



IN THIS HEALTH TALK SPECIAL INSERT

Emergency and post-stabilization care
Referrals and prior authorization
Appeals and grievances
Rights and responsibilities
Plus, more information about how to use your plan



Need to know

Learn how your plan works for you.

Need care now?

How to get emergency and post-stabilization care

If you have an emergency, go immediately to the emergency room (ER) at the nearest hospital or call **911**. You do not need approval from UnitedHealthcare Community Plan or your doctor.

A medical emergency is when you suddenly become seriously injured or very sick, and not getting care right away could result in:

- placing your health in serious danger.
- putting your health, a body part or body function in danger.
- injury to yourself or bodily harm to others.
- in the case of a pregnant woman, placing your life or the life of your unborn child in danger.

Some examples of emergencies are:

- severe pain
- convulsions
- unconsciousness
- severe or unusual bleeding
- a serious accident
- a suspected heart attack or stroke
- for pregnant women, having contractions

If you have a medical emergency, you can use *any* hospital or provider. If you have to, you can go to a hospital or provider that is not in the network. You do not need approval from UnitedHealthcare Community Plan or your doctor.



POST-STABILIZATION CARE

Post-stabilization care is covered services you get after emergency care to keep your condition stable. The emergency room or clinic must examine you and make sure you are well enough before they can discharge you (allow you to leave the emergency room). You may then go home, be admitted or be transferred to another hospital to get the care you need when discharged. We will pay for post-stabilization care you get after your emergency room care. You do not need prior authorization for post-stabilization services.

Out-of-network services

When you need prior authorization

You or your PCP might decide that you need to see a provider for services or treatments that are not available in our network. Your PCP will need to call us to get an OK before these services will be covered. This is called a prior authorization.

You do not need a prior authorization for emergency services or to see a women's health care provider for women's health or if you are pregnant.



SERVICES FROM OTHER AGENCIES

Additional services are covered through other state and community programs. If you or your child qualifies, we can help you get in touch with these programs, such as:

- WIC, the Supplemental Nutrition Program for Women, Infants and Children
- Early Intervention Section Program (EIS) and Department of Education (DOE) school-based services
- Other behavioral health programs such as Child and Adolescent Mental Health Division (CAMHD)



Learn more. Call our local Member Services toll-free. For QExA members, the number is **1-888-980-8728 (TTY 711)**. For QUEST members, the number is **1-877-512-9357 (TTY 711)**.



Getting referrals

A referral is a request from your PCP for you to see a specialist. A referral is not needed when you see any specialist that is in our network. You also do not need a referral for the following services:

- emergency services
- women's health care services, including yearly exams, pap smears, breast exams and birth control
- behavioral health services, such as counseling or treatment for alcohol and drug use
- covered family planning services



Prior authorization

You may need approval or permission to get some services under our plans. This is called a prior authorization. Some services that need a referral will also need a prior authorization. Your PCP will work with us to get prior authorization if needed.

You do not need a prior authorization for emergencies. You do not need it to see a women's health provider for women's health or if you are pregnant.

REPORTING CHANGES

If you have a big change in your life, you need to tell us and your eligibility worker as soon as possible.

These changes include, but are not limited to:

- change of name
- change of address or phone number
- birth of a child, marriage, divorce or death of a family member (dependent or spouse)
- getting a new job
- getting other medical insurance, or if you are being treated for injuries from a workers compensation claim or automobile accident
- pregnancy
- permanent disability



Let us know. Call our local Member Services toll-free. For QExA members, the number is **1-888-980-8728 (TTY 711)**. For QUEST members, the number is **1-877-512-9357 (TTY 711)**.



Women's health care and family planning

Women have direct access to family planning, women's health care services and women's health care providers that are available in our network. No referral or prior authorization is needed. Women's health care includes routine and preventive care such as:

- breast cancer screening, pap smears and pelvic exams.
- care related to pregnancy.
- care for any female medical condition.

Cost sharing

Members may have to share in the cost of their health care services. This is based on Medicaid financial eligibility. Your State of Hawaii Medicaid eligibility worker will figure the amount of your cost-share and let both you and UnitedHealthcare Community Plan know. If you have cost share, you must pay this to one of your providers every month.

We care for you

UnitedHealthcare Community Plan provides care management to members with special needs. Care managers work with the health plan, your physician and outside agencies. They help members get the special services and care they need. Care management helps people who have:

- physical disabilities
- serious mental illness
- complex health problems
- other special needs

We also have disease management programs. Members in these programs get reminders about their care and advice from a nurse. Disease management helps members with chronic illnesses and high risk conditions such as:

- diabetes
- CHF
- asthma
- COPD
- substance abuse
- obesity
- high risk pregnancy



Help is here. If you have special needs or need help managing a chronic illness, call Member Services toll-free. For QExA members, the number is **1-888-980-8728 (TTY 711)**. For QUEST members, the number is **1-877-512-9357 (TTY 711)**. Ask if you are eligible for care management or disease management.



Appeals and grievances

How to get help if you are not satisfied with us or your doctor

Our local Member Services staff is here to help you if you are not happy with the services you get from the plan or from your doctor.

GRIEVANCES

A grievance is when you are not happy with us or one of our providers. Examples of something that you might not be happy about are:

- issues with quality of service or care.
- how the plan or your provider run their office.
- if the plan or your provider was rude.
- wait times during provider visits.
- not getting the information you need.

A grievance does not include being unhappy with an action that was made by the plan.

WHAT TO DO IF YOU HAVE A GRIEVANCE

We want to help. You, your representative, or provider on your behalf can let us know by calling or writing to us. If you need, a translator can be provided at no cost. You can call us at:

- QUEST: toll-free 1-877-512-9357 (TTY 711)
- QExA: toll-free 1-888-980-8728 (TTY 711)

YOU CAN ALSO SEND IT IN WRITING TO:

UnitedHealthcare Community Plan
Attention: Appeals Department
P.O. Box 2960
Honolulu, HI 96802

There is no time limit on filing a grievance with us. After we get your grievance, we will send you a letter within five business days. This letter will tell you that we got your grievance. We will also let you know about the results of your grievance in writing. This letter will be sent to you within 30 days after we get your grievance.

EXPEDITED APPEALS

An expedited appeal is when you, your authorized representative or your provider thinks that we need to make a quick decision based on your health. This is when taking the time for a standard appeal could risk your life or health.

We will tell you and your doctor within 24 hours if it meets the criteria for our expedited appeals process. If we process it as an expedited appeal, we will notify you of our decision within three business days. We will also let you know about the decision for your appeal in writing. We will send a letter to your doctor. If you ask for more time, we may extend the time frame for up to 14 days. If we need more information, we may also extend the time frame for up to 14 days. We will send you a letter if we extend the time frame.

If we deny an expedited appeal, the appeal is then processed through the standard appeal process, which will be resolved within 30 days. We will call you to tell you that the appeal is not going to be processed as an expedited appeal. We will follow up in writing. The notice will tell you that you may file a grievance with us for the denial of the expedited process.

APPEALS

An appeal is when you are unhappy or do not agree with our decision or action about health care related services. For example, an appeal can be filed when a covered service is denied, delayed, limited or stopped. You can also file an appeal if a request for reimbursement is denied.

HOW TO FILE AN APPEAL

You, your representative or provider on your behalf can let us know by calling or writing to us. If you need, a translator can be provided at no cost. You can call us at:

- QUEST: toll-free 1-877-512-9357 (TTY 711)
- QExA: toll-free 1-888-980-8728 (TTY 711)

YOU CAN ALSO SEND IT IN WRITING TO:

UnitedHealthcare Community Plan
Attention: Appeals Department
P.O. Box 2960
Honolulu, HI 96802

If you call, you must also send your appeal in writing, unless you are asking for an expedited appeal. You can give us evidence to support your appeal in person or in writing.

You must appeal within 30 days of the date on the denial letter, also called a Notice of Action. After we get your appeal,

we will send you a letter within five business days. This letter will tell you that we got your appeal. We will also let you know about the decision for your appeal in writing. This letter will be sent to you within 30 days after we get your appeal. If you ask for more time, we may extend the time frame for up to 14 days. If we need more information, we may also extend the time frame for up to 14 days. We will send you a letter if we extend the time frame.

WHAT HAPPENS WITH YOUR SERVICE DURING THE APPEAL PROCESS?

To continue to get service during an appeal, your request for an appeal must be received by us within 10 days of the Notice of Action or the date the service will be stopped or reduced. Services will only continue under the following conditions:

- You request an extension of benefits.
- The appeal or request for State Administrative Hearing was filed in a timely manner.
- The appeal or request for State Administrative Hearing involves the termination, suspension or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The original authorization period has not ended.

If you do not ask for the appeal or hearing within 10 days, your service may be stopped.

STATE ADMINISTRATIVE HEARINGS

If you do not agree with our decision, you may ask for a State Administrative Hearing. You have 30 days after the date of our decision to ask for a hearing.

YOU CAN REQUEST A HEARING BY WRITING TO:

State of Hawaii Department of
Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809

You have the right to have someone represent you at the hearing, such as a provider or any authorized representative.



The Med-QUEST Division Ombudsman Program. The ombudsman is a person who can help you with QExA or QUEST problems. The State of Hawaii Department of Human Services oversees this program.

The Med-QUEST Division Ombudsman Program phone numbers are: **808-791-3467** (Oahu), **808-270-1536** (Maui and Lanai), **808-240-0485** (Kauai), **808-333-3053** (Hawaii) and **808-660-0063** (Molokai).

Member rights and responsibilities

AS A UNITEDHEALTHCARE COMMUNITY PLAN MEMBER YOU HAVE THE RIGHT TO:

- get information in a language you understand.
- be treated with respect for your dignity and privacy.
- have all records and medical and personal information kept private.
- get information on treatment options in a way you can understand, regardless of cost or benefit coverage.
- take part in decisions on your care, including the right to refuse treatment.
- be free from restraints or seclusion unless it is needed for your health.
- ask for and get a copy of your records and ask to amend or correct them.
- get health services.
- use your rights and file a complaint or appeal about UnitedHealthcare Community Plan without any effect on the way you are treated.
- have access to a women's doctor who participates with UnitedHealthcare Community Plan.
- get a second opinion at no cost.
- get services from non-UnitedHealthcare Community Plan doctors if the type of doctor you need does not participate with UnitedHealthcare Community Plan, and not pay extra.
- get information about UnitedHealthcare Community Plan, its services and providers.
- get information on rights and responsibilities and make recommendations on UnitedHealthcare Community Plan member rights and responsibilities.
- get services per waiting time standards.
- get care in a way that works for your culture.
- get coordinated services.
- have your privacy protected.
- take part in your care plan.
- have access to special doctors (if you have need).
- not have services denied or reduced solely due to diagnosis or condition.
- take part in choosing nursing homes or hospitals and services in your home or other community setting.
- get facts on cost sharing, if any.
- not be held liable for:
 - UnitedHealthcare Community Plan's debts if UnitedHealthcare Community Plan went out of business.
 - the covered services provided by UnitedHealthcare Community Plan for which the State of Hawaii Department of Human Services (DHS) does not pay UnitedHealthcare Community Plan.
 - covered services for which DHS or UnitedHealthcare Community Plan does not pay the health care provider.
 - payment of covered services given under a contract, referral or other arrangement that is more than what you would owe if UnitedHealthcare Community Plan provided the services directly.
- only be responsible for cost sharing that is allowed by the state.
- get a notice 30 days before the effective date of a major change in benefit.

AS A UNITEDHEALTHCARE COMMUNITY PLAN MEMBER YOU HAVE THE RESPONSIBILITY TO:

- understand each right you have under UnitedHealthcare Community Plan.
- ask questions if you do not understand your rights.
- follow the UnitedHealthcare Community Plan and Medicaid policies and procedures. To:
 - learn and follow UnitedHealthcare Community Plan and Medicaid rules.
 - choose a primary care provider.
 - make changes in your primary care provider as set up by UnitedHealthcare Community Plan.
 - keep your appointments.
 - cancel appointments in advance.
 - contact your primary care provider first for nonemergency medical needs.
 - be sure you have approval from your primary care provider before going to a specialist.
 - understand when you should and should not go to the emergency room.
- share information on your health with your primary care provider and be informed about treatment options. To:
 - give information that UnitedHealthcare Community Plan and your providers need to give you care.
 - talk to your providers about your health and ask questions about your care.
 - help your providers get your medical records.
- take part in decisions about treatment, make choices and take action to maintain your health. To:
 - understand your health problems. Work with your provider to decide what care is best and develop treatment goals.
 - follow care plans and instructions that you have agreed to.
 - understand how things you do affect your health.
 - do the best you can to stay healthy.
 - treat providers and staff with respect.

