



Welcome to the
community.

Texas – November 2016

**UnitedHealthcare Community Plan
STAR Kids Member Handbook**

1-877-597-7799, TTY 711,
for hearing impaired



Counties Served:

Anderson, Angelina, Austin, Bell, Blanco, Bosque, Bowie, Brazoria, Brazos, Burleson, Cameron, Camp, Cass, Chambers, Cherokee, Colorado, Comanche, Cooke, Coryell, Delta, DeWitt, Duval, Erath, Falls, Fannin, Fort Bend, Franklin, Freestone, Galveston, Gillespie, Gonzales, Grayson, Gregg, Grimes, Hamilton, Hardin, Harris, Harrison, Henderson, Hidalgo, Hill, Hopkins, Houston, Jackson, Jasper, Jefferson, Jim Hogg, Lamar, Lampasas, Lavaca, Leon, Liberty, Limestone, Llano, Madison, Marion, Matagorda, Maverick, McLennan, McMullen, Milam, Mills, Montague, Montgomery, Morris, Nacogdoches, Newton, Orange, Panola, Polk, Rains, Red River, Robertson, Rusk, Sabine, San Augustine, San Jacinto, San Saba, Shelby, Smith, Somervell, Starr, Titus, Trinity, Tyler, Upshur, Van Zandt, Walker, Waller, Washington, Webb, Wharton, Willacy, Wood and Zapata counties.

1-877-597-7799, TTY 711, for hearing impaired

Monday – Friday, 8:00 a.m. – 5:00 p.m. CST **UHCommunityPlan.com**

What to Do in an Emergency

Call **911** or go to the nearest hospital/emergency facility if you think you need emergency care. You can call **911** for help in getting to the hospital emergency room. If you receive emergency services, call your doctor to schedule a follow-up visit as soon as possible. Please call us and let us know of the emergency care you received. An emergency is a condition in which you think you have a serious medical condition, or not getting medical care right away will be a threat to your life, limb or sight.

What to Do in a Behavioral Health Emergency

You should call **911** if you are having a life-threatening behavioral health emergency. You can also go to the nearest emergency room. You need to call Optum Behavioral Health toll-free at **1-877-597-7799** as soon as possible.

In Case of Emergency Call **911**

*If you think that it is not an Emergency, but you need help, call the NurseLine at **1-844-222-7326**.*

If you have questions about your health plan, please call us. Our toll-free Member Services number is **1-877-597-7799, TTY 711**, for hearing impaired. There will be people who can speak to you in English and Spanish when you call.

This Member Handbook is available in audio, Braille, larger print and in other languages at your request. Please call 1-877-597-7799 for help.

Toll-Free Telephone Numbers

Member Services (8:00 a.m. to 5:00 p.m. Monday through Friday) **1-877-597-7799**
TTY (for hearing impaired) **711**

- After hours, please contact NurseLine.
- Interpreter services available.
- Se Habla Español.
- How to access covered services and Service Coordination.

NurseLine (Available 24 hours a day, 7 days a week) **1-844-222-7326**
Nurses are knowledgeable about the STAR Kids Program,
Covered Services, STAR Kids members, and provider resources.

Service Coordination **1-877-352-7798**
8:00 a.m. – 5:00 p.m. Monday – Friday
Service Coordinators are knowledgeable about
the STAR Kids Program, Covered Services,
STAR Kids members, and provider resources.

For Dental Services, call your child’s Medicaid dental plan.
DentaQuest
1-800-516-0165
MCNA Dental
1-855-691-6262

For a crisis and you have trouble with the phone line, call 911 or go to the nearest emergency room.

For Eye Care Appointments, Call Member Services **1-877-597-7799**
Texas Health and Human Services Commission **1-877-541-7905**

Rides to Doctor Visits
Rides to doctor visits in Harris and Jefferson Service Delivery Areas,
call Medical Transportation Management toll-free at **1-855-687-4786**
All other Service Delivery Areas call Medical Transportation Program toll-free at ... **1-877-633-8747**

Mental Health and Substance Abuse Services
Optum Behavioral Health; available 24 hours a day, 7 days a week. **1-877-597-7799**
Information and Interpreters are available in many languages.

Ombudsman Managed Care Assistance Team **1-866-566-8989**

Medicaid Managed Care Helpline **1-866-566-8989**

Medicaid Managed Care Helpline TTY **1-866-222-4306**

STAR Kids Program Helpline **1-800-964-2777**

Pharmacy Benefits **1-877-597-7799**

Non-Emergent Transportation Service in any Service Delivery Area, Call LogistiCare **1-866-529-2117**

UnitedHealthcare Community Plan • 14141 Southwest Freeway, Suite 800 • Sugar Land, TX 77478
Phone: **1-877-597-7799**

Welcome to **UnitedHealthcare Community Plan.**

Thank you for choosing UnitedHealthcare Community Plan as your health plan. The UnitedHealthcare Community Plan, a trade name of United Healthcare Insurance Company, a Health Maintenance Organization (HMO), is committed to helping you get the health care you need. At UnitedHealthcare Community Plan, our goal is to help all of our members live healthier lives. You will have your own doctor, called a Primary Care Provider (PCP), who will know your medical history and will work hard to help you stay healthy. Your PCP knows that managing your health care is important. Regular checkups with your PCP can help spot problems early. Your PCP wants to help before problems become serious. Your PCP will give you a referral to specialists when you need one. UnitedHealthcare Community Plan has a network of doctors, hospitals and other health caregivers that you can count on. Many are near your home. UnitedHealthcare Community Plan will work hard to help make sure you get access to the care you need.

Your guide to good health.

Please read this Member Handbook. It will tell you about your benefits. It will help you use your health plan right away. If you feel you need this handbook in Braille, larger print, another language or in audio, you can call us at **1-877-597-7799**. UnitedHealthcare Community Plan Member Services is always ready to help you.

Look at your UnitedHealthcare Community Plan identification card. Make sure all the information is right. We want to make it easy for you to use your health plan. If you have questions, please call us. Our toll-free Member Services number is **1-877-597-7799**. We are here to help you Monday to Friday, 8:00 a.m. to 5:00 p.m. After hours and weekend coverage is available via an automated telephone system.

***Note:** References to “you,” “my,” or “I” apply if you are a STAR Kids member. References to “my child” apply if your child is a STAR Kids member.*

All phone numbers listed in this handbook are toll-free.

Language and Interpreter Services

UnitedHealthcare Community Plan has staff that speaks English and Spanish. If you speak another language or are hearing impaired and need help, call Member Services at **1-877-597-7799** or **TTY 711** for hearing impaired.

Our Office Locations

UnitedHealthcare Community Plan

Regional Service Delivery Area Office

14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478

Or visit our website at:

UHCCommunityPlan.com

What Is Member Services?

UnitedHealthcare Community Plan has a Member Services department that can answer questions and give you information in English and Spanish on:

- Membership.
- Choosing a PCP.
- Specialists, hospitals and other providers.
- Covered services.
- Extra Benefits.
- Changing PCPs.
- Filing a complaint.
- Getting an interpreter.
- Anything else you might have a question about.

Member Services:
1-877-597-7799
(TTY 711)

**Our office is closed
on these major holidays:**

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day



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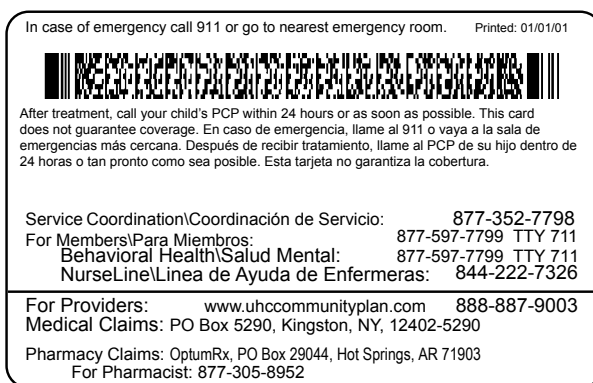
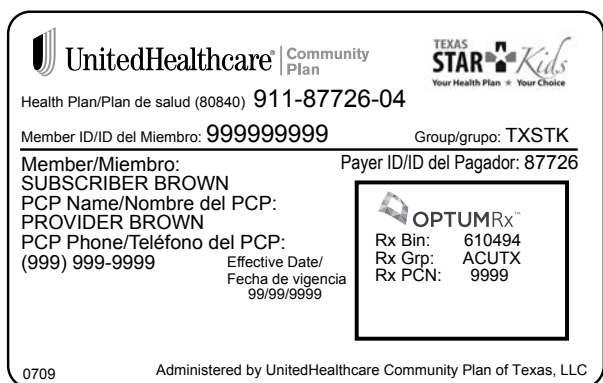
Health Plan Highlights

Your UnitedHealthcare Community Plan ID Card

When and where do I use my UnitedHealthcare Community Plan ID card?

Every person who becomes a member of UnitedHealthcare Community Plan gets an ID card. The ID card gives the doctor and office staff important information about your child. You will get a new ID card if you change your child's Primary Care Provider (PCP).

Check your child's card to make sure the information is correct. If you get an ID card that has no PCP name but says to call **1-877-597-7799**, please call Member Services to select a PCP. Give your child's ID card to the doctor to verify coverage when getting services. The ID card is not a guarantee of benefits or coverage. For STAR Kids members who are covered by Medicare, no Primary Care Provider will be assigned.



How to read your UnitedHealthcare Community Plan ID card.

Your ID card will have the STAR Kids logo and the UnitedHealthcare Community Plan logo. This will let your provider know that you are a UnitedHealthcare Community Plan member. Your name, ID number, the date you joined the UnitedHealthcare Community Plan program, and your date of birth will be seen on your card. Your group number will also be on your card.

Remember to take your card with you and present it whenever you get services. Your provider will need the information on your card to find out about your benefits and coverage.

How to replace your card if it is lost.

If you lose your UnitedHealthcare Community Plan ID card, call Member Services right away at **1-877-597-7799**. Member Services will send you a new one. Call **TTY 711** for hearing impaired.

Your Temporary Medicaid Verification Form (Form 1027A)

You can request a temporary Medicaid verification form if your *Your Texas Benefits Medicaid card* is lost or stolen. You need to contact your local Eligibility office or call 211 for information on getting the Temporary Medicaid verification form.

- Take your temporary verification form with you to the doctor and to get other medical care.
- Show your UnitedHealthcare Community Plan ID card and your *Your Texas Benefits Medicaid card* every time you go to a doctor's office or clinic.
- If you move or change your phone number, call 211 or visit your local HHSC benefits office. Also call Member Services at **1-877-597-7799** so we can update our records. Call **TTY 711** for hearing impaired.

4.15.1 Medicaid Eligibility Verification (Form H1027-A)

Texas Health and Human Services Commission/Form H1027-A(03-2017)

Medicaid Eligibility Verification
Confirmación de elegibilidad para Medicaid

THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.
ESTA FORMA ES VÁLIDA SOLAMENTE EN LAS FECHAS INDICADAS ABAJO. NO ES VÁLIDA NI ANTES NI DESPUÉS DE ESTAS FECHAS.

Each person listed below has applied and is eligible for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacists have 30 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filing deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.

Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid Identification form is lost or late. The client number must appear on all claims for health services.

Qual Eligible/Verificado
Verification Method
 Local DCU SAVERR Direct Inquiry Regional Procedure S.D DCU (A & D Staff Only)

EN 610098

Client Name Nombre del Cliente	Date of Birth Fecha de Nacimiento	Client No. Cliente Num.	Eligibility Dates Período de Elegibilidad	Medicare Claim No. Núm. de Seguro de Pago de Medicare	Plan Name and Member Services Toll-Free Telephone No. Nombre del plan y teléfono gratuito de Servicios para Miembros
			From/Desde	Through/Hasta	

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form H1027) for the current month. I have requested and received Form H1027-A, Medicaid Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

CAUTION: If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for these services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Por este medio certifico, bajo pena de perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la identificación para Medicaid (Forma H1027) del corriente mes. Solicito y recibo esta Confirmación de Elegibilidad Médica (Forma H1027-A) para comprobar nuestra elegibilidad para Medicaid durante el período cubierto especificado arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos de Medicaid) para alguna persona no nombrada arriba como beneficiario constituye fraude y es castigable por una multa y/o la cárcel.

ADVERTENCIA: Si usted acepta beneficios de Medicaid (servicios o artículos), otorga y concede al estado de Texas el derecho a recibir pagos por los servicios o artículos de otras compañías de seguros y otras fuentes responsables, hasta completar la cantidad que se requiere para cubrir lo que haya gastado Medicaid.

Signature - Client or Representative/Firma - Cliente o Representante Date/Fecha

Office Address and Telephone No./Oficina y Teléfono

Name of Worker (Type)/Nombre del Trabajador	Worker B.N.N.	Worker Signature	Date
Name of Supervisor (Type)/Nombre del Supervisor	Supervisor B.N.N.	Supervisor Signature	Date

or Authorized Lead Worker/o Trabajador encargado

(Temporary Medicaid Verification Form Sample - Front)

(Temporary Medicaid Verification Form Sample - Back)

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pay. It is very important that you have Medicaid when you go to the doctor, hospital, or you if you still Medicaid puede que usted tenga que pagar estas cuentas. Si no las dice que tiene Medicaid puede que usted tenga que pagar estas cuentas. Si usted recibe una cuenta de un doctor, un hospital, u otro proveedor de servicios médicos, asegure por que le mande la cuenta. Si todavía le mandan una cuenta, llame al número gratis de Medicaid al 1-800-252-0263 para pedir ayuda. Si Medicaid no va a pagar la cuenta o si no le pagan los beneficios de Medicaid (los servicios o los artículos), usted puede pedir por escrito una audiencia imparcial. La dirección y el número de teléfono aparecen en la carta que recibió.

Note: Family planning clinics and other providers give free physical exams, lab tests, birth control methods (including sterilization) and contraceptive counseling.

Note: Las clínicas de planificación familiar y los otros proveedores ofrecen gratis exámenes físicos, análisis de laboratorio, métodos anticonceptivos (inclusive la esterilización) y consejería sobre los anticonceptivos.

get a bill, call the Medicaid hotline at 1-800-252-0263 for help. If Medicaid will not pay the bill or Medicaid benefits (services and supplies) are denied, you may request a fair hearing by writing to the address or calling the telephone number listed on the letter you get.

Note: Family planning clinics and other providers give free physical exams, lab tests, birth control methods (including sterilization) and contraceptive counseling.

Provider Information/Información para el proveedor

Only those people listed under "CLIENT NAME" have Medicaid coverage. Payment is allowed ONLY for services received during the eligibility dates reflected on the front of this form.

Note: Payment for Family Planning Services is available without the consent of the client's parent or spouse. Confidentiality is required. Family planning drugs, supplies, and services are exempt from the prescription drug and "LIMITED" restrictions.

If there is a health plan named on the front of this form, the client is a member of that health plan in a Medicaid Managed Care program.

Key to terms that may appear on this form:

Limited- Except for family planning services, and for Texas Health Steps (EPST), medical screening, dental, and hearing aid services, the client is limited to seeing the doctor and/or limited to using the pharmacy named on the form for drugs obtained through the Vendor Drug Program. In the event of an emergency medical condition as defined below, the "LIMITED" restriction does not apply.

Emergency- The client is limited to coverage for an emergency medical condition. This means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms sufficient severity (including severe pain) such that the absence of immediate medical care could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

Hospice- The client is in hospice and waives the right to receive services related to the terminal condition through other Medicaid programs. If a client claims to have cancer/hospice, call the local hospice agency or HHSC to verify.

OMB- The Medicaid agency is providing coverage of Medicare premiums, deductible, and coinsurance liabilities, but the client is not eligible for regular Medicaid benefits.

QMB- The Medicaid agency is providing regular Medicaid coverage as well as coverage of Medicare premiums, deductibles, and coinsurance liabilities.

PE- Medicaid covers only family planning and medically necessary outpatient services.

Women's Health Program- Medicaid coverage is limited to an annual exam, health screenings and contraceptives. The client is not eligible for regular Medicaid benefits.

Note to Pharmacy: Medicaid will pay for more than three prescriptions each month for any Medicaid client who is under age 21, or lives in a nursing facility, or has the STAR/STAR-PLUS Health Plan, or gets services through the Community Living Assistance and Support Services (CLASS), Community Based Alternatives (CBA) and other non-301 community-based waiver programs. Clients with Medicare who are enrolled in STAR-PLUS may be limited to three prescriptions per month.

Your Texas Benefits Medicaid Card

When you are approved for Medicaid, you will get a *Your Texas Benefits Medicaid card*. This plastic card will be your everyday Medicaid ID card. You should carry and protect it just like your driver's license or a credit card. The card has a magnetic strip that holds your Medicaid ID number. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.

You will only be issued one card, and will only receive a new card in the event of the card being lost or stolen. If your Medicaid ID card is lost or stolen, you can get a new one by calling toll-free at 1-855-827-3748.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 1-800-252-8263. You can also call 211. First pick a language and then pick Option 2. Your health history is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your health history through the secure online network, call toll-free at 1-800-252-8263.

The *Your Texas Benefits Medicaid card* has these facts printed on the front:

- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
 - Medicare (QMB, MQMB),
 - Texas Women's Health Program (TWHP),
 - Hospice,
 - STAR Kids Health,
 - Emergency Medicaid, or
 - Presumptive Eligibility for Pregnant Women (PE).
- Facts your drug store will need to bill Medicaid.
- The name of your doctor and drug store if you're in the Medicaid Lock-in program.

The back of the *Your Texas Benefits Medicaid card* has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call (1-800-252-8263) if you have questions about the new card.

If you forget your card, your doctor, dentist or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

Each person who gets Medicaid gets a card. For example, if you have 3 people in your home who get Medicaid, there should be 3 cards — one for each person.

- Take this card when you go to a Medicaid doctor, dentist or drug store.
- Carry and protect the card just like your driver's license or a credit card.
- If you lose the card, call 1-855-827-3748. The number is free to call.

What Is a Primary Care Provider (PCP)?

Your PCP has the job of taking care of you. Regular checkups with your PCP are important and can help you stay healthy. Your PCP will do regular health screenings that can find problems.

Finding and treating problems early can prevent them from becoming bigger problems later. Your PCP will be your personal doctor from now on. Your PCP will take care of you and refer you to a specialist when needed. You should talk to your PCP about all of your health care needs.

Always talk to your PCP when you want to visit another doctor. Your PCP will give you a referral form if you need one. Your relationship with your PCP is important. Get to know your PCP as soon as possible. It is important to follow the PCP's advice. A good way to build a relationship with your PCP is to call and schedule a checkup. You can meet your PCP then. He or she will get to know your medical history, any medications you are taking and any other health problems. Don't forget that your PCP is the first one you call with any health problems or questions.

Depending on your medical needs, a specialist may be your PCP. You, the PCP, the specialist and UnitedHealthcare Community Plan will make this decision. Please call Member Services for information.

How do I pick a primary care provider?

Call Member Services for help in choosing a PCP. All members of UnitedHealthcare Community Plan must pick a PCP. You can also request a UnitedHealthcare Community Plan Provider Directory by calling Member Services at **1-877-597-7799**, or you can look online at **UHCCommunityPlan.com**.

What do I need to bring with me to my doctor's appointment?

You must take your UnitedHealthcare Community Plan ID card and your Your Texas Benefits Medicaid card with you when you receive any health care services. You will need to show your UnitedHealthcare Community Plan ID card and *Your Texas Benefits Medicaid card* each time you need services. If you have a new doctor, bring any important medical records you may have and any medications prescribed by a doctor.

Can a clinic be my primary care provider?

Your PCP can be a doctor, a clinic, a Rural Health Center (RHC) or a Federally Qualified Health Center (FQHC). If you go to a doctor you like, you can keep going to that doctor if he or she is in the UnitedHealthcare Community Plan network.

If your doctor is a specialist, he or she might be allowed to be your PCP. UnitedHealthcare Community Plan will send you a UnitedHealthcare Community Plan ID card with your PCP's name and phone number.

For STAR Kids members who are covered by Medicare or commercial insurance, no Primary Care Provider will be assigned.

What if my doctor is not in network?

If your doctor is NOT in the UnitedHealthcare Community Plan network, please call Member Services to select a PCP. If you do not pick a doctor, one will be assigned for you.

What if I choose to go to another doctor who is not my primary care provider?

Except in emergencies, always call your PCP before you go to another doctor or the hospital. You can reach your PCP or back-up doctor 24 hours a day, seven days a week.

If you go to another doctor who is not your PCP, you may need to pay the bill.

Can I stay with my provider if they are not with my health plan?

You should try to choose a PCP that is in your health plan's Provider Network. Please contact Member Services if you need help.

How can I change my primary care provider?

It is good to stay with the same PCP. Your PCP knows you, has your medical records, and knows what medications you take. Your PCP is the best person to make sure you are getting good medical care. Call Member Services to tell us if you want to change your PCP.

How many times can I change my/my child's primary care provider?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us toll-free at **1-877-597-7799** or writing to us at:

UnitedHealthcare Community Plan
Attn: Member Advocate Team
14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478

When will my primary care provider change be effective?

The PCP change will become effective the day following the change.

Reasons you might change your PCP:

- You have moved and you need a PCP that is closer to your home.
- You are not happy with your PCP.

Are there any reasons why a request to change a primary care provider may be denied?

- You asked for a PCP who is not part of the UnitedHealthcare Community Plan health plan.
- You asked for a PCP who is not accepting new patients because he or she is seeing too many patients.

Questions about
seeing a provider?

Call Member Services
toll-free at

1-877-597-7799.

Can a primary care provider move me to another primary care provider for non-compliance?

Yes, if your PCP does not feel you are following his/her medical advice or if you miss a lot of appointments, the doctor can ask you to see another doctor. Your PCP will send you a letter telling you that you need to find another doctor. If this happens, call Member Services at **1-877-597-7799**. We will help you find another doctor.

Physician incentive plans.

The MCO cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to members. UnitedHealthcare Community Plan rewards doctors for treatments that reduce or limit services for people covered by Medicaid. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call **1-877-597-7799** to learn more about this.

What if I Need to See a Special Doctor (Specialist)?

Your PCP might want you to see a special doctor (specialist) for certain health care needs. While your PCP can take care of most of your health care needs, sometimes they will want you to see a specialist for your care. A specialist has received training and has more experience taking care of certain diseases, illnesses and injuries. UnitedHealthcare Community Plan has many specialists who will work with you and your PCP to care for your needs.

What is a referral? Do I need a referral to see a specialist?

Your PCP will talk to you about your needs and will help make plans for you to see the specialist that can provide the best care for you, including providing a referral if the specialist asks for one. A referral is a special kind of agreement between doctors that says the specialist will treat you.

UnitedHealthcare Community Plan does not require referrals for you to see a specialist. You can see any specialist with or without a referral.

What services do not need a referral?

You do NOT need a referral for:

- Emergency Services.
- OB/GYN care.
- Behavioral Health Services.
- Routine Vision Services.
- Routine Dental Services.

Contact your PCP or Member Services at **1-877-597-7799** to determine if you need a referral.

How soon can I expect to be seen by a specialist?

In some situations, the specialist may see you right away. Depending on the medical need, it may take up to a few weeks after you make the appointment to see the specialist.

How can I ask for a second opinion?

You have the right to a second opinion from a UnitedHealthcare Community Plan provider if you are not satisfied with the plan of care offered by the specialist. Your primary care provider should be able to give you a referral for a second opinion visit. If your doctor wants you to see a specialist that is not a UnitedHealthcare Community Plan provider, that visit will have to be approved by UnitedHealthcare Community Plan. You can call Member Services at **1-877-597-7799** for help with getting a second opinion.

How do I get help if I have behavioral health, mental health, alcohol or drug problems?

Do I need a referral for this?

UnitedHealthcare Community Plan covers medically necessary Substance Abuse and Behavioral Health Care services. If you have a drug problem or are very upset about something, you can get help. Call **1-877-597-7799** for help. You do not need a referral for these services.

There will be people who can speak with you in English or Spanish. If you need help with other languages, please tell them. Member Services will connect you to the AT&T Language Line and answer your questions. Please call **TTY 711**, for hearing impaired.

*If it is a crisis and you have trouble with the phone line, call **911** or go to the nearest emergency room and contact UnitedHealthcare Community Plan within 24 hours.*

How Do I Get My Medications?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

How do I find a network drug store?

Please contact Member Services for assistance at **1-877-597-7799** or look for a pharmacy on our website at UHCCommunityPlan.com.

What if I go to a drug store not in network?

This may affect your ability to get the medications you need. Please contact Member Services for assistance at **1-877-597-7799** or to find an in-network pharmacy. You can also look on our website at UHCCommunityPlan.com.

Going to the Doctor

What do I bring with me to the drug store?

You will need your prescription, your UnitedHealthcare Community Plan member ID card and your *Your Texas Benefits Medicaid card*.

What if I need my medications delivered to me?

Some drug stores are in our delivery program. Ask the drug store if they deliver to UnitedHealthcare Community Plan members.

For a list of network pharmacies that deliver, go to this web address:

<http://www.UHCCommunityPlan.com/assets/TX-DeliveryPharmacies.pdf>.

Who do I call if I have problems getting my medications?

All prescriptions you get from your doctor can be filled at any drug store that accepts UnitedHealthcare Community Plan. If you need help finding a drug store, call UnitedHealthcare Community Plan at **1-877-597-7799**. Remember — always take your prescription, your UnitedHealthcare Community Plan ID card and your *Your Texas Benefits Medicaid card* with you to the doctor and to the drug store.

What if I can't get the medication my doctor ordered approved?

If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication. Call UnitedHealthcare Community Plan at **1-877-597-7799** for help with your medications and refills. For a list of covered medications, please visit UHCCommunityPlan.com.

What if I lose my medications?

Please contact Member Services for assistance at **1-877-597-7799**.

What if I need Durable Medical Equipment (DME) or other products normally found in a pharmacy?

Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all members, UnitedHealthcare Community Plan pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through 20), UnitedHealthcare Community Plan also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

For more information about these benefits or questions about whether your pharmacy provides DME or other supplies, call UnitedHealthcare Community Plan at **1-877-597-7799**.

How do I get my medications if I am in a nursing facility?

The way you get your medications in the nursing facility will not change. Prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D.

What is the Medicaid Lock-in Program?

You may be put in the Lock-in Program if you do not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same. Changing to a different MCO will not change the Lock-in status.

To avoid being put in the Medicaid Lock-in Program:

- Pick one drug store at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors who give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more, call **1-877-597-7799**.

Who Do I Call if I Have Special Health Care Needs and I Need Someone to Help Me?

If you have special health care needs, like a serious ongoing illness, disability or chronic or complex conditions, please call your Service Coordinator toll-free at 1-877-352-7798 for help with your special health care needs.

What Other Programs Are Available to Help Me Manage My Chronic Illness?

If you have a special need or need help managing a chronic illness, call **1-877-597-7799** to get in contact with a Service Coordinator. We have disease management programs that help members with chronic illnesses such as:

- Diabetes.
- Asthma.
- Heart Failure.
- COPD.
- Coronary Artery Disease.
- Obesity.

Members in these programs receive reminders about their care and advice from a nurse.

What if I Need OB/GYN Care? Will I Need a Referral?

ATTENTION FEMALE MEMBERS: UnitedHealthcare Community Plan allows you to pick any OB/GYN, whether that doctor is in the same network as your Primary Care Provider or not.

You have the right to pick an OB/GYN without a referral from your PCP. An OB/GYN can give you:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to a special doctor within the network.

You can get OB/GYN services from your doctor. You can also pick an OB/GYN specialist to take care of your female health needs. An OB/GYN can help with pregnancy care, yearly checkups or if you have female problems.

You DO NOT need a referral from a doctor for these services. Your OB/GYN and doctor will work together to make sure you get the care you need.

Do I have the right to choose an OB/GYN as my primary care provider?

If your OB/GYN is willing to be your Primary Care Provider, have them contact our Member Services team.

Can I stay with my OB/GYN if they aren't with UnitedHealthcare Community Plan?

If you are past the 24th week of your pregnancy, you can keep seeing your current OB/GYN through the postpartum checkup, even if the provider is Out-of-Network. If you want to change to an in-network OB/GYN, you are allowed to do so if the Provider agrees to accept you in the last trimester of your pregnancy. For questions, please contact UnitedHealthcare Community Plan Member Services at **1-877-597-7799**. UnitedHealthcare Community Plan will arrange for you to continue treatment with the OB/GYN doctor you have been seeing. The doctor may also contact UnitedHealthcare Community Plan to see if they can become one of our providers.

If you are not pregnant or are not in the last three months of your pregnancy, you may choose any OB/GYN within the UnitedHealthcare Community Plan network. If you see a doctor who is not in our Network, you may be responsible for any charges. If you need a provider list, please call Member Services. *You can call us for help in picking an OB/GYN doctor at **1-877-597-7799**.*

How do I choose an OB/GYN?

Call Member Services at **1-877-597-7799** for help choosing an OB/GYN. You can also request a UnitedHealthcare Community Plan Provider Directory by calling Member Services at **1-877-597-7799**, or you can look online at **UHCCommunityPlan.com**.

If I do not choose an OB/GYN, do I have direct access?

Yes. If your OB/GYN is not your PCP, you can still get all the services you need from your OB/GYN including family planning services, OB care, and routine GYN services and procedures.

Will I need a referral for OB/GYN services?

No, you do not need a referral for OB/GYN services.

How soon can I be seen after contacting my OB/GYN for an appointment?

If you need prenatal care, your doctor should see you within two weeks of your request for a visit.

What if I am pregnant? Who do I need to call?

UnitedHealthcare Community Plan knows that healthy moms have healthy babies, that is why we take special care of all of our moms-to-be. We have a special prenatal program called Healthy First Steps that provides information and support for you.

If you are or may be pregnant:

- We can help you with your pregnancy.
- Healthy First Steps will provide education and support to help reduce problems while you are pregnant.
- See your PCP or an OB/GYN. You don't have to see your PCP first.

Here's how:

- Make an appointment with an OB/GYN. You should try to visit in the next 10 days (or as soon as possible) for your first prenatal visit.
- The OB/GYN you select **MUST** be in our provider network.
- It is important for pregnant women to see their doctor many times while pregnant, even if this is not your first child.
- If you do not have an OB/GYN already, please call Member Services at **1-877-597-7799**.

Going to the Doctor

Where can I find a list of birthing centers?

To find a birthing center, call UnitedHealthcare Community Plan at **1-877-597-7799**.

What other services/activities/education does UnitedHealthcare Community Plan offer pregnant women?

Pregnant women not only get Case Management Services through our Healthy First Steps Program, but they get special services too. All pregnant women will also be invited to attend our Baby Showers. Members and their guests are invited to join us for the Baby Showers where we offer prizes, refreshments, and educational information on pregnancy subjects such as the Healthy First Steps Program, Texas Health Steps, common discomforts of pregnancy and pre-term labor.

How do I sign up my newborn baby? How and when do I tell my health plan?

How and when do I tell my caseworker?

Call UnitedHealthcare Community Plan Member Services at **1-877-597-7799** and let us know about your new baby as soon as your baby is born. Ask for a Healthy First Steps nurse. In addition, call the Texas Health and Human Services Commission Caseworker at 1-800-252-8263 to apply for Temporary Assistance for Needy Families (TANF) if you need help with buying food for you and your baby.

How can I receive health care after my baby is born (and I am no longer covered by Medicaid)?

After your baby is born, you may lose Medicaid coverage. You may be able to get some health care services through the Texas Women's Health Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

Texas Women's Health Program

The Texas Women's Health Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.

To learn more about services available through the Texas Women's Health Program, write, call or visit the program's website:

Texas Women's Health Program
P.O. Box 14000
Midland, TX 79711-9902
Phone: 1-800-335-8957
Website: www.texaswomenshealth.org/
Fax: (toll-free) 1-866-993-9971

DSHS Primary Health Care Program

The DSHS Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a copayment, but no one is turned down for services because of a lack of money.

Primary Health Care focuses on prevention of disease, early detection and early intervention of health problems. The main services provided are:

- Diagnosis and treatment.
- Emergency services.
- Family planning.
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, X-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services) and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at <http://txclinics.com/>.

To learn more about services you can get through the Primary Health Care program, email, call or visit the program's website:

Website: www.dshs.state.tx.us/phc/

Phone: 512-776-7796

Email: PPCU@dshs.state.tx.us

DSHS Expanded Primary Health Care Program

The Expanded Primary Health Care program provides primary, preventive, and screening services to women age 18 and above whose income is at or below the program's income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breastfeeding.

Going to the Doctor

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at <http://txclinics.com/>.

To learn more about services you can get through the DSHS Expanded Primary Health Care program, visit the program's website, call or email:

Website: www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx

Phone: 512-776-7796

Fax: 512-776-7203

Email: PPCU@dshs.state.tx.us

DSHS Family Planning Program

The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men.

To find a clinic in your area, visit the DSHS Family and Community Health Services Clinic Locator at <http://txclinics.com/>.

To learn more about services you can get through the Family Planning program, visit the program's website, call or email:

Website: www.dshs.state.tx.us/famplan/

Phone: 512-776-7796

Fax: 512-776-7203

Email: PPCU@dshs.state.tx.us

How Do I Make Appointments?

Call your PCP when you need medical care. Your PCP will arrange for the care you need. The name and phone number of your PCP is on your UnitedHealthcare Community Plan ID card. If you have Medicare or commercial insurance, you will not have a PCP listed on your ID card.

What do I need to bring with me to my appointment?

When you go to your appointment, always take your UnitedHealthcare Community Plan member ID card, your *Your Texas Benefits Medicaid card*, a list of problems you are having, and a list of all drugs or herbal medications you are taking.

How do I get medical care after my primary care provider's office is closed?

If your PCP's office is closed, your PCP will have a number you can call 24 hours a day and on weekends. It is best to call your PCP as soon as you need health care. Do not wait until the evening or a weekend to call your PCP if you can get help during the day. Your illness might get worse as the day goes on. If you get sick during the night or on a weekend and cannot wait for help, call your PCP at the phone number on the front of your ID card. If you cannot reach your PCP or want to talk to someone while you wait for the PCP to call you back, call NurseLine at 1-800-535-6714 to talk to a nurse. Our nurses are ready to help you 24 hours a day, 7 days a week. **If you think you have a real emergency, call 911 or go to the nearest Emergency Room.**

What if I Get Sick When I Am Out of Town Traveling?

If you need medical care when traveling, call us toll-free at **1-877-597-7799** and we will help you find a doctor. If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-877-597-7799**.

What if I am out-of-state?

If you have an emergency out-of-state, go to the nearest emergency room for care. If you get sick and need medical care while you are out-of-state, call your UnitedHealthcare Community Plan PCP. Your PCP can tell you what you need to do if you are not feeling well. If you visit a doctor or clinic out-of-state, they must be enrolled in Texas Medicaid to get paid. Please show your *Your Texas Benefits Medicaid card* and UnitedHealthcare Community Plan ID card before you are seen. Have the doctor call UnitedHealthcare Community Plan for an authorization number. The phone number to call is on the back of your UnitedHealthcare Community Plan card.

What if I am out of the country?

Medical services performed out of the country are not covered by Medicaid.

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office by calling 211, and UnitedHealthcare Community Plan Member Services at **1-877-597-7799**. Before you get Medicaid services in your new area, you must call UnitedHealthcare Community Plan, unless you need emergency services. You will continue to get care through UnitedHealthcare Community Plan until HHSC changes your address.

What if I Want to Change Health Plans?

You can change your health plan by calling the Texas STAR Kids Program Helpline at 1-800-964-2777. You can change health plans as often as you want. If you are in the hospital, a residential Substance Use Disorder (SUD) treatment facility, or residential detoxification facility for SUD, you will not be able to change health plans until you have been discharged.

Who do I call?

You can change your health plan by calling the STAR Kids Program Helpline at 1-800-964-2777.

How many times can I change health plans?

You can change health plans as many times as you want, but not more than once a month.

When will my health plan change become effective?

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place June 1.

Can UnitedHealthcare Community Plan ask that I get dropped from their health plan?

Yes. UnitedHealthcare Community Plan might ask that a member be taken out of the plan for “good cause.” “Good Cause” could be, but is not limited to:

- Fraud or abuse by a member;
- Threats or physical acts leading to harming of UnitedHealthcare Community Plan staff or providers;
- Theft;
- Refusal to go by UnitedHealthcare Community Plan’s policies and procedures, like:
 - Letting someone use your ID card;
 - Missing visits over and over again;
 - Being rude or acting out against a provider or a staff person; or
 - Using a doctor that is not a UnitedHealthcare Community Plan provider.

UnitedHealthcare Community Plan will not ask you to leave the program without trying to work with you. If you have any questions about this process, call UnitedHealthcare Community Plan at **1-877-597-7799**. The Texas Health and Human Services Commission will decide if a member can be told to leave the program.

Can Someone Interpret for Me When I Talk With My Doctor? Who Do I Call for an Interpreter? How Far in Advance Do I Need to Call?

It is your right to talk with your doctor in the language you prefer. UnitedHealthcare Community Plan can arrange interpreter services for you. Please call **1-877-597-7799** if you need a translator. Call **TTY 711** for hearing impaired. Please call as soon as you make your appointment or at least 24 hours in advance.

How can I get a face-to-face interpreter in the provider's office?

Translators can meet you at your doctor's office and help you talk to your doctor face-to-face in the language you prefer. Please contact Member Services at **1-877-597-7799** for more information.

What Does Medically Necessary Mean?

Medically Necessary means:

1. For members birth through age 20, the following Texas Health Steps services:
 - (a) screening, vision and hearing services; and
 - (b) other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
 - (i) must comply with the requirements of the *Alberto N., et al. v. Smith, et al.* partial settlement agreements; and
 - (ii) may include consideration of other relevant factors, such as the criteria described in Parts (2)(b – g) and (3)(b – g) of this definition.
2. For members over age 20, non-behavioral health-related health care services that are:
 - (a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
 - (b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
 - (c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
 - (d) consistent with the diagnoses of the conditions;

- (e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency;
 - (f) are not experimental or investigative; and
 - (g) are not primarily for the convenience of the member or provider; and
3. For members over age 20, behavioral health services that:
- (a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder;
 - (b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
 - (c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
 - (d) are the most appropriate level or supply of service that can safely be provided;
 - (e) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
 - (f) are not experimental or investigative; and
 - (g) are not primarily for the convenience of the member or provider.
-

What Is Emergency Medical Care?

Emergency medical care.

Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

Emergency medical condition means:

A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency behavioral health condition means:

Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

1. Requires immediate intervention or medical attention without which the member would present an immediate danger to themselves or others; or
2. Which renders the member incapable of controlling, knowing or understanding the consequences of their actions.

Emergency services and emergency care means:

Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or Emergency Behavioral Health Condition, including post-stabilization care services.

How soon can I expect to be seen?

Emergency wait time will be based on your medical needs and determined by the emergency facility that is treating you.

What is post-stabilization?

Post-stabilization care services are services covered by Medicaid that keep your condition stable following emergency medical care.

What Is Urgent Medical Care?

Another type of care is urgent care. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

- Minor burns or cuts.
- Earaches.
- Sore throat.
- Muscle sprains/strains.

What should I do if my child or I need urgent medical care?

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes UnitedHealthcare Community Plan Medicaid. For help, call us toll-free at **1-877-597-7799**. You can also call our 24-hour Nurse HelpLine at 1-800-535-6714 for help with getting the care you need.

Going to the Doctor

How soon can I expect to be seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take UnitedHealthcare Community Plan Medicaid.

What Is Routine Medical Care and How Soon Can I Expect to Be Seen?

If you need a physical checkup, then the visit is ROUTINE. Your doctor should see you within four weeks. UnitedHealthcare Community Plan will be happy to help you make an appointment, just call us at **1-877-597-7799**.

***Remember:** It is best to see your doctor BEFORE you get sick so that you can build your relationship with him/her. It is much easier to call your doctor with your medical problems if he/she knows who you are.*

You must see a UnitedHealthcare Community Plan provider for routine and urgent care. You can always call UnitedHealthcare Community Plan at **1-877-597-7799** if you need help picking a UnitedHealthcare Community Plan provider.

How Do I Get Eye Care Services?

If you need eye care services, please call UnitedHealthcare Community Plan Member Services at **1-877-597-7799**. We can help you find a provider close to you.

How Do I Get Dental Services for My Child?

Your child's Medicaid dental plan provides dental services including services that help prevent tooth decay and services that fix dental problems. Call your child's Medicaid dental plan to learn more about the dental services they offer.

UnitedHealthcare Community Plan covers emergency dental services your child gets in a hospital or ambulatory surgical center. This includes services the doctor provides and other services your child might need like anesthesia.

There are two Medicaid dental plans for children under age 21:

DentaQuest: 1-800-516-0165

MCNA Dental: 1-855-691-6262

For more information, call the Texas STAR Kids Program Helpline at 1-800-964-2777.

Are emergency dental services for children covered by the health plan?

UnitedHealthcare Community Plan covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

- Treatment for dislocated jaw.
- Treatment for traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Hospital, physician, and related medical services such as drugs for any of the above conditions.

What dental services does UnitedHealthcare Community Plan cover for children?

UnitedHealthcare Community Plan covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

- Treatment of dislocated jaw.
- Treatment for traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.

UnitedHealthcare Community Plan covers hospital, physician and related medical services for the above conditions. This includes services the doctor provides and other services your child might need, like anesthesia or other drugs.

UnitedHealthcare Community Plan is also responsible for paying for treatment and devices for craniofacial anomalies.

Going to the Doctor

Your child's Medicaid dental plan provides all other dental services including services that help prevent tooth decay and services that fix dental problems. Call your child's Medicaid dental plan to learn more about the dental services they offer.

What do I do if my child needs emergency dental care?

During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call us toll-free at **1-877-597-7799** or call **911**.

What Is a Health Home?

A health home offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home connects community supports and resources, and helps coordinate and integrate primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

What Is a Prescribed Pediatric Extended Care Center (PPECC)?

Prescribed Pediatric Extended Care Centers (PPECCs) allow minors from birth through age 20 with medically complex conditions to receive daily medical care in a non-residential setting.

When prescribed by a physician, minors can attend a PPECC up to a maximum of 12 hours per day to receive medical, nursing, psychosocial, therapeutic and developmental services appropriate to their medical condition and developmental status.

What Is a Service Coordinator?

What is service coordination and what will a Service Coordinator do for me?

Service coordination is a service UnitedHealthcare Community Plan gives you to help with your health and well-being. A Service Coordinator will review, plan and help you in meeting your health care needs.

You will be assigned a Service Coordinator when you join UnitedHealthcare Community Plan STAR Kids. Your Service Coordinator will call you or visit you in person to talk to you about your health care needs and tell you more about the services you can get. He or she will ask you questions about your health. Please be honest and open. Your Service Coordinator will keep anything you talk about confidential. Your Service Coordinator can help you:

- Arrange care with your Primary Care Provider.
- Help with any medical, behavioral health and Long-Term Services and Supports.
- Solve any problems with your medical care or providers.
- Find ways for you to live at home or in other community settings.
- Explain service and placement choices to you.

How can I talk with a Service Coordinator?

To contact a Service Coordinator, look on your UnitedHealthcare Community Plan ID card for the phone number. You can also call Member Services at **1-877-597-7799** to help you reach your Service Coordinator. Call **TDD/TTY 711** for hearing impaired.

What is a Transition Specialist? What will a Transition Specialist do for me?

For children with special health care needs, the transition to adulthood often brings many changes. A Transition Specialist can help you understand and plan for these changes. All STAR Kids members have access to a Transition Specialist.

How can I talk to a Transition Specialist?

If you want to speak with a Transition Specialist or have a Transition Specialist as part of your Care Team, let your Service Coordinator know and he or she can help you.

Did You Know That You Might Be Able to Pick Your Own Health Caregiver?

UnitedHealthcare Community Plan can help you manage your home services. Consumer Directed Services (CDS) is a program for people with attendant/provider services. With this program, you find, hire and train your attendant/provider. You also review the budget for the services. You decide how much to pay your attendant. You decide how much to spend for the supplies and equipment you need. You can pick the person to handle the services for you. If you pick this program, an agency will teach you what to do. The agency will also handle the payroll for your services.

If you pick the CDS choice, you are the employer. You can hire, fire and manage your own health service providers. This can include your attendant(s), back-up attendant(s), in-home and out-of-home respite providers and habilitation providers. You have control over how your program funds are spent on salary and benefits for your employee(s). You pick a CDS agency to manage fiscal services for you. As an employer, you need to arrange payment of employment taxes. You need to pay your employees from your program funds. Your CDS agency will offer this service for you.

Why would I want to pick CDS?

When you hire your own employees, you can often find people you prefer to work for you. Within your allotted service budget, you can set your employees' wages and benefits. You can hire back-up employees for times when your regular employees cannot work. You can give benefits, such as vacation days and bonuses. You pick a CDS agency (CDSA) to do your payroll and federal and state taxes.

How does CDS work?

You pick the Consumer Directed Services Administrator (CDSA) to do your payroll and act as your agent to pay taxes. The CDSA helps you set up a budget. In some programs, the CDSA offers guidance on recruitment, salaries, benefits and administrative costs.

Which services can be self-directed in which programs?

Program	Services
STAR Kids Waiver Program	Personal Assistance Services, Respite, Physical Therapy, Occupational Therapy, Speech/Hearing Therapy
Primary Home Care	Community Attendant Services, Personal Assistance Services

What Are My Health Care Benefits?

UnitedHealthcare Community Plan STAR Kids covers specified medically necessary services. This list includes some of your health care benefits:

- Ambulance services.
- Audiology services, including hearing aids, for adults and children.
- Behavioral health services.
- Birthing services.
- Cancer screening, diagnostic and treatment services.
- Chiropractic services.
- Day Activity and Health Services (DAHS).
- Dialysis.
- Drugs and biologicals provided in an inpatient setting.
- Durable medical equipment and supplies.
- Early Childhood Intervention (ECI) services.
- Emergency services.
- Family planning services.
- Home health care services.
- Hospital services, inpatient and outpatient.
- Laboratory.
- Mastectomy, breast reconstruction and related follow-up procedures.
- Medical checkups and Comprehensive Care Program (CCP) Services for children through the Texas Health Steps Program.
- Optometry, glasses and contact lenses, if medically necessary.
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Outpatient drugs and biologicals.
- Personal Care Services (PCS).
- Physical, occupational and speech therapies.
- Podiatry.
- Prenatal care.
- Prescribed Pediatric Extended Care Center (PPECC) services.
- Preventive services including an annual adult well check for patients 21 years of age and over.
- Primary care services.

Benefits and Services

- Private Duty Nursing (PDN) services.
- Psychiatry services.
- Radiology, imaging and X-rays.
- Specialty physician services.
- Substance use disorder treatment services.
- Transplantation of organs and tissues.
- Vision.

How do I get these services?

Call UnitedHealthcare Community Plan Member Services at **1-877-597-7799**.

Are there any limits to any covered services?

There may be limitations to some of the covered services. If you would like more details, contact Member Services at **1-877-597-7799**.

What Services Are Not Covered Benefits?

If you want to know if a procedure or medication is covered under STAR Kids, ask your PCP or call Member Services at **1-877-597-7799**. Call **TDD/TTY 711**, for hearing impaired.

- Services by non-approved providers.
- Services by Christian Science Nurses.
- Dentures.
- Services or supplies not covered by Medicaid.
- Services or supplies given to a member after a finding has been made following a review that these services or supplies are not medically necessary.
- Services or supplies paid by any health, accident, and federal government benefits program or U.S. public health services hospitals.
- Services given solely for beauty reasons.
- Sex change operations.
- Reversal of self-requested sterility.
- Services and supplies to any person who is an inmate of a public institution.
- Social and educational counseling services (except parent training).
- Experimental or investigational procedures or services.

What Are My Prescription Drug Benefits?

Contact Member Services for more information on your prescription benefits. For more information, please refer to page 18 of this Member Handbook.

What Are Mental Health Rehabilitation Services and Mental Health Targeted Case Management? How Do I Get These Services?

Mental Health Rehabilitative Services are a community-based program. These services are provided to people with mental health disorders. You will learn new skills. These new skills build on your strengths and abilities. These new skills will help you during a crisis. Your mental health provider will assess your need for these services. These services can be provided with other mental health services.

Mental Health Targeted Case Management is a community-based program. These services are provided to people with mental health disorders. Your mental health provider will pair you with a staff member. This is your Case Manager. Your Case Manager will work with you to find services or resources in your area to help you. The Case Manager may come to your home. You may also see them at their office. This service can be provided with other mental health services.

What Are LTSS and How Do I Get These Services?

Long-Term Services and Supports (LTSS) are services provided by health care professionals who offer direct in-home and community-based services for persons with disabilities. Contact Member Services at **1-877-597-7799** to ask for these services.

What are my long-term services and supports (LTSS) benefits?

- Adaptive aids such as wheelchairs, walkers, canes and durable medical equipment.
- Adjunct services.
- Assisted living/residential care services.
- Day activity and health services.
- Dietician/nutritional services.
- Emergency response services.
- Home-delivered meals.
- Home health care services.
- Medical supplies.
- Member managed attendant care (Consumer-Directed Services).
- Minor home modifications – to ensure accessibility and improve mobility.
- Nursing facility care.
- Nursing services.
- Parent training – to enhance parenting and caretaking skills.
- Personal assistance services.
- Respite care.
- Sub-acute care.
- Therapy services to include occupational, physical and speech/language therapy.

How do I get these services? What number do I call to find out about these services?

Call your UnitedHealthcare Community Plan Service Coordinator at **1-877-352-7798**.

What Are My Acute Care Benefits?

The medically necessary services that UnitedHealthcare Community Plan STAR Kids covers are listed below. STAR Kids network hospitals will give all necessary items and services when requested by your doctor. These services include, but are not limited to:

Hospital care inpatient:

- Bed and board in a semi-private room, critical care or heart unit.
- Whole blood required for the treatment of sickness or injury.
- Child delivery care (the usual care and special prenatal care for pregnant women with specific problems).
- Newborn care (regular newborn care and special nursery care for newborns with problems).
- All necessary support services and supplies ordered by a doctor.
- Transplant services, including: liver, heart, lung, bone marrow and cornea.
- Ambulance services for emergencies and non-emergency situations for severely disabled members.
- Substance abuse and behavioral health services.

Outpatient hospital care:

For emergency services, STAR Kids will cover outpatient hospital care as follows:

- Services performed in the emergency room or hospital clinic.
- Testing or rehabilitative items or services that are requested by your doctor.
- Surgery not requiring a hospital stay.
- Substance abuse and behavioral health services (when medically necessary).

Walk-in surgery centers:

- Minor surgery not requiring a hospital stay.

Professional services:

- Office visits for regular care including:
 - Care to prevent illness (annual physical for adults).
 - Regular medical care.
 - Shots to prevent sickness (immunization).
 - 12 chiropractic service visits per year.
 - Podiatry services.
- Laboratory and X-ray services, including tests to prevent birth defects.
- Genetic services.

Benefits and Services

- Hearing examinations and medically necessary hearing aids.
- Emergency dental services.
- Dialysis for kidney problems.
- Family planning services.
- Licensed professional counselors, social workers and mental health services (1-866-302-3996).
- Eye doctor services — Children under 21 years old can get one eye exam each state fiscal year (September 1 through August 31).

Other services:

Rural health clinic services, including:

- Physician services and their support services.
- Nurses and social workers.
- Visiting nurse services.
- Basic laboratory services.
- Maternity clinic services.
- Certified nurse midwife services.
- Birthing center, including admission, labor, delivery, postpartum and total obstetrical care.
- Texas Health Steps medical checkups.
- Occupational, hearing, language or speech therapy.
- Federally Qualified Health Centers. (These are community clinics that have served local people for a long time. You may want to visit one and see what kind of medical services they offer.)

Note: For Medicaid-only members, UnitedHealthcare Community Plan STAR Kids will help the member transition to Medicare if approved or transition to traditional Medicaid.

How do I get these services? What number do I call to find out about these services?

Call Member Services at **1-877-597-7799** for questions on how to get these services.

What are Community First Choice services and how do I get those services?

If you are eligible for Medicaid and would otherwise qualify for care in a nursing facility, you can get additional services to help you live in the least-restrictive setting.

I am in the Medically Dependent Children Program (MDCP). How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) as well as all MDCP services will be delivered through your STAR Kids MCO. Please contact your MCO Service Coordinator if you need assistance with accessing these services.

I am in the Youth Empowerment Services waiver (YES). How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your YES waiver services will be delivered through the Department of State Health Services. Please contact your MCO Service Coordinator if you need assistance with accessing these services. You can also contact your Local Mental Health Authority (LMHA) Case Manager for questions specific to YES waiver services.

I am in the Community Living Assistance and Support Services (CLASS) waiver. How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your CLASS waiver services will be delivered through the Department of Aging and Disability Services. Please contact your MCO Service Coordinator if you need assistance with accessing these services. You can also contact your CLASS Case Manager for questions specific to CLASS waiver services.

I am in the Deaf Blind with Multiple Disabilities (DBMD) waiver. How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your DBMD waiver services will be delivered through the Department of Aging and Disability Services. Please contact your MCO Service Coordinator if you need assistance with accessing these services. You can also contact your DBMD Case Manager for questions specific to DBMD waiver services.

I am in the Home and Community-Based Services (HCBS) waiver. How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your HCS waiver services will be delivered through the Department of Aging and Disability Services. Please contact your MCO Service Coordinator if you need assistance with accessing these services. You can also contact your HCS Service Coordinator at your local intellectual and developmental disability authority (LIDDA) for questions specific to HCS waiver services.

I am in the Texas Home Living (TxHmL) waiver. How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your TxHmL waiver services will be delivered through the Department of Aging and Disability Services. Please contact your MCO Service Coordinator if you need assistance with accessing these services. You can also contact your TxHmL Service Coordinator at your local intellectual and developmental disability authority (LIDDA) for questions specific to TxHmL waiver services.

Will my STAR Kids benefits change if I am in a Nursing Facility?

Starting November 1, 2016, people covered by Medicaid who are eligible for STAR Kids and live in a Nursing Facility will get their basic health services (acute care) and long-term care services through STAR Kids. People who get both Medicaid and Medicare (dual eligible) will get their basic health services through Medicare and their long-term care services through STAR Kids Medicaid.

Will I continue to receive STAR Kids benefits if I go into a Nursing Facility?

A STAR Kids member who enters a Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) will remain a STAR Kids member. The MCO must provide Service Coordination and any Covered Services that occur outside of the Nursing Facility or ICF/IID when a STAR Kids member is a Nursing Facility or ICF/IID resident. Throughout the duration of the Nursing Facility or ICF/IID stay, the STAR Kids MCO must work with the member and the member's Legally Authorized Representative (LAR) to identify Community-Based Services and LTSS programs to help the member return to the community.

How Can I Get Family Planning Services? Do I Need a Referral for This?

You can go to your PCP or any doctor or Family Planning clinic that takes Medicaid to help you with family planning. You do not need a referral form. Tell your PCP where you are going so your records can be kept up-to-date. Family Planning Services are very private. You do not have to worry about anyone else knowing that you are going there. Providers and family planning agencies cannot require parental consent for minors to receive family planning services.

Where do I find a family planning service provider?

You can find the locations of family planning providers near you online at www.dshs.state.tx.us/famplan/, or you can call UnitedHealthcare Community Plan at **1-877-597-7799** for help in finding a family planning provider.

What Extra Benefits Do I Get as a Member of UnitedHealthcare Community Plan?

Value-added services.

As a member of UnitedHealthcare Community Plan, you can also receive value-added services in addition to the required Medicaid services. Some of the value-added services that UnitedHealthcare Community Plan offers are:

- Non-emergent transportation.
- Additional Vision Services.
- Sports/School/Camp Physical.
- Assistance for Asthmatics.
- Respite Services.
- Name Bands.
- Animal Therapy.
- Hyper-Sensory Clothing.
- Planning Guide.
- Food Allergy Labels.
- Leisure Program (Recreation Program).
- Gift Card for Wellness Visit.
- Mikey's Guide.
- Wheelchair Bag.
- Smart Device Applications.
- Live and Work Well.

How can I get these benefits?

It is easy to get these extra benefits by calling Member Services at **1-877-597-7799**. Limitations or restrictions may apply.

What Other Services Can UnitedHealthcare Community Plan Help Me Get?

The STAR Kids program covers the following services. These services are offered by other providers outside of the UnitedHealthcare Community Plan network. We are happy to refer you to one of these providers if you are in need of these types of services:

- Case Management for Children and Pregnant Women — Visit the website below to learn more: <http://www.dshs.state.tx.us/caseman/default.shtm>.
- Texas Health Steps dental services.
- Tuberculosis (TB) clinics.
- Women, Infants and Children Services (WIC).
- Early Childhood Intervention (ECI).
- Services by federal or state hospital doctors.
- Mental Health and Mental Retardation (MHMR) Case Management.
- Mental Retardation Diagnostic Assessment (MRDA).
- Mental health rehabilitation.
- Texas School Health and Related Services (SHARS).
- Texas Commission for the Blind (TCB).

How do I get these services?

Call Member Services at **1-877-597-7799** for questions on how to get these services.

What health education classes does UnitedHealthcare Community Plan offer?

UnitedHealthcare Community Plan can refer you to Health Education classes such as parenting courses and classes to help you quit smoking. Call Member Services at **1-877-597-7799** for more information about Health Education classes and meetings.

Texas Health Steps

What services are offered by Texas Health Steps?

Texas Health Steps is the Medicaid health care program for children, teens and young adults, birth through age 20.

Texas Health Steps gives your child:

- Free regular medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.
- A Case Manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:

- Find health problems before they get worse and are harder to treat.
- Prevent health problems that make it hard for children to learn and grow like others their age.
- Help your child have a healthy smile.

When to set up a checkup:

- You will get a letter from Texas Health Steps telling you when it's time for a checkup. Call your child's doctor to set up the checkup.
- Set up the checkup at a time that works best for your family.

If the doctor or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:

- Eye tests and eyeglasses.
- Hearing tests and hearing aids.
- Dental care.
- Other health care.
- Treatment for other medical conditions.

Call UnitedHealthcare Community Plan at **1-877-597-7799** or Texas Health Steps at 1-877-847-8377 (1-877-THSTEPS) (toll-free) if you:

- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps.
- Need help finding and getting other services.

If you can't get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital or drug store.

- Houston/Beaumont area: 1-855-687-4786.
- All other areas: 1-877-633-8747 (1-877-MED-TRIP).

How and when do I get Texas Health Steps medical and dental checkups for my child?

Every parent wants their child to be happy and healthy. Keeping them up-to-date with all checkups is one of the ways to promote your child's well-being. Your children should visit the doctor at these times for their Texas Health Steps checkups:

INFANCY:

- At birth while still in the hospital.
- 3 to 5 days of life.
- 2 weeks.
- At 2, 4, 6 and 9 months.

EARLY CHILDHOOD:

- At 12, 15 and 18 months.
- 2, 3 and 4 years.

LATE CHILDHOOD:

- At 5, 6, 7, 8, 9, 10, 11 and 12 years.

ADOLESCENCE:

- At 14, 15, 16, 17, 18 and 20 years.

Your children should visit the dentist at these times for their Texas Health Steps checkups:

- Children need to start seeing the dentist at 6 months, then every 6 months thereafter through 20 years of age.

Contact any Texas Health Steps doctor in Texas when your child is due for a checkup. If you are not sure your child is up-to-date with medical, dental, vision or hearing care, please call Member Services at **1-877-597-7799**.

Remember, if you do not keep your child's Texas Health Steps checkups and vaccines up-to-date, the amount of your TANF check could be reduced.

Does my doctor have to be part of the UnitedHealthcare Community Plan network?

No, your child can be seen by any Texas Health Steps doctor. By getting regular checkups, your doctor is able to find and treat problems before they become serious. You do not need a referral. You have the freedom to pick any Texas Health Steps doctor.

Do I have to have a referral?

No, you do not need a referral for Texas Health Steps services.

What if I need to cancel an appointment?

Call your doctor's or dentist's office if you need to cancel a Texas Health Steps appointment. Reschedule the checkup as soon as you can so your child will stay healthy.

What if I am out of town and my child is due for a Texas Health Steps checkup?

If you are out of town and your child is due for a Texas Health Steps checkup, call UnitedHealthcare Community Plan at **1-877-597-7799**. They will help you set up a visit with your doctor as soon as you get home.

What if I am a migrant farmworker?

Children of Migrant Farmworkers can receive a Texas Health Steps medical checkup before it is due. You can get your checkup sooner if you are leaving the area. The appointment should be made and the exam done before leaving the area. You can call **1-877-597-7799** for help setting up the appointment. This is a benefit only to children of Migrant Farmworkers and is considered an "accelerated" service under Texas Health Steps, or one that is given before it is actually due. Please call us and let us know if anyone in your family works as a Migrant Farmworker.

THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at: www.dshs.state.tx.us/thsteps/providers.shtm.

AGE	DEVELOPMENTAL SURVEILLANCE				MEASUREMENTS							VISION			HEARING			Dental Referral	LABORATORY TESTS									
	History	Nutritional Screening	Review of Milestones	ASQ, ASQ:SE, or PEDS	M-CHAT	Mental Health: Psychosocial/Behavioral Health Screening	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	Length	Height	Weight	BMI	Fronto-Occipital Circumference	Blood Pressure	Visual Acuity	Subjective Vision	Newborn Hearing Test (OAE or ABR)	Audiometric Screening	Subjective Hearing	Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	Newborn Screening Panel	Blood Lead Screening	Anemia	Hyperlipidemia	Type 2 Diabetes	Health Education/Anticipatory Guidance	
Newborn	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
D/C to 5 days	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
2 weeks	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
4	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
6	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
9	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
12	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
15	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
18	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
24	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
30	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
3	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
4	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
5	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
6	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
7	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
8	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
9	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
10	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█

LEGEND OF SYMBOLS

- █ Mandatory at this age.
- █ If a component is not completed at the required age, it is mandatory for the provider to complete at the first opportunity if age-appropriate.
- █ When symbols appear at the same age for developmental, vision, or hearing screening, perform the most appropriate-level screen.
- █ Risk-based.

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: www.dshs.state.tx.us/thsteps/providers_components.shtm. For free online provider education: www.txhealthsteps.com.



THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at: www.dshs.state.tx.us/thsteps/providers.shtm.

AGE	History	Nutritional Screening	Mental Health: Psychosocial/ Behavioral Health Screening	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	MEASUREMENTS				VISION		HEARING		Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	Anemia ♀	LABORATORY TESTS				Health Education/Anticipatory Guidance
						Height	Weight	BMI	Blood Pressure	Visual Acuity	Subjective Vision	Audiometric Screening	Subjective Hearing				Hyperlipidemia	Type 2 Diabetes	STD/STI Screening	HIV Test	
11	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
12	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
13	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
14	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
15	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
16	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
17	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
18	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
19	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
20	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨

LEGEND OF SYMBOLS

- Mandatory at this age.
- If a component is not completed at the required age, it is mandatory for the provider to complete at the first opportunity if age-appropriate.
- When symbols appear at the same age for developmental, vision, or hearing screening, perform the most appropriate-level screen.
- Risk-based.
- Females screened once between 12 and 16 years of age.

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: www.dshs.state.tx.us/thsteps/providers_components.shtm. For free online provider education: www.txhealthsteps.com.



What Is Case Management for Children and Pregnant Women?

Case management for children and pregnant women.

Need help finding and getting services? You might be able to get a Case Manager to help you.

Who can get a Case Manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- Have health problems, or
- Are at high risk for getting health problems.

What do Case Managers do?

A Case Manager will visit with you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?

Case Managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you can get a Case Manager?

Call Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8:00 a.m. to 5:00 p.m.

To learn more, go to: www.dshs.state.tx.us/caseman.

What is Early Childhood Intervention?

Early Childhood Intervention.

EI provides services and support to Texas families and their children, birth to 36 months, with developmental delays or disabilities. EI services are unique because:

- Parents and professionals work together as a team.
- Services are convenient for families.
- Children learn new skills through everyday activities.
- Services are coordinated with others in the community.
- Families of all income levels receive EI services.

Do I need a referral for this?

Anyone can make a referral (a parent, family member, health care professional, social worker, caregiver, friend or neighbor.) Simply call EI at 1-888-754-0524.

A child who already has a medically diagnosed condition, which has a high probability of resulting in a developmental delay, automatically qualifies for EI. To get started, call EI and make a referral: 1-888-754-0524.

Next, an EI professional will provide an evaluation to determine if your child is eligible and will discuss with you the need for services.

Where do I find an EI provider?

All of the professionals in EI have expertise in working with babies, toddlers and their families. Licensed and/or credentialed specialties include:

- Early Intervention Specialists.
- Speech and Language Pathologists.
- Physical Therapists.
- Occupational Therapists.
- Registered Dietitians.
- Professional Counselors.
- Hearing and Vision Specialists.
- Social Workers.
- Nurses.

Transportation

Medical Transportation Program (MTP)

What is MTP?

MTP is an HHSC program that helps with non-emergency transportation to health care appointments for eligible Medicaid clients who have no other transportation options. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?

- Passes or tickets for transportation such as mass transit within and between cities.
- Air travel.
- Taxi, wheelchair van and other transportation.
- Mileage reimbursement for enrolled individual transportation participant (ITP). The enrolled ITP can be the responsible party, family member, friend, neighbor or client.
- Meals at a contracted vendor (such as a hospital cafeteria).
- Lodging at a contracted hotel and motel.
- Attendant services (responsible party such as a parent/guardian, etc., who accompanies the client to a health care service).

How to get a ride?

If you live in the Dallas/Ft. Worth Area:

Call LogistiCare

Phone Reservations: **1-855-687-3255**

Where's My Ride: 1-877-564-9834

Hours: LogistiCare takes requests for routine transportation by phone Monday through Friday from 8:00 a.m. to 5:00 p.m. Routine transportation should be scheduled 48 hours (2 business days) before your appointment.

If you live in the Houston/Beaumont Area:

Call MTM

Phone Reservations: **1-855-687-4786**

Where's My Ride: 1-888-513-0706

Hours: 7:00 a.m. to 6:00 p.m., Monday – Friday. Call 1-855-MTP-HSTN or 1-855-687-4786 at least 48 hours before your visit. If it's less than 48 hours until your appointment and it's not urgent, MTM might ask you to set up your visit at a different date and time.

All other areas of the state:

Call MTP

Phone Reservations: **1-877-633-8747 (1-877-MED-TRIP)**

All requests for transportation services should be made within 2 – 5 days of your appointment.

Can someone I know give me a ride to my appointment and get money for mileage?

If someone you know can give you a ride to the doctor, they may be able to get money for their mileage. Before they can get paid, they have to fill out a form stating that they have a:

1. Current driver's license.
2. Inspection sticker.
3. License tags.
4. Liability insurance.

The form they fill out is called an "Individual Contractor Agreement." You can get one of these forms by calling MTP at 1-877-MED-TRIP (1-877-633-8747).

What Happens if I Lose My Medicaid Coverage?

If you lose Medicaid coverage but get it back again within six (6) months, you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same PCP you had before.

For non-emergent transportation, please call LogistiCare at **1-866-528-0441**.

What Do I Have to Do if I Need Help With Completing My Renewal Application?

How to renew.

Families must renew their CHIP or Children's Medicaid coverage every year. In the months before a child's coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family's income and cost deductions. The family needs to:

- Look over the information on the renewal application.
- Fix any information that is not correct.
- Sign and date the application.
- Look at the health plan options, if Medicaid health plans are available.
- Return the renewal application and documents of proof by the due date.

Once HHSC receives the renewal application and documents of proof, staff checks to see if the children in the family still qualify for their current program or if they qualify for a different program. If a child is referred to another program (Medicaid or CHIP), HHSC sends the family a letter telling them about the referral and then looks to see if the child can get benefits in the other program. If the child qualifies, the coverage in the new program (Medicaid or CHIP) begins the month following the last month of the other program's coverage. During renewal, the family can pick new medical and dental plans by calling the CHIP/Children's Medicaid call center at 1-800-964-2777.

Completing the renewal process.

When children still qualify for coverage in their current program (CHIP or Medicaid), HHSC will send the family a letter showing the start date for the new coverage period. If the children qualify for CHIP and an enrollment fee is due, the family must pay the enrollment fee by the due date or risk losing the coverage.

CHIP renewal is complete when the family:

- Pays any enrollment fee due by the due date.
- If the family changes their medical or dental plan, then they must sign and send the appropriate Enrollment/Transfer Form to HHSC showing the change.

If HHSC receives and processes the CHIP enrollment fee before the cutoff in the 12th month of coverage, then new coverage begins without interruption on the first day of the following month. If HHSC does not get the enrollment fee in time, then new coverage will not begin until the first day of the following month.

Medicaid renewal is complete when the family signs and sends to HHSC the appropriate Enrollment/Transfer Form if the family picks a new medical or dental plan.

What if I Get a Bill From My Doctor? Who Do I Call? What Information Will They Need?

If you get a bill from a doctor, hospital or other health care provider, ask why they are billing you. Your doctor, health care provider or hospital cannot bill you for covered and approved Medicaid services. You do not have to pay bills that UnitedHealthcare Community Plan should pay.

If you still get a bill, call Member Services at 1-877-597-7799 for help.

Be sure you have your bill in front of you when you call. You will need to tell Member Services who sent you the bill, the date of service, the amount and the provider's address and phone number.

What Do I Have to Do if I Move?

As soon as you have your new address, give it to the local HHSC benefits office and UnitedHealthcare Community Plan Member Services Department at 1-877-597-7799. Before you get Medicaid services in your new area, you must call UnitedHealthcare Community Plan, unless you need emergency services. You will continue to get care through UnitedHealthcare Community Plan until HHSC changes your address.

What if I Have Other Health Insurance in Addition to Medicaid?

Medicaid and private insurance.

You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

- Your private health insurance is canceled.
- You get new insurance coverage.
- You have general questions about third party insurance.

You can call the hotline toll-free at 1-800-846-7307. **If you have other insurance, you may still qualify for Medicaid.** When you tell Medicaid staff about your other health insurance, you help make sure Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

What if I also have Medicare?

Medicare or your Medicare Health Plan will pay for your services before UnitedHealthcare Community Plan will. UnitedHealthcare Community Plan might cover some services that are not covered by Medicare for STAR Kids members.

Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid?

You cannot be billed for Medicare “cost-sharing,” which includes deductibles, coinsurance, and copayments that are covered by Medicaid.

You Have the Right to Respect and Dignity, Including Freedom From Abuse, Neglect, and Exploitation

What Are Abuse, Neglect and Exploitation?

Abuse is mental, emotional, physical or sexual injury, or failure to prevent such injury.

Neglect results in starvation, dehydration, overmedicating or undermedicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care and personal hygiene.

Exploitation is misusing the resources of another for personal or monetary gain. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Reporting Abuse, Neglect and Exploitation

The law requires that you report suspected Abuse, Neglect or Exploitation, including unapproved use of restraints or isolation that is committed by a provider.

Call 9-1-1 for life-threatening or emergency situations.

Report by phone (non-emergency): 24 hours a day, 7 days a week, toll-free.

Report to the Department of Aging and Disability Services (DADS) by calling 1-800-647-7418 if the person being abused, neglected or exploited lives in or receives services from a:

- Nursing facility;
- Assisted living facility;
- Adult day care center;
- Licensed adult foster care provider; or
- Home and Community Support Services Agency (HCSSA) or Home Health Agency.

Suspected Abuse, Neglect or Exploitation by an HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

Report all other suspected abuse, neglect or exploitation to DFPS by calling 1-800-252-5400.

Report electronically (non-emergency).

Go to <https://txabusehotline.org>. This is a secure website. You will need to create a password-protected account and profile.

Helpful information for filing a report.

When reporting abuse, neglect or exploitation, it is helpful to have the names, ages, addresses and phone numbers of everyone involved.

Complaints and Appeals

What Should I Do if I Have a Complaint?

We want to help. If you have a complaint, please call us toll-free at **1-877-597-7799** to tell us about your problem. A UnitedHealthcare Community Plan Member Services Advocate can help you file a complaint. Just call **1-877-597-7799**. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the UnitedHealthcare Community Plan complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations – H-320
PO Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If you can get on the Internet, you can send your complaint in an email to **HPM_Complaints@hhsc.state.tx.us**.

Who do I call?

Call UnitedHealthcare Member Services for help **1-877-597-7799**.

Where can I mail a complaint?

For written complaints, please send your letter to UnitedHealthcare Community Plan. You must state your name, your member ID, your telephone number and address, and the reason for your complaint. Please send your letter to:

UnitedHealthcare Community Plan
Attn: Complaint and Appeals Department
PO Box 31364
Salt Lake City, UT 84131-0364

Ombudsman program.

UnitedHealthcare Community Plan members can access an independent ombudsman through our new internal complaints unit. Referrals can be made by a member advocate based on interaction with members that appear to need an independent advocate to work through their concerns. In addition, the ombudsman may make referrals to the UnitedHealthcare Community Plan complaints unit concerning members of their organization needing help. UnitedHealthcare Community Plan has contracts with several non-profit entities to provide support for members.

What are the requirements and time frames for filing a complaint?

There is no time limit on filing a complaint with UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will send you a letter telling you what we did about your complaint.

How long will it take to process my complaint?

Most of the time we can help you right away or at the most within a few days. You will get the letter within 30 days from when your complaint got to UnitedHealthcare Community Plan.

Can someone from UnitedHealthcare Community Plan help me file a complaint?

Yes, a UnitedHealthcare Community Plan Member Services representative can help you file a complaint, just call **1-877-597-7799**. Most of the time, we can help you right away or at the most within a few days.

What Can I Do if My Doctor Asks for a Service or Medicine That Is Covered but UnitedHealthcare Community Plan Denies or Limits It?

UnitedHealthcare Community Plan will send you a letter if a covered service that you requested is not approved or if payment is denied in whole or in part. If you are not happy with our decision, call UnitedHealthcare Community Plan within 30 days from when you get our letter.

You must appeal within 10 days of the date on the letter to make sure your services are not stopped. You can appeal by sending a letter to UnitedHealthcare Community Plan or by calling UnitedHealthcare Community Plan. You can ask for up to 14 days of extra time for your appeal. UnitedHealthcare Community Plan can take extra time on your appeal if it is better for you. If this happens, UnitedHealthcare Community Plan will tell you in writing the reason for the delay.

You can call Member Services and get help with your appeal. When you call Member Services, we will help you file an appeal. Then we will send you a letter and ask you or someone acting on your behalf to sign a form.

Other Plan Details

How will I find out if services are denied?

UnitedHealthcare Community Plan will send you a letter if a covered service requested by your child's PCP is denied, delayed, limited or stopped.

What are the time frames for the appeal process?

UnitedHealthcare Community Plan has up to 30 calendar days to decide if your request for care is medically needed and covered. We will send you a letter of our decision within 30 days. In some cases you have the right to a decision within one business day. If your provider requests, we must give you a quick decision. You can get a quick decision if your health or ability to function could be seriously hurt by waiting.

When do I have the right to ask for an appeal?

You may request an appeal for denial of payment for services in whole or in part. If you ask for an appeal within 10 days from the time you get the denial notice from the health plan, you have the right to keep getting any service the health plan denied or reduced at least until the final appeal decision is made. If you do not request an appeal within 10 days from the time you get the denial notice, the service the health plan denied will be stopped.

Does my appeal request have to be in writing?

You may request an appeal by phone, but an appeal form will be sent to you, which must be signed and returned. An appeal form will be included in each letter you receive when UnitedHealthcare Community Plan denies a service to you. This form must be signed and returned.

Can someone from UnitedHealthcare Community Plan help me file an appeal?

Member Services is available to help you file a complaint or an appeal. You can ask them to help you when you call **1-877-597-7799**. They will send you an appeal request form and ask that you return it before your appeal request is taken.

What Is an Expedited Appeal?

An Expedited Appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an expedited appeal?

You may ask for this type of appeal in writing or by phone. Make sure you write "I want a quick decision or an expedited appeal," or "I feel my health could be hurt by waiting for a standard decision." To request a quick decision by phone, call UnitedHealthcare Community Plan Member Services at **1-877-597-7799**.

Does my request have to be in writing?

We can record your verbal request. Your request will then be made into a written request. We will send a form to you to complete, sign and return to us as soon as possible.

Mail written requests to:

UnitedHealthcare Community Plan
Attn: Complaint and Appeals Department
PO Box 31364
Salt Lake City, UT 84131-0364

What are the time frames for an expedited appeal?

UnitedHealthcare Community Plan must decide this type of appeal in one working day from the time we get the information and request.

What happens if UnitedHealthcare Community Plan denies the request for an expedited appeal?

If UnitedHealthcare Community Plan denies an expedited appeal, the appeal is processed through the normal appeal process, which will be resolved within 30 days. You will receive a letter explaining why and what other choices you may have.

Who can help me file an expedited appeal?

If your child is in the hospital, ask someone to help you mail, fax or call in your request for this type of appeal. You may also call UnitedHealthcare Community Plan Member Services at **1-877-597-7799** and ask someone to help you start an appeal or ask your child's doctor to do it for you.

Can I Ask for a State Fair Hearing?

Members can request a state fair hearing at any time during or after the health plan's appeals process. If you, as a member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 90 days of the date on the health plan's letter with the decision. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should call UnitedHealthcare Community Plan at **1-877-597-7799** or send a letter to the health plan at:

UnitedHealthcare Community Plan
Attn: Fair Hearings Coordinator
14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478

Other Plan Details

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of: (1) 10 calendar days following the MCO's mailing of the notice of the Action, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Advance Directives

What are Advance Directives?

All adults in hospitals, nursing centers and other health care settings have certain rights. For instance, you have the right to have your personal and medical records kept private. You have the right to know what treatment you will get. Under federal law, you have the right to fill out an Advance Directive. Advance Directives are written documents that let you decide and put into writing what kind of treatment you want or do not want, and any actions you want carried out if you are too sick to make decisions about your health care. It is our policy to let all adult UnitedHealthcare Community Plan members know that they can prepare these documents. The federal law on Advance Directives requires hospitals, nursing centers and other health care providers to give you information about Advance Directives. The information will explain your legal choices in making decisions about medical care. The law was written to increase your control over medical treatment decisions.

Advance Directives are written documents that give you the chance to decide and put into writing what kind of treatment you want or do not want, and any actions you want carried out if you become too sick to make decisions about your health care.

How do I get an Advance Directive?

Contact your PCP or call Member Services at **1-877-597-7799**. Call **TTY 711**, for hearing impaired.

Who has the right to make health care decisions?

You do, if you are an adult and able to let providers know of your health care decisions. You decide what health care, if any, you will not accept.

What if I become unable to make or let providers know of my health care decisions?

You can still have some control over these decisions if you have signed an Advance Directive. Your PCP must include in your medical record whether you have signed an Advance Directive. If you have not named someone in your Advance Directive, your doctor must seek a person authorized by law to make these decisions.

What if I am too sick to make a decision about my medical care?

You can still have some control over these decisions if you have signed an Advance Directive. Your PCP must include in your medical record whether you have signed an Advance Directive. If you have not named someone in your Advance Directive, your doctor must seek a person authorized by law to make these decisions.

What are my options for making an Advance Directive?

Under Texas law, you can make the following directives:

1. **A Durable Power of Attorney for Health Care** – a written document giving the designated person the power to act in your place and make decisions on your health care. Your Durable Health Care Power of Attorney will also include any details or guidance about health care you want or do not want. This could include withholding or withdrawing procedures if you are in a “terminal condition.” A “terminal condition” is when a patient cannot be cured and will die without life-sustaining procedures. (Two doctors must state this in writing.) A patient is also in a “terminal condition” if that patient is in a permanent vegetative state or an irreversible coma.
2. **A Living Will** – a written statement about health care you want or do not want if you cannot make these decisions. For example, a Living Will can say whether you would want to be fed through a tube if you were unconscious and not likely to recover. A Living Will directs doctors to withhold/withdraw or continue life-sustaining procedures if you are in a “terminal condition.” You can also tell doctors whether to use other life-sustaining procedures.

Must my Advance Directive be followed?

Yes. Your PCP, other health providers and the person you name in your directive must follow your Advance Directive.

Must a lawyer prepare my Advance Directive?

No. There are local and national groups that will give you facts on Advance Directives, including forms. Be sure any Advance Directive you use is valid under Texas law.

Who should have a copy of my Advance Directive?

Give a copy of your Advance Directive to your PCP and to any health care center on admission. If you have a Durable Power of Attorney for Health Care, give a copy to the person you have named on it. You should also keep extra copies for yourself.

Other Plan Details

Do I have to make an Advance Directive?

No. Whether you make an Advance Directive is up to you. A health care provider cannot refuse care based on whether you have an Advance Directive or not.

Can I change or cancel my Advance Directive?

Yes. If you change or cancel your Advance Directive, let anyone who has a copy of it know.

What if I already have an Advance Directive?

You might want to review it or have it reviewed. If it has been prepared in another state, make sure it is valid under Texas law.

Who can legally make health care decisions for me if I cannot make those decisions and I have no Advance Directive?

A court might appoint a guardian to make health care decisions for you. Otherwise, your PCP must go down the following list to find someone else to make health care decisions for you:

1. Your husband or wife, unless you are legally separated.
2. Your adult child. If you have more than one adult child, a majority of them.
3. Your mother or father.
4. Your brother or sister.

If your PCP cannot find a person able to make health care decisions for you, then he or she can decide on your care. Your PCP can do this with the advice of an ethics committee, or the approval of another doctor. You can make sure your wishes are honored by putting them in writing. The person you name in your Advance Directive will not have the right to refuse life-sustaining procedures, such as the use of tubes to give you food or fluids unless:

- a. You have appointed that person to make health care decisions for you in a Durable Power of Attorney for Health Care.
- b. A court has appointed that person as your guardian to make health care decisions for you.
- c. You have stated in an Advance Directive that you do not want this specific treatment. If you need any help in learning about Advance Directives, or to order a copy of a Living Will, call Member Services at **1-877-597-7799**.

Member Rights and Responsibilities

What are my health care rights and responsibilities as a member of UnitedHealthcare Community Plan?

Member rights:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
 - a. Be treated fairly and with respect.
 - b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - a. Be told how to choose and change your health plan and your primary care provider.
 - b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
 - c. Change your primary care provider.
 - d. Change your health plan without penalty.
 - e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
 - b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - a. Work as part of a team with your provider in deciding what health care is best for you.
 - b. Say yes or no to the care recommended by your provider.

Other Plan Details

5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
 - a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
 - b. Get a timely answer to your complaint.
 - c. Use the plan's appeal process and be told how to use it.
 - d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
 - b. Get medical care in a timely manner.
 - c. Be able to get in and out of a health care provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
 - d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
 - e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals and others who care for you can advise you about your health status, medical care and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals and others cannot require you to pay copayments or any other amounts for covered services.

Member responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
 - a. Learn and understand your rights under the Medicaid program.
 - b. Ask questions if you do not understand your rights.
 - c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
 - a. Learn and follow your health plan's rules and Medicaid rules.
 - b. Choose your health plan and a primary care provider quickly.
 - c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
 - d. Keep your scheduled appointments.
 - e. Cancel appointments in advance when you cannot keep them.
 - f. Always contact your primary care provider first for your non-emergency medical needs.
 - g. Be sure you have approval from your primary care provider before going to a specialist.
 - h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
 - a. Tell your PCP about your health.
 - b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
 - c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
 - a. Work as a team with your provider in deciding what health care is best for you.
 - b. Understand how the things you do can affect your health.
 - c. Do the best you can to stay healthy.
 - d. Treat providers and staff with respect.
 - e. Talk to your provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Other Plan Details

Each year you have the right to ask UnitedHealthcare Community Plan to send you certain information.

As a member of UnitedHealthcare Community Plan, you can ask for and get this information each year:

- Information about network providers — at a minimum primary care doctors, specialists and hospitals in our service area. This information will include names, addresses, telephone numbers and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:
 - What makes up emergency medical conditions, emergency services and post-stabilization services.
 - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
 - How to get emergency services, including instructions on how to use the **911** telephone system or its local equivalent.
 - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
 - A statement saying you have a right to use any hospital or other settings for emergency care.
 - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- UnitedHealthcare Community Plan's practice guidelines.

UnitedHealthcare Community Plan must provide information to members on how it evaluates new technology for inclusion as a covered benefit. It may publish this information in newsletters, member handouts or other member materials. If a newsletter is the chosen method, UnitedHealthcare Community Plan must publish this information annually.

Fraud and Abuse

Do you want to report waste, abuse or fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit <https://oig.hhsc.state.tx.us/>; under the box labeled "I WANT TO," click "Report Fraud, Waste, or Abuse" to complete an online form; or,
- You can report directly to your health plan:
UnitedHealthcare Community Plan Compliance
14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478
1-877-597-7799

To report waste, abuse or fraud, gather as much information as possible.

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

When reporting about someone who gets benefits, include:

- The person's name.
- The person's date of birth, Social Security Number, or case number if you have it.
- The city where the person lives.
- Specific details about the waste, abuse or fraud.

Other Plan Details

HEALTH PLAN NOTICES OF PRIVACY PRACTICES.

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

Effective January 1, 2016.

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

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

We must by law follow the terms of this notice.

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

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

How we use or share your information.

We must use and share your HI with:

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

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

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

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

We may use or share your HI as follows:

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

Other Plan Details

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

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

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

Your rights.

You have a right:

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

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

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 **1-877-597-7799** or **TTY 711**.
- **To Submit a Written Request.** Mail to:
UnitedHealthcare Government Programs Privacy Office
MN017-E300
P.O. Box 1459
Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

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

Effective January 1, 2016.

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

Information we collect.

We get FI about you from:

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

Sharing of FI.

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

Other Plan Details

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

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

Confidentiality and security.

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

Questions about this notice.

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-877-597-7799** or **TTY 711**.

¹ This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Health Plan of Nevada, Inc.; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

² For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1 on this page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women’s and Children’s Health, LLC; AmeriChoice Health Services, Inc.; Connexions HCI, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group healthplans in states that provide exceptions.

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

Revised: January 1, 2016.

The first part of this Notice (pages 71 – 75) says how we may use and share your health information (“HI”) under federal privacy rules. Other laws may limit these rights. The charts below:

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

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

SUMMARY OF FEDERAL LAWS

Alcohol and Drug Abuse Information

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

Genetic Information

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

SUMMARY OF STATE LAWS

General Health Information

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

Other Plan Details

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

HIV/AIDS

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

Mental Health

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

Child or Adult Abuse

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

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-877-597-7799**, **TTY 711**, for hearing impaired. You can also visit our website at **UHCCommunityPlan.com**.

UnitedHealthcare Community Plan
Regional Service Delivery Area Office
14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478

UHCCommunityPlan.com

1-877-597-7799, TTY 711, for hearing impaired
8:00 a.m. to 5:00 p.m., Monday through Friday

