Indiana – April 2021

Welcome to the community

Hoosier Care Connect Member Handbook

United Healthcare Community Plan

CSIN20MC4860876_000

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Getting started

New member checklist

As a new member you will receive several important mailings from UnitedHealthcare Community Plan. Below is a checklist created to help you make the most of your Hoosier Care Connect benefits and coverage.

Call Member Services at **1-800-832-4363**, TTY **711**, if you need help completing any of these tasks.

✔	Task	Notes
	Register for your online portal account	Visit **myuhc.com/CommunityPlan/IN** to sign up.
	Complete your Health Needs Survey	If you take the survey during your first 90 days as a new member, you will earn a $50 gift card. There are three ways to take the survey: • Access the survey through your online portal account • Complete a paper form. This form will come in the mailing that includes your member ID card. There is a prepaid envelope with that packet so that you do not need to pay for postage when you return the survey. • If you do not have internet access or have not received your member ID card mailing, you may complete the survey over the phone with Member Services
	Get the UnitedHealthcare app	Download the UnitedHealthcare app to your Apple® or Android® smartphone or tablet to stay connected.
	View or print your member ID card	If you have your member ID card, check to make sure your details are accurate. If any of the information is wrong, call Member Services. If you have not received your member ID card in the mail, you can print one online using your portal account.

✔	Task	Notes
	Choose or change your PMP (Primary Medical Provider)	Choose a Hoosier Care Connect registered provider. You can follow this link directly to the Doctor Lookup feature: https://www.uhccommunityplan.com/IN.
	Make an appointment with your PMP	Your PMP is the main doctor you see. When you see the same PMP over time, it's easier to develop a relationship with them. Your PMP is available to assist you 24/7 to address your health concerns.
	Connect with your Member Services Advocate (MSA)	Having trouble with any of these to-do list tasks? Your MSA is here to help. Call Member Services to meet your MSA. This is your main support person while you are our member.

Your Hoosier Care Connect quick reference guide

I want to:	You can contact:
Find a doctor, specialist or health care service	Your Primary Medical Provider (PMP). If you need help choosing your PMP call Member Services at **1-800-832-4643**.
Get the information in this handbook in another format or language	Member Services at **1-800-832-4643**.
Get a ride to and from my health care appointments	Member Services at **1-800-832-4643**. You can also find more information on transportation services in this handbook.
Get help to deal with my stress or anxiety	911 if you are in danger or need immediate medical attention. Behavioral health crisis hotline 24/7 at **1-800-832-4643**.
Get answers to basic questions or concerns about my health, symptoms or medicines	Your PMP. You can also contact the 24/7 NurseLine at 1-866-801-4407.
Understand a letter or notice about my health care	Your Member Services Advocate (MSA). To connect with your MSA, call Member Services at **1-800-832-4643**.

I want to:	You can contact:
Get help with social needs. These are things like housing, getting food every day, getting to the grocery or feeling safe.	Your Member Services Advocate (MSA). To connect with your MSA, call Member Services at **1-800-832-4643**.
Update my address	Family and Social Services Administration (FSSA). Call 1-800-403-0864 or visit a local office. A list of office locations can be found here: **https://www.in.gov/fssa/dfr/**
Find a Provider Directory or other general information about my health plan	Online at **UHCCommunityPlan.com**
Replace a lost member ID card	Online at **myuhc.com/CommunityPlan/IN** to print a new card. You can also call Member Services at **1-800-832-4643**.
Tell my health plan how I want to be contacted (mail, email)	Online at **myuhc.com/CommunityPlan/IN**. Or call your Member Services Advocate (MSA). To connect with your MSA, call Member Services at **1-800-832-4643**.
Contact the State enrollment broker (to change health plans, to ask questions during open enrollment)	Maximus by phone at **1-866-963-7383**.

Important phone numbers

There are many resources listed in this handbook. Here is a list of some phone numbers important to your health care journey as a Hoosier Care Connect member:

Emergencies (available 24/7)

Medical Emergency	**911**
Behavioral Health Crisis Line	**1-800-832-4643**, TTY **711**
National Poison Control Center	**1-800-222-1222**
National Suicide Prevention Lifeline	**1-800-273-8255**
Senior Help Line	**1-602-264-4357**

UnitedHealthCare Community Plan resources

Member Services (8:00 a.m.–8:00 p.m. EST, Monday–Friday)	**1-800-832-4643**, TTY **711**
NurseLine (24/7 health advice from a nurse)	**1-866-801-4407**
Medical Transportation (call 2+ business days ahead)	**1-800-832-4643**, TTY **711**
Medical Management/Prior Authorization	**1-800-832-4643**, TTY **711**
Live and Work Well Substance Abuse Helpline	**1-855-780-5955**

State of Indiana resources

Family and Social Services Administration (FSSA)	**1-800-403-0864**
Indiana Tobacco (and Vaping) Quitline	**1-800-QUIT-NOW (1-800-784-8669)**
Women, Infant and Children (WIC) program	**1-800-522-0874**
Maximus (enrollment broker)	**1-866-963-7383**

Your personal details

My UnitedHealthcare Community Plan ID number is: _____

Be sure to fill in the blanks so you will have these numbers ready. Use the blanks in the grid to list specialists or other important numbers that you need.

Contact	Name	Phone Number
Member Services Advocate		
Care Manager		
Primary Medical Provider (PMP)		
Pharmacy		
Behavioral Health Provider		
Dentist		
Eye Doctor		

Welcome to UnitedHealthcare Community Plan

We are glad to have you as a member. We look forward to serving your health care needs. UnitedHealthcare Community Plan is your health plan. We will help you get all of the medical care and services you need. You must request and get your care from a doctor or health provider who is registered with the Indiana Health Coverage Programs (IHCP). Your Primary Medical Provider (PMP) will be part of the UnitedHealthcare Community Plan network.

UnitedHealthcare Community Plan is a contractor for Hoosier Care Connect. Hoosier Care Connect is a Medicaid program. It was created by the Indiana Family and Social Services Administration (FSSA). This program serves individuals who are aged, blind or disabled, including children receiving foster care services and wards of the State.

This Member Handbook will help you find services and understand how our health plan works. We will also provide you with valuable resources.

How our health plan works

One of the first steps to getting to know you and understanding your needs is to collect a brief Health Needs Survey. Our goal is to help you understand your coverage, get you connected with resources and answer any questions you have.

You will get to meet your Member Services Advocate. Depending on your long-term needs, you may also connect with a Care Manager. You, your doctor and our team work together on a plan of care. The Care Manager will then set up follow-up phone calls and home visits to meet your needs. You are responsible for working with your doctor, known as your PMP. A Primary Medical Provider (PMP) is your main doctor. They take care of your medical treatment. Your PMP can also refer you to a specialist. Your PMP works with you to manage your care. Talk to your PMP about all your health care needs.

It is important that you have honest and straightforward communication with your PMP and follow your PMP's instructions. Your PMP will be able to identify the services that you need to keep you healthy.

An important step to getting and staying healthy is to pick a Primary Medical Provider (PMP). Call us as soon as possible to confirm your PMP. If you don't have one we will help you find one. And start learning more about your new Hoosier Care Connect health plan.

Member ID card

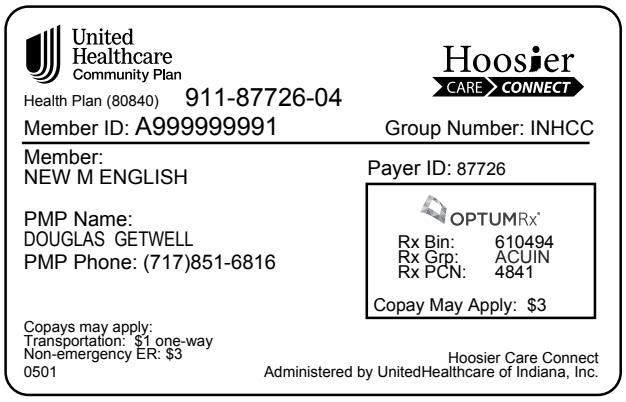
When you join our plan, you will receive an ID card from UnitedHealthcare Community Plan. Your ID card is your key to getting health care services including behavioral health. It has your ID number, your name, and other important information. Your ID card identifies you as a UnitedHealthcare Community Plan member.

If you change your Primary Medical Provider (PMP), we will send you a new card. It is important to throw away your old card when you get the new one.

When you get your card, check it carefully. Call Member Services right away if any of the information on your card is wrong. Member Services can be reached by calling **1-800-832-4643**, TTY **711**.

Quick tips

- Your ID card is for your use only. Do not let others use it.
- Always carry your ID card when you need it. Keep it in a safe place.
- Do not lose your card or throw it away
- You will need your card when you get medical care or when you pick up medicine at the pharmacy
- Misusing your medical ID number, like loaning or selling the card or the information on it, is against the law
- Misusing your card or medical ID number may result in legal actions and you could lose your Medicaid eligibility, benefits and health care services
- If you notice others getting benefits they are not eligible for or someone misusing the medical ID card, please tell us right away. You can call Member Services at **1-800-832-4643**. The Indiana Health Coverage Programs (IHCP) also has a way to report problems. The IHCP Provider and Member Concerns Line is 1-800-457-4515. You can email them at **program.integrity@fssa.in.gov**.
- You should call the Indiana Family and Social Services Administration (FSSA) at 1-800-403-0864 or UnitedHealthcare Community Plan to report any provider you believe may be giving services to members that are not needed or should not be given



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Lost your member ID card?

If you or a family member loses a card, you can print a new one at **myuhc.com/CommunityPlan/IN**. If you need a new card sent to you, call Member Services.

Member Services

Member Services is here to help you with questions and tell you how to renew your coverage. They can:

- Answer questions about your physical and behavioral health benefits
- Help solve a problem or concern you might have with your doctor or any part of the health plan
- Help you find a doctor or dentist
- Tell you about our doctors, their backgrounds, and the care facilities in our network
- Help you if you get a medical bill
- Tell you about community resources available to you
- Help you if you speak another language, are visually impaired, need interpreter services, or sign language services
- Help you connect with your Member Services Advocate and/or Care Manager
- Help answer other questions you may have
- Provide you with a copy of the Member Handbook at no cost to you

Services to help you communicate with us are provided at no cost to members, such as other languages, braille or large print. Or you can ask for an interpreter. To ask for help, please call Member Services at **1-800-832-4643**, TTY **711**, 8:00 a.m.–8:00 p.m. EST, Monday–Friday.

When you call us ...

We ask questions to check your identity. We do this to protect your privacy. This is federal and state law. Gather the following information before you call:

- Member ID number
- Current address and phone number on file with FSSA (Family and Social Services Administration)
- Date of birth

Member Services is here to help you

Call **1-800-832-4643**, TTY **711**, 8:00 a.m.–8:00 p.m. EST, Monday–Friday, excluding state holidays.

Discover your plan online

Go to **myuhc.com/CommunityPlan/IN** to sign up for web access to your account. This secure website keeps all of your health information in one place. Registration is easy and fast. Sign up today! Just visit **myuhc.com/CommunityPlan/IN**. Select "Register" on the home page. Follow the simple prompts. You're just a few clicks away from access to all types of information. Get more from your health care.

Great reasons to use myuhc.com/CommunityPlan/IN

- Find a doctor
- Find a hospital
- Get access to free apps
- Keep track of your medical history
- Learn how to stay healthy
- Look up your benefits
- Print an ID Card
- Take your Health Needs Screening
- View claims history

Mobile app

Our UnitedHealthcare® app is available for use on your smartphone. Just search **UnitedHealthcare** in the App Store or Google Play to download. You can review health benefits, access claims information, locate doctors and more.

NurseLine

Our NurseLine gives you 24/7 telephone access to experienced registered nurses. They can give you information, support and education for any health-related question or concern. Call the NurseLine at 1-866-801-4407, TTY 711.

Our NurseLine can answer your questions and help you make an informed decision whether to call your doctor, visit an urgent care or go to the emergency room (ER). If NurseLine tells you to go to the ER, this is called a waiver. You will not be charged a $3 copay if you get a waiver before going to the ER.

Renew your coverage

If you want to keep your benefits you must renew your Medicaid. For some Hoosier Care Connect members an annual redetermination is required. Prior to expiration, the Family and Social Services Administration (FSSA) will mail you a "Notice of Renewal" reminder, which may ask you for information. Read carefully the directions that come with your renewal form. You may be required to sign the form and return it with some information; or you may only need to review the form and report if any of the information has changed (if it is all correct, you won't have to respond). You must remain Medicaid eligible to stay in the Hoosier Care Connect program.

Here are some exceptions. These groups have automatic renewal of Hoosier Care Connect.

- Supplement Security Income (SSI) recipients enrolled in Hoosier Care Connect
- Youth in foster care and wards of the State

Native American members

Native Americans/Alaskan Natives may opt out of Hoosier Care Connect and return to fee-for-service benefits (sometimes called traditional Medicaid). This is done upon request. For more information, call Member Services.

First things you should know

How can I be involved in my health care?

Be involved in your care by seeing your PMP often. You will take part in choices about your care. We will send you newsletters with helpful information about health care. We will also tell you about new things going on with your plan.

In addition, we may send you surveys about your health and UnitedHealthcare Community Plan. Completing these surveys is another way to take part in your health care.

Take advantage of these materials

We want you to feel in control of your health and your health care. We have many brochures that can be of help to you. They include:

- **Preventive care** — Preventive Services Reminder, Immunizations, Glaucoma Screenings
- **Chronic conditions** — Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Heart Failure, Coronary Artery Disease, Taking Charge of Blood Pressure, Spinal Stenosis, Dementia, Depression, Dysrhythmia, Peripheral Vascular Disease, Deep Vein Thrombosis and Pulmonary Embolisms, Neuropathic Foot Care
- **Ways to keep your living area safe**
- ***You Can Quit Smoking*** **brochure**
- **Flu and pneumonia vaccination information** — Signs and Symptoms of the Flu, Caring for the Flu, Flu Guide – Q and A, ***No More Excuses*** brochure

To get brochures, contact your Member Services Advocate or Care Manager. You may also review your Plan of Care at **myuhc.com/CommunityPlan/IN**.

Culturally competent services

Culturally competent care is having knowledge and skills for positive outcomes. This includes language, lifestyles, values, beliefs and attitudes. Ask for culturally sensitive, translated materials or printed materials in alternative formats to be provided at no cost to you. Contact your Member Services Advocate at **1-800-832-4643**, TTY **711**.

Materials in alternative formats

Auxiliary Aids are services or devices to help people with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the health plan. They are provided at no cost to you upon request. These alternative formats include: materials with large print, materials in other languages, braille and materials in audio or electronic formats. Call your Member Services Advocate at **1-800-832-4643**, TTY **711**.

Interpretation services

If English is not your main language, we can provide you with an interpreter at no cost to you. Call your Member Services Advocate at **1-800-832-4643**, TTY **711**.

If you are deaf or hard of hearing, we can provide you with an American Sign Language interpreter at no cost to you. Call your Member Services Advocate at **1-800-832-4643**, TTY **711**.

You can also find a provider who speaks languages other than English. Ask your Member Services Advocate if you need help when you choose your Primary Medical Provider (PMP).

Choose your Primary Medical Provider (PMP)

An important step to getting healthy and staying healthy is to pick a Primary Medical Provider (PMP). This is your main doctor that you see for annual check-ups. Your PMP can refer you to specialists. This provider should know about all the medications you take and any services you receive.

Your PMP may be any of the following:

- General or family doctor
- Internal medicine doctor
- Nurse practitioner or clinical nurse specialist
- Physician Assistant
- OB/GYN or nurse midwife, for women
- Pediatrician, for children under age 18

If your current PMP is a UnitedHealthcare Community Plan PMP, you do not need to pick a new PMP. If your current PMP does NOT work with UnitedHealthcare Community Plan, call Member Services at **1-800-832-4643** to get assistance with choosing a PMP. Refer to the list of UnitedHealthcare Community Plan PMPs. If you do not pick a PMP, one will be assigned to you. We will then inform you of your PMP's name, address and phone number.

You must choose a PMP who is in our provider network. A provider network is a group of providers who contract with UnitedHealthcare Community Plan to provide services. You can use the Doctor Lookup feature online which is a provider search tool to find a doctor, hospital, other health care provider or facility. The tool allows you to search by specific categories. You can follow this link directly to the Doctor Lookup feature: **https://www.uhccommunityplan.com/IN**.

You can find additional information on a network provider for the following:

- Provider's name, address and telephone number
- Professional qualifications and specialty
- The provider's board certification and status
- Cultural and linguistic capabilities, including languages offered by the provider or a skilled medical interpreter at the provider's office
- Offices that accommodate members with physical disabilities by using the UnitedHealthcare Community Plan Provider Directory online at **https://www.uhccommunityplan.com/IN**

Your Member Services Advocate can also help you choose providers from within its provider network. They can provide additional details, like which medical school a provider attended. If you'd like to select a provider based on convenience, location or cultural preference, you can tell your Member Services Advocate.

You can receive a paper copy of the provider directory, at no cost, by contacting Member Services at **1-800-832-4643**, TTY **711**.

Change your PMP

Usually it is better to stay with the same PMP. Your PMP knows you and has your records and knows what medications you take. Your PMP is the best person to make sure you get good care. There may be a time you want to change PMPs. If so, you need to call Member Services at **1-800-832-4643**, from 8:00 a.m.–8:00 p.m. EST, Monday–Friday. We can answer your questions and help you find a new PMP or send you a list of UnitedHealthcare Community Plan providers to pick from.

You can also use the Provider Lookup tool at **UHCCommunityPlan.com**. Your PMP change will happen on the first day of the month after we get your request.

Some reasons you may change your PMP:

- You have moved and need a PMP closer to your home
- You are not happy with your PMP

Some reasons you may not change your PMP:

- You asked for a PMP who is not in network with UnitedHealthcare
- You asked for a PMP who is not taking new patients

Your PMP may ask you to change to another PMP if:

- You and your PMP do not get along
- You do not follow your PMP's advice
- You are late or do not show up for appointments

Member Services is here to help you

Call **1-800-832-4643**, TTY **711**, 8:00 a.m.–8:00 p.m. EST, Monday–Friday, excluding state holidays.

How to get regular health care

Your PMP and Member Services Advocate or Care Manager will work with you to get the care you need. PMPs are required to provide coverage 24 hours a day, 7 days a week. If you need an immediate or urgent appointment and your PMP is not able to give you one, you may call UnitedHealthcare Community Plan at **1-800-832-4643**, TTY **711** for help. Try to set up PMP visits as far ahead as possible. Your PMP sees many patients every day. Your PMP visit will occur within the number of days shown below.

If you need help making an appointment, call your Member Services Advocate.

PMP appointments

Urgent care:	Appointments are to be scheduled as soon as your health condition requires, but no later than 2 business days of request.
Routine care:	Within 21 calendar days of the request.

Specialist appointments, including dental specialty appointments

Urgent care:	Appointments are to be scheduled as soon as your health condition requires, but no later than 2 business days from the request.
Routine care:	Within 45 calendar days of the request.

Canceling or changing appointments

Call at least 24 hours in advance of your appointment or as soon as possible to cancel or change appointments (PMP and Specialist). If you miss more than one visit without calling, your doctor may not see you again.

Well visits (also called well exams or checkups) are covered for all members. Most well visits include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations.

How to get specialty care – Referrals

A specialist is a health care provider who cares for a certain area of the body.

Your PMP is in charge of ALL your covered health care needs. If you need specialty care, your PMP may refer you to a specialist or another doctor.

If you need services that can only be provided in the hospital, contact the PMP or specialist you are seeing about that problem. Your PMP or specialist will make all arrangements for your hospital stay and give you direction.

You may also request services without a referral and may choose a provider from UnitedHealthcare Community plan's provider network.

For urgent specialty care appointments you will be seen no later than 2 business days from the request. Routine care appointments are within 45 calendar days of the request.

If your PMP wants you to see a specialist who is not contracted with UnitedHealthcare Community Plan:

- The specialist must be registered with the Indiana Health Coverage Programs (IHCP)
- Your PMP must get approval (prior authorization) from UnitedHealthcare Community Plan

We want to make sure you are living in the best place for your situation. Care management makes a plan with you to meet your personal care and medical needs during the assessment process. Person-Centered Service Planning is for Care Managers, members and their family, friends, Health Care Decision Makers and caregivers to work together to create and implement a service plan **driven by you and addressing what is important to you and for you**. This process:

- Builds on strengths, life preferences, and support needs
- Includes opportunities for meaningful activities such as social connections, employment, community activities and volunteering
- Promotes independence and community inclusion

If you have questions, contact your Member Services Advocate or Care Manager. They will contact you to help with your health care needs. They can help you:

- Pick a doctor (PMP)
- Get care with your doctor
- Manage medical services
- Solve problems with your care through goal setting
- Find ways to live at home
- Explain service and placement options
- Obtain behavioral health services

Visit our website or contact Member Services to obtain a copy of the UnitedHealthcare Community Plan Provider Directory at no cost to you. Our directory contains information about how our providers can meet your cultural, language, or accessibility needs.

UnitedHealthcare Community Plan does not restrict access to services based upon moral or religious principles. This includes counseling or referral services. If a provider refuses to provide services they find objectionable because of moral or religious grounds, we will assist you to get access to another provider who is willing to provide these services. For help, contact your Member Services Advocate or call Member Services at **1-800-832-4643**, TTY **711**.

Native American and Alaskan Native members are able to receive health care services from any Native American Health Service provider or tribally owned and/or operated facility at any time. These providers may refer the member to a UnitedHealthcare Community Plan provider.

Self-referral services

Some services are available to you without seeking guidance from your Primary Medical Provider (PMP). You can see any provider that is in the Indiana Medicaid Network. This means that these providers do not need to be in the UnitedHealthcare Network. The grid below shows those services.

Self-referral benefit	Covered service
Chiropractor	Office visits, X-rays and physical treatments are covered when you see any chiropractor that is in the Indiana Medicaid Network.
Diabetes Self-Management Training (self-care)	Diabetes self-management training and education includes things like blood glucose (blood sugar) self-monitoring or medication counseling. These services can be given by any type of provider in the Indiana Medicaid Network.
Emergency Care	Emergency Room (ER) visits are covered at any hospital in the Indiana Medicaid Network. You may need to make a $3 copay. If you are referred to the ER by the UnitedHealthcare 24-hour NurseLine, Crisis Line or your Primary Medical Provider (PMP), you will not be charged a copay. See **Emergency care** for details.
Family Planning	Family planning covers: • Pap smear tests including the screening for cervical cancer and human papillomavirus (HPV) • Any service to temporarily or permanently prevent or delay pregnancy for members who are within childbearing age including birth control and sterilization • Diagnosis and treatment of sexually transmitted diseases (STDs) and the screening, testing and counseling for members at risk for human immunodeficiency virus (HIV) The provider must be in the Indiana Medicaid Network.
Immunizations	Immunizations (shots) are covered for babies, children and adults by any Indiana Medicaid Network Provider.

Self-referral benefit	Covered service
Podiatrist (foot doctor)	Office visits, X-rays, surgical services and corrective shoes and inserts are covered when you see any podiatrist in the Indiana Medicaid Network.
Psychiatric Services	Evaluation and counseling services are covered when provided by any psychiatrist in the Indiana Medicaid Network.
Urgent Care	Urgent care visits are covered at any facility in the Indiana Medicaid Network. See **After-hours care/Urgent care** for more information.
Vision (eye) Care	Routine vision exams and eyeglasses (frames and lenses) are covered when you see any vision provider in the Indiana Medicaid Network. See **Vision care** for details.

The services in the grid below are considered self-referral. You must see a provider that is in the UnitedHealthcare Network to get these services.

Self-referral benefit	Covered service when in the network
Routine Dental	Routine dental includes, but is not limited to: • Exams and cleanings • Restorations (fillings) • Oral surgery (extractions) • Endodontics (root canals) Orthodontia (braces) and emergency dental services are not considered routine. See **Dental care** for more information.
Behavioral Health Services	Behavioral Health Services includes mental health and substance use disorder treatment provided by a mental health provider (not a psychiatrist). See **Behavioral health** for more information.

Out of network providers

If you choose to see a provider who is not contracted with UnitedHealthcare Community Plan, you will need to verify the provider is registered with IHCP, show the provider your ID card, and make sure the provider obtains prior authorization for services to be performed. For services to be paid, prior authorization must be obtained by the provider from us. We can also help you:

- Make an appointment or verify the status of a provider
- Find a provider if there is no option in our network within 60 miles of where you live

Emergency care

An emergency is a medical condition with such severe symptoms that you reasonably believe not getting medical attention right away may be life threatening or cause serious damage to you or your unborn child.

If you have an emergency, call 911 or go to the nearest emergency room. If you have an emergency, you will not be charged a $3 copayment.

Prior authorization is not required for emergency care. You have the right to go to any hospital emergency room or other setting for emergency services, such as an urgent care center when your doctor's office is closed.

Not all health problems are an emergency. Some reasons to call 911 or go to the emergency room include:

- Sudden loss of feeling, or not being able to move
- Chest pain
- Severe pain in your stomach area
- Poisoning
- A serious accident
- Severe shortness of breath
- Severe burns
- Severe wound or heavy bleeding
- Damage to your eyes
- Severe spasms/convulsions
- Broken bones

- Choking or being unable to breathe
- Throwing up (vomiting) blood
- Strong feeling that you might hurt yourself or another person
- Faint or pass out for no reason (will not wake up)
- Danger of losing life or limb
- Loss of speech

If you are not sure it's a real emergency or if you have questions about whether your situation requires treatment in an urgent care center or an emergency room, call your PMP or NurseLine at **1-866-801-4407**. NurseLine is available 24 hours per day/7 days a week, 365 days a year. The NurseLine will give you advice regarding whether you should visit the emergency room.

If you do go to an emergency room, show ALL ID cards when you arrive. Call your PMP and Member Services Advocate or Care Manager within 2 days/48 hours, or as soon as possible. Any follow-up care will be given by your PMP. You should see your PMP within 7 days after you leave the hospital.

If you get emergency services, ask the hospital or doctor to send your records to your PMP. If you go to an emergency room, tell them:

- You are on Hoosier Care Connect
- Your health plan is UnitedHealthcare Community Plan
- To send your medical records to your PMP

If you cannot do this yourself, have a friend or family member do this.

When not to use the emergency room

Most sicknesses are not emergencies and can be treated at your doctor's office. You can also be treated at an Urgent Care site. You should not use an emergency room if you have one of these minor problems:

- A sprain or strain
- A cut or scrape
- An earache
- A sore throat
- A cough or cold
- A minor burn or rash

Please note that you may have a $3 copayment if you use the ER for a non-emergency reason, such as a sprain or strain, a cut or scrape, an earache, a sore throat, a cough or cold, a minor burn or rash. If you are unsure if you need to go to the ER, call your Primary Medical Provider (PMP) or Nurseline at **1-866-801-4407**, which is available 24/7, 365 days a year. If your PMP or NurseLine tells you to go to the ER, this is called a waiver. You will not be charged a $3 copay if you get a waiver before going to the ER.

After-hours care/Urgent care

If it is not an emergency but your PMP (Primary Medical Provider) is not available, you can get services at an Urgent Care center.

If you are not sure your symptoms are life-threatening:

- Contact NurseLine at **1-866-801-4407**, TTY **711** 24 hours per day, 7 days a week, 365 days per year
- Call your PMP

Visit **UHCCommunityPlan.com/IN** to see a listing of in-network Urgent Care centers.

Behavioral health crisis services

What if I am experiencing a behavioral health crisis?

If you are experiencing a behavioral health or substance abuse crisis, it is important to get help right away. Remember, you should always call 911 if you are experiencing a medical, police and/or fire emergency situation.

Crisis line:

If you are experiencing a behavioral health or substance abuse crisis call **1-800-832-4643**, TTY **711**. The crisis line is available 24 hours a day, 7 days a week, 365 days per year. Crisis calls are answered by a live trained crisis specialist.

National 24-hour crisis hotlines:

Phone:
National suicide prevention lifeline . . . . . **1-800-273-8255 (TALK)**

National substance use and disorder issues referral and treatment hotline . . . . . **1-800-662-4357 (HELP)**

Text:
Text the word . . . . . **"HOME"** to **741741**

Chat: . . . . . **https://suicidepreventionlifeline.org/chat**

Online: . . . . . **https://suicidepreventionlifeline.org**

Senior Help Line: 24-hour senior help line **602-264-4357**

Telehealth (virtual visits)

There are many reasons that it is hard to get to your doctor. Telehealth is a way to be seen by your doctor without having to leave the house. If you are high risk due to health reasons, talk to your doctor's office. You may be able to do a telehealth visit. This is also called a virtual office visit. It can happen in the comfort of your home.

This option usually requires access to a smart phone that includes video and a data plan. If you do not have an unlimited data plan, usage fees may apply.

We also have a 24/7 virtual visit solution called Dr. Chat. You can talk with a health care provider online to ask about urgent care needs if your PMP is not available. Learn more at **UHCdoctorchat.com**. Some of the reasons to use Dr. Chat include:

- You think you have the flu
- You are having trouble with your allergies
- You might have pink eye

Care outside Indiana

If you are out of town and need to get approval for medical care, contact Member Services at **1-800-832-4643**.

If you have an emergency, go to the nearest emergency room. For anything that is not an emergency, you will need to get approval in advance. See the **Prior authorization for services** section for more information.

Covered services and benefits

Covered services

These are many of the Hoosier Care Connect covered services you can receive if they are medically necessary. Your PMP or primary specialist will help you decide if you need them. If you receive services that are not covered by Hoosier Care Connect, you may be required to pay for them.

If a provider asks you to sign a document that explains a service is not covered, this is called a waiver. This means that the service is something that you will need to pay for. The provider must give you a waiver before you agree to have that service. The form will have information about the service that is not covered and the cost of that service.

Benefit	Coverage
Ambulance, Land and Air	Covered
Behavioral health (mental health, help with alcohol or drug use)	Covered
Chiropractor care	Covered See **Self-referral services** for details.
Continued care after hospital stays (post-stabilization)	Covered
Dental care	Covered See **Self-referral services** for details.
Developmental Delay treatment and evaluation	Covered
Diabetes self-management	Covered See **Self-referral services** for details.
Diabetes strips, blood sugar monitoring equipment	Covered
Diagnostic Tests, such as a CT Scan or MRI	Covered

Benefit	Coverage
Emergency Room	Covered, $3 copay required if not an emergency See **Transportation** for details.
Vision (optical) care	Covered See **Self-referral services** for details.
Hearing Aids	Covered (every 5 years)
Home Health Care	Covered
Hospice care	Covered
Hospital stays	Covered
Immunizations	Covered See **Self-referral services** for details.
Labs and X-rays	Covered
Maternity Services	Covered
Medical equipment and supplies	Covered
Office visits	Visits with a: • PMP (Primary Medical Provider) • Specialist (for adults and children) • OB/GYN (for women)
Orthotics – leg braces, orthopedic shoes, prosthetics	Covered
Outpatient Surgeries and follow up care	Covered
Physical therapy Occupational therapy Speech therapy Respiratory therapy	Covered in an office, outpatient or inpatient hospital setting
Prescriptions and medication therapy management	Covered: $3 copay per prescription

Benefit	Coverage
Routine Foot Care by a Podiatrist (Foot Doctor)	Covered See **Self-referral services** for details.
Skilled nursing facility services	Covered, based on the condition, up to 30 days for short-term stay or up to 60 days for long-term stays
Transportation	Covered. $1 copay each way ($2 round trip) See **Transportation** for details.
Urgent Care	Covered See **Self-referral services** for details.
Well-child checkups (Early Periodic Screening, Diagnosis and Treatments)	Covered

Services not covered

These are not covered:

- Services that are not medically necessary
- Nursing home or long-term care facility services
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities
- Services under the Home- and Community-based Services (HCBS) waiver
- Psychiatric residential treatment facility
- Services/care you receive in another country
- Experimental or investigational treatments
- Surgery or drugs to help you get pregnant
- Sex change surgery or treatments
- Cosmetic surgery (this does not apply to reconstructive surgery)
- Vitamins, supplements and over-the-counter medicines not covered through the pharmacy benefit
- Over-the-counter birth control
- Personal attendant care services

Other programs offered by the State of Indiana

Indiana Health Coverage Programs (IHCP) offers some types of care for Hoosier Care Connect members. These are called carve-outs. These services are also available from any IHCP-enrolled doctor. Carve-out services include:

- Medicaid Rehabilitation Option (MRO)
- Individualized Education Plan (IEP) services
- Individualized Family Services Plan (First Steps)
- 1915i waiver wrap around services

If you need help setting up these education services, contact your Member Services Advocate or Care Manager.

Copayments

The Hoosier Care Connect program requires a copayment or small fee for certain services. Check the chart below.

Service	Amount
Emergency room	$3 for each visit if it is not an emergency
Pharmacy	$3 for each prescription
Transportation	$1 for each one-way trip

Hoosier Care Connect members do not have copays if:

- They are under 18
- Pregnant
- American Indian or Alaskan Native
- Receiving services related to pregnancy or family planning

Cost sharing

There are limits to what you pay in cost sharing. Your family's total cost sharing for health care can't be more than 5% of your family's income per quarter (3-month period). This is looked at over each quarter of the year. Once you reach the limit, your cost sharing will be stopped for that quarter.

UnitedHealthcare Community Plan tracks your cost sharing. You do not need to do anything. If you reach the 5% limit, your copays will be automatically stopped for that quarter. You will not have a copay the next time you pick up a prescription or need transportation. If you think you have met this 5% cost share limit, please call your Member Services Advocate to discuss.

Can a provider bill me?

I received a bill for medical services, or my doctor wants a copay

Tell your provider you are a Hoosier Care Connect member. Show them your ID card. You do not have to pay bills or copays for any service covered by IHCP registered providers. The provider is not allowed to bill you. If you do get a bill, call the provider and tell them to stop billing you and to send a claim to UnitedHealthcare Community Plan.

When can members be billed for benefits that are not covered by FSSA?

If you agree to receive services that are not covered by UnitedHealthcare Community Plan or agree to receive services that are in excess of what is allowed by the plan, you may have to pay the bill.

A provider can charge, submit a claim to, or demand or collect payment for services from a member only if:

1. The member requests a benefit that is not covered or not authorized by the health plan or FSSA; and
2. The provider provides the member with a document describing the benefits and the approximate cost; and
3. The member signs the document prior to getting the benefits, showing that the member understands and accepts responsibility for payment.

Transportation

Emergency transportation

Emergency care and transport is available 24 hours a day, 7 days a week. Call **911** or your local emergency number.

As soon as you are able, **call your PMP and your Member Services Advocate or Care Manager**. If you cannot call, have a friend or family member call. If you live in a nursing home or an assisted living facility, let staff know. They will arrange for emergency care and transport for you.

Transportation (non-emergency)

If you need a ride to an appointment, ask a friend, family member or neighbor first. If you cannot get a ride, UnitedHealthcare Community Plan will help you. Members may receive non-emergency transportation services through UnitedHealthcare Community Plan for Hoosier Care Connect covered services. You are responsible for setting up your own transportation. Members and/or family may schedule non-emergency transportation. There is no additional authorization necessary.

You get unlimited transportation to doctor visits. We also cover trips for WIC appointments, the food pantry and Medicaid eligibility appointments.

Following these rules will help you get a ride:

- Call at least **two business days** ahead of time
- Call **1-800-832-4643**, TTY **711** to set up your ride
- If you cancel your visit, call **1-800-832-4643** to cancel your ride
- Have your Medicaid ID card available
- Know the address of your health care provider and the date and time of your appointment
- After your visit, call for a ride home
- If your doctor gives you a prescription you can stop at the pharmacy to get it
- Let us know if you have special needs like a wheelchair
- Members under the age of 16 must have a parent or guardian with them
- Transportation may be limited to a provider near you unless authorization is approved. Trips over 50 miles must have a prior authorization approval.
- Bus passes or friends and family mileage reimbursement may be an option. Call Member Services for details.
- You may have a $1 copay (each way). Ask about this copay when you schedule your ride.
- A member who is pregnant may be accompanied by anyone
- Both parents may go with a child to attend a scheduled appointment

If you have a life-threatening emergency, call 911. Non-emergency transportation is not for emergencies.

Our programs

Customer engagement center

You will have a personal Member Services Advocate (MSA) assigned to help you throughout your health care journey. Your MSA can help:

- Understand the Hoosier Care Connect program
- Find a doctor, dentist or eye doctor
- Explain your benefits and coverage
- Talk to you about special programs that are available to you
- Connect you with a Care Manager if you have ongoing health needs
- Find resources located near you to help you with other problems like food, housing, transportation, employment, feeling safe or education
- Make sure you are aware of other State programs and services available to you, such as SNAP (Supplemental Nutrition Assistance Program) or WIC (Women Infants and Children) program
- Help you update your personal contact information like address, phone number or email
- Make sure we know how you would like to be contacted (email, phone or mail)
- Resolve issues with providers, including specialty care and behavioral health
- Assist with challenges due to prior approval, payment for services, care delivery and family welfare

Care coordination

Our care coordination services will help you and your doctors address your health care needs. Our goal is to help you get the right care at the right time and in the right place. We do this by working together with you and your doctors on your individual care plan. We coordinate all your needs including physical, behavioral health and social needs. Care coordination includes:

- Complex care management
- Care management
- Disease management

Complex care management

If you have two or more diseases or health care issues, you may qualify for complex care management. Complex care management strives to help you address your health care goals by working with you and your doctors on a single plan of care. We want to make sure you get the care that is right for you. Your Complex Care Manager will work with you and your providers to address your needs and help you use community resources that may benefit you.

Disease and care management

If you have a chronic health condition like heart disease, chronic kidney disease, asthma or diabetes, UnitedHealthcare has a program to help you live with your condition and improve the quality of your life. These programs are voluntary and available at no cost to you. The programs give you important information about your health condition, medications, treatments and the importance of follow-up visits with your provider.

A team of registered nurses and social workers will work with you, your family, your primary medical provider (PMP), other health care providers and community resources to design a plan of care to meet your needs in the most appropriate setting. They can also help you with other things like weight loss, stop using tobacco products, making appointments with your doctor and reminding you about special tests that you might need.

You or your provider can call us to ask if our care management or disease management programs could help you. If you or your doctor thinks a Care Manager could help you, or if you want more information about our care management or disease management programs, call us at **1-800-832-4643**, TTY **711**.

Individuals with special needs

We have many services that support individuals with special needs. We are here to make sure you have:

- A Member Services Advocate to be your personal guide and help you navigate the health care system
- Help to get all your needed services
- Support with social needs, such as housing, job opportunities and healthy food
- Help getting a ride to and from health care appointments
- Materials available in the formats you need

We also offer specialized dental care for our members with sensory issues. Please contact your Member Services Advocate to learn more.

Foster care members

The UnitedHealthcare Community Plan offers special programs to assist foster children who are enrolled in Hoosier Care Connect. This includes voluntary enrollment for wards, foster children, former foster children and children receiving adoption assistance.

Our Care management team are trained on the safety and needs unique to ward and foster children. We work with community resources, foster parents, wards, and providers to promote heath care services including well-child visits. Some of the community resources available include:

- Children's Bureau
  Website: **www.childrensbureau.org**
  Office: 1-317-634-5050
- Indiana Association of Resources and Child Advocacy
  Website: **www.iarca.org**
  Office: 1-317-849-8497
- Indiana Department of Child Services
  Website: **www.in.gov/dcs/fostercare.htm**

HealthWatch

HealthWatch is a program to help make sure children in foster care are being seen by their doctor for all screening and treatment for each age group.

To learn more, contact your Member Services Advocate or Member Services.

UnitedHealthcare On My Way

Young adults aging out of foster care are often at risk for crisis, depression, anxiety and substance use. Along with care coordination, we provide On My Way, a tool to guide and support young adults through the process of "aging-out" of foster care and becoming independent. All youth ages 14–21 can participate. Sign up at **www.uhcomw.com** to sign up. Contact your Member Services Advocate or Care Manager for more information.

Quit using tobacco and vaping products

Be nicotine-free. We can help. As soon as you quit, your body begins to repair the damage caused by using tobacco products.

Trying to stop using tobacco products is hard. But all the benefits of quitting are worth it. Did you know that 20 minutes after you quit, your heart rate drops to a normal level? And 12–24 hours after quitting, the carbon monoxide level in your blood drops to normal. We support our members who are trying to quit.

- Reach out to the Indiana Quit Line for coaching and counseling. They offer additional support for pregnant members and teens who use tobacco. Call 1-800-QUIT-NOW (1-800-784-8669).
- Visit your doctor to get advice and medicines that can help you quit. We can help you schedule an appointment.
- Medicines come in different forms like patches, gum, lozenges and pills. Most of these are covered by your benefits. We can also help you understand your other benefits too.
- Get access to educational materials and other resources. We offer a wide variety of resources and links to valuable material.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is important to making sure children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Early: Assessing and identifying problems early,

Periodic: Checking children's health at periodic, age-appropriate intervals,

Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems,

Diagnostic: Performing diagnostic tests to follow up when a risk is identified, and

Treatment: Control, correct or reduce health problems found.

Well-child visits (EPSDT)

UnitedHealthcare Community Plan will pay for children under 21 to see the doctor regularly. These visits are part of the EPSDT program. EPSDT is covered by the Hoosier Care Connect program. Well-child visits are a time for your PMP to see how your child is growing normally and check for any problems or conditions. They will also give the needed screenings and shots during these visits. These exams include screenings and are recommended by the American Academy of Pediatrics (AAP). These screenings will include many things:

- Health history
- Complete physical exam
- Lab tests (as appropriate)
- Immunizations
- Vision, hearing and dental screenings
- Developmental and behavioral screenings
- Advice on how to keep your child healthy

These routine visits are also a great time for you to ask any questions you have about your child's behavior and overall well-being, including:

- Eating
- Sleeping
- Behavior
- Physical activity

Well-child visits (checkup) schedule

It's important to schedule your well-child visits for these ages:

2 to 5 days	15 months
1 month	18 months
2 months	24 months (2 years)
4 months	30 months (2.5 years)
6 months	3 years
9 months	4 years
12 months	Once a year after age 5–21 years

AAP (American Academy of Pediatrics, 2018)

For more information, you can visit this site: **https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx**

Under the EPSDT benefit, you also get other services, such as:

Treatment, including:

- Rehabilitation for any physical, developmental or mental health conditions discovered during a screening
- Regular visits to a dentist for checkups and treatment (a benefit offered through your dental plan)
- Immunizations (shots)
- Regular tests of and treatment for the child's hearing and eyesight
- Routine lab tests, as well as tests for lead in the blood and sickle cell anemia, if the child is at-risk
- Lead investigations, if your child has a high level of lead in his or her blood
- Other tests and services needed to correct or prevent defects, physical conditions and mental illnesses discovered by the screenings

Making and keeping your child's EPSDT appointments can help your child stay healthy. The best time to prevent serious health problems is before they develop.

Immunizations

Immunizations (shots) can help keep your child from getting sick. Talk with your PMP about recommended childhood immunizations and when they should get them. The best place for children to get immunizations is at their PMP's office. Your child's doctor should provide an immunization schedule (calendar) to help you know when your child needs to get their shots, and have the calendar updated with each visit to your child's doctor.

Here are some facts you should know about each immunization:

DTaP: protects against diphtheria, tetanus, and pertussis (whooping cough). 5 total doses are needed during infancy and childhood and boosters are given during adolescence and adulthood for full protection.

HepA: protects against hepatitis A. 2 doses are given between ages 1 and 2 years.

HepB: protects against hepatitis B (infection of the liver). HepB is given in 3 shots, the first given at birth.

Hib: protects against Haemophilus influenzae type b. This infection used to be the main cause of bacterial meningitis. Hib shots are given in 3–4 doses.

HPV: protects against cancers caused by the Human papillomavirus. Children 11 or 12 years old should get 2 shots of HPV, six to twelve months apart.

Influenza (flu): protects against the flu. This is a seasonal shot that is given yearly. Flu shots can be given to your child each year, starting at age 6 months old. Flu season can run from September through May.

IVP: protects against polio and is given in 4 doses.

Meningococcal: protects against the bacteria that causes meningococcal disease. Children should get this shot at 11–12 years of age.

MMR: protects against measles, mumps, and rubella (German measles). MMR is given in 2 doses. The first dose is given between 12–15 months of age. The second dose is usually given between 4–6 years old. However, it can be given as soon as 28 days after the first dose.

PCV: protects against pneumococcal disease, which includes pneumonia. PCV is given in a series of 4 doses.

RV: protects against rotavirus, a major cause of diarrhea. RV is given in 2–3 doses, depending on the type of vaccine that is used.

Tdap: protects your child from diphtheria, tetanus, and whooping cough. Children should get this at 11–12 years of age.

Varicella: protects against chickenpox. Varicella is recommended for all healthy children and is given in 2 doses.

Lead screening in children

Lead poisoning is dangerous. If it is not treated in small children, it can cause long term problems. Lead can be found in:

- Paint
- Soil
- Dust
- Air
- Pottery

A special blood test is ordered by your doctor to check for lead poisoning. The test is usually given between the ages of 9 months and 2 years. If your child has not been tested, your doctor might want to test up to the age of 6 years. For more information, contact your Member Services Advocate.

Adult care

Getting care early may help your doctor find and treat health problems and keep you healthy. Follow the schedule below for your wellness care. Your PMP will also give you tips to stay healthy, like eating right and exercising regularly.

Adult care schedule

Type of service	21–64 years old	65 years old and over
Blood pressure check	Every year (additional tests based on your health history)	Every year (additional tests based on your health history)
Breast exam	Every year	Every year
Cholesterol check	Once (additional tests based on history)	Based on history
Colorectal cancer	Every year from age 50	Every year
Flu vaccine	Every year	Every year
Health education	Every doctor visit	Every doctor visit
HIV screening	Ask your doctor if you are at risk	Ask your doctor if you are at risk
Immunizations (shots)	Ask your doctor if you are at risk	Ask your doctor if you are at risk
Mammogram	Every year for age 40 and over or based on medical need	Every year
Pap smear	Annually for sexually active women	See your PMP or GYN
Physical exam (unclothed)	Every year	Every year
Pneumonia vaccine		Once on or after age 65

Type of service	21–64 years old	65 years old and over
Prostate screening	Every year after age 50 (additional tests based on your health history)	Every year
Sexually Transmitted Disease screening	At least once during pregnancy (additional tests based on your health history)	Ask your doctor if you are at risk
Tdap (tetanus/diphtheria/ acellular pertussis)	Every 10 years	Every 10 years
Testicular exam	Every 2 years from age 18–39	Not required
Tuberculosis screening	Once (additional tests based on your health history)	Ask your doctor if you are at risk

These are general guidelines. Your PMP may want you to get these services more or less often.

Women's health and pregnancy services

UnitedHealthcare Community Plan knows that healthy moms have healthy babies. That is why we take special care of all our moms-to-be. UnitedHealthcare Community Plan has a program called Healthy First Steps for UnitedHealthcare Community Plan members. Healthy First Steps provides information, education and support to help reduce problems while you are pregnant. If you think you may be pregnant or as soon as you know you are pregnant, call Healthy First Steps at 1-800-599-5985.

Female members, or members assigned female at birth, have direct access to preventive and well care services from a gynecologist within the Contractor's network without a referral from a Primary Medical Provider.

As a member, UnitedHealthcare Community Plan will help you:

- Choose a Primary Care Obstetrician (PCO), nurse practitioner, physician assistant, or Certified Nurse Midwife (CNM) for pregnancy care
- Get information about Healthy First Steps — a maternity program for you and your baby. You can call Healthy First Steps at 1-800-599-5985.
- Schedule appointments and exams
- Choose a pediatrician (child's doctor) for your new baby
- Choose a PMP for you after the birth or return to the PMP you had before your pregnancy. Call Member Services after your delivery.
- Get information on community programs such as SNAP (Supplemental Nutritional Assistance Program) and WIC (Women, Infants, and Children). You can call WIC at 1-800-522-0874.

Here are some things your doctor will help you learn about:

- Local resources
- Nutrition, weight, exercise and well-being
- Quit using tobacco or vaping products
- Sexual health
- Substance abuse
- Domestic violence
- Low birth weight
- Early childhood
- Infant mortality
- Information about childbirth options and childbirth classes
- Help with family planning choices and services after your baby's birth (including but not limited to birth control pills, condoms, and sterilizations)

Your pregnancy appointments are very important to your health and the health of your baby. You should see your doctor during pregnancy even if you feel good. If you need to change your appointment, contact your doctor before your appointment.

You should also see your doctor between 7 and 84 days after your baby's birth. This is called postpartum care. If you had a cesarean section, your doctor may want to see you sooner. Please see the **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** section of this handbook for important details about doctor visits and immunizations (shots) that your new baby will need.

At your postpartum checkup, your doctor will:

- Check to make sure you are healing well
- Screen you for postpartum depression
- Do a pelvic exam to make sure reproductive organs are back to pre-pregnancy condition
- Answer questions about breastfeeding and examine your breasts
- Address questions about having sex again and birth control options

You can have an HIV test at any time. If your test is positive, you can get specialty treatment and medical counseling. Talk to your PMP or contact your local department of health for testing.

Healthy First Steps Program

With Healthy First Steps Program, you and baby can earn gifts by completing your prenatal, postpartum and well-child doctor visits. Visit **UHCHealthyFirstSteps.com** for more information.

If you are pregnant and you have been seeing a doctor that is not in our network, you may be able to change plans. This is because you may have a medical continuity of care issue during your pregnancy. Please see the **Changing health plans** section of this handbook for more information.

Substance use disorder helpline

When you're pregnant, using alcohol and illegal drugs puts the health of your unborn child in danger. The chemicals that you breathe and come in contact with go right to your baby. And it puts your baby at risk for low birth weight, birth defects, behavioral issues, developmental delays and even death. And if you've just had a baby and are breastfeeding, drinking alcohol or taking drugs can still be very harmful to your baby. If you are having problems with substance abuse as a mom or a mom- to-be, we can help.

Get help for yourself today

Call the Substance Use Disorder Helpline toll-free at **1-855-780-5955** or visit **liveandworkwell.com/recovery** to use live chat. Available 24/7.

Family planning services

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can also visit one of our family planning providers. You do not need a referral from your PMP for family planning services. Family planning services include:

- Birth control
- Birth control devices such as IUDs, implantable contraceptive devices, and others that are available with a prescription
- Emergency contraception
- Sterilization services
- HIV and sexually transmitted infection (STI) testing, treatment and counseling
- Screenings for cancer and other related conditions

Vision care

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

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

- One routine eye exam per year — no referral is necessary
- One pair of prescription eyeglasses every twelve months

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

- One routine eye exam every two years — no referral is necessary
- One pair of prescription eyeglasses every 5 years

See the **Covered services** section of this handbook for additional benefit information.

Call Member Services at **1-800-832-4643**, TTY **711**, 8:00 a.m.–8:00 p.m. ET, Monday–Friday if you have questions or need help finding a vision care provider.

Dental care

Getting a yearly dental check-up is important to your health. Your Hoosier Care Connect coverage includes these dental services:

- Two exams and cleanings per year
- Bitewing X-ray once every 12 months and one complete set of X-rays every three years
- Minor restorations such as filling
- Major restorations such as crowns and root canals (one of each per 12 months)
- Periodontal care, which includes deep cleanings and surgical treatment for gum disease
- Partial, full dentures, and repairs to partials and dentures
- Sedation and nitrous oxide, if medically necessary

You may find benefit information and dental providers online at **myuhc.com/CommunityPlan/IN**.

Social needs

Being healthy is not always about your medical needs. Sometimes you need help connecting to resources out in the community. We call these social needs. These are things like housing, getting food every day, getting to the grocery or feeling safe. We can also help you get access to help with employment or finishing your education.

Want to find help on your own? Check out the **Community resources** section of this handbook. We include a list of a few organizations who help online or by phone.

Your Member Services Advocate (MSA) is here to help. They can give you more information about programs or services. Call us at**1-800-832-4643**. Ask to speak with your MSA.

Other programs to help you stay healthy

Call Member Services to learn more about:

Free rewards programs

- $50 gift card for one-time completion of your Health Needs Survey within the first 90 days
- $25 gift card for diabetes HbA1c screening
- $25 gift card for yearly well child visit or adolescent well care 3 to 21 years old
- $25 gift card for lead screening (under age 2)
- $25 gift card for annual dental visit

Rewards for moms and babies

- $15 gift card for enrolling in our Maternal Health program: Healthy First Steps™
- $25 gift card for timely postpartum care
- Extra gifts like gift cards, digital thermometers, home safety kits, books, and more
- Community baby showers with gifts
- Help to quit using tobacco products while pregnant from Indiana Quitline and Quit 4 Life

Customer engagement center

Every Hoosier Care Connect member is assigned a Member Services Advocate (MSA) who can help resolve issues with coordinating care and resolving issues with providers, including specialty care, behavioral health and home and social supports. MSAs can also assist with challenges due to insurance and payment, care delivery and family welfare.

Community health workers

We offer face-to-face support for qualifying members with chronic and complex health conditions. Community health workers use an integrated care model that serves members' medical, behavioral and social needs.

Resources for low-cost internet

Services are available for Internet in your home. The monthly rates range from $5 – $10 per month through AT&T or Xfinity/Comcast.

Mom's Meals

This program provides 14 home delivered meals for members with chronic conditions, after they have a hospital stay. Your Care Manager can coordinate this delivery service for you so that mealtime is easier while you heal.

High School Equivalency (HSE)

It's not too late to finish high school. If you would like to get your HSE, we can help. Any member age 16 or older can be part of this program.

24/7 NurseLine

Our NurseLine gives you 24/7 telephone access to experienced registered nurses. They can give you information, support and education for any health-related question or concern. Call the NurseLine at 1-866-801-4407, TTY 711.

Alternative healing

We offer up to $100 annual reimbursement for purchases or services such as herbal medications/ herbal remedies, vitamins and minerals, therapeutic massage or acupuncture.

Member Advisory Council

UnitedHealthcare Community Plan Hoosier Care Connect Advisory Councils provide a forum for Health Plan Members and local community agencies to give recommendations. At meetings we discuss new and ongoing Hoosier Care Connect programs. It is a great opportunity for Members to provide input about current processes and future changes to the Hoosier Care Connect program. We talk about how to improve care for our members. Any Health Plan member can go to meetings. We would like you to be a part of our Member Advisory Council. For more information contact Member Services at **1-800-832-4643**, TTY **711**.

SafeLink phone program

Do you have limited access to a mobile phone? You may be eligible to receive free monthly wireless service. SafeLink is a program provided by TracFone Wireless. Visit **www.safelinkwireless.com** for more information. Your Member Services Advocate can also help you with the application.

Fresh EBT

If you receive SNAP (Supplemental Nutrition Assistance Program) benefits, this app helps you make healthy choices on a budget. Check your balance quickly and easily, track spending, habits, find places that accept EBT, locate grocery deals, keep a shopping list and get healthy low-cost recipes.

Pharmacy

Getting your prescriptions (medications)

Getting prescription medications is an important part of your health care. UnitedHealthcare Community Plan covers many prescription medications as well as over the counter medications, tobacco cessation drugs and diabetes supplies. If your doctor prescribes a medicine that is listed on your plan's preferred drug list (PDL), it is covered. You will have a $3 copayment for each prescription. If your drug is not preferred, your health care provider may request a different drug for you that is preferred. They can also work with UnitedHealthcare Community Plan to get an approval (prior authorization) to allow for that medication.

You can get your prescriptions filled at any pharmacy in our network. Many are available 24 hours a day, 7 days a week.

Visit **UHCCommunityPlan.com/IN** to:

- View the PDL
- Find a pharmacy near you

You can also call Member Services at **1-800-832-4643**. Your Member Services Advocate can send you information in the mail or help you over the phone.

If you have a problem getting your prescription during normal business hours, call Member Services at **1-800-832-4643**. If you have a problem getting your prescriptions after normal business hours, on weekends, or holidays, ask your pharmacist to call the pharmacy help desk at 1-866-215-5046. Both numbers can be found on the back of your member ID card.

Fill your prescription at one of the pharmacies in our network. You can find a list of these pharmacies on our website. Show your member ID card at the pharmacy when you get your prescriptions filled. This shows you are eligible and helps the pharmacy to process your claim.

Prior approval

Prior approval (authorization) of prescription drugs

If your prescription drug is not listed on the PDL, or is listed but requires prior approval, your provider can request prior approval for you, so you can still get that drug. We will approve or deny the request within 24 hours. If a request is approved, you and your Primary Medical Provider (PMP) will be informed of the decision in writing including the drug approval length of time. If a request is denied, you and your PMP will be informed of the decision in writing. The written decision notice will tell you how and when to appeal this decision and how to file a complaint or grievance with UnitedHealthcare Community Plan.

90 day supply benefit

Members can fill a 90 day supply of select maintenance medication at the retail pharmacy. Maintenance medications are typically those medications you take on a regular basis for a chronic or long term condition.

With a 90 day supply, you won't need to get a refill every month. To find out more details, talk to your doctor or pharmacist. For a complete list of medications included in this benefit call Member Services.

You have the ability to get maintenance medications by mail order. If you qualify, you can get a 90-day supply of your maintenance medications by mail and you won't need to get a refill every month. Call Member Services for more information and to request a Mail Order Enrollment form.

Medication therapy management

To help you improve the way you take your medicines, we may enroll you in our Medication Therapy Management program. A pharmacist may contact you to discuss better use of your medications or in managing any health issues. If you would like to be part of this program, please contact Member Services for assistance.

The Right Choices Program

The Right Choices Program (RCP) monitors member utilization and, when appropriate, implements an assignment to one doctor and one pharmacy for members who would benefit from increased case coordination. Member utilization review identifies members who use Indiana Health Coverage Programs (IHCP) services more extensively than their peers.

Each RCP member is assigned to a physician and a pharmacy. In some situations, the member can be restricted to additional provider types, if such action is warranted. For example, the RCP member's lock-in physician can refer the member to a specialist. That specialist is then added to the member's list of providers. In an emergency, other providers can render services without the need for a referral.

When you are enrolled in the Right Choices Program (RCP), your Care Manager will work with you and your doctors to arrange your care and make sure you are getting the care you need at the right time and right place. The Care Manager and your doctor will monitor your care for any changes. You can be removed from the Right Choices Program (also called graduation) when you no longer need this additional help.

Behavioral health services

You have the right to accept or refuse behavioral health services offered to you. If you want to get the behavioral health services offered, you or your legal guardian must sign a "Consent to Treatment" form. This form gives you or your legal guardian's permission for you to get behavioral health services. When you sign a "Consent to Treatment" form, you're also giving FSSA permission to access your records.

To give you certain services, your provider needs to get your permission. Your provider may ask you to sign a form or to give verbal permission to get a specific service. Your provider will give you information about the service so you can decide if you want that service or not.

This is called informed consent. Informed consent means advising a patient of a proposed treatment, surgical procedure, psychotropic drug or diagnostic procedure; alternatives to the treatment surgical procedure, psychotropic drug or diagnostic procedure; associated risks and possible complications; and getting documented authorization, or approval for the proposed treatment, surgical procedure, psychotropic drug or diagnostic procedure from the patient or the patient's representative.

Members are assessed for their health care needs and social needs by their PMP, behavioral health provider, or care manager.

Covered behavioral health services include, but may not be limited to, the following:

- Behavioral health medicines, monitoring, and adjustment
- Doctor services
- Emergency and non-emergency transportation
- Emergency behavioral health care
- Individual, group and family therapy and counseling
- Inpatient hospital services
- Inpatient psychiatric services
- Intensive outpatient treatment (IOT)
- Opioid treatment
- Partial hospitalization program (PHP)
- Psychotropic medications, adjustments and monitoring
- Screening, evaluation, and diagnosis
- Substance use (drug, opioid, and alcohol) counseling, medication assisted treatment

- Substance use disorder residential treatment
- Support services
- Treatment planning

You may self -refer to a behavioral health provider, or be referred by providers, schools, State agencies, or other parties. You may see a behavioral health counselor, addiction specialist, psychologist, or psychiatrist without a referral from your PMP. To access behavioral health services call the behavioral health number on your ID card, use your provider directory or visit our website at **https://www.uhccommunityplan.com/in**.

Mental health and substance use treatment benefits

As a member of UnitedHealthcare Community Plan, you are covered for mental health and substance use treatment. Remember to always show your current UnitedHealthcare member ID card when getting services. It confirms your coverage. If a provider tells you a service is not covered by UnitedHealthcare and you still want these services, you may be responsible for payment. You can always call Member Services at **1-800-832-4643**, TTY **711**, to ask questions about benefits. The amount and length of services provided will be based on your needs and medical necessity. Services may be provided in a provider's office, your home or the community.

Some services need prior authorization. This means your provider must contact us before providing the service. Your provider will coordinate referrals with other doctors. You do not need an authorization for emergency service. We will be notified of mental health and substance use hospitalizations. That way we can help with discharge planning and coordination. Your provider can request an authorization by calling the Behavioral Health Line.

What is a mental health and substance use treatment care provider?

A mental health and substance use treatment care provider can be a licensed (or otherwise certified) mental health and substance use treatment, substance use disorder counselor, doctor, psychiatrist, psychiatric nurse, psychologist, licensed clinical social worker, other professional counselors, care manager, board certified behavior analyst or a peer support staff. They can support you by helping you create and fulfill your recovery plan, and work with you before and after a crisis. They can connect you with other community services.

Substance Use Disorder (SUD) residential treatment

UnitedHealthcare Community Plan offers coverage for both low and high intensity, short-term SUD residential treatment in settings of all sizes. Your doctor will get prior approval from UnitedHealthcare Community Plan before you start your SUD residential stay. To qualify for SUD residential treatment, we use the criteria (rules) based on the American Society of Addiction Medicine (ASAM).

Peer Recovery Services

UnitedHealthcare Community Plan covers peer recovery services. These services are individual, face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. These services are provided by certified peer support specialists. Members should speak to their behavioral health provider to see if they offer this service.

Making a behavioral health appointment

Behavioral health appointments are to be scheduled as soon as the member's health condition requires but no later than the following:

Urgent behavioral health appointments — Are within 24 hours from the identification of need.

Routine care appointments — The initial assessment to be completed within 7 calendar days of referral or request. The first behavioral health service following the initial assessment is as soon as the member's health condition requires but for members age 18 or older, no later than 23 calendar days after the initial assessment and for members under the age of 18 years old, no later than 21 days after the initial assessment. All other behavioral health services to be completed as soon as the member's health condition requires, no later than 45 calendar days.

If you feel you may harm yourself or others, call 911 for emergency help.

For referrals for psychotropic medications

For Psychotropic Medications the need will be immediately assessed. An appointment will be scheduled no later than 30 calendar days from the identification of need. If you are running out of medication or if you have a decline in your behavioral health condition prior to starting medication you can be seen sooner.

Resources and support

Liveandworkwell.com/recovery
1-855-780-5955
This online resource for UnitedHealthcare Community Plan members has many recovery tools and resources. It is a great one-stop shop to start your journey to health and well-being.

Crisis Text Line

Crisis Text Line provides free, 24/7 support via text message. They are there for everything: anxiety, depression, suicide, school. **Text HOME to 741741.**

KEY Warmline

A warmline is a non-crisis talk line where members with mental health challenges can talk to trained volunteers who also cope with mental health conditions. You can call the Warmline toll-free at 1-800-933-5397. This line is open 8:00 a.m. to 4:30 p.m. ET., Monday through Friday.

Plan procedures

Prior authorization process

How will I know if a service has been approved (authorization) or denied?

UnitedHealthcare Community Plan reviews the service request from you, your PMP, or your specialist. Your doctor will tell you if the service is approved and UnitedHealthcare Community Plan will send you a letter. If the service has been denied, UnitedHealthcare Community Plan will send you a letter, called a Notice of Adverse Benefit Determination. You have a right to know the criteria that are used to make decisions. Normal authorization decisions will be made within 7 calendar days from the date the request is received.

Extensions of up to 14 calendar days can be received if it is in your best interest. For example, we may be waiting to receive your medical records from your doctor. Instead of making a decision without those records, we may ask you if it's okay to get more time to receive the records. That way, the decision can be made with the best information. We will send you a letter asking for the extension.

Expedited (Rush) decisions in urgent, life-threatening situations should be made in no later than 72 hours following the receipt of the authorization request unless an extension is in effect. For more information, call Member Services on Notice of Adverse Benefit Determination letters and actions you can take. If you do not agree with a decision made by UnitedHealthcare Community Plan you can ask us to review the request again. This request for a review is called an appeal.

Call Member Services for more information about filing an appeal

If you have questions, contact Member Services at **1-800-832-4643**, TTY **711**, 8:00 a.m.–8:00 p.m. EST, Monday–Friday, excluding state holidays. You may also view the **Appeals** section of this handbook for detailed information about the appeals process.

Prior approval for an out-of-network provider

UnitedHealthcare Community Plan is your Hoosier Care Connect health plan. You should use the providers in our contracted network. However, there may be times when you need care from a provider that's not in our network. An out-of-network provider must request prior authorization to treat you. If the request is approved, you may see the out-of-network provider. If the request is denied, your Care Manager will work with you and your primary doctor to identify an in-network provider who offers the same service.

Prior authorization medication

Some medications may require prior authorization. Prior authorization decisions for medications will be made within 24 hours from the receipt of the request. If additional information is needed, UnitedHealthcare will send a request to your provider and issue a final decision no later than 7 working days from the date of the request. Please see UnitedHealthcare's drug list at **UHCCommunityPlan.com/IN**.

Other insurance

It is important to tell us if you have other insurance. It does not change any of the services or benefits you get from UnitedHealthcare Community Plan. Try to choose a PMP who works with both UnitedHealthcare Community Plan and your other insurance. This will help us coordinate your benefits.

Always tell your doctor if you have other insurance. Your other insurance is considered your primary insurance. They may pay for your medical services. You must use your primary insurance plan first. UnitedHealthcare Community Plan is your secondary insurance. UnitedHealthcare Community Plan may help you pay copays, coinsurance or deductibles that other insurance may charge you. Make sure to show the doctor your UnitedHealthcare Community Plan ID card and your other insurance ID cards. This will help them to know where to send the bill. If you do not tell your doctor that you have other insurance, this may delay payment from UnitedHealthcare Community Plan.

Your Care Manager will help you manage benefits. Make sure your Member Services Advocate or Care Manager has all of your insurance information.

Coordination of benefits/third party liability

Your Medicaid benefits under Hoosier Care Connect are the payer of last resort. That means they will pay only after all other sources/insurance have been used.

New medical treatments

If you or your doctor would like to use a new medical treatment, call your Member Services Advocate or Care Manager. We want you to be healthy. A group of doctors and specialists will review the request from your doctor. They will let your PMP or specialist know if the treatment is medically necessary and will share the reasons for the decision.

Provider incentive program

Your PMP participates in a program that encourages them to see our members. It focuses on making sure that you receive the care you need. If you would like to receive more details about this program, please contact your Member Services Advocate.

Member complaints and grievances

If you have a problem or complaint about UnitedHealthcare Community Plan, ask your Member Services Advocate, Care Manager or Member Services for help. If they are able to help you, your complaint will be considered resolved. In that case, you will not get any other notice.

If you are not happy with the response from your Member Services Advocate, Care Manager or Member Services, you may file a grievance. You may file a complaint or grievance against us (the health plan) or a provider with us. You may file your grievance within 60 calendar days from the day the problem happened.

Members may file a grievance over the phone with Member Services at **1-800-832-4643**, TTY **711**. All members can file a grievance through this process.

Members may also file a written grievance by sending it to:

UnitedHealthcare
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

UnitedHealthcare Community Plan will send an acknowledgment letter within 3 business days from the day we receive your grievance.

If your provider has your written permission they can file a grievance on your behalf. We will make a decision on your grievance within 30 calendar days from the date of receipt, then notify you in writing within 5 business days of the date of decision.

If you need help in filing a grievance, contact your Member Services Advocate or call Member Services at **1-800-832-4643**, TTY **711**. Grievance information is available in alternative formats.

Should you need advocate services or additional assistance navigating a health plan process or decision, UnitedHealthcare provides a Member Advocate/Non-Discrimination Coordinator to serve as an ombudsperson, or advocate, for you.

Notice of adverse benefit determination

An adverse benefit determination is when UnitedHealthcare Community Plan does any of the following:

- Denies or limits a requested service based on type or level of service, meeting medical necessity, appropriateness, setting, effectiveness
- Reduces, suspends, or terminates a previously authorized service
- Denies partial or full payment of a service
- Fails to make an authorization decision or to provide services in a timely manner
- Fails to resolve a grievance or appeal in a timely manner
- Denies a rural member's request for services outside the network when the health plan is the only one in the area

If UnitedHealthcare Community Plan makes an adverse benefit determination, you will receive a letter called a Notice of Adverse Benefit Determination. This letter will tell you:

- What your doctor asked for
- What action was taken and why
- The guideline used to make the decision
- Your right to file an appeal with United Healthcare Community Plan. You should file an appeal with us if you disagree with our decision.
- How you can ask for an expedited (rush) appeal
- Details about the steps of the appeal process through UnitedHealthcare Community Plan before you request a State Fair Hearing
- If you were receiving benefits, your right to have your benefits continue during your appeal and how to do it
- If you continue to receive benefits and the appeal is denied, you may be required to pay the costs for the services

If you do not understand your Notice of Adverse Benefit Determination, call Member Services. You have a right to know the criteria that are used to make decisions. You can also file a grievance if you do not feel the letter was clear enough for you. Details about your choices are found in the **Appeals** section of this handbook.

Appeals

If you do not agree with a decision made by UnitedHealthcare Community Plan you can ask us to review the request again. This request for a review is called an appeal. The appeal can be written or verbal. If you want to file a verbal appeal, call Member Services.

UnitedHealthcare Community Plan will help you complete the steps related to filing an appeal. Your provider or representative can also file an appeal on your behalf with your written permission. Appeals must be started within 60 calendar days from the date of the notice letter.

Send your written appeal to:

UnitedHealthcare
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

When UnitedHealthcare Community Plan gets your appeal, we will send you a letter within 3 business days telling you that we received your appeal. If you want to continue your services during the appeal process, you must file your appeal and tell us no later than 10 calendar days from the date of the Notice of Adverse Benefit Determination letter.

UnitedHealthcare Community Plan will decide within 30 calendar days of receipt and notify you in writing within 5 business days of our decision. This is called a standard appeal.

If you need your appeal reviewed more quickly, you can request an expedited (rush) appeal and will get an answer back from us within 48 hours.

If your expedited appeal request does get approved, it becomes a standard appeal. We will notify you in writing within 2 days of your request. We will try to contact you by phone so that you know the outcome. A standard appeal will be reviewed within 30 calendar days.

If you or UnitedHealthcare needs more time to get or submit information from other places, the appeal process may take up to 14 calendar days longer. If we need additional information, we will give you written notice of the reason for the delay. The letter will explain how to file a grievance if you don't agree with our decision to take more time.

When UnitedHealthcare Community Plan decides your appeal, we will mail a Notice of Appeal Resolution letter to you. This letter will tell you the reason for the decision. If we decide that you should not receive the denied service, the letter will also tell you how to ask for a State Fair Hearing and/or External Review by Independent Review Organization, if you were receiving benefits, your right to have your benefits continue during your State Fair Hearing and how to do it.

You or your provider can't be retaliated against for filing an expedited appeal. This means UnitedHealthcare Community Plan will not be upset at you or your provider or attempt to get back at either of you for filing an expedited appeal.

State Fair Hearing

After you have submitted an appeal and received a decision from your health plan, if you are still unhappy you can appeal to the state. You have 120 calendar days from the date of the health plan's decision to appeal to the state. This is called a State Fair Hearing. You can write a letter telling the state why you think a decision is wrong. Please make sure your name and other important information, like the dates of the decision, is on the letter. Send your appeal to:

Office of Administrative Law Proceedings
402 West Washington Street, Room E034
Indianapolis, IN 46204

The Office of Administrative Law Proceedings (OALP) will send you information on how your State Fair Hearing will be handled. OALP will decide if UnitedHealthcare Community Plan's decision was correct. You or your representative can attend the State Fair Hearing. If OALP decides that UnitedHealthcare Community Plan's decision was correct, you may have to pay for the services you had appealed. If OALP decides that UnitedHealthcare Community Plan's decision was not correct, UnitedHealthcare Community Plan will authorize and pay for services promptly.

External Review by Independent Review Organization

You may also ask UnitedHealthcare Community Plan for an External Review by an Independent Review Organization (IRO). You must request IRO review in writing within 120 calendar days of receiving our appeal decision letter. The IRO will make a decision within 15 business days. The decision by the IRO is binding, meaning we have to obey their decision.

Will my services continue during the appeal process?

If you file an appeal, you will continue to get any services you were already getting as long as you file within 10 calendar days from the date of the Notice of Adverse Benefit Determination letter. Your services can continue if:

- Your appeal involves the halting or reduction of services previously approved
- The services were ordered by your authorized provider
- The original period authorized has not expired
- You request the extension

If the appeal is not decided in your favor, UnitedHealthcare Community Plan may require you to pay for the services you received during the appeal process.

Questions and answers on appeals

Q: What if I need help in filing a grievance or appeal or need an interpreter?

A: If you need help in filing a grievance or appeal for any reason, contact your Member Services Advocate or call Member Services at **1-800-832-4643**, TTY **711**.

Q: How do I file an appeal?

A: You may file an appeal over the phone or in writing. All letters of appeal must be sent to:

UnitedHealthcare
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

Or call Member Services at **1-800-832-4643**, TTY **711**.

You may file a complaint or grievance against us (the health plan) or a provider with us. Refer to the **Member Complaints and Grievances** section of this handbook for details on filing.

Advance Directives

An advance health directive is a legal form. On it, you can list what health care you want in case you cannot talk or make decisions later on.

- You can list what care you do not want
- You can name someone, such as a spouse, to make decisions for your health care if you cannot

You can get an advance directive form at drugstores, hospitals, law offices and doctors' offices. You may have to pay for the form. You can also find and download a free form online. You can ask your family, PMP or someone you trust to help you fill out the form.

You have the right to have your advance directive placed in your medical records. You have the right to change or cancel your advance directive at any time. You have the right to learn about changes to advance directive laws.

UnitedHealthcare Community Plan is providing general Advance Directive information; always consult your lawyer or legal advisor before signing any legal document.

Fraud, waste and abuse

When you pay attention to things that may be fraud, waste or abuse, this helps protect the Hoosier Care Connect program. are generally wrongs done to others. If you think a Hoosier Care Connect member has committed waste, abuse or fraud, it is your responsibility to let someone know.

Fraud and abuse are illegal. Committing acts that are fraudulent or abusive may cause you to lose your Hoosier Care Connect eligibility. Penalties include fines or jail.

Examples of fraud, waste and abuse:

- You did not tell FSSA, your Member Services Advocate or Care Manager that you got a large sum of money or sold your house
- You give a fake address of where you are living
- You do not tell FSSA, your Member Services Advocate or Care Manager that you are getting money
- Failure to report that you have other insurance coverage. You do not tell FSSA, your Member Services Advocate or Care Manager about other insurance you have.
- Failure to notify your Member Services Advocate, Care Manager and FSSA when there is a change in family size or other demographic changes

A provider may commit fraud, waste or abuse. Examples are:

- Giving you care you do not need
- Billing for services you did not get
- Keeping you in a hospital longer than you need
- Inflicting mental or physical harm
- Misuse of your trust fund
- Failure to carry out your plan of care

If you think fraud, waste or abuse is going on with providers, staff, or other members, call Member Services at **1-800-832-4643**, TTY **711**. We will not use your name in your report. You will not get in trouble for reporting this. We will look into the matter for you.

The State of Indiana has a fraud, waste and abuse toll-free hotline. You can call 1-800-403-0864. Reports can be made anonymously.

Life changes

Changes you should report to your Member Services Advocate include:

- Adoption
- Marriage
- Birth
- Moving to a new county
- Death
- Divorce
- Moving to a new state
- Guardianship change
- Address change
- Phone number change

Changing health plans

Every year you have the option to change plans during annual open enrollment. This is the date you enroll or re-enroll with Hoosier Care Connect. You have ninety (90) days to change health plans when you become a new member or renew your eligibility.

The State of Indiana will send you a notice two months before the date you can change. If you want to change health plans, call UnitedHealthcare Community Plan Member Services. We want to help with any problems you have first.

If you want to change health plans and it is not your open enrollment period, you may still be able to change plans in special cases. Some of the reasons you may be able to change your health plan are:

- Receiving poor quality of care
- We are unable to get you the services covered by the Hoosier Care Connect program
- Serious language or cultural barriers
- Lack of access to a primary care clinic or other health services that are reasonably close to where you live
- Another health plan offers medication or treatment that our health plan does not offer
- No access to providers experienced in dealing with your health care needs
- Your PMP leaves our health plan and enrolls with another Hoosier Care Connect health plan

Contact your Member Services Advocate to ask for a program contractor change request if you desire to change plans. We will help you file a grievance with our health plan. You must follow the grievance process first. See **Member complaints and grievances** section of this handbook for details.

If you are not satisfied with the result and still wish to change health plans, you can then request a just cause plan change. Maximus is the name of the enrollment broker that serves the Hoosier Care Connect Program. Maximus will process a just cause request only after your grievance has been completed.

If your request is for medical continuity of care, Medical Directors of both Plans must agree the change is needed. If not, your request will be denied. If your request is denied, you will be told of the denial. You have the right to appeal.

Transition of care if you change plans

If you change plans and have questions, you may call Member Services at **1-800-832-4643**, TTY **711**. A Transition Coordinator will help you with this process.

Our Transition Coordinator contacts your new health plan to make sure they have needed information regarding your care. This includes any current authorizations and care plans. Getting this information to your new health plan will help everyone stay connected to needed treatment as you transition. Our Transition Coordinator is available to you and to the other health plan to answer questions.

Reccomendations for changes

We are always interested in what you have to say. If you want to recommend a change to a service, program or health plan procedure, let us know. You can:

- Send an email through your member portal account at **myuhc.com**
- Contact your Member Services Advocate, who will take down your suggestion and get it to the right person
- Write a letter and send it to:

  UnitedHealthcare Community Plan
  P.O. Box 31349
  Salt Lake City, UT 84130-9702

Other plan details

Member rights and responsibilities

Member rights

You have the right to:

- Receive information about the organization, its services, its practitioners and providers
- Be treated with respect and with due consideration for your dignity and privacy
- Receive information about your treatment options and alternatives, in a way that you can understand them
- Talk to your providers and the health plan about your medical care and treatment plan
- Receive information on treatment options regardless of cost or coverage
- Refuse treatment directly or through an advance directive
- Participate with practitioners in making decisions about your health care
- Be free from any action of being held against your will or cut off from others when these actions are intended to pressure you into doing something, punish you, or show revenge against you or make it easier for the medical staff
- Review your medical records and request changes and/or additions to any area you feel is needed
- Change your PMP at any time for any reason
- Tell us if you are not satisfied with your treatment or with us; you can expect a prompt response
- Voice complaints or file an appeal
- Know that you will not be treated poorly if you file a grievance or complaint about the health plan or the care provided
- Make suggestions about our member rights and responsibilities policies
- Talk to your Member Services Advocate or Care Manager to ask questions, get help or better understand your health care
- Receive information:
  - In the format that you need, like braille, large print or audio
  - In the language you need

Member responsibilities

You have the responsibility to:

Use services

- Ask questions if you do not understand your rights or plan of treatment
- Keep your appointments
- Cancel appointments in advance when you cannot keep them
- Contact your PMP first for non-emergency medical needs
- Understand when you should and should not go to an emergency room
- Know whom to call if you need a ride to the doctor or for other covered services
- Treat providers and health plan staff with respect and dignity
- Be in charge of your planning meeting
- Ask anyone you want to come to your planning meetings
- Choose your goals to work on and what is on your plan
- Follow plans and instructions for agreed upon care
- Schedule your person-centered planning meeting at a time and place when the people who you want to attend are available
- Agree to the services I want from the choice of services you can have
- Pick an available provider you want to give you your services
- Know that you may need help from your guardian, family and/or friends to make good choices

Give information

- Tell your PMP and Member Services Advocate or Care Manager about your health and changes in your health
- Tell your Member Services Advocate about changes in your private insurance. This includes adding or ending other insurance.
- Talk to your providers and your Care Manager about your health care. Ask questions about the ways your health problems can be treated.
- Notify your Care Manager and the Indiana FSSA if your family size changes, if you move or if your income changes

“Healthier lives. Healthier you.”

- Work as a team with your PMP and Care Manager to decide what care is best for you
- Understand how what you do can affect your health
- Do the best you can to stay healthy
- Treat providers and staff with respect. This includes refraining from use of disparaging remarks, racial or ethnic slurs, profanity towards providers, caregivers and/or Care Managers.

Community resources

Behavioral health

Indiana Addiction Hotline (24/7)
https://www.in.gov/fssa/addiction/
(online chat)
1-800-662-HELP (4357)

Look Up Indiana (24/7)
www.lookupindiana.org (online chat or text)
1-877-257-0208

Mental Health America of Indiana
www.mhai.net
1-317-638-3501

National Alliance on Mental Illness (NAMI)
1-800-677-6442
www.nami.org

Opioid Information and Referral
https://www.in.gov/recovery/know-the-facts/index.html

Overdose Lifeline, Inc.
1-844-554-3354
www.overdoselifeline.org

KEY Warmline
Toll-Free: 1-800-933-5397

National Suicide Prevention Lifeline
Toll-Free: 1-800-273-8255
https://suicidepreventionlifeline.org/

Teen Suicide Hotline
Toll-Free: 1-800-784-2433

Social needs

211 Indiana
Dial 2-1-1 within Indiana or
1-866-211-9966, TTY 711
http://www.in211.communityos.org

Find Help
http://www.findhelp.org

Food Assistance Directory
https://www.in.gov/fssa/dfr/food-assistance-availability-map/

AARP Friendly Voices
1-888-281-0145

SNAP (food assistance)
https://www.in.gov/fssa/dfr/snap-food-assistance/

Long-term medical conditions

American Cancer Society
www.cancer.org
1-800-227-2345

American Diabetes Association
www.diabetes.org
Toll-Free: 1-800-DIABETES (1-800-342-2383)

American Heart Association
www.heart.org
1-800-242-8721

American Lung Association
www.lung.org
1-800-586-4872

American Stroke Association
www.stroke.org

The ARC of Indiana
1-800-382-9100
www.arcind.org

Indiana Alzheimer's Association
http://www.alz.org/indiana/
or by phone: 1-800-272-3900 for the Alzheimer's Association 24-hour helpline

Resources for children

About Special Kids
1-800-964-4746
www.aboutspecialkids.org

Family Voices
1-844-323-4636
www.fvindiana.org

First Steps Program
https://www.in.gov/fssa/firststeps/

Head Start
https://www.indianaheadstart.org/

WIC
1-800-522-0874

Other resources

Covering Kids and Families
1-888-975-4CKF
www.ckfindiana.org

Indiana Breastfeeding Resources
https://www.in.gov/isdh/25939.htm

Indiana Coalition Against Sexual and Domestic Violence
https://icadvinc.org/
24/7 Toll-Free Hotline: 1-800-332-7385
Videophone for individuals with hearing impairments: 1-317-644-6206

Indiana Minority Health Coalition
1-317-926-4011
www.imhc.org

Poison Control
1-800-222-1212
www.poison.org

Quit Using Tobacco and Vaping Products
1-800-QUIT-NOW (1-800-784-8669)

Senior Help Line (24/7)
1-602-264-4357

Indiana Division of Aging
https://www.in.gov/fssa/da/index.html

Health plan definitions

Appeal — To ask for review of a decision that denies or limits a service.

Certified Nurse Midwife (CNM) — An individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Indiana by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

Copayment — Money a member is asked to pay for a covered health service, when the service is given.

Durable Medical Equipment — Equipment and supplies ordered by a health care provider for a medical reason for repeated use.

Emergency Room Care — Care you get in an emergency room.

Emergency Services — Services to treat an emergency condition.

Grievance — A complaint that the member communicates to their health plan. It does not include a complaint for a health plan's decision to deny or limit a request for services.

Hospitalization — Being admitted to or staying in a hospital.

In-Network Provider — A health care provider that has a contract with your health plan.

Medically Necessary — A service given by a doctor, or licensed health practitioner that helps with health problem, stops disease, disability, or extends life.

Network — Physicians, health care providers, suppliers and hospitals that contract with a health plan to give care to members.

Out of Network Provider — A health care provider that has a provider agreement with FSSA but does not have a contract with your health plan. You may be responsible for the cost of care for out-of-network providers.

Outpatient — Care in a hospital that usually does not require an overnight stay.

Peer Support Specialist — A service provided by a certified specialist (who has lived experience and received mental health and substance use treatment services themselves) to help you learn to manage difficulties in your life.

Physician Assistant (PA) — A health care provider who practices medicine on a team under the supervision of physicians. They are formally educated to examine patients, diagnose injuries and illnesses, prescribe medication, order and interpret diagnostic tests, refer patients to specialists as required and provide treatment.

Physician Services — Health care services given by a licensed physician.

Postpartum Care — Health care provided for a period of up to days post-delivery. Family planning services are included.

Practitioner — Refers to certified nurse practitioners in midwifery, physician's assistants and other nurse practitioners. Physician's assistants and nurse practitioners are defined in A.R.S. Title 32, Chapters 15 and 25, respectively.

Prescription Drugs — Medications ordered by a health care professional and given by a pharmacist.

Primary Medical Provider (PMP) — A person who is responsible for the management of the member's health care. A PMP may be a:

- Person licensed as an allopathic or osteopathic physician, or
- Practitioner defined as a physician assistant licensed, or
- Certified nurse practitioner.

Prior Authorization — Approval from a health plan that may be required before you get a service. This is not a promise that the health plan will cover the cost of the service.

Provider — A person or group who has an agreement with FSSA to provide services to FSSA members.

Psychiatric Nurse — A mental health nurse who provides a broad range of psychiatric and medical services. This includes assessment and treatment of mental illnesses, care management and talk-therapy.

Psychiatrist — A doctor who specializes in the diagnosis, treatment and prevention of mental health and emotional problems and can prescribe medications.

Psychologist — A person trained to administer and interpret a number of tests and assessments that can help diagnose a condition or tell more about the way a person thinks, feels and behaves. Psychologists can also provide talk-therapy.

Rehabilitation — Services that help a person restore and keep skills and functioning for daily living that have been lost or impaired.

Specialist — A doctor who practices a specific area of medicine or focuses on a group of patients.

Urgent Care — Care for an illness, injury, or condition serious enough to seek immediate care, but not serious enough to require emergency room care.

Contract services are funded under contract with the State of Indiana. UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 calendar days of when you found out about it. A decision will be sent to you within 30 calendar days. If you disagree with the decision, you have 15 calendar days to ask us to look at it again.

If you need help with your complaint, please call Member Services at **1-800-832-4643**, TTY **711**, 8 a.m.–8 p.m. EST, Monday–Friday.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone:
Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

If you need help with your complaint, please call Member Services at **1-800-832-4643**, TTY **711**.

Services to help you communicate with us are provided at no cost to members, such as other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at **1-800-832-4643**, TTY **711**, 8 a.m.–8 p.m. EST, Monday–Friday.

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ATTENTION: If you speak English language assistance services, free of charge, are available to you. Call **1-800-832-4643, TTY 711.**

ATENCIÓN: Si habla español (Spanish), tiene a su disposición servicios de asistencia gratuitos en su idioma. Llame al **1-800-832-4643, TTY 711.**

注意：如果您說中文 (Chinese)，您可獲得免費語言協助服務。請致電 **1-800-832-4643，聽障專線 (TTY) 711**。

HINWEIS: Wenn du Deutsch (German) sprichst, stehen dir kostenlose Sprachdienste zur Verfügung. Anrufe unter **1-800-832-4643, TTY 711.**

Attention: Vann du Pennsylvania Deitsh (Pennsylvania Dutch) shvetsht, dann kansht du hilf greeya funn ebbah es deitsh shvetzt, un's kosht dich nix. **Call 1-800-832-4643, TTY 711.**

သတိမူရန်- သင်သည် မြန်မာ (Burmese) စကားပြောတတ်လျှင်၊ ဘာသာစကားအကူအညီအား အခမဲ့ရယူနိုင်ပါသည်။ ခေါ်ဆိုရန် **1-800-832-4643, TTY 711.**

تنبيه: إذا كنت تتحدث العربية (Arabic)، فتتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم **1-800-383-2464، الهاتف النصي TTY 711.**

참고: 한국어(Korean)를 구사하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-800-832-4643(TTY는 711)번으로 문의하십시오.**

LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-800-832-4643, TTY 711.**

ATTENTION : si vous parlez français (French), vous pouvez obtenir une assistance linguistique gratuite. Appelez le **1-800-832-4643, TTY 711.**

注意：日本語 (Japanese) をお話しになる場合は、言語支援サービスを無料でご利用いただけます。電話番号 **1-800-832-4643、または TTY 711 までご連絡ください。**

LET OP: Als u Nederlands (Dutch) spreekt, kunt u gratis gebruikmaken van taalhulpdiensten. Bel **1-800-832-4643, TTY 711.**

ATENSYON: Kung nagsasalita ka ng Tagalog (Tagalog), may magagamit kang mga serbisyo na pantulong sa wika na walang bayad. Tumawag sa **1-800-832-4643, TTY 711.**

ВНИМАНИЕ: Если Вы говорите по-русски (Russian), Вы можете бесплатно воспользоваться помощью переводчика. Позвоните: **1-800-832-4643, TTY 711.**

ਸਾਵਧਾਨ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। **1-800-832-4643, TTY 711 ਤੇ ਕਾਲ ਕਰੋ।**

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-832-4643, TTY 711** पर कॉल करें।

Health Plan Notices of Privacy Practices

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

Effective January 1, 2019.

By law, we[1] must protect the privacy of your health information ("HI"). We must send you this notice. It tells you:

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

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

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

How We Use or Share Your Information

We must use and share your HI with:

- You or your legal representative
- Government agencies

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

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

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

We may use or share your HI as follows:

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

- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

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

Your Rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. You can have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete, you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.

- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons: (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website **(www.uhccommunityplan.com)**.

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or TTY **711**.
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare Privacy Office
  MN017-E300
  P.O. Box 1459
  Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

[1] This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Inc.; Symphonix Health Insurance, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; 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. This list of health plans is completed as of the effective date of this notice. For a current list of health plans subject to this notice go to **www.uhc.com/privacy/entities-fn-v2-en** or call the number on your health plan ID card.

Financial Information Privacy Notice

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

Effective January 1, 2019.

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

Questions About This Notice

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

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; Lifeprint East, Inc.; Lifeprint Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women's and Children's Health, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services LLC; and UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. This list of health plans is completed as of the effective date of this notice. For a current list of health plans subject to this notice, go to **www.uhc.com/privacy/entities-fn-v2-en** or call the number on your health plan ID card.

We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-832-4643**, TTY **711**. You can also visit our website at **UHCCommunityPlan.com/IN**.

UnitedHealthcare Community Plan
P.O. Box 31349
Salt Lake City, UT 84131

UHCCommunityPlan.com/IN

1-800-832-4643, TTY **711**

United Healthcare
Community Plan