Welcome to the
community.

Texas – April 2016

UnitedHealthcare Community Plan
STAR+PLUS Nursing Facility Member Handbook
Harris, Jefferson, Travis, Nueces, MRSA Central and MRSA Northeast Service Delivery Areas

1-888-887-9003, **TDD/TTY: 711**, for hearing impaired

TEXAS STAR PLUS
Your Health Plan ★ Your Choice

UnitedHealthcare®
Community Plan

CSTX15MC3673201_001

1-888-887-9003, TDD/TTY: 711, for hearing impaired

Monday – Friday, 8:00 a.m. – 8:00 p.m. CST UHCCommunityPlan.com

What to Do in an Emergency

In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services. 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

In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.

If you have questions about your health plan, please call us. Our toll-free Member Services number is **1-888-887-9003**, **TDD/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 1-888-887-9003 for help.

Toll-Free Telephone Numbers

Member Services 1-888-887-9003
Information and Interpreters are available in many languages from 8:00 a.m. to 8:00 p.m. Monday through Friday. After hours, please contact NurseLine. Se habla Español.
TDD/TTY (for hearing impaired) 711

Service Coordination 1-888-887-9003
(8:00 a.m. to 8:00 p.m., Monday through Friday)

NurseLine (available 24 hours a day, 7 days a week) 1-877-839-5407

For Dental Services, Call Member Services 1-888-887-9003

For Eye Care Appointments, Call Member Services 1-888-887-9003

Texas Health and Human Services Commission 1-877-541-7905

Medical Transportation Program 1-877-633-8747

Mental Health and Substance Abuse Services 1-866-302-3996
Optum Behavioral Health; available 24 hours a day, 7 days a week.
Information and Interpreters are available in many languages.
For a crisis and you have trouble with the phone line, call 911 or go to the nearest emergency room.

Medicaid Managed Care Helpline 1-866-566-8989

Medicaid Managed Care Helpline TDD/TTY 1-866-222-4306

Pharmacy Benefits 1-888-887-9003

STAR+PLUS Program Helpline 1-800-964-2777

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

Welcome to UnitedHealthcare Community Plan.
UnitedHealthcare Community Plan, 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 care givers that you can count on. Many are near your home. We will help you stay healthy and get good health care when you are not well. 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 **1-888-887-9003**. 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. We can answer any questions you have about getting started. If you have questions, please call us. Our toll-free Member Services number is **1-888-887-9003**. We are here to help you Monday to Friday, 8:00 a.m. to 8:00 p.m. After hours and weekend coverage is available via an automated telephone system.

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

UnitedHealthcare Community Plan is a trade name of United Healthcare Insurance Company in the HHSC STAR+PLUS MRSA Service Delivery Areas and UnitedHealthcare Community Plan of Texas, L.L.C. in all other HHSC Medicaid/CHIP Service Delivery Areas.

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.
1-888-887-9003
(TDD/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

STAR+PLUS Coverage and Medicare

How does my UnitedHealthcare Community Plan STAR+PLUS coverage affect me if I have both Medicare and STAR+PLUS?
If you have both Medicare and STAR+PLUS, you have "dual eligibility." This means that you have more than one form of medical coverage. Your UnitedHealthcare Community Plan STAR+PLUS benefits will not be reduced or change any of your Medicare benefits.

As a "dual eligible" Member with both Medicare and STAR+PLUS, Medicare Part D will cover your prescriptions. Your Service Coordinator will help arrange your care with Medicare or your Medicare HMO.

If you have traditional Medicare coverage, you can still use the doctor you have been seeing. You can also get Medicare-covered specialty services without approval from UnitedHealthcare Community Plan STAR+PLUS. We will work with your doctor for the services you get through UnitedHealthcare Community Plan STAR+PLUS. Tell your Service Coordinator the name of your regular doctor, especially if you change doctors.

We can help you pick a doctor if you have traditional Medicare coverage but do not have a doctor you see regularly. This doctor can arrange both your UnitedHealthcare Community Plan STAR+PLUS and your Medicare services.

If you join a Medicare HMO, your Primary Care Provider will be the doctor you have chosen through your Medicare HMO. You do not have to pick another Primary Care Provider for UnitedHealthcare Community Plan STAR+PLUS. Your Medicare doctor will work with your UnitedHealthcare Community Plan STAR+PLUS Service Coordinator to arrange your STAR+PLUS services. Be sure to tell your Service Coordinator the name of your Medicare Primary Care Provider.

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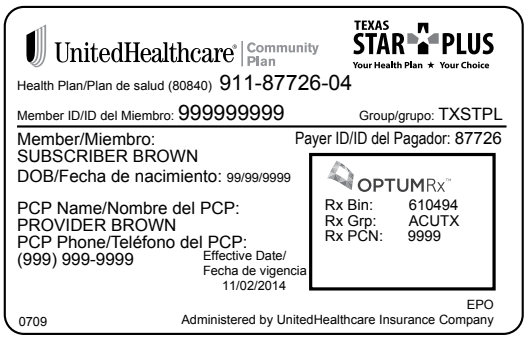
When and Where Do I Use My UnitedHealthcare Community Plan ID Card?

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 you. You will get a new ID card if you change your PCP.

Check your card to make sure the information is correct. If you get an ID card that has no PCP name but says to call **1-888-887-9003**, please call Member Services to select a PCP. Give your ID card to the doctor to verify coverage when getting services. The ID card is not a guarantee of benefits or coverage.

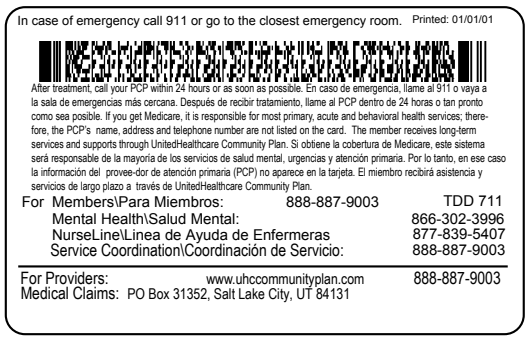
Members with Medicaid only ID card.


UnitedHealthcare | Community Plan
TEXAS STAR PLUS Your Health Plan ★ Your Choice
Health Plan/Plan de salud (80840) 911-87726-04
Member ID/ID del Miembro: 999999999 Group/grupo: TXSTPL
Member/Miembro:
SUBSCRIBER BROWN
DOB/Fecha de nacimiento: 99/99/9999
Payer ID/ID del Pagador: 87726
OPTUMRx
Rx Bin: 610494
Rx Grp: ACUTX
Rx PCN: 9999
PCP Name/Nombre del PCP:
PROVIDER BROWN
PCP Phone/Teléfono del PCP:
(999) 999-9999
Effective Date/ Fecha de vigencia 11/02/2014
EPO
0709
Administered by UnitedHealthcare Insurance Company


In case of emergency call 911 or go to the closest emergency room. Printed: 01/01/01
After treatment, call your PCP within 24 hours or as soon as possible. This card does not guarantee coverage. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible. Esta tarjeta no garantiza la cobertura.
Service Coordination\Coordinación de servicio: 888-887-9003
For Members\Para Miembros: 888-887-9003 TDD 711
Mental Health\Salud Mental: 866-302-3996
NurseLine\Linea de Ayuda de Enfermeras: 877-839-5407
For Providers: www.uhccommunityplan.com 888-887-9003
Medical Claims: PO Box 31352, Salt Lake City, UT 84131
Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952

Members with Medicaid and Medicare ID card.


UnitedHealthcare | Community Plan
TEXAS STAR PLUS Your Health Plan ★ Your Choice
Health Plan/Plan de salud (80840) 911-87726-04
Member ID/ID del Miembro: 999999999 Group/grupo: TXSTPL
Member/Miembro:
SUBSCRIBER BROWN
DOB/Fecha de nacimiento: 99/99/9999
Payer ID/ID del Pagador: 87726
OPTUMRx
Rx Bin: 610494
Rx Grp: ACUTX
Rx PCN: 9999
PCP Name/Nombre del PCP:
USE MEDICARE
Long term care services only
Solo servicios de atención a largo plazo
EPO
0709
Administered by UnitedHealthcare Insurance Company


In case of emergency call 911 or go to the closest emergency room. Printed: 01/01/01
After treatment, call your PCP within 24 hours or as soon as possible. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible. If you get Medicare, it is responsible for most primary, acute and behavioral health services; therefore, the PCP's name, address and telephone number are not listed on the card. The member receives long-term services and supports through UnitedHealthcare Community Plan. Si obtiene la cobertura de Medicare, este sistema será responsable de la mayoría de los servicios de salud mental, urgencias y atención primaria. Por lo tanto, en ese caso la información del provee-dor de atención primaria (PCP) no aparece en la tarjeta. El miembro recibirá asistencia y servicios de largo plazo a través de UnitedHealthcare Community Plan.
For Members\Para Miembros: 888-887-9003 TDD 711
Mental Health\Salud Mental: 866-302-3996
NurseLine\Linea de Ayuda de Enfermeras 877-839-5407
Service Coordination\Coordinación de Servicio: 888-887-9003
For Providers: www.uhccommunityplan.com 888-887-9003
Medical Claims: PO Box 31352, Salt Lake City, UT 84131

If you have Medicare and Medicaid, your UnitedHealthcare ID card will not show doctor's name or phone number. Your ID card will show Long Term Care services only.

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How to Read Your UnitedHealthcare Community Plan ID Card

Your ID card will have the STAR+PLUS symbol and the UnitedHealthcare Community Plan symbol. 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.

If you have Medicare, your UnitedHealthcare Community Plan ID card will say that you get Long-Term Services and Supports only. This means you will get your doctor, hospital, lab, X-ray and other acute care services from Medicare or your Medicare HMO.

How to Replace Your Card if It Is Lost

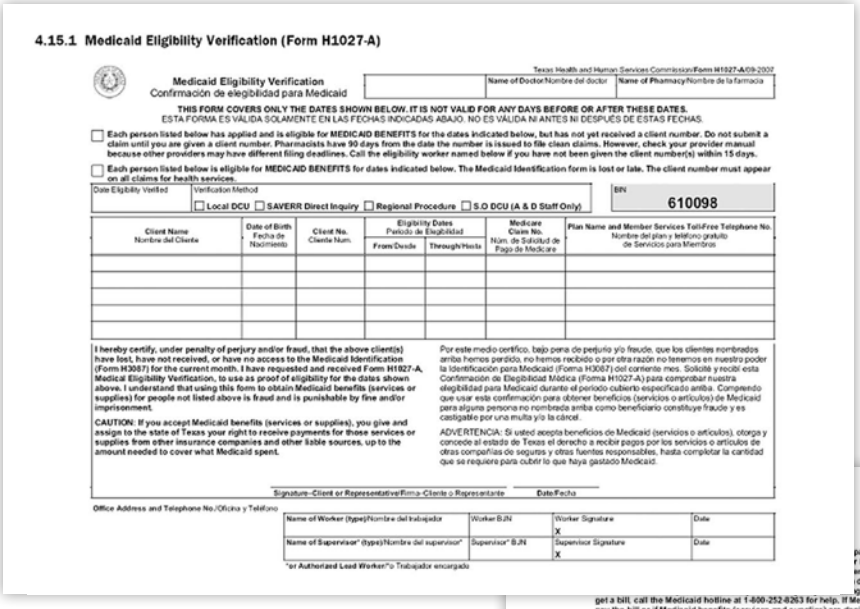
If you lose your UnitedHealthcare Community Plan ID card, call Member Services right away at **1-888-887-9003**. Member Services will send you a new one. Call **TDD/TTY: 711** for hearing impaired.

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 what your coverage is.

Your Temporary Medicaid Verification Form (Form 1027A)

You can request a temporary Medicaid verification form if you lose your Your Texas Benefits Medicaid Card. 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 **1-888-887-9003** so we can update our records. Call **TDD/TTY: 711** for hearing impaired.



4.15.1 Medicaid Eligibility Verification (Form H1027-A)

Medicaid Eligibility Verification
Confirmación de elegibilidad para Medicaid

Texas Health and Human Services Commission Form H1027-A/09-2007

Name of Doctor/Nombre del doctor | Name of Pharmacy/Nombre de la farmacia

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 90 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.

Date Eligibility Verified | Verification Method: ☐ Local DCU ☐ SAVERR Direct Inquiry ☐ Regional Procedure ☐ S.O DCU (A & D Staff Only) | BIN: 610098

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

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 H3067) for the current month. I have requested and received Form H1027-A, Medical 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 those 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 H3067) del corriente mes. Solicité y recibí 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 requiera para cubrir lo que haya gastado Medicaid.

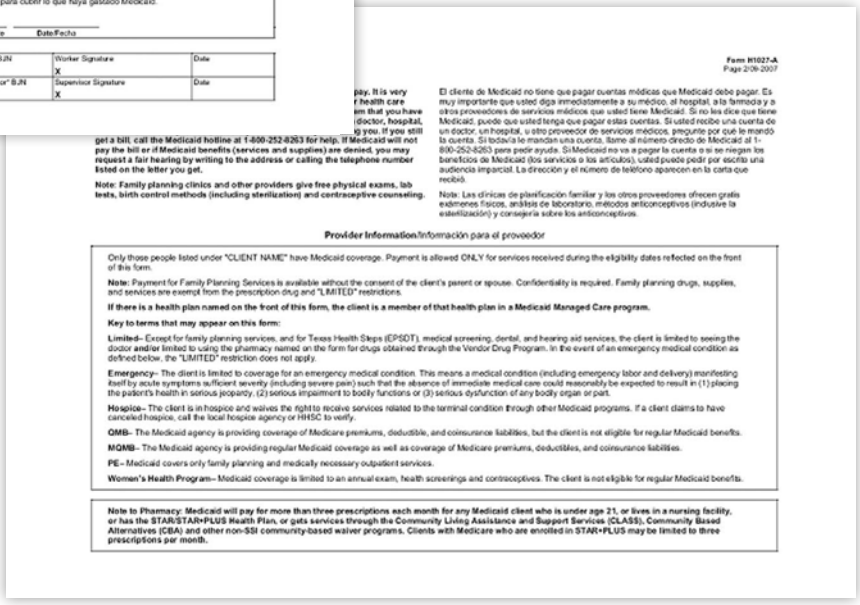
Signature–Client or Representative/Firma–Cliente o Representante | Date/Fecha

Office Address and Telephone No./Oficina y Teléfono

Name of Worker (type)/Nombre del trabajador	Worker BJN	Worker Signature X	Date
Name of Supervisor* (type)/Nombre del supervisor*	Supervisor* BJN	Supervisor Signature X	Date

or Authorized Lead Worker/o Trabajador encargado

(Temporary Medicaid Verification Form Sample – Front)



Form H1027-A
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get a bill, call the Medicaid hotline at 1-800-252-8263 for help. If Medicaid will not pay the bill or if 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.

El cliente de Medicaid no tiene que pagar cuentas médicas que Medicaid debe pagar. Es muy importante que usted diga inmediatamente a su médico, al hospital, a la farmacia y a otros proveedores de servicios médicos que usted tiene Medicaid. Si no les 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, pregunte por qué le mandó la cuenta. Si todavía le mandan una cuenta, llame al número directo de Medicaid al 1-800-252-8263 para pedir ayuda. Si Medicaid no va a pagar la cuenta o si se niegan 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.

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

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 (EPSDT) 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 canceled hospice, call the local hospice agency or HHSC to verify.

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

MQMB– 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-SSI community-based waiver programs. Clients with Medicare who are enrolled in STAR+PLUS may be limited to three prescriptions per month.

(Temporary Medicaid Verification Form Sample – Back)

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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 be issued one card, and will only receive a new card in the event your card being lost or stolen. If your Medicaid ID card is lost or stolen, you can get a new one by calling toll-free 1-855-827-3748, or by going online to print a temporary card at www.YourTexasBenefits.com.

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 2-1-1. 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 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 toll-free (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.

Note: *For STAR+PLUS Members who are covered by Medicare, no Primary Care Provider will be assigned.*

How do I see my primary care provider if s/he does not visit my nursing home?
If you need to leave the nursing facility for a doctor visit, the nursing facility will provide transportation.

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 **1-888-887-9003**, or you can look online at UHCCommunityPlan.com.

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.

When will my primary care provider change become 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.

Physician Incentive Plans

UnitedHealthcare Community Plan rewards doctors for treatments that are cost-effective 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 **1-888-887-9003** to learn more about this.

Questions about seeing a provider?

Call Member Services toll-free at **1-888-887-9003**.

What Is Service Coordination?

Specialized services/care process that includes, but is not limited to:

- Identifying the physical, mental or long term needs of the Member.
- Addressing any unique needs of the Member that could improve outcomes and health/well-being.
- Assisting the Member to ensure timely and coordinated access to array of services and/or covered Medicaid eligible services.
- Partner with nursing facility to ensure the best possible outcomes for the Member's health and safety.
- Coordinate the delivery of services for Members who are transitioning back to the community.

What Is a Service Coordinator?

You will be assigned a Service Coordinator when you join UnitedHealthcare Community Plan STAR+PLUS. Your Service Coordinator will call you or visit you in person to talk to you about our 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.

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.

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 **1-888-887-9003** to help you reach your Service Coordinator. Call **TDD/TTY: 711** for hearing impaired.

What other programs are available to help me manage my chronic illness?
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. If you have a special need or help managing a chronic illness call **1-888-887-9003** to get in contact with your Service Coordinator.

Did You Know That You Might Be Able to Hire and Manage the People Who Provide Your Services?

UnitedHealthcare Community Plan Can Help You Manage Your Home Services. Consumer Directed Services (CDS) is a program for people receiving certain services available under the CDS option. With this program, you find, hire and train the people providing these specific services. You also review the budget for the services. You decide how much to pay these providers. 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 providers for services available under the CDS option. 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+PLUS Waiver Program (formerly known as Community Based Alternatives)	Personal Assistance Services/Protective Supervision, Respite, Physical Therapy, Occupational Therapy, Speech/Language Therapy, Nursing services, Support Consultation, Supported Employment/Employment Assistance, Cognitive Rehabilitation Therapy
Primary Home Care/ Community Attendant Services	Personal Assistance Services Support Consultation

Contact your UnitedHealthcare Community Plan Service Coordinator to help you pick the best choice. He or she can tell you what services you can get. Call **1-888-887-9003** or **TDD/TTY: 711** for hearing impaired.

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?
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. This is called a referral. Your doctor is the only one that can give you a referral to see a specialist. If you have a visit, or receive services from a specialist without your PCP's referral, or if the specialist is not a UnitedHealthcare Community Plan provider, you might be responsible for the bill. In some cases, an OB/GYN can also give you a referral for related services.

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 **1-888-887-9003** 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 **1-888-887-9003** for help with getting a second opinion.

How Do I Get Help if I Have Behavioral (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 1-866-302-3996 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 TDD/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.

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.

How Do I Get My Medications?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription and send the prescription for you by calling, faxing or submitting by electronic means to the nursing facility to order, fill, dispense and administer to you.

How do I find a network drug store?
Please contact Member Services for assistance at **1-888-887-9003** 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 **1-888-887-9003** or to find an in-network pharmacy. You can also look on our website at UHCCommunityPlan.com.

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/content/dam/communityplan/plandocuments/findapharmacy/Texas_Listing_of_Delivery_Pharmacies.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 **1-888-887-9003**. 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 **1-888-887-9003** for help with your medications and refills.

What if I lose my medications?
Please contact Member Services for assistance at **1-888-887-9003**.

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+PLUS Members. Prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D.

What Is the Medicaid Lock-in Program?

You may be placed 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 that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more, call UnitedHealthcare Community Plan Member Services at **1-888-887-9003**.

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 contact UnitedHealthcare Community Plan Member Services at **1-888-887-9003** to request help with your special health care needs.

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.

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 **1-888-887-9003**. 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 3 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 **1-888-887-9003**.

How do I choose an OB/GYN?
Call Member Services at **1-888-887-9003** for help choosing an OB/GYN. You can also request a UnitedHealthcare Community Plan Provider Directory by calling Member Services at **1-888-887-9003**, 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.

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.

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 Medicaid Benefits 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 1-877-839-5407 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 the Facility and Traveling Out of Town?

If you need medical care when traveling, call us toll-free at **1-888-887-9003** 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 **1-888-887-9003**.

What if I am out of the 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 **1-888-887-9003**. 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 STAR+PLUS Program Helpline at 1-800-964-2777. 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 Texas STAR+PLUS 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 (for non-compliance, etc.)?
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 **1-888-887-9003**. The Texas Health and Human Services Commission will decide if a Member can be told to leave the program.

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 **1-888-887-9003** or **TDD/TTY: 711** for hearing impaired. You can also contact your Service Coordinator by calling **1-888-887-9003**.

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 **1-888-887-9003** if you need a translator. Call **TDD/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 **1-888-887-9003** for more information.

What Does Medically Necessary Mean?

1. For Members age 21 and over, 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
2. For Members age 21 and over, behavioral health services that are:
   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.

UnitedHealthcare Community Plan will determine medical necessity for Nursing Facility Add-on Services and Acute Care Services only. Nursing Facility Add-on Services include, but are not limited to emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, and audio communication devices.

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 or Emergency Behavioral Health Condition, including post-stabilization care services.

How soon can I expect to be seen in an emergency?
Emergency wait time will be based on your medical needs and determined by the emergency facility that is treating you.

Do I need a prior authorization?
You do not need a referral for emergency care.

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 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 **1-888-887-9003**. You also can call our 24-hour Nurse HelpLine at 1-877-839-5407 for help with getting the care you need.

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 **1-888-887-9003**.

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 **1-888-887-9003** if you need help picking a UnitedHealthcare Community Plan provider.

Are Emergency Dental Services Covered?

UnitedHealthcare Community Plan covers limited emergency dental services for the following:

- Dislocated jaw.
- Traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment and devices for craniofacial anomalies.
- Drugs for any of the above conditions.

UnitedHealthcare Community Plan also covers dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs).

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- Open or closed reduction of fracture of the maxilla or mandible;
- Repair of laceration in or around oral cavity;
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- Incision and drainage of cellulitis;
- Root canal therapy. Payment is subject to dental necessity review and pre- and post-operative X-rays are required; and
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Are non-emergency dental services covered?

UnitedHealthcare Community Plan is not responsible for paying for routine dental services provided to Medicaid Members.

How Do I Get Eye Care Services?

If you need eye care services, please call UnitedHealthcare Community Plan Member Services at **1-888-887-9003**. We can help you find a provider close to you.

What Are My Health Care Benefits?

UnitedHealthcare Community Plan STAR+PLUS 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.
- Psychiatry services.
- Counseling services for adults.
- Substance use disorder treatment services.
- Prenatal care.
- Birthing services.
- Cancer screening, diagnostic, and treatment services.
- Chiropractic services.
- Dialysis.
- 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.
- 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.
- Optometry, glasses, and contact lenses, if medically necessary.
- Outpatient drugs and biologicals.
- Drugs and biologicals provided in an inpatient setting.
- Podiatry.
- Prenatal care.
- Primary care services.
- Preventive services including an annual adult well check for patients 21 years of age and over.
- Radiology, imaging, and X-rays.
- Specialty physician services.
- Physical, occupational and speech therapies.
- Transplantation of organs and tissues.
- Vision.

How do I get these services?
Call UnitedHealthcare Community Plan Member Services at **1-888-887-9003**.

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 **1-888-887-9003**.

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 elderly people and persons with disabilities. Contact Member Services **1-888-887-9003** to ask for these services.

What are my Nursing Facility LTSS benefits?
Members will get services covered under the nursing facility daily rate that are provided by the nursing facility. Nursing facility add-on services are also provided when medically necessary and are covered outside of the daily rate.

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 **1-888-887-9003**.

How Would My Benefits Change if I Moved Into the Community?

Members moving back into the community will receive community based long term care services or STAR+PLUS Waiver services including:

Community based long term care services for all Members.

- Personal Attendant Services.
- Day Activity and Health Services.

HCBS STAR+PLUS waiver services for those Members who qualify for these services.

- Personal Attendant Services (including the three service delivery options: Self-Directed; Agency Model, Self-Directed; and Agency Model).
- In-Home or Out-of-Home Respite Services.
- Nursing Services (in home).
- Emergency Response Services (Emergency call button).
- Home Delivered Meals.

Minor home modifications.

- Adaptive Aids and Medical Equipment.
- Medical Supplies not available under the Texas Medicaid State Plan/Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver.
- Physical Therapy, Occupational Therapy, Speech Therapy.
- Day Activity Health Services (DAHS).
- Adult Foster Care.
- Assisted Living.
- Transition Assistance Services.
- Dental Services.
- Cognitive Rehabilitation Therapy.
- Financial Management Services.
- Support Consultation.
- Employment Assistance.
- Supported Employment.

What Are My Acute Care Benefits?

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

- Ambulance services.
- Audiology services, including hearing aids.
- Behavioral Health Services, including:
  - Inpatient mental health services for Adults and Children. The MCO may provide these services in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
  - Outpatient mental health services for Adults and Children.
  - Psychiatry services.
  - Counseling services for adults (21 years of age and over).
  - Substance use disorder treatment services, including.
- Outpatient services, including:
  - Assessment.
  - Detoxification services.
  - Counseling treatment.
  - Medication assisted therapy.
  - Residential services, which may be provided in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting, including § Detoxification services.
  - Substance use disorder treatment (including room and board).
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center.
- Birthing services provided by a physician and CNM in a licensed birthing center.
- Birthing services provided by a licensed birthing center.
- Cancer screening, diagnostic, and treatment services.
- Chiropractic services.
- Dialysis.
- 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, including:
  - Outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
  - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
  - Surgery and reconstruction on the other breast to produce symmetrical appearance;
  - Treatment of physical complications from the mastectomy and treatment of lymphedemas; and
  - Prophylactic mastectomy to prevent the development of breast cancer.
  - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) Services for children (birth through age 20) through the Texas Health Steps Program.
- 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; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals.
- Drugs and biologicals provided in an inpatient setting.
- Podiatry.
- Prenatal care.
- Primary care services.
- Preventive services including an annual adult well check for patients 21 years of age and over.
- Radiology, imaging, and X-rays.
- Specialty physician services.
- Therapies — physical, occupational and speech.
- Transplantation of organs and tissues.
- Vision. (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
- Telemedicine.
- Telemonitoring.
- Telehealth.

Note: For Medicaid-only Members, UnitedHealthcare Community Plan STAR+PLUS 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 **1-888-887-9003** for questions on how to get these services.

What Services Are Not Covered?

If you want to know if a procedure or medication is covered under STAR+PLUS, ask your PCP or call Member Services at **1-888-887-9003**. Call **TDD/TTY: 711**, for hearing impaired.

- Services by non-approved providers.
- Services by Christian Science Nurses.
- Dentures.
- Private duty nursing.
- 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 Services Can I Still Get Through Regular Medicaid But Are Not Covered by UnitedHealthcare Community Plan?

- Preadmission Screening and Resident Review (PASRR). PASRR is a federal requirement to help determine whether an individual is not inappropriately placed in a nursing home for long term care.
- Hospice.

What Are My Prescription Drug Benefits?

Contact Member Services for more information on your prescription benefits. For more information, please refer to page 21 of this Member Handbook.

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. 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?
The following is a list of family planning providers by county. You can find the locations of family planning providers near you online at https://www.healthytexaswomen.org/find-a-doctor, or you can call UnitedHealthcare Community Plan Member Services at **1-888-887-9003** 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:

Extra dental services for adults (21 years and older).

A $500 annual benefit to cover routine exam, cleaning, X-rays. Access to discounts for non-covered services.

Limitations:

- Must use in-network provider.
- Only for Medicaid Members (not Medicare).
- $500 per year.

Call Member Services at **1-888-887-9003**, **TDD/TTY: 711**, to find an in-network dentist.

Extra vision services.

A $105 annual benefit to cover upgraded selection of frames and lenses or damaged/lost frames and lenses.

Limitations:

- Must use in-network provider.
- $105 per year.
- For replacement lenses/frames only.
- Only for Medicaid Members (not Medicare).

Call Member Services at **1-888-887-9003**, **TDD/TTY: 711**, to find an in-network provider.

Diabetic management: Gift card.

Members who are diagnosed with diabetes may receive gift cards for completing diabetic exams: HbA1c, Eye exam, LDL cholesterol test.

Limitations:

- Member must have doctor sign redemption card at time of exam.
- Member must mail in the signed redemption card.
- One $20 gift card per exam, per year.
- Must use in-network provider.

Call Member Services at **1-888-887-9003**, **TDD/TTY: 711**, to request redemption card.

Diabetic management: Insoles.

Members who are diagnosed with diabetes may receive two pairs of shoe insoles.

Limitations:

- Member must mail in the redemption card.
- Two pairs of insoles per year.
- Medicaid Members only (not Medicare) and must be over 18 years of age.

Call Member Services at **1-888-887-9003**, **TDD/TTY: 711**, to request redemption card.

Crossword Puzzle/Sudoku/Word Search Subscription.

Member will receive a $20 gift card for a subscription to the puzzle of their choice.

Limitations:

- Member will complete the request form for the gift card.
- One $20 gift card per year.
- Excludes SNF admissions.

Call Member Services at **1-888-887-9003**, **TDD/TTY: 711**, to request redemption card.

Welcome Kit.

All UnitedHealthcare Community Plan Members entering a Nursing Facility will receive a Welcome Kit upon admission. Welcome kit will include items like: coffee cup/water bottle, shower cap, lighted-magnifier, and reusable bag.

Limitations:

- Must be an in-network facility.
- Excludes SNF Admissions.
- Items in kit are subject to change.
- One kit per Member, per year.

Call Member Services at **1-888-887-9003**, **TDD/TTY: 711**.

Alzheimer's Association Safe Return.

Members with Alzheimer's disease are eligible to receive the MedicAlert + Alzheimer's Association Safe Return program. This national program assists with the safe and timely return of a Member who may wander and get lost.

Limitations:

- Member must have an Alzheimer's diagnosis.

Call Member Services at **1-888-887-9003**, **TDD/TTY: 711**, to request redemption card.

How do I get these benefits?
Call Member Services at **1-888-887-9003** 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. Please call your Service Coordinator at **1-888-887-9003** for more information about Health Education.

What Other Services Can UnitedHealthcare Community Plan Help Me Get?

The STAR+PLUS 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.
- Prescription drugs.
- 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).

UnitedHealthcare Community Plan Transportation Services for Nursing Facility Residents

What transportation services are offered?
The Nursing Facility is responsible for providing routine non-emergency transportation services. If medically necessary, UnitedHealthcare Community Plan provides non-emergency ambulance transportation for Members that require this service.

How do I get this service?
To get non-emergency ambulance transportation, your provider must contact UnitedHealthcare Community Plan to request authorization for these services at **1-888-887-9003**.

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 Primary Care Provider you had before.

What if I Get a Bill From My Nursing Facility? 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 **1-888-887-9003** 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 is applied income?
It is the Member's personal income that the Member must provide to the nursing facility as part of their cost sharing obligation as a Medicaid beneficiary.

What are my responsibilities?
Any time Medicaid is billed by the nursing facility, the Member must give their applied income to the facility. The amount is determined by the total amount of monthly income divided by the number of days the Member resides in the facility each month. The Member is allowed to keep $60 themselves for personal needs.

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 at **1-888-887-9003**.

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.

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 co-payments that are covered by Medicaid.

Complaints and Appeals

What should I do if I have a complaint about my health care, my provider, my service coordinator, or my health plan?
We want to help. If you have a complaint, please call us toll-free at **1-888-887-9003** to tell us about your problem. A UnitedHealthcare Community Plan Member Services Advocate can help you file a complaint. Just call **1-888-887-9003**. 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 Community Plan Member Services for help at **1-888-887-9003**.

Where can I mail a complaint?
For written complaints please send your letter to UnitedHealthcare Community Plan-STAR+PLUS. You must state your name, your Member ID number, 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 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. Please call **1-888-887-9003** to talk to a Member Advocate.

What are the requirements and timeframes 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 **1-888-887-9003**. 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.

How will I find out if services are denied?
UnitedHealthcare Community Plan will send you a letter if a covered service requested by your PCP is denied, delayed, limited or stopped.

What are the timeframes 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 **1-888-887-9003**. 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 **1-888-887-9003**.

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 timeframes 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 you are 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 **1-888-887-9003** and ask someone to help you start an appeal or ask your 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 **1-888-887-9003** 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

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 **1-888-887-9003**. Call **TDD/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.

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 Advanced 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 **1-888-887-9003**.

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.

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.
10. You have a right to make recommendations regarding the organization's Member rights and responsibilities policy.

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 Primary Care Provider 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.

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 limits to those benefits.
- How you get after hours and emergency coverage and 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.
  - In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.
  - 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 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
  1-888-887-9003

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.

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.
We[1] 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 UHCCommunityPlan.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 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: UHCCommunityPlan.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 **1-888-887-9003** 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.
We[2] protect your "personal financial information" ("FI"). This means non-health information about someone with health care coverage or someone applying for coverage. It is information that identifies the person and is generally not public.

Information we collect.
We get FI about you from:

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

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

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

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

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

Questions about this notice.
If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-888-887-9003** 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.; Connextions 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 60 – 65) 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

Recetas	
Podremos compartir la información sobre recetas únicamente (1) en casos limitados y/o (2) con ciertas personas o entidades.	ID, NH, NV
Enfermedades contagiosas	
Podremos compartir información sobre enfermedades contagiosas únicamente (1) en casos limitados y/o (2) con ciertas personas o entidades.	AZ, IN, KS, MI, NV, OK
Enfermedades de transmisión sexual y salud reproductiva	
Estamos autorizados a compartir información sobre las enfermedades de transmisión sexual y/o salud reproductiva únicamente (1) en casos limitados y/o (2) con ciertas personas o entidades.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Abuso de alcohol y drogas	
Podremos usar y compartir información sobre el abuso de alcohol y drogas únicamente (1) en casos limitados y/o compartir solamente con (2) recipientes específicos.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
La divulgación de la información sobre el abuso de alcohol y drogas podrá ser limitada por la persona que es sujeto de dicha información.	WA
Información genética	
No podremos divulgar información genética sin su consentimiento por escrito.	CA, CO, KS, KY, LA, NY, RI, TN, WY
Podremos compartir la información genética únicamente (1) en casos limitados y/o (2) con ciertas personas o entidades.	AK, AZ, FL, GA, IA, IL, MD, MA, ME, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Se aplican restricciones a (1) el uso, y/o (2) el mantenimiento de la información genética.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT

VIH / SIDA	
Podremos compartir la información relacionada con el VIH/SIDA (1) en casos limitados y/o (2) con ciertas personas o entidades.	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
Se aplican algunos límites para la divulgación oral de información relacionada con el VIH/SIDA.	CT, FL
Recabamos cierta información sobre VIH/SIDA sólo con su consentimiento por escrito.	OR
Salud mental	
Podremos compartir información sobre salud mental únicamente (1) en casos limitados y/o (2) con ciertas personas o entidades.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
La divulgación de la información podrá ser limitada por la persona que es el sujeto de dicha información.	WA
Se aplican ciertas restricciones para la divulgación oral de información sobre la salud mental.	CT
Se aplican ciertas restricciones al uso de información sobre salud mental.	ME
Abuso de menores o de adultos	
Podremos usar y compartir información sobre abuso de menores y/o adultos únicamente (1) en casos limitados y/o (2) con ciertas personas o entidades.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

We're here for you.

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-888-887-9003**, **TDD/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

1-888-887-9003, **TDD/TTY: 711**, for hearing impaired
8:00 a.m. to 8:00 p.m., Monday through Friday

UnitedHealthcare® Community Plan