicines such as the nicotine patch and nicotine gum help reduce withdrawal symptoms. Other medicines can also help make quitting easier. Call your PCP or other provider to learn more about these medicines.

**Physical exam.**
See your PCP at least once a year. When you go for a physical exam, your PCP will ask you questions about your medical history and your family’s medical history. This is important because you may have a greater risk of having a disease if someone in your family had it. Your PCP will also check your height and weight, measure your body mass index (BMI), discuss healthy eating habits, listen to your heart, perform a physical exam and take your blood pressure.

Routine physicals usually take longer to schedule. Be sure to call far enough in advance of when you would like an appointment.

**Pregnancy.**
The care that a woman receives from a doctor, nurse or nurse-midwife before the birth of a baby is known as prenatal care. Prenatal care is very important! It checks how well the pregnancy is going and if there are any problems. Even if a woman has been pregnant before, it is important that she go to her doctor or other prenatal care provider regularly for each pregnancy. If you think you are pregnant and need a pregnancy test, see your PCP or a family planning provider. If you are pregnant, you can:

- Call or visit your PCP, who will help you find a prenatal care provider.
- Visit a UnitedHealthcare Community Plan OB/GYN or nurse-midwife on your own.
- Visit a participating health center that offers OB/GYN services.
During your pregnancy you should be seen at the following times:

- First trimester (first three months) — at least one time.
- Second trimester (months four to six) — every month.
- Third trimester (months seven to delivery) — every one to two weeks.
- After delivery — 21 to 56 days after your delivery for postpartum care.

Keeping appointments helps your provider tell how you and your baby are doing. Sometimes you may need to be seen more often. It is important to keep all of your appointments. This will help you have a healthy baby.

Call the Department of Human Services Change Center 1-877-395-8930 and for Philadelphia County residents 1-215-560-7226. Tell them about your new baby. This is very important. They will make sure you get the benefits and services your baby needs.

- Call UnitedHealthcare Community Plan Member Services (1-800-414-9025, TTY: 711) to let us know the baby's name and the name of your baby's doctor. We can help you choose a doctor for your baby if you have not already chosen one.
- Call the baby's doctor to make an appointment for your baby. Your baby should have an appointment when he/she is 2-4 weeks old, unless the doctor wants to see your baby sooner.

**The baby blues.**

Sometimes women feel down or sad after having a baby. This is normal. Please ask yourself these 2 questions:

- During the past month, have I often been bothered by feeling down, depressed or hopeless?
- During the past month, have I often been bothered by little interest or pleasure in doing things?

If you answered “yes” to one or both of these questions, please call Member Services at our toll free number, (1-800-414-9025, TTY: 711). We want to make sure you get the help you need.
**Healthy First Steps.**
Our Healthy First Steps program makes sure that both mom and baby get good medical attention.

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

Call us toll-free at **1-877-813-3417, TTY: 711**, Monday through Friday, from 7 a.m. to 6 p.m. Central.

It’s important to start pregnancy care early. Be sure to go to all of your doctor visits, even if this isn't your first baby.
Mental Health/Drug and Alcohol Treatment

Your PCP can help you get mental health or drug and alcohol treatment. If you want to know more about available services or are having problems with treatment, call your county HealthChoices behavioral health provider directly.

<table>
<thead>
<tr>
<th>County</th>
<th>Behavioral Health Plan</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>Community Care Behavioral Health</td>
<td>1-866-738-9849</td>
</tr>
<tr>
<td>Allegheny</td>
<td>Community Care Behavioral Health</td>
<td>1-800-553-7499</td>
</tr>
<tr>
<td>Armstrong</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5969</td>
</tr>
<tr>
<td>Beaver</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5970</td>
</tr>
<tr>
<td>Bedford</td>
<td>Perform Care</td>
<td>1-866-773-7891</td>
</tr>
<tr>
<td>Berks</td>
<td>Community Care Behavioral Health</td>
<td>1-866-292-7886</td>
</tr>
<tr>
<td>Blair</td>
<td>Perform Care</td>
<td>1-866-773-7892</td>
</tr>
<tr>
<td>Bucks</td>
<td>Magellan Behavioral Health of PA</td>
<td>1-877-769-9784</td>
</tr>
<tr>
<td>Butler</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5971</td>
</tr>
<tr>
<td>Cambria</td>
<td>Value Behavioral Health of PA</td>
<td>1-866-404-4562</td>
</tr>
<tr>
<td>Chester</td>
<td>Community Care Behavioral Health</td>
<td>1-866-622-4228</td>
</tr>
<tr>
<td>Cumberland</td>
<td>Perform Care</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Dauphin</td>
<td>Perform Care</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Delaware</td>
<td>Magellan Behavioral Health of PA</td>
<td>1-888-207-2911</td>
</tr>
<tr>
<td>Fayette</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5972</td>
</tr>
<tr>
<td>Franklin</td>
<td>Perform Care</td>
<td>1-866-773-7917</td>
</tr>
<tr>
<td>Fulton</td>
<td>Perform Care</td>
<td>1-866-773-7917</td>
</tr>
<tr>
<td>Greene</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5973</td>
</tr>
<tr>
<td>County</td>
<td>Behavioral Health Plan</td>
<td>Phone Number</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Huntingdon</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Indiana</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5974</td>
</tr>
<tr>
<td>Lancaster</td>
<td>Perform Care</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Lawrence</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5975</td>
</tr>
<tr>
<td>Lebanon</td>
<td>Perform Care</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Lehigh</td>
<td>Magellan Behavioral Health of PA</td>
<td>1-866-238-2311</td>
</tr>
<tr>
<td>Montgomery</td>
<td>Magellan Behavioral Health of PA</td>
<td>1-877-769-9782</td>
</tr>
<tr>
<td>Northampton</td>
<td>Magellan Behavioral Health of PA</td>
<td>1-866-238-2312</td>
</tr>
<tr>
<td>Perry</td>
<td>Perform Care</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>Community Behavioral Health</td>
<td>1-888-545-2600</td>
</tr>
<tr>
<td>Somerset</td>
<td>Perform Care</td>
<td>1-866-773-7891</td>
</tr>
<tr>
<td>Washington</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5976</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5977</td>
</tr>
<tr>
<td>York</td>
<td>Community Care Behavioral Health</td>
<td>1-866-542-0299</td>
</tr>
</tbody>
</table>

*Mental health or drug and alcohol treatment services are not included in your UnitedHealthcare Community Plan benefits. You will need to take your Pennsylvania ACCESS Card when you visit the behavioral health provider.*
Benefits and Services

Children’s Health Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
UnitedHealthcare Community Plan wants to help you keep your children healthy. A child should have EPSDT exams regularly based on his or her age. Babies need to go several times in one year. Children ages 6 up to the age of 21 need to go once a year.

Your PCP will tell you when your children need to come in for another EPSDT exam. Call to schedule an appointment one month before your next recommended EPSDT exam. These visits include:

- Immunizations, or shots, that protect your child from diseases.
- A complete unclothed physical exam.
- Vision test to see if eyeglasses are needed.
- Hearing test.
- Check Body Mass Index (BMI) and to screen for obesity.
- Blood pressure check.
- Screenings for Autism, Development and Psychosocial/behavioral health problems.
- Lab tests, including blood tests, lead levels, and urine tests.
- Referral to a specialist, when medically necessary.
- Order any special equipment, services, or other testing, if needed.
- Schedule another visit to follow up with the PCP if needed.
- Screen and/or counsel for tobacco, alcohol, and substance abuse starting at age 11.
- Perform a urinalysis screening, if needed.
- Perform a tuberculosis (TB) screening.
- Check oral health and take a dental history. Check teeth for any dental problems, provide an application of topical fluoride varnish, and refer the child to a dentist.
- Growth measurements.
- Health and safety education.

Children are covered for these EPSDT services:

- Vision care. Vision check-ups are recommended every year, beginning at age 1.
- Hearing services, including exams and hearing aids for hearing loss.
- Dental care, including routine dental exams, preventive care, and treatment for pain, infections, cavities, and tooth loss. Dental check-ups are suggested every 6 months, beginning at age 1. Sealants to protect against tooth decay are also recommended by age 8 and again by age 14.
UnitedHealthcare Community Plan members under age 21 with special needs can get more EPSDT services. When medically necessary, EPSDT provides a wide range of medical, behavioral health and social services that are not normally covered by Medicaid or have limits. A PCP, other provider or member can call UnitedHealthcare Community Plan's pediatric case manager to ask for these extra services. You can call Member Services at 1-800-414-9025, TTY: 711, for help with EPSDT services.

**Lead screening blood test.**
This test helps to identify children who may have high amounts of lead in their blood. If children have too much lead in their blood, it can stop them from growing and developing. The best time to have the test done is when the child is one year old and again before the age of two.

**Early intervention program.**
The early intervention program is for children from birth to age 5 who have or are at risk for developmental delays. This program helps children grow and develop by helping parents, service providers and others work together. It is important to talk to your child's PCP if you think your child may have a physical or emotional development problem. Examples of children who could be helped by early intervention services are:

- Babies who are born small or early and need special care.
- A child up to age 3 who is not growing as quickly as he or she should.
- Children who have high levels of lead in their blood.

The program can:

- Answer questions about your child's development.
- Help you interact with your child through daily routines at home and in the community.
- Support your child's developmental and educational growth.
- Help your child become more independent.
- Prevent the need for more costly services in the future.
- Let communities know about the gifts and abilities of all children.

Talk to your child's PCP about any questions or concerns about your child's development. For more information on the early intervention program, call DHS' CONNECT Information and Referral line at 1-800-692-7288.
Additional Services

COMPASS community partner.
UnitedHealthcare Community Plan is now a registered COMPASS (Commonwealth of Pennsylvania Access to Social Services) community partner. Through this partnership, we can help you learn more about, apply for and renew social service programs. For more information about COMPASS, call Member Services at 1-800-414-9025, TTY: 711.

Health education programs.
UnitedHealthcare Community Plan offers many special health education and outreach programs. Call Member Services at 1-800-414-9025, TTY: 711, for a full list and more information. We may offer educational classes in your neighborhood about topics like smoking prevention and cessation, asthma, healthy lifestyles, wellness events, screenings, nutrition, HIV/AIDS and STDs.

Domestic violence.
If you or someone you know is being abused, there is help. Free information and private help from a domestic violence program is available in your area. Domestic violence programs can help you develop a safety plan. Services include:

- 24-hour operator available to talk with you.
- Shelter/safe home.
- Children’s counseling services and programs.
- Individual and group counseling.
- Court and emergency help.
- Help with medical assistance application.

For more information about free counseling, go to www.ndvh.org or call 1-800-799-7233, TTY: 711.

Legal/advocacy help.
AIDS Health Information Hotline Client Services .............................................. 1-800-929-5602

Domestic Violence Hotline .......................................................... 1-800-799-7233

Child Abuse Hotline ................................................................. 1-717-783-1964

Pennsylvania Elder Abuse Hotline ................................................. 1-800-490-8505

Smoking Quitline ................................................................. 1-800-784-8669
(managed by the PA Health Department and the American Cancer Society)
Disease and Case Management Programs

Special needs services.
UnitedHealthcare Community Plan Special Needs Services helps members who have Physical, emotional or behavioral conditions, complex or chronic illnesses or other special needs. You or your doctor can call us to ask if our case management or disease management programs could help you. If you or your doctor thinks a Case Manager could help you, or if you want more information about our case management or disease management programs, call us at 1-877-844-8844.

The UnitedHealthcare Special Needs Case Manager will work with members and any outside agencies to help members get the care they need. To talk to a special needs case manager or to receive educational information about your disease, call UnitedHealthcare Community Plan Special Needs Services at 1-877-844-8844.

Asthma.
Asthma is a chronic inflammatory disease that affects 15 million people. It is the most common chronic disease of children, affecting 5 million children, and that number is growing every day. UnitedHealthcare Community Plan has developed an asthma program to help members with asthma care. To learn how to manage asthma or to receive educational material, call Special Needs Services at 1-877-844-8844.

Chronic Obstructive Pulmonary Disease (COPD).
COPD happens when the airways in the lungs are swollen and do not allow air to enter or exit. You may have a cough and become short of breath with very little exertion. People with COPD are often smokers or people who have lived or worked in environments with fumes, smoke or other things that bother lungs. COPD cannot be cured, but it can be managed with help from your PCP or pulmonary (lung) specialist. If you are a smoker, it is important to stop smoking. You should also avoid smoky areas and irritating fumes. To learn how to manage COPD or to receive educational material, call Special Needs Services at 1-877-844-8844.

Congestive Heart Failure (CHF).
CHF is when the heart does not pump blood as well as it should. When this happens, fluid builds up in the lungs and you may have swelling in your legs and feet. Often, you are easily out of breath with very little activity. You may have a cough, need to rest more than usual, or be unable to lie flat when you sleep. Many people need extra pillows or find sleeping in a chair more comfortable. CHF can be caused by many things, like a heart attack, obesity, high blood pressure, diabetes and viruses that attack the heart. People who get care from their PCP or a cardiologist (heart specialist) can lead productive lives with CHF. To learn how to manage CHF or to receive educational material, call Special Needs Services at 1-877-844-8844.
**Coronary Artery Disease (CAD).**

CAD is the most common type of heart disease. It is the leading cause of death in the United States in both men and women. CAD occurs when the coronary arteries that supply blood to the heart muscle narrow due to a build-up of a material called plaque on their inner walls. The build-up of plaque is known as atherosclerosis. As the plaque increases in size, the insides of the coronary arteries get narrower and less blood can flow through them. Eventually, the heart muscle does not get the oxygen it needs. Reduced blood flow and the oxygen supply to the heart muscle can cause chest pain or a heart attack.

Over time, CAD can weaken the heart muscle and contribute to:

- Heart failure (when the heart cannot pump blood effectively to the rest of the body). Heart failure does not mean that the heart has stopped or is about to stop. It means that the heart is failing to pump blood the way it should.

- Arrhythmias, or changes in the normal beating rhythm of the heart. Some can be quite serious.

To learn how to manage CAD or to receive educational material, call Special Needs Services at 1-877-844-8844.

**Diabetes.**

Diabetes is a disease that affects the way your body uses food. Your body changes the food you eat into sugar. Body cells use sugar for energy. With diabetes, sugar builds up in the blood. The build-up of blood sugar can cause blindness, kidney disease and heart attacks. 16 million Americans have diabetes. One-third of people with diabetes don’t know they have it. Some of the signs of diabetes are frequent urination, extreme thirst, tiredness and hunger.

Diabetes is manageable. Maintaining a healthy weight, eating low-fat foods, monitoring carbohydrate intake and getting plenty of exercise can control diabetes. In some cases, your doctor may also prescribe medicine to control your blood sugar. To learn how to manage diabetes or to receive educational material, call Special Needs Services at 1-877-844-8844.

**HIV/AIDS.**

HIV (human immunodeficiency virus) is a virus that invades a person’s body. AIDS is caused by HIV. The term AIDS applies to the most difficult stages of HIV infection. By killing or damaging cells of the body’s immune system, HIV destroys the body’s ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by viruses or bacteria that usually do not make healthy people sick.

If you have AIDS or an HIV-related disease, a UnitedHealthcare Community Plan case manager will help you get medical and social services. Your case manager will know the resources available for housing, support groups and other community services. To learn more about these special services, call Special Needs Services at 1-877-844-8844.
When you are at home, you may get services from home health nurses and nurse aides, if needed. You can also get homemaker services to help you with daily household chores. UnitedHealthcare Community Plan can also give you nutritional and other supplemental services to help you stay healthy. You will still need to see your UnitedHealthcare Community Plan PCP for medical care, though.

## Copayments and Billing

**Copayments.**

Copayments (copays) are charges you pay to get certain services, but you cannot be denied a service if you cannot pay the copayment. Tell your provider if you cannot pay. Here are the copays that you may be asked to pay:

<table>
<thead>
<tr>
<th>Covered benefit</th>
<th>Adult copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractor Services</td>
<td>$1</td>
</tr>
<tr>
<td>Diabetic Supplies and Equipment</td>
<td>$1 limit to $3 max</td>
</tr>
<tr>
<td>Durable Medical Equipment, Purchase</td>
<td>$1 limit to $3 max</td>
</tr>
<tr>
<td>Hearing Aids and Batteries</td>
<td>$1 limit to $3 max</td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>$1</td>
</tr>
<tr>
<td>Inpatient Hospitalization (acute)</td>
<td>$3 per day, up to $21 maximum per stay</td>
</tr>
<tr>
<td>X-rays</td>
<td>$1</td>
</tr>
<tr>
<td>Orthopedic Shoes</td>
<td>$1 limit to $3 max</td>
</tr>
<tr>
<td>Outpatient Surgery (ambulatory surgical center or short procedure unit)</td>
<td>$3</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td>$1</td>
</tr>
</tbody>
</table>
## Other Plan Details

<table>
<thead>
<tr>
<th>Covered benefit</th>
<th>Adult copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap Smears and Pelvic Exams</td>
<td>$1</td>
</tr>
<tr>
<td>Podiatry Care (medically necessary)</td>
<td>$1</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Brand: $3, Generic: $1</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>$1 limit to $3 max</td>
</tr>
<tr>
<td>Radiology Scans (MRI, MRA, PET)</td>
<td>$1</td>
</tr>
<tr>
<td>Rehabilitation (inpatient hospital)</td>
<td>$3 per day, up to $21 maximum per stay</td>
</tr>
<tr>
<td>Rehabilitation (outpatient occupational, and physical and speech therapy)</td>
<td>$1</td>
</tr>
<tr>
<td>Specialty Physician Services</td>
<td>$1</td>
</tr>
<tr>
<td>Tobacco Cessation Products</td>
<td>Brand: $3, Generic: $1</td>
</tr>
</tbody>
</table>

You do not have to pay a copay if you are under age 18, pregnant or in a nursing home. Pregnant women have no copays through the 60-day postpartum period. The following services are excluded from copayments:

- Services or items provided to a terminally ill person who is receiving hospice care.
- Services provided to women in the Breast and Cervical Cancer and Treatment (BCCPT) coverage group.
- Services provided to individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance.
- Services provided in emergency situations.

There are no copays for the following services: Laboratory services, family planning services and supplies, home health services, renal dialysis services, oxygen, rental of durable medical equipment, targeted case management services, tobacco cessation counseling, blood and blood products, ostomy supplies and screenings provided under the EPSDT Program.
If you get a bill.

UnitedHealthcare Community Plan pays for all authorized covered services while you are a member of the plan. If UnitedHealthcare Community Plan does NOT cover a service, the provider must tell you this in advance, tell you the cost of the service and make sure you agree to pay this cost.

You never have to pay a bill for covered services by a doctor in our network. Sometimes, UnitedHealthcare Community Plan and the doctor will have a dispute over the payment. Even if we deny the doctor’s claim, you will not have to pay. The doctor can appeal the payment denial with UnitedHealthcare Community Plan or ask your permission to file a grievance on your behalf. It is your decision to give the permission or not. The amount UnitedHealthcare Community Plan pays a provider is payment-in-full. A provider cannot bill you for any remaining charges if they receive payment from us.

If you choose to go to a provider who is not part of UnitedHealthcare Community Plan’s network, you must get a prior authorization from UnitedHealthcare Community Plan unless it is an emergency. If there are enough doctors in our network near you who can treat your condition, you will need to see a network provider. If you still go to the non-network doctor, you will have to pay for the services.

If you receive a bill from a provider, call the provider and make sure they have all your insurance information. Call Member Services at 1-800-414-9025, TTY: 711, if you are asked to pay for a service or if you have any questions about what is covered.

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Complaints and Grievances

If a provider or UnitedHealthcare Community Plan does something that you are unhappy about or do not agree with, you can tell UnitedHealthcare Community Plan or the Department of Human Services what you are unhappy about or that you disagree with what the provider or UnitedHealthcare Community Plan has done. This section describes what you can do and what will happen.

---

Complaints

What is a complaint? A complaint is when you tell us you are unhappy with UnitedHealthcare Community Plan or your provider or do not agree with a decision by UnitedHealthcare Community Plan. Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that UnitedHealthcare Community Plan has approved.
What Should I Do if I Have a Complaint?

First-level complaint.
To file a complaint, you can:

• Call us at 1-800-414-9025, TTY: 711, and tell us your complaint, or
• Write down your complaint and send it to us at:
  UnitedHealthcare Community Plan of Pennsylvania
  P. O. Box 31364
  Salt Lake City, UT 84131-0364
• Your provider can file a complaint for you if you give him or her your consent in writing to do so.

This is called a first-level complaint. For more information on how to authorize a member representative, please refer to the Personal Representative Authorization form at the end of this guide.

When should I file a first-level complaint?
You must file a complaint within 45 days of getting a letter telling you that:

• UnitedHealthcare Community Plan has decided you cannot get a service or item you want because it is not a covered service or item,
• UnitedHealthcare Community Plan will not pay a provider for a service or item you got, or
• UnitedHealthcare Community Plan did not decide a complaint or grievance you told us about before within 30 days.

You must file a complaint within 45 days of the date you should have gotten a service or item if you did not get a service or item. The time by which you should have received a service or item is listed on page 20. You may file all other complaints at any time.

What happens after I file a first-level complaint?
After you file your complaint, you will get a letter from UnitedHealthcare Community Plan telling you that we have received your complaint, and about the first-level complaint review process. You may ask UnitedHealthcare Community Plan for copies of information we have about your complaint. You may also send information that may help with your complaint to UnitedHealthcare Community Plan.

You may attend the complaint review if you want to. You may come to our offices or be included by phone or by videoconference, if available. We will send you a letter notifying you of the date of your complaint review. If you decide that you do not want to attend the complaint review, it will not affect our decision.
A committee of one or more UnitedHealthcare Community Plan staff who has not been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint. A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

If you need more information about help during the complaint process, see page 68 of this handbook.

What to do to continue getting services.
If you have been receiving services or items that are being reduced, changed or stopped and you file a complaint that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you, the service or items will continue until a decision is made.

What if I Don’t Like UnitedHealthcare’s Decision?

Second-level complaint.
If you do not agree without first-level complaint decision, you may file a second-level complaint with UnitedHealthcare Community Plan.

When should I file a second-level complaint?
You must file your second-level complaint within 45 days of the date you receive the first-level complaint decision letter. To file a second-level complaint, you can:

- Call UnitedHealthcare Community Plan at 1-800-414-9025, TTY: 711, and tell us your second-level complaint, or
- Write down your second-level complaint and send it to us at:
  UnitedHealthcare Community Plan of Pennsylvania
  P. O. Box 31364
  Salt Lake City, UT 84131-0364

What happens after I file a second-level complaint?
You will receive a letter from UnitedHealthcare Community Plan telling you that we have received your complaint, and telling you about the second-level complaint review process. You may ask UnitedHealthcare Community Plan for copies of any information we have about your complaint. You may also send information that may help with your complaint to UnitedHealthcare Community Plan.
You may attend the complaint review if you want to. You may come to our offices or be included by phone or by videoconference, if available. If you decide that you do not want to attend the complaint review, it will not affect our decision. A committee made up of three or more people, including at least one person who is not employed by UnitedHealthcare, will review your complaint and make a decision.

Your complaint will be decided no later than 45 days after we receive your complaint. A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision. If you need more information about help during the complaint process, see page 68 of this handbook.

**What to do to continue getting services.**
If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file a second-level complaint that is hand-delivered or postmarked within 10 days of the date on the first-level complaint decision letter, the services or items will continue until a decision is made.

**What Can I Do if I Still Don’t Like UnitedHealthcare’s Decision?**

**External complaint review.**
If you do not agree with UnitedHealthcare Community Plan’s second-level complaint decision, you may ask for an external review by either the Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve UnitedHealthcare Community Plan’s policies and procedures.

You must ask for an external review within 15 days of the date you received the second-level complaint decision letter. If you ask, the Department of Health will help you put your complaint in writing. You must send your request for external review in writing to either:

**Pennsylvania Department of Health**
**Bureau of Managed Care**
Attention: Complaint Appeals
Room 912, Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Phone: 1-888-466-2787

**Pennsylvania Insurance Department**
**Bureau of Consumer Services**
1142 Strawberry Square
Harrisburg, PA 17120
Phone: 1-877-881-6388
If you send your request for external review to the wrong department, it will be sent to the correct department.

The Department of Health or the Insurance Department will get your file from UnitedHealthcare Community Plan. You may also send them any other information that may help with the external review of your complaint.

You may be represented by an attorney or another person during the external review. A decision letter will be sent to you after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

**What to do to continue getting services.**
If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file a request for an external complaint review that is hand-delivered or postmarked within 10 days of the date on the second-level complaint decision letter, the services or items will continue until a decision is made.

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**Grievances**

What is a grievance? When UnitedHealthcare Community Plan denies, decreases or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a letter (notice) telling you UnitedHealthcare Community Plan's decision. A grievance is when you tell us you disagree with UnitedHealthcare Community Plan's decision.

**What Should I Do if I Have a Grievance?**

**First-level grievance.**
To file a grievance, you can:
- Call UnitedHealthcare Community Plan at **1-800-414-9025, TTY: 711**, and tell us your grievance,
- Your provider can file a grievance for you if you give your PCP your consent in writing to do so, or
- Write down your grievance and send it to us at:
  UnitedHealthcare Community Plan of Pennsylvania
  P. O. Box 31364
  Salt Lake City, UT 84131-0364

**Note:** If your provider files a grievance for you, you cannot file a separate grievance on your own.
**Other Plan Details**

**When should I file a first-level grievance?**
You have 45 days from the date you receive the letter (notice) that tells you about the denial, decrease or approval of a different service or item to file your grievance.

**What happens after I file a first-level grievance?**
After you file your grievance, you will get a letter from UnitedHealthcare Community Plan telling you that we have received your grievance, and about the first-level grievance review process. You may ask UnitedHealthcare Community Plan for copies of any information we have about your grievance. You may also send information that may help with your grievance to UnitedHealthcare Community Plan.

You may attend the grievance review if you want to. You may come to our offices or be included by phone or by videoconference, if available. If you decide that you do not want to attend the grievance review, it will not affect our decision. A committee of one or more UnitedHealthcare Community Plan staff, including a licensed doctor or dentist, who have not been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 30 days after we received your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

If you need more information about help during the grievance process, see page 68 of this handbook.

**What to do to continue getting services.**
If you have been receiving services or items that are being reduced, changed or stopped, and you file a grievance that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are being reduced, changed or stopped, the services or items will continue until a decision is made.
What if I Don’t Like UnitedHealthcare’s Decision?

Second-level grievance.
If you do not agree with our first-level grievance decision, you may file a second-level grievance with UnitedHealthcare Community Plan.

When should I file a second-level grievance?
You must file your second-level grievance within 45 days of the date you receive the first-level grievance decision letter. To file a second-level grievance, you can:

- Call UnitedHealthcare Community Plan at 1-800-414-9025, TTY: 711, and tell us your grievance,
- Write down your grievance and send it to us at:
  UnitedHealthcare Community Plan of Pennsylvania
  P. O. Box 31364
  Salt Lake City, UT 84131-0364

What happens after I file a second-level grievance?
You will receive a letter from UnitedHealthcare Community Plan telling you that we have received your grievance and telling you about the second-level grievance review process. You may ask UnitedHealthcare Community Plan for copies of any information we have about your grievance. You may also send information that may help with your grievance to UnitedHealthcare Community Plan.

You may attend the grievance review if you want to. You may come to our offices or be included by phone or by videoconference, if available. If you decide that you do not want to attend the grievance review, it will not affect our decision. A committee of three or more people including a doctor or dentist who have not been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 45 days after we receive your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

What to do to continue getting services.
If you have been receiving services or items that are being reduced, changed or stopped and you file a second-level grievance that is hand-delivered or postmarked within 10 days of the date on the first-level grievance decision letter, the services or items will continue until a decision is made.
What Can I Do if I Still Don’t Like UnitedHealthcare’s Decision?

External grievance review.
If you do not agree with UnitedHealthcare Community Plan’s second-level grievance decision, you may ask for an external grievance review. You must call or send a letter to UnitedHealthcare Community Plan asking for an external grievance review within 15 days of the date you received our grievance decision letter. The address is:

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

We will then send your request to the Department of Health. The Department of Health will notify you of the external grievance reviewer’s name, address and phone number. You will also be given information about the external review process.

UnitedHealthcare Community Plan will send your grievance file to the reviewer. You may provide additional information that may help with the external review of your grievance to the reviewer, within 15 days of filing the request for an external grievance review.

You will receive a decision letter within 60 days of the date you asked for an external grievance review. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

You may call UnitedHealthcare Community Plan’s toll-free telephone number at 1-800-414-9025, TTY: 711, if you need help or have questions about complaints and grievances, you can contact your local legal aid office at 1-800-322-7572; or call the Pennsylvania Health Law Project at 1-800-274-3258 if you need help or have questions about complaints and grievances.

What to do to continue services.
If you have been receiving services or items that are being reduced, changed or stopped and you request an external grievance review that is hand-delivered or postmarked within 10 days of the date on the second-level grievance decision letter, the services or items will continue until a decision is made.
What Can I Do if My Health Is at Immediate Risk?

Expedited complaints and grievances.
If your doctor or dentist believes that the usual time frames for deciding your complaint or grievance will harm your health, you or your doctor or dentist can call UnitedHealthcare Community Plan at 1-800-414-9025, TTY: 711, and ask that your complaint or grievance be decided faster. You will need to have a letter from your doctor or dentist faxed to 1-877-866-8120 explaining how the usual time frame for deciding your complaint or grievance will harm your health.

If your doctor or dentist does not fax UnitedHealthcare Community Plan this letter, your complaint or grievance will be decided within the usual time frames.

Expedited complaints.
The expedited complaint will be decided by a licensed doctor who has not been involved in the issue you filed your complaint about.

UnitedHealthcare Community Plan will call you with our decision within 48 hours of when we receive the letter from your doctor explaining how the usual time frame for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review, whichever is sooner. You will also receive a letter telling you the reasons for the decision and how to file a second-level complaint, if you don’t like the decision. An expedited complaint decision may not be requested after a second-level complaint decision has been made on the same issue.

For information on how to file a second-level complaint see page 61 of this handbook.

Expedited grievances and expedited external grievances.
A committee of three or more people, including a licensed doctor and, will review your grievance. The licensed doctor or dentist will decide your expedited grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your grievance about.

UnitedHealthcare Community Plan will call you with our decision within 48 hours of when we receive the letter from your doctor explaining how the usual time frame for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review, whichever is sooner. You will also receive a letter telling you the reasons for the decision and that you can ask for an expedited external grievance review, if you don’t like the decision.
If you want to ask for an expedited external grievance review by the Department of Health, you must call UnitedHealthcare Community Plan at 1-800-414-9025, TTY: 711, within 2 business days from the date you get the expedited grievance decision letter. UnitedHealthcare Community Plan will send your request to the Department of Health within 24 hours after receiving it. An expedited grievance decision may not be requested after a second-level grievance decision has been made on the same issue.

Help With the Complaint and Grievance Processes

If you need help filing your complaint or grievance, a staff member of UnitedHealthcare Community Plan will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review. For legal assistance you can contact Legal Aid at 1-800-322-7572.

At any time during the complaint or grievance process, you can have someone you know represent you or act on your behalf. If you decide to have someone represent or act for you, tell UnitedHealthcare Community Plan, in writing, the name of that person and how we can reach him or her.

You or the person you choose to represent you may ask UnitedHealthcare Community Plan to see any information we have about your complaint or grievance.

Persons whose primary language is not English: If you ask for language interpreter services, UnitedHealthcare Community Plan will provide the services at no cost to you.

Persons with disabilities: UnitedHealthcare Community Plan will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by UnitedHealthcare Community Plan at the complaint or grievance review in a different format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

Note: For some issues you can request a fair hearing from the Department of Human Services in addition to or instead of filing a complaint or grievance with UnitedHealthcare Community Plan. See below for the reasons you can request a fair hearing.
# Department of Human Services Fair Hearings

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something UnitedHealthcare Community Plan did or did not do. These hearings are called fair hearings. You can ask for a fair hearing at the same time you file a complaint or grievance or you can ask for a fair hearing after UnitedHealthcare Community Plan decides your first- or second-level complaint or grievance.

What kinds of things can I request a fair hearing about and by when do I have to ask for your fair hearing?

<table>
<thead>
<tr>
<th>If you are unhappy because:</th>
<th>You must ask for a Fair Hearing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Community Plan decided to deny a service or item because it is not a covered service or item</td>
<td>within 30 days of getting a letter from UnitedHealthcare Community Plan telling you of this decision</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan decided to not pay a provider for a service or item you got and the provider can bill you for the service or item</td>
<td>within 30 days of getting a letter from UnitedHealthcare Community Plan telling you of this decision</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan did not decide within 30 days a complaint or grievance you told UnitedHealthcare Community Plan about before</td>
<td>within 30 days of getting a letter from UnitedHealthcare Community Plan telling you that we did not decide your complaint or grievance within the time we were supposed to</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan decided to deny, decrease or approve a service or item different than the service or item you requested because it was not medically necessary</td>
<td>within 30 days of getting a letter from UnitedHealthcare Community Plan telling you of this decision or within 30 days of getting a letter from UnitedHealthcare Community Plan telling you of its decision after you filed a complaint or grievance about this issue</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan did not provide a service or item by the time you should have received it (the time by which you should have received it is listed on page 20)</td>
<td>within 30 days from the date you should have received the service or item</td>
</tr>
</tbody>
</table>
How do I ask for a Fair Hearing?
You must ask for a fair hearing in writing and send it to:

- Department of Human Services
- Office of Medical Assistance Programs – HealthChoices Program
- Complaint, Grievance and Fair Hearings
- P.O. Box 2675
- Harrisburg, PA 17105-2675

Your request for a fair hearing should include:
- Member name, social security number and date of birth.
- Telephone number where you can be reached during the day.
- If you want to have the fair hearing in person or by telephone.
- Any letter you may have received about the issue you are requesting your fair hearing for.

What happens after I ask for a Fair Hearing?
You will get a letter from the Department of Human Services’ Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing. You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing. UnitedHealthcare Community Plan will also go to your fair hearing to explain why we made the decision or explain what happened.

If you ask, UnitedHealthcare Community Plan must give you (at no cost to you) any records, reports and other information we have that is relevant to what you requested your fair hearing about.

When will the Fair Hearing be decided?
If you ask for a fair hearing after a first-level complaint or grievance decision, the fair hearing will be decided no more than 60 days after the Department of Human Services gets your request. If your appeal is not decided within 90 days from the date that the Department of Human Services receives your request, you may be able to get interim assistance from the Department of Human Services until the decision is made. If you ask for a fair hearing and did not file a first-level complaint or grievance, or if you ask for a fair hearing after a second-level complaint or grievance decision, the fair hearing will be decided within 90 days from when the Department of Human Services gets your request.
What to do to continue getting services.
If you have been receiving services or items that are being reduced, changed or stopped and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that UnitedHealthcare Community Plan has reduced, changed or denied your services or items or telling you UnitedHealthcare Community Plan’s decision about your first or second-level complaint or grievance, your services or items will continue until a decision is made.

What Can I Do if My Health Is at Immediate Risk?

Expedited Fair Hearing.
If your doctor or dentist believes that using the normal amount of time to decide your fair hearing will harm your health, you or your doctor or dentist can call the Department of Human Services at 1-800-798-2339 and ask that your fair hearing be decided faster. This is called an expedited fair hearing. You will need to have a letter from your doctor or dentist faxed to 1-800-757-2617 explaining why using the usual time frames to decide your fair hearing will harm your health. If your doctor or dentist does not send a written statement, your doctor or dentist may testify at the fair hearing to explain why using the usual time frames to decide your fair hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within 3 business days after you ask for the fair hearing.

If your doctor does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date you asked for the fair hearing. If your doctor sent a written statement or testifies at the hearing, the decision will be made within 3 business days after you asked for the fair hearing.

You may call UnitedHealthcare Community Plan’s toll-free telephone number at 1-800-414-9025, TTY: 711, if you need help or have questions about fair hearings, you can contact Legal Aid at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258 if you need help or have questions about complaints and grievances.
Rights and Responsibilities

As a member of UnitedHealthcare Community Plan, you have the right:

• To receive information about UnitedHealthcare Community Plan, its services and benefits, network health care providers, how to file complaints and grievances and other information about UnitedHealthcare Community Plan and the member’s rights and responsibilities.
• To receive materials and information that is readable and in a different format or language.
• To have your personal and health information kept private.
• To request an accounting of disclosures of protected health information.
• To request that UnitedHealthcare Community Plan amends certain protected health information.
• To be treated with courtesy, consideration, respect and dignity.
• To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
• To expect that your records and anything you say to your doctor will be treated confidentially and will not be released without your consent.
• To receive information that you can understand about available treatment options and choices.
• To participate in decision making regarding your health care. This includes open discussion of appropriate or medically necessary treatment options and choices suitable for your condition, regardless of cost or benefit coverage. This includes the right to refuse treatment.
• To know what treatment you will receive, what the expected outcome is, what risks there are and the side effects.
• To ask for a second opinion about any medical treatment or procedure you are offered.
• To voice a complaint or grievance with or about UnitedHealthcare Community Plan or care provided and to receive timely response.
• To file a fair hearing appeal with the Department of Human Services.
• To offer suggestions for changes in UnitedHealthcare Community Plan's member rights and responsibilities.
• To receive health care services without discrimination based on race, color, ethnicity, age, mental or physical disability, religion, gender, sexual orientation, national origin or income.
• To choose your own PCP within the limits of the UnitedHealthcare Community Plan network, including the right to refuse the care of specific providers.
• To request and receive a copy of your medical records according to applicable federal and state laws, and to request that they be corrected or amended.
• To expect that your written permission will be obtained before we give out your medical information to anyone except those directly providing your care except for purpose specifically permitted by state and federal laws such as to make sure that UnitedHealthcare Community Plan members are getting quality care.

• To make an advance directive that tells others about the types of health care you want to receive when you are unable to speak for yourself.

• To receive information on the cost of your care.

• To exercise your rights freely, without it adversely affecting the way UnitedHealthcare Community Plan, its providers and state agencies treat you.

As a member of UnitedHealthcare Community Plan, you have a responsibility:

• To carry your UnitedHealthcare Community Plan card at all times.

• To learn and follow UnitedHealthcare Community Plan rules.

• To supply information to UnitedHealthcare Community Plan and your provider as well as let UnitedHealthcare Community Plan, your case worker and your provider know about important changes such as changes in your name, address and telephone number that are needed in order to provide you care.

• To get medical services from UnitedHealthcare Community Plan providers.

• To get an authorization from your PCP before you see a consultant or specialist except for dental, family planning, vision care, chiropractic services or OB/GYN services.

• To use the emergency room only in cases of an emergency.

• To treat your health care providers with courtesy, consideration, respect and dignity. This includes scheduling appointments, arriving on time for scheduled appointments and canceling appointments when you cannot keep them.

• To request protected health information by calling the UnitedHealthcare Community Plan Member Helpline at 1-800-414-9025, TTY: 711.

• To ask questions to understand your health problems and work with your provider and UnitedHealthcare Community Plan to develop agreed upon treatment goals.

• To follow treatment plans and instructions for care that you have agreed on with your provider.

• To learn about any procedure or treatment and to think about it before it is done.

• To learn about any procedure or treatment and to think about the outcome of refusing treatment that is suggested.

• To consider your health care choices carefully.

• To state your complaints and concerns in a polite and appropriate way.

• To report your symptoms, problems and related health information to your PCP.

• To tell your PCP about yourself and to sign consent forms so that your PCP can get a copy of your old records.
Other Plan Details

**Fraud and Abuse**

UnitedHealthcare Community Plan has a hotline if you want to report a medical provider (for example, a doctor, dentist, therapist or hospital) or business (for example, a medical supplier) if you think there is fraud or abuse. You can call the UnitedHealthcare Community Plan fraud and abuse hotline at 1-877-401-9430. Some examples of fraud and abuse are:

- Billing or charging you for services that your health plan covers.
- Offering you gifts or money to receive treatment or services.
- Members loaning their ACCESS or UnitedHealthcare Community Plan ID cards to another person to get services using the member’s name.
- Offering you free services, equipment or supplies in exchange for your ACCESS number.
- Giving you treatment or services that you do not need.
- Physical, mental or sexual abuse by medical staff.
- Being offered prescription or prescription medications without being seen or treated by the prescribing doctor.
- A member who visits an unusually high number of doctors to obtain narcotic drugs.

DHS also has a Medical Assistance Provider Compliance hotline that you can reach by dialing 1-844-DHS-TIPS (1-844-347-8477), Monday through Friday, 8:30 a.m. to 3:30 p.m. You may leave a voice-mail message at other times. You can also report suspected fraud and abuse by visiting [http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse](http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse) or emailing omaptips@state.pa.us. You don’t have to give your name. If you do, the provider won’t be told that you called. If you don’t speak English, an interpreter will be made available. If you are hearing-impaired, you can call the hotline using your TTY device.

**Review your policy and benefits statements.**

Review the paperwork you receive related to your health care coverage. Make sure you received the treatments for which your health plan was charged, and question suspicious expenses.

**Protect your health plan ID card like your credit card.**

In the wrong hands, a health plan ID card is a license to steal. Don’t give policy numbers to door-to-door salespeople or telephone solicitors. Never give your card to a friend to use for medical services. Help control the cost of health insurance by reporting suspect behavior. Join the effort to fight fraud and abuse in the health care system.

**If you aren’t sure, call us. You can make us aware of potential fraud via our helpline.**
Important Terms

**Abuse:** harming someone on purpose (this includes yelling, ignoring a person’s need and inappropriate touching).

**Advance Directive:** a decision about your health care that you make ahead of time in case you are ever unable to speak for yourself. This will let your family and your doctors know what decisions you would make if you were able to.

**Authorization:** an O.K. or approval for a service.

**Benefits:** services, procedures and medications that are covered by your membership.

**Clinical Care Management:** one-on-one help by a nurse providing education and coordination of benefits, tailored to your needs.

**Complaint:** when you tell UnitedHealthcare you are unhappy or do not agree with a decision by UnitedHealthcare Community Plan, the health plan’s policies or a provider.

**Disenrollment:** to stop your membership.

**Emergency:** a sudden and, at the time, unexpected change in a person’s physical or mental condition which, if a procedure or treatment is not performed right away, could be expected to result in 1) the loss of life or limb, 2) significant impairment to a bodily function, or 3) permanent damage to a body part.

**Fraud:** any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself or herself, or some other person in a managed care setting. Fraud can be committed by anyone, including managed care plans, providers, state employees and members.

**Grievance:** when you tell us in writing that you disagree with a decision UnitedHealthcare Community Plan made about services your doctor requested for you.

**Health Information:** facts about your health and care. This information may come from UnitedHealthcare or a provider. It includes information about your physical and mental health, as well as payments for care.

**ID Card:** an identification card that says you are a member. You should have this card with you at all times.

**Immunization:** a shot that protects, or “immunizes,” a member from a disease. Children should receive different shots at different ages. These shots are often given during regular doctor visits.

**Informed Consent:** understanding and agreeing to treatment before you receive it. You may have to agree in writing. You have the right to say yes or no. If you do not want the treatment, your PCP will give you other choices.
**In-Network**: doctors, specialists, hospitals, pharmacies and other providers who have an arrangement with UnitedHealthcare Community Plan to provide health care services to members.

**Inpatient**: what you are called when you are admitted into a hospital for a length of time.

**Medically Necessary**: A service or benefit is Medically Necessary if it is compensable under the MA Program and 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.
- The service or benefit will assist 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.

**Member**: an eligible person enrolled with UnitedHealthcare Community Plan in the Medical Assistance program.

**Out-of-Network**: doctors, specialists, hospitals, pharmacies and other providers who do not have an arrangement with UnitedHealthcare Community Plan to provide health care services to members.

**Outpatient**: when you have a procedure done that does not require a hospital stay overnight.

**Prescription**: a doctor’s written instructions for medication or treatment.

**Primary Care Provider (PCP)**: a doctor you choose to be your physician. These physicians are not employees of UnitedHealthcare.

**Provider or Practitioner**: a person or facility that offers health care (doctor, pharmacy, dentist, clinic, hospital, etc.).

**Provider Directory**: a list of providers who participate with UnitedHealthcare Community Plan to take care of your health needs.

**Prior Authorization**: when your doctor gets approval for services that need a detailed review before being covered.

**Referral**: when you and your PCP agree you need to see another doctor and your PCP sends you to a network specialist.

**Self-Referral Services**: services for which you do not need a referral from your PCP before receiving.

**Specialist**: any doctor who has special training for a specific condition or illness.

**Urgent Care**: when you need care, treatment or medical advice within a 24-hour time period.
HEALTH PLAN NOTICES OF PRIVACY PRACTICES.
THIS NOTICE SAYS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED.
IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2015.
We must by law protect the privacy of your health information ("HI"). We must send you this notice. It tells you:

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

We must by law follow the terms of this notice.

“Health information” (or HI) in this notice means information that can be used to identify you. And it must relate to your health or health care services. We have the right to change our privacy practices. If we change them, we will, in our next annual mailing, either mail you a notice or provide you the notice by e-mail, if permitted by law. We will post the new notice on your health plan website MyUHC.com/CommunityPlan. We have the right to make the changed notice apply to HI that we have now and to future information. We will follow the law and give you notice of a breach of your HI.

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

How we use or share information.
We must use and share your HI if asked for by:

• You or your legal representative.
• The Secretary of the Department of Health and Human Services to make sure your privacy is protected.

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

• For Payments. This also may include coordinating benefits. For example, we may tell a doctor if you are eligible for coverage and how much of the bill may be covered.
• For Treatment or managing care. For example, we may share your HI with providers to help them give you care.
• For Health Care Operations related to your care. For example, we may suggest a disease management or wellness program. We may study data to see how we can improve our services.
Other Plan Details

- **To tell you about Health Programs or Products.** This may be other treatments or products and services. These activities may be limited by law.

- **For Plan Sponsors.** We may give enrollment, disenrollment and summary HI to an employer plan sponsor. We may give them other HI if they agree to limit its use per federal law.

- **For Underwriting Purposes.** We may use your HI to make underwriting decisions but we will not use your genetic HI for underwriting purposes.

- **For Reminders on benefits or care.** Such as appointment reminders.

**We may** use or share your HI as follows:

- **As Required by Law.**

- **To Persons Involved With Your Care.** This may be to a family member. This may happen if you are unable to agree or object. Examples are an emergency or when you agree or fail to object when asked. If you are not able to object, we will use our best judgment. Special rules apply for when we may share HI of people who have died.

- **For Public Health Activities.** This may be to prevent disease outbreaks.

- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.

- **For Health Oversight Activities to an agency allowed by the law to get the HI.** This may be for licensure, audits and fraud and abuse investigations.

- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.

- **For Law Enforcement.** To find a missing person or report a crime.

- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.

- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.

- **For Workers’ Compensation.** To comply with labor laws.

- **For Research.** To study disease or disability, as allowed by law.

- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death or as stated by law. We may give HI to funeral directors.

- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.

- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) To give health care; (2) To protect your health and the health of others; (3) For the security of the institution.

- **To Our Business Associates if needed to give you services.** Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.
• Other Restrictions. Federal and state laws may limit the use and sharing of highly confidential HI. This may include state laws on:
  1. HIV/AIDS.
  2. Mental health.
  3. Genetic tests.
  4. Alcohol and drug abuse.
  5. Sexually transmitted diseases (STD) and reproductive health.
  6. Child or adult abuse or neglect or sexual assault.

If stricter laws apply, we aim to meet those laws. Attached is a “Federal and State Amendments” document.

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

Your rights.
You have a right:

• To ask us to limit use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others involved in your care or payment for it. We may allow your dependents to ask for limits. We will try to honor your request, but we do not have to do so.

• To ask to get confidential communications in a different way or place. (For example, at a P.O. Box instead of your home.) We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.

• To see or get a copy of certain HI that we use to make decisions about you. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you will have the right to ask for an electronic copy to be sent to you. You can ask to have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.

• To ask to amend. If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.

• To get an accounting of HI shared in the six years prior to your request. This will not include any HI shared: (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does require us to track.
Other Plan Details

• To get a paper copy of this notice. You may ask for a copy at any time. Even if you agreed to get this notice electronically, you have a right to a paper copy. You may also get a copy at our website, MyUHC.com/CommunityPlan.

Using your rights.
• To Contact your Health Plan. Call the phone number on your ID card. Or you may contact the UnitedHealth Group Call Center at 1-800-414-9025, TTY: 711.
• To Submit a Written Request. Mail to:
  UnitedHealthcare Government Programs Privacy Office
  MN006-W800
  P.O. Box 1459
  Minneapolis, MN 55440
• To File a Complaint. If you think your privacy rights have been violated, you may send a complaint at the address above.

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

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

Effective January 1, 2015.
We protect your “personal financial information” (“FI”). This means non-health information about someone with health care coverage or someone applying for coverage. It is information that identifies the person and is generally not public.

Information we collect.
We get FI about you from:
• Applications or forms. This may be name, address, age and social security number.
• Your transactions with us or others. This may be premium payment data.

Sharing of FI.
We do not share FI about our members or former members, except as required or permitted by law.
To run our business, we may share FI without your consent to our affiliates. This is to tell them about your transactions, such as premium payment.

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

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

Questions about this notice.
If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-800-414-9025, TTY: 711.


2For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1 on this page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; ProcessWorks, 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 Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.
UNITEDHEALTH GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS.

Revised: January 1, 2015.

The first part of this Notice (pages 77 – 81) 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

<table>
<thead>
<tr>
<th>General Health Information</th>
<th>CA, NE, PR, RI, VT, WA, WI</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.</td>
<td>CA, IA</td>
</tr>
<tr>
<td>HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.</td>
<td>KY</td>
</tr>
<tr>
<td>You may be able to restrict certain electronic disclosures of health information.</td>
<td>NC, NV</td>
</tr>
<tr>
<td>We are not allowed to use health information for certain purposes.</td>
<td>CA, IA</td>
</tr>
<tr>
<td>We will not use and/or share information regarding certain public assistance programs except for certain purposes.</td>
<td>KY, MO, NJ, SD</td>
</tr>
<tr>
<td>We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.</td>
<td>KS</td>
</tr>
</tbody>
</table>
## 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 (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, IL, 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, MD, MA, 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
## Other Plan Details

### HIV/AIDS

<table>
<thead>
<tr>
<th>Details</th>
<th>States</th>
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<tbody>
<tr>
<td>We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
<td>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</td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of HIV/AIDS-related information.</td>
<td>CT, FL</td>
</tr>
<tr>
<td>We will collect certain HIV/AIDS-related information only with your written consent.</td>
<td>OR</td>
</tr>
</tbody>
</table>

### Mental Health

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

### Child or Adult Abuse

<table>
<thead>
<tr>
<th>Details</th>
<th>States</th>
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<tbody>
<tr>
<td>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.</td>
<td>AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI</td>
</tr>
</tbody>
</table>
**Personal Representative Authorization**

**Instructions:** Please complete and sign this form to appoint a personal representative. A separate form is required for each member. Return in the self-addressed stamped envelope. UnitedHealthcare Community Plan will grant your personal representative the same rights to your protected health information (PHI) that is provided to you.

**Member Information:** (individual whose information will be released)

Full Name ____________________________ ID # __________________
Address ____________________________________________

Social Security # (last 4 digits) ______ Date of Birth _________ Phone # __________________

**Authorization:** I hereby authorize the request and release of my PHI held by UnitedHealthcare Community Plan to my personal representative. By appointing the person named on this form as my personal representative, I understand that I am authorizing UnitedHealthcare Community Plan to give this person access to my PHI and medical records and the right to talk to UnitedHealthcare Community Plan about my account.

I understand that my authorization will remain in effect for the length of time specified below. I have had full opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization for the request and release of my PHI, as described in this form.

I __________________________ appoint __________________________ to be my personal representative.

(Member Name) (Personal Representative)

**Time Period for Representation:** From ___________ To ____________

Note: If no time period is provided, this request will remain in effect until the member or his/her legal representative notifies UnitedHealthcare Community Plan in writing requesting a change.

**Your Right to Revoke:** You may revoke this authorization at any time by giving written notice to UnitedHealthcare Community Plan. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please call UnitedHealthcare Community Plan for more information if you desire to cancel this authorization.

**Personal Representative Information:** (required for privacy verification purposes)

Full Name ____________________________ Date of Birth ____________________________
Address ____________________________________________ Phone # __________________

Social Security # (last 4 digits) _________ Relationship to Member __________________________________

**Important:** Guardians, court appointed representatives or other responsible parties must send a copy of legal documents. If you have questions or need help, call Member Services at the number listed on the back of the member card.

______________________________  __________________
Signature of Member/Requestor        Date

______________________________
Printed Name
We’re here for you.

Remember, we’re always ready to answer any questions you may have. Just call Member Services at **1-800-414-9025, TTY: 711**. You can also visit our website at [MyUHC.com/CommunityPlan](http://MyUHC.com/CommunityPlan).

UnitedHealthcare Community Plan
1001 Brinton Road
Pittsburgh, PA 15221

[MyUHC.com/CommunityPlan](http://MyUHC.com/CommunityPlan)

1-800-414-9025, TTY: 711