



Welcome to the
community.

Texas – January 2014

CHIP Member Handbook

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

Counties served:

Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, and Wharton Counties.

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

Monday – Friday, 8:00 a.m. – 8:00 p.m. CT

www.UHCCommunityPlan.com

What to do in an Emergency

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

What to do in a Behavioral Health Emergency

You should call 911 if you are having a life-threatening behavioral health emergency. You can also go to a crisis center or the nearest emergency room. You need to call Optum Behavioral Health at 1-800-495-5660 as soon as possible.

In Case of Emergency Call **911**

If you think that it is not an Emergency, but you need help, call the NurseLine at 1-800-850-1267.

If you have questions about your health plan, please call us. Our toll-free Member Services number is **1-888-887-9003; TDD/TTY 711**, for hearing impaired. There will be people who can speak to you in English and Spanish when you call.

This Member Handbook is available in audio, Braille, larger print and in other languages at your request. Please call 1-888-887-9003 for help.

Toll-Free Telephone Numbers

Member Services (8 a.m. to 8 p.m. Monday through Friday) **1-888-887-9003**
TDD/TTY (for hearing impaired) **711**

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

Behavioral Health and Substance Abuse Services

(for CHIP members and CHIP Perinate Newborn members)

Optum Behavioral Health 1-800-495-5660

- Available 24 hours, 7 days a week.
- Authorizations, referrals and benefit verification.
- Interpreter services available.
- Se Habla Español.

24/7 NurseLine Available 24 hours a day, 7 days a week. 1-800-850-1267

If you have an emergency or a crisis, call 911.

Dental Care (for CHIP members and CHIP Perinate Newborn members)

DentaQuest 1-800-508-6775

MCNA Dental 1-855-691-6262

Texas CHIP Program Helpline 1-800-647-6558

Texas Health and Human Services Commission 1-800-252-8263

Vision Care 1-888-887-9003

(for CHIP members and CHIP Perinate Newborn members)

Prescription Drugs 1-888-887-9003

UnitedHealthcare Community Plan • 14141 Southwest Freeway, Suite 800 • Sugar Land, TX 77478
Phone: **1-888-887-9003**

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

Welcome to UnitedHealthcare Community Plan.

Thank you for choosing UnitedHealthcare Community Plan as your/your child's health plan. UnitedHealthcare Community Plan, offered by UnitedHealthcare Community Plan of Texas, L.L.C., a Health Maintenance Organization (HMO), is committed to helping you get the health care you/your child needs.

At UnitedHealthcare Community Plan, our goal is to help all of our members live healthier lives. You/your child will have their own doctor, called a Primary Care Provider (PCP), who will know your/your child's medical history and will work hard to help you/your child stay healthy. Your/your child's PCP knows that managing your/your child's health care is important. Regular checkups with your/your child's PCP can help spot problems early. Your/your child's PCP wants to help before problems become serious. Your/your child's PCP will give you a referral to specialists when you/your child needs one. UnitedHealthcare Community Plan has a network of doctors, hospitals and other health care providers that you can count on. Many are near your home. We will help you/your child stay healthy and get good health care when you/your child is not well. UnitedHealthcare Community Plan will work hard to help make sure you get access to the care you/your child needs.

Your guide to good health.

Please read this Member Handbook. It will tell you about your/your child's benefits. It will help you use your health plan right away.

Look at your/your child's UnitedHealthcare Community Plan identification card. Make sure all the information is right. We want to make it easy for you to use your/your child's health plan. We can answer any questions you have about getting started. If you have questions, please call us. Our toll-free Member Services number is **1-888-887-9003**. We are here to help you Monday through Friday, 8 a.m. to 8 p.m. After-hours and weekend coverage is available through an automated telephone system.

Our Office Locations

UnitedHealthcare Community Plan

Regional Service Delivery Area Office

14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478

Phone: **1-888-887-9003** (toll-free)

or visit our website at: www.UHCCommunityPlan.com.

Note: References to “you,” “my,” or “I ” apply if you are a CHIP member. References to “my child” apply if your child is a CHIP member or a CHIP Perinate Newborn member.

The CHIP portion of the Member Handbook also applies to CHIP Perinate Newborns with noted exceptions.

What Is Member Services?

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

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

Member Services

1-888-887-9003
(TDD/TTY 711)

Our office is closed on these major holidays:

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



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Health Plan Highlights

Member Identification (ID) Cards

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

Check your/your child's card to make sure the information is right.

If you/your child get an ID card that has no PCP name but says to call **1-888-887-9003**, please call Member Services to pick a PCP. CHIP Perinate Member ID cards will not have a PCP name listed.

How to read your/your child's UnitedHealthcare Community Plan ID card.

Your/your child's ID card will say CHIP and will have the UnitedHealthcare Community Plan logo. This will let your/your child's health care provider know that you/your child is a UnitedHealthcare Community Plan member.

CHIP ID Card

CHIP Perinate Member ID Card

CHIP Perinate Newborn ID Card

UnitedHealthcare Community Plan **CHIP** We've got your kids covered. TDI
 Health Plan/Plan de salud (80840) 999-999999-99
 Member ID/ID del Miembro: 9999999999 Group/grupo: TXCHIP
 Member/Miembro: Payer ID/ID del Pagador: 87726
 SUBSCRIBER BROWN
 PCP Name/Nombre del PCP:
 PCP Phone/Teléfono del PCP: (999) 999-9999
 Effective Date/Fecha de vigencia 99/99/9999
 Copay: Office/Prev/ER/Inpatient/RxGen/RxBrand \$0/\$0/\$0/\$0/\$0/\$0
 0709 Administered by UnitedHealthcare Community Plan of Texas, LLC

UnitedHealthcare Community Plan **CHIP** We've got your kids covered. TDI
 Health Plan/Plan de salud (80840) 999-999999-99 **Perinate Member**
 Member ID/ID del Miembro: 9999999999 Group/grupo: TXCHIP
 Member/Miembro: Payer ID/ID del Pagador: 87726
 SUBSCRIBER BROWN
 Effective Date/Fecha de vigencia 99/99/9999
 Copay/Copago: No copay or cost sharing/No hay copago o participación en los costos
 0709 Administered by UnitedHealthcare Community Plan of Texas, LLC

UnitedHealthcare Community Plan **CHIP** We've got your kids covered. TDI
 Health Plan/Plan de salud (80840) 999-999999-99 **Perinate Newborn**
 Member ID/ID del Miembro: 9999999999 Group/grupo: TXCHIP
 Member/Miembro: Payer ID/ID del Pagador: 87726
 SUBSCRIBER BROWN
 PCP Name/Nombre del PCP: PROVIDER BROWN
 PCP Phone/Teléfono del PCP: (999) 999-9999
 Effective Date/Fecha de vigencia 99/99/9999
 Copay/Copago: No copay or cost sharing/No hay copago o participación en los costos
 0709 Administered by UnitedHealthcare Community Plan of Texas, LLC

In case of emergency call 911 or go to nearest emergency room. Printed: 01/01/01

After treatment, call your child's PCP within 24 hours or as soon as possible. This card does not guarantee coverage. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta garantiza cobertura.

For Members/Para Miembros: 888-887-9003 TDD 711
 Mental Health/Salud Mental: 800-495-5660
 NurseLine/Línea de Ayuda de Enfermeras: 800-850-1267

For Providers: www.uhcommunityplan.com 888-887-9003
 Medical Claims: PO Box 5270, Kingston, NY, 12402-5270
 Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
 For Pharmacist: 877-305-8952

In case of emergency call 911 or go to the closest emergency room. Printed: 01/01/01

This card does not guarantee coverage. Esta tarjeta garantiza cobertura.
 En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana.

Hospital Facilities Billing: Category A: Bill TMHP (0-185% FPL)
 Category B: Bill UnitedHealthcare Community Plan (185-200% FPL)
 Professional/Other Services Billing: UnitedHealthcare Community Plan

For Members/Para Miembros: 888-887-9003 TDD 711
 Mental Health/Salud Mental: 800-495-5660
 NurseLine/Línea de Ayuda de Enfermeras: 800-850-1267

For Providers: www.uhcommunityplan.com 888-887-9003
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For Members/Para Miembros: 888-887-9003 TDD 711
 Mental Health/Salud Mental: 800-495-5660
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For Providers: www.uhcommunityplan.com 888-887-9003
 Medical Claims: PO Box 5270, Kingston, NY, 12402-5270
 Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
 For Pharmacist: 877-305-8952

How to Use Your/Your Child's ID Card

Give your/your child's ID card to the doctor to verify coverage when getting services. The ID card is not a guarantee of benefits or coverage.

Your/your child's UnitedHealthcare Community Plan card is in English and Spanish, and has the following information on it:

- Member's name.
- Member's ID number.
- Doctor's name and phone number. (CHIP Perinate Member ID cards will not have a PCP name listed.)
- Toll-free number for UnitedHealthcare Community Plan Member Services (**1-888-887-9003**, for hearing impaired **TDD/TTY 711**).
- Toll-free number for 24 hour a day/7 day a week access to Behavioral Health Services (1-800-495-5660).
- Directions on what to do in an emergency.

How to Replace Your/Your Child's Card if It Is Lost

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

Remember to take your/your child's card with you and present it whenever your child gets services. Your/your child's provider will need the information on the card to find out what your/your child's coverage is.

Going to the Doctor

Note: References to “you,” “my,” or “I” apply if you are a CHIP member. References to “my child” apply if your child is a CHIP member or a CHIP Perinate Newborn member.

What Is a Primary Care Provider (PCP)?

Your/your child’s PCP has the job of taking care of you/your child. Regular checkups with your/your child’s PCP are important and can help you/your child stay healthy. You/your child’s PCP will do regular health tests that can find problems. Finding and treating problems early can prevent them from becoming bigger problems later. Your/your child’s PCP will be your/your child’s personal doctor. Your/your child’s PCP will take care of you/your child and refer you/your child to a specialist when needed. You should talk to your child’s PCP about all of your/your child’s health care needs.

Always talk to your/your child’s PCP when you want to visit another doctor. Your/your child’s PCP will give you a referral form if you need one.

Your relationship with your/your child’s PCP is important. Get to know your/your child’s PCP as soon as possible. It is important to follow the provider’s advice.

A good way to build a relationship with your/your child’s PCP is to call and schedule a well-child visit or regular checkup. You can meet your/your child’s PCP then. He or she will get to know your/your child’s medical history, any medications you/your child is taking and any other health problems.

In special cases, a specialist may be your/your child’s PCP. You, the PCP, the specialist and UnitedHealthcare Community Plan will make this decision. Please call Member Services for information.

Don’t forget that your/your child’s PCP is the first one you call with any health problems or questions.

How do I pick a PCP?

Call Member Services for help in choosing a PCP. All members of UnitedHealthcare Community Plan must pick a PCP. You can also ask for a UnitedHealthcare Community Plan Provider Directory by calling Member Services at **1-888-887-9003**.

If you are a UnitedHealthcare Community Plan Member when you have your baby, your baby is enrolled with UnitedHealthcare Community Plan on his/her date of birth. UnitedHealthcare Community Plan gets information from the hospital to add your baby as a new UnitedHealthcare Community Plan Member.

However, it is IMPORTANT that YOU contact the Texas CHIP Program to also report the birth of your baby, so your baby can get all the health care he/she needs.

As soon as UnitedHealthcare Community Plan knows you are pregnant, we send you information about your pregnancy and your unborn baby. UnitedHealthcare Community Plan will ask you to choose a doctor for your baby, even before the baby is born. This will ensure that your baby’s doctor will check the baby while in the hospital, and then take care of your baby’s health care needs after you and the baby are discharged from the hospital.

Going to the Doctor

After the baby is born, UnitedHealthcare Community Plan is told about your baby's birth. We enter your baby's information in our system.

If you have not selected a doctor for the baby before birth, you will be contacted to select a doctor for your baby. After the baby is 30 days old, you can also change the doctor for the baby if you want a different doctor than the one you originally picked.

What do I need to bring to my/my child's doctor's appointment?

You must take your/your child's UnitedHealthcare Community Plan ID card with you when you get any health care services. You will need to show your child's UnitedHealthcare Community Plan ID card each time you/your child needs services. If you/your child has a new doctor, bring any important records you may have, like your/your child's immunization records.

Can a clinic be my/my child's PCP?

Your/your child's PCP can be a doctor, a clinic, a Rural Health Center (RHC) or a Federally Qualified Health Center (FQHC). If you have questions, please call Member Services at **1-888-887-9003**.

How can I change my/my child's PCP?

It is good to stay with the same PCP. Your child's PCP knows you/your child, has your/your child's medical records, and knows what medications you/your child takes. Your/your child's PCP is the best person to make sure your child is getting good medical care. Call Member Services if you decide you want to change your/your child's PCP.

How many times can I change my/my child's PCP?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us toll-free at **1-888-887-9003** or writing to us at:

UnitedHealthcare Community Plan
14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478

When will a PCP change become effective?

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

Reasons you might change your/your child's PCP:

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

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

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

Can a PCP move me or my child to another PCP for non-compliance?

Yes, if your/your child's PCP does not feel you are following his/her medical advice or if you/your child miss a lot of visits, the doctor can ask you to see another doctor. Your/your child's PCP will send you a letter telling you that you need to find another doctor. If this happens, call Member Services at **1-888-887-9003**. We will help you find another doctor.

Questions about seeing a provider?

Call Member Services toll-free at

1-888-887-9003.

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

If you go to another doctor who is not your child's PCP without the referral of your/your child's PCP or without getting approval from UnitedHealthcare Community Plan, you may be billed and may have to pay for those services.

Your/your child's PCP is the best person to help ensure you are/your child is getting good medical care.

How do I get health care after my/my child's PCP's office is closed?

It is best to call your/your child's PCP as soon as you/your child is sick. Do not wait until the evening or a weekend to call your/your child's PCP if you can get help during the day. Your/your child might get worse as the day goes on. If you/your child gets sick during the night or on a weekend, call your/your child's PCP at the phone number on the front of your child's ID card.

If you cannot reach your/your child's doctor or want to talk to someone while you wait for the doctor to call you back, call NurseLine at 1-800-850-1267. Our nurses are ready to help you 24 hours a day, 7 days a week. If you think you have a real emergency, call 911 or go to the nearest Emergency Room.

What if my doctor leaves the UnitedHealthcare Community Plan network?

If your/your child's doctor leaves the UnitedHealthcare Community Plan network, and that doctor is treating you/your child for an illness, UnitedHealthcare Community Plan will work with the doctor to keep caring for you/your child until you can be moved to a new doctor in the network. Call Member Services at **1-888-887-9003** for help picking a new doctor close to you.

Physician Incentive Plans

UnitedHealthcare Community Plan rewards doctors for treatments that reduce or limit services for people covered by CHIP. This is called a physician incentive plan. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call **1-888-887-9003** to learn more about this.

How Do I Choose a Perinatal Provider? Will I Need a Referral for This?

If you need help choosing a Perinatal Provider, please contact Member Services at **1-888-887-9003**. You will not need a referral for this service.

How soon can I be seen after contacting a Perinatal Provider for an appointment?

You should be able to see your Perinatal Provider within two weeks of calling them. If you have any problem getting a visit within two weeks of calling your Perinate Provider, please call UnitedHealthcare Community Plan at **1-888-887-9003**.

Can I stay with a CHIP Perinatal Provider if they are not with my health plan?

You should try to choose a CHIP Perinatal Provider that is in your health plan's CHIP Perinatal Provider Network. If you have 12 weeks or less remaining before the expected delivery date of your baby, you can stay under your current Perinatal Provider through your postpartum checkup, even if the Perinatal Provider is, or becomes, out of network. Please contact Member Services.

What if I choose to go to another doctor who is not my CHIP Perinatal Provider?

Except in emergencies, always call your CHIP Perinatal Provider before you go to another doctor or the hospital. You can reach your CHIP Perinatal Provider or backup doctor 24 hours a day, 7 days a week. If you go to another doctor who is not your CHIP Perinatal Provider, you may need to pay the bill. If your emergency care is not related to labor with the birth of your child, you will have to apply for Emergency Medicaid or pay for the services yourself.

What do I need to bring to a Perinatal Provider's appointment?

When you go to your visit, always take your UnitedHealthcare Community Plan Member ID card, a list of problems you are having, and a list of all prescription drugs or herbal medications you are taking.

Can a clinic be a Perinatal Provider?

Your Perinatal Provider can be a doctor, a clinic, a Rural Health Center (RHC) or a Federally Qualified Health Center (FQHC). If you have questions, please call Member Services at **1-888-887-9003**.

How do I get after-hours care?

Please call your pregnancy doctor. If you cannot reach your doctor or want to talk to someone while you wait for the doctor to call you back, call NurseLine at 1-800-850-1267. Our nurses are ready to help you 24 hours a day, 7 days a week. If you think you have a real emergency, call 911 or go to the nearest emergency room.

Changing Health Plans for CHIP Members

What if I want to change health plans?

You are allowed to make health plan changes:

- For any reason within 90 days of enrollment in CHIP and once thereafter;
- For cause at any time;
- If you move to a different service delivery area; and
- During the annual CHIP re-enrollment period.

Who do I call?

For more information, call CHIP toll-free at 1-800-647-6558.

When will my health plan change become effective?

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

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

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

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

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

UnitedHealthcare Community Plan will not ask you to leave the program without trying to work with you. If you have any questions about this process, call UnitedHealthcare Community Plan at **1-888-887-9003**. The Texas Health and Human Services Commission will decide if a Member can be told to leave the program.

Changing Health Plans for CHIP Perinatal Members

- **Attention:** If you meet certain income requirements, your baby will be moved to Medicaid and get 12 months of continuous Medicaid coverage from date of birth.
- Your baby will continue to receive services through the CHIP Program if you meet the CHIP Perinatal requirements. Your baby will get 12 months of continuous CHIP Perinatal coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

What if I want to change health plans?

- Once you pick a health plan for your unborn child, the child must stay in this health plan until the child's CHIP Perinatal coverage ends. The 12 month CHIP Perinatal coverage begins when your unborn child is enrolled in CHIP Perinatal and continues after your child is born.
- If you live in an area with more than one CHIP health plan, and you do not pick a plan within 15 days of getting the enrollment packet, HHSC will pick a health plan for your unborn child and send you information about that health plan. If HHSC picks a health plan for your unborn child, you will have 90 days to pick another health plan if you are not happy with the plan HHSC chooses.
- If you have children covered by CHIP, their health plans might change once you are approved for CHIP Perinatal coverage. When a member of the family is approved for CHIP Perinatal coverage and picks a perinatal health plan, all children in the family that are enrolled in CHIP must join the health plan providing the CHIP Perinatal services. The children must remain with the same health plan until the end of the CHIP Perinatal member's enrollment period, or the end of the other children's enrollment period, whichever happens last. At that point, you can pick a different health plan for the children.
- You can ask to change health plans:
 - For any reason within 90 days of enrollment in CHIP Perinatal;
 - If you move into a different service delivery area; and
 - For cause at any time.

Who do I call?

For more information, call toll-free at 1-800-647-6558.

Concurrent Enrollment of Family Members in CHIP and CHIP Perinatal and Medicaid Coverage for Certain Newborns

If you have children covered by CHIP, their health plans might change once you are approved for CHIP Perinatal coverage. When a member of the family is approved for CHIP Perinatal coverage and picks a perinatal health plan, all children in the family that are enrolled in CHIP must join the health plan providing the CHIP Perinatal services. The children must remain with the same health plan until the end of the CHIP Perinatal member's enrollment period, or the end of the other children's enrollment period, whichever happens last. Then, you can pick a different health plan for the children.

Copayments, cost-sharing, and enrollment fees still apply for those children enrolled in the CHIP program.

An unborn child who is enrolled in CHIP Perinatal will be moved to Medicaid and get 12 months of continuous Medicaid coverage from date of birth, if your family's income is at or below 185% of the Federal Poverty Level.

Your baby will continue to receive coverage through the CHIP Program as a CHIP Perinate Newborn if your family's income is above 185% of the Federal Poverty Level up to 200% of the Federal Poverty Level. Your baby will get 12 months of continuous CHIP Perinatal coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

How Do I Make Appointments?

Call your/your child's PCP when you/your child need medical care. Your/your child's PCP will arrange for the care you/your child needs. The name and phone number of your/your child's PCP is on your/your child's UnitedHealthcare Community Plan ID card.

When making appointments, the sicker your child is, the sooner your child needs to see the doctor.

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

When you go to your appointment, always take your UnitedHealthcare Community Plan Member ID Card, a list of problems you are having, and a list of all prescription drugs or herbal medications you are taking.

How do I get health care after my/my child's PCP's office is closed?

It is best to call your/your child's PCP as soon as you/your child needs health care. Do not wait until the evening or a weekend to call your/your child's PCP if you can get help during the day. Your/your child's illness might get worse as the day goes on. If you/your child gets sick during the night or on a weekend and cannot wait for help, call your/your child's PCP at the phone number on the front of your child's ID card.

If you cannot reach your/your child's doctor or want to talk to someone while you wait for the doctor to call you back, call NurseLine, UnitedHealthcare Community Plan's nurse helpline, at 1-800-850-1267. Our nurses are ready to help you 24 hours a day, 7 days a week. If you think you have a real emergency, call 911 or go to the nearest Emergency Room.

Benefits and Services

Benefits for CHIP Members and CHIP Perinate Newborn Members

Note: References to “you,” “my,” or “I” apply if you are a CHIP Member. References to “my child” apply if your child is a CHIP Member or a CHIP Perinate Newborn Member.

What are my CHIP benefits?

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Hospital-provided Physician or Provider services. • Semi-private room and board (or private if medically necessary as certified by attending physician). • General nursing care. • Special duty nursing when medically necessary. • ICU and services. • Patient meals and special diets. • Operating, recovery and other treatment rooms. • Anesthesia and administration (facility technical component). • Surgical dressings, trays, casts, splints. • Drugs, medications and biologicals. • Blood or blood products that are not provided free-of-charge to the patient and their administration. • X-rays, imaging and other radiological tests (facility technical component). • Laboratory and pathology services (facility technical component). • Machine diagnostic tests (EEGs, EKGs, etc.). • Oxygen services and inhalation therapy. • Radiation and chemotherapy. • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care. • In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care. <p><i>(continues on next page)</i></p>

Benefits and Services

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
<p>Inpatient General Acute and Inpatient Rehabilitation Hospital Services (continued)</p>	<ul style="list-style-type: none"> • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> – Dilation and curettage (D&C) procedures; – Appropriate provider-administered medications; – Ultrasounds, and – Histological examination of tissue samples. • Surgical implants. • Other artificial aids including surgical implants. • Inpatient services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> – All stages of reconstruction on the affected breast; – External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; – Surgery and reconstruction on the other breast to produce symmetrical appearance; and – Treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> – Cleft lip and/or palate; or – Severe traumatic skeletal and/or congenital craniofacial deviations; or – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
<p>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</p>	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semi-private room and board. • Regular nursing services. • Rehabilitation services. • Medical supplies and use of appliances and equipment furnished by the facility.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	<p>Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component). • Laboratory and pathology services (technical component). • Machine diagnostic tests. • Ambulatory surgical facility services. • Drugs, medications and biologicals. • Casts, splints, dressings. • Preventive health services. • Physical, occupational and speech therapy. • Renal dialysis. • Respiratory services. <ul style="list-style-type: none"> – Radiation and chemotherapy. • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products. • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> – Dilation and curettage (D&C) procedures; – Appropriate provider-administered medications; – Ultrasounds, and – Histological examination of tissue samples. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Surgical implants. • Other artificial aids including surgical implants. <p><i>(continues on next page)</i></p>

Benefits and Services

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
<p>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center (continued)</p>	<ul style="list-style-type: none"> • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: <ul style="list-style-type: none"> – All stages of reconstruction on the affected breast; – External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; – Surgery and reconstruction on the other breast to produce symmetrical appearance; and – Treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> – Cleft lip and/or palate; or – Severe traumatic skeletal and/or congenital craniofacial deviations; or – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
<p>Physician/ Physician Extender Professional Services</p>	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations). • Physician office visits, inpatient and outpatient services. • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation. • Medications, biologicals and materials administered in Physician’s office. • Allergy testing, serum and injections. • Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> – Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care. – Administration of anesthesia by Physician (other than surgeon) or CRNA. – Second surgical opinions. – Same-day surgery performed in a Hospital without an overnight stay. – Invasive diagnostic procedures such as endoscopic examinations. <p>(continues on next page)</p>

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
<p>Physician/ Physician Extender Professional Services <i>(continued)</i></p>	<ul style="list-style-type: none"> • Hospital-based Physician services (including Physician-performed technical and interpretive components). • Physician and professional services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> – All stages of reconstruction on the affected breast; – External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; – Surgery and reconstruction on the other breast to produce symmetrical appearance; and – Treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> – Dilation and curettage (D&C) procedures; – Appropriate provider-administered medications; – Ultrasounds, and – Histological examination of tissue samples. • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> – Cleft lip and/or palate; or – Severe traumatic skeletal and/or congenital craniofacial deviations; or – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.

Benefits and Services

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
Prenatal Care and Pre-Pregnancy Family Services and Supplies	<p>Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services.</p> <p>Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.</p>
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	<p>\$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including:</p> <ul style="list-style-type: none"> • Orthotic braces and orthotics. • Dental devices. • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses. • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease. • Hearing aids. • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. <i>(See Attachment A)</i>
Home and Community Health Services	<p>Services that are provided in the home and community, including, but not limited to:</p> <ul style="list-style-type: none"> • Home infusion. • Respiratory therapy. • Visits for private duty nursing (R.N., L.V.N.). • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. • Speech, physical and occupational therapies. <p><i>(continues on next page)</i></p>

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
Home and Community Health Services <i>(continued)</i>	<p>Services that are provided in the home and community, including, but not limited to <i>(continued)</i>:</p> <ul style="list-style-type: none"> • Services are not intended to replace the CHILD’S caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services.
Inpatient Mental Health Services	<p>Mental health services, including for serious mental illness, furnished in a freestanding psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:</p> <ul style="list-style-type: none"> • Neuropsychological and psychological testing. • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • Does not require PCP referral.
Outpatient Mental Health Services	<p>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</p> <ul style="list-style-type: none"> • The visits can be furnished in a variety of community-based settings (including school- and home-based) or in a state-operated facility. • Neuropsychological and psychological testing. • Medication management. • Rehabilitative day treatments. • Residential treatment services. • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment). • Skills training (psycho-educational skill development). • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. <p><i>(continues on next page)</i></p>

Benefits and Services

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
<p>Outpatient Mental Health Services <i>(continued)</i></p>	<ul style="list-style-type: none"> • A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services. • Does not require PCP referral.
<p>Inpatient Substance Abuse Treatment Services</p>	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. • Does not require PCP referral.
<p>Outpatient Substance Abuse Treatment Services</p>	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services. • Partial hospitalization. • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for 4 to 12 weeks, but less than 24 hours per day. • Outpatient treatment service is defined as consisting of at least 1 to 2 hours per week providing structured group and individual therapy, educational services, and life skills training. • Does not require PCP referral.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
Rehabilitation Services	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to, the following: <ul style="list-style-type: none"> – Physical, occupational and speech therapy. – Developmental assessment.
Hospice Care Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Palliative care, including medical and support services, for those children who have six (6) months or less to live, to keep patients comfortable during the last weeks and months before death. • Treatment services, including treatment related to the terminal illness. • Up to a maximum of 120 days with a life expectancy of 6 months. • Patients electing hospice services may cancel this election at any time. • Services apply to the hospice diagnosis.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	<p>MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</p> <p>Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Emergency services based on prudent lay person definition of emergency health condition. • Hospital emergency department room and ancillary services and physician services 24 hours a day, seven (7) days a week, both by in-network and out-of-network providers. • Medical screening examination. • Stabilization services. • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services. • Emergency ground, air and water transportation. • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin.
Transplants	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.

Benefits and Services

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members
Vision Benefit	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <p>Services include:</p> <ul style="list-style-type: none">• One (1) examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization.• One (1) pair of non-prosthetic eyewear per 12-month period.
Chiropractic Services	<p>Services do not require physician prescription and are limited to spinal subluxation.</p>
Tobacco Cessation Program	<p>Covered up to \$100 for a 12-month period limit for a plan-approved program.</p> <ul style="list-style-type: none">• Health Plan defines plan-approved program.• May be subject to formulary requirements.
Case Management and Care Coordination	<p>These services include outreach informing, case management, care coordination and community referral.</p>
Drug Benefits	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none">• Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and• Drugs and biologicals provided in an inpatient setting.
Value-Added Services	<p><i>See Extra Benefits Section.</i></p>

How do I get these services/How do I get these services for my child?

You can get these benefits by calling Member Services at **1-888-887-9003**.

Are there any limits to any covered services?

Covered CHIP services must meet the CHIP definition of Medically Necessary Covered Services. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Copays apply until a family reaches its specific cost-sharing maximum.

How much do I pay for health services?

The table on the next page shows the CHIP copayments according to your family income. Copayments are paid by you to the health care provider (at time of service) when they provide you medical services or prescription drugs. There are no copayments for preventive care such as well-child or well-baby visits or immunizations. CHIP Perinate and Newborn members, American Indian members and Alaskan Native members do not pay any enrollment fees or copayments.

Your child's health plan ID card will show the copayments that apply to your family. Show your child's ID card at all office visits or if you need emergency room services or have a prescription filled.

Families may be required to pay an enrollment fee. These fees may be from \$0 to \$50. This amount is paid only when you re-enroll your child(ren) every year.

The Member Guide you got when you enrolled in CHIP has a tear-out form that you should use to keep track of your child's CHIP costs. To make sure that you do not go above your out-of-pocket limits, please keep track of your CHIP-related expenses on this form.

The enrollment packet welcome letter tells you exactly how much you must spend before you are able to mail the form back to CHIP. If you cannot find your welcome letter, please call CHIP at 1-800-647-6558 and they will tell you what your limit is.

When you reach your annual out-of-pocket expenses, please send the form to CHIP and they will notify us. We will issue you a new member ID card. This new card will show that no copayments are due when your child gets medical services. CHIP and CHIP Perinate Members may have to pay for non-covered services.

What Are Copayments?

How much are they and when do I have to pay them?

Copayments for medical services or prescription drugs are paid to the health care provider at the time of service. You do not have to pay copayments for preventive care such as well-child or well-baby visits or immunizations. Your/your child’s UnitedHealthcare Community Plan card lists the copayments that apply to your family. Present your card when you/your child get office visits or emergency room services or has a prescription filled.

The table below lists the CHIP copayment schedule. It is listed according to a family’s income. There are no copayments for CHIP Perinate Program members.

Federal Poverty Level	Office Visits	Preventive Health Care and Shots	Cost per Emergency Room Visit	Inpatient Hospital Care per Admission	Prescriptions Generic Name	Prescriptions Brand Name
Native Americans	\$0	\$0	\$0	\$0	\$0	\$0
At or below 100%	\$0	\$0	\$3	\$15	\$0	\$3
101% – 150%	\$5	\$0	\$5	\$35	\$0	\$5
151% – 185%	\$20	\$0	\$75	\$75	\$10	\$35
186% – 200%	\$25	\$0	\$75	\$125	\$10	\$35

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

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

If you still get a bill, call Member Services at **1-888-887-9003** for help.

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

What Benefits Does My Baby Receive at Birth?

An unborn child who is enrolled in CHIP Perinatal will be moved to Medicaid for 12 months of continuous Medicaid coverage, beginning on the date of birth, if the child lives in a family with an income at or below 185% of the Federal Poverty Level (FPL).

An unborn child will continue to receive coverage through CHIP Perinatal after birth if the child lives in a family with an income above 185% to 200% FPL.

What services are not covered?

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to, artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.

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- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care. (Care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under this Health Plan.

What Are My Prescription Drug Benefits?

CHIP covers most of the medicine your/your child's doctor says you need. Your/your child's doctor will write a prescription so that you can take it to the drug store, or may be able to send the prescription for you.

Exclusions include: contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain.

You may have to pay a copayment for each prescription filled, depending on your income.

CHIP and CHIP Perinate Newborn Covered and Excluded Supplies

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency, it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.

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Supplies	Covered	Excluded	Comments/Member Contract Provisions
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	<p>Exception: Eligible for coverage only for chronic hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan).</p> <p>Physician documentation to justify prescription of formula must include:</p> <ul style="list-style-type: none"> • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product. <p><i>(continues on next page)</i></p>

Benefits and Services

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Formula (continued)		X	<p>Does not include formula:</p> <ul style="list-style-type: none"> • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding. • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product). • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. <p>Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are not medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.</p>
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.

Supplies	Covered	Excluded	Comments/Member Contract Provisions
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies.
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal.
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.

Benefits and Services

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc., are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter and Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan.
Urinary, Indwelling Catheter and Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catheterization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy Supplies			See Ostomy Supplies.

What Extra Benefits Does a Member of UnitedHealthcare Community Plan Get?

Value-added services.

Value-added services are extra services UnitedHealthcare Community Plan offers. As a member of UnitedHealthcare Community Plan, in addition to the standard CHIP services, you or your child can also receive:

- Access to 24-hour NurseLine.
- Non-emergent transportation assistance (as approved by your Health Plan Care Manager).
- Glasses for your child from a larger selection of frames.
- Contact lenses (up to a \$105.00 value) for your child instead of glasses.
- Replacement pair of glasses if your child's get broken or are lost.
- One sports or school physical per year to be performed by your child's PCP.
- Assistance for asthmatics.
- Enrollment to Weight Watchers for qualified members.
- Youth Recreation Program.
- Infant Care book for pregnant CHIP Members.
- Baby Showers.
- Gift programs for completion of annual well checks.
- Obesity and Nutrition Services.
- Diaper Rewards program.
- Home Health after delivery.

How can I get these benefits/How can I get these benefits for my child?

To get these services, call Member Services at **1-888-887-9003**.

What health education classes does UnitedHealthcare Community Plan offer?

UnitedHealthcare Community Plan can refer you to Health Education classes such as parenting courses and classes to help you quit smoking. Call Member Services at **1-888-887-9003** for more information about Health Education classes and meetings.

What Are My Unborn Child’s CHIP Perinatal Benefits?

EXCEPT IN AN EMERGENCY, CALL YOUR CHIP PERINATAL PROVIDER FIRST BEFORE GOING FOR HEALTH CARE. If your emergency care is not related to labor with the birth of your child, you will have to apply for Emergency Medicaid or pay for the services yourself.

Covered CHIP Perinatal services must meet the definition of Medically Necessary Covered Services. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services. Copays do not apply to CHIP Perinatal Members. CHIP Perinate Newborns are eligible for 12-months continuous coverage, beginning with the month of enrollment as a CHIP Perinate Newborn.

You can get these benefits by calling Member Services at **1-888-887-9003**.

How do I get these services?

Your Perinatal Provider will work with you to make sure your unborn child gets the services needed. These services **MUST** be given by your Perinatal Provider or referred by your Perinatal Provider to another provider.

Call UnitedHealthcare Community Plan at **1-888-887-9003**.

Covered Benefit	CHIP Perinate Members (Unborn Child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	<p>For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit.</p> <p>For CHIP Perinates in families with incomes above 185% to 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy.</p> <p>Services include:</p> <ul style="list-style-type: none">• Operating, recovery and other treatment rooms.• Anesthesia and administration (facility technical component). <p>Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</p> <p><i>(continues on next page)</i></p>

Covered Benefit	CHIP Perinate Members (Unborn Child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services <i>(continued)</i>	Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples.
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Not a covered benefit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component). • Laboratory and pathology services (technical component). • Machine diagnostic tests. • Drugs, medications and biologicals that are medically necessary prescription and injection drugs. • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> – dilation and curettage (D&C) procedures; – appropriate provider-administered medications; – ultrasounds, and – histological examination of tissue samples. <p>(1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth.</p> <p>(2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy.</p> <p><i>(continues on next page)</i></p>

Benefits and Services

Covered Benefit	CHIP Perinate Members (Unborn Child)
<p>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center <i>(continued)</i></p>	<p>(3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis.</p> <p>(4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.</p> <p>(5) Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.</p>
<p>Physician/Physician Extender Professional Services</p>	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. • Physician office visits, inpatient and outpatient services. • Laboratory, x-rays, imaging and pathology services including technical component and/or professional interpretation. • Medically necessary medications, biologicals and materials administered in Physician's office. • Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> – Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. – Administration of anesthesia by Physician (other than surgeon) or CRNA. – Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. – Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Hospital-based Physician services (including Physician performed technical and interpretive components). <p><i>(continues on next page)</i></p>

Covered Benefit	CHIP Perinate Members (Unborn Child)
Physician/Physician Extender Professional Services <i>(continued)</i>	<ul style="list-style-type: none"> • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT. • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> – Dilation and curettage (D&C) procedures; – Appropriate provider-administered medications; – Ultrasounds, and – Histological examination of tissue samples.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	<p>Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:</p> <ol style="list-style-type: none"> 1. One (1) visit every four (4) weeks for the first 28 weeks of pregnancy; 2. One (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and 3. One (1) visit per week from 36 weeks to delivery. <p>More frequent visits are allowed as Medically Necessary.</p> <p>Benefits are limited to:</p> <ul style="list-style-type: none"> • Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. <p>Visits after the initial visit must include:</p> <ul style="list-style-type: none"> • Interim history (problems, marital status, fetal status); • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); and • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).

Benefits and Services

Covered Benefit	CHIP Perinate Members (Unborn Child)
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	Not a covered benefit.
Home and Community Health Services	Not a covered benefit.
Inpatient Mental Health Services	Not a covered benefit.
Outpatient Mental Health Services	Not a covered benefit.
Inpatient Substance Abuse Treatment Services	Not a covered benefit.
Outpatient Substance Abuse Treatment Services	Not a covered benefit.
Rehabilitation Services	Not a covered benefit.
Hospice Care Services	Not a covered benefit.

Covered Benefit	CHIP Perinate Members (Unborn Child)
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	<p>MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery.</p> <p>Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth.</p> <ul style="list-style-type: none"> • Emergency services based on prudent lay person definition of emergency health condition. • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor with delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. • Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. <p>Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.</p>
Transplants	Not a covered benefit.
Vision Benefit	Not a covered benefit.
Chiropractic Services	Not a covered benefit.
Tobacco Cessation Program	Not a covered benefit.
Case Management and Care Coordination	Covered benefit.
Drug Benefits	Not a covered benefit unless identified elsewhere in this table.
Value-Added Services	<i>See Extra Benefits Section.</i>

Benefits and Services

What if I need services that are not covered by the CHIP Perinate program?

If you need services that are not covered by CHIP Perinatal, UnitedHealthcare Community Plan will try to help you find clinics and/or doctors that might be able to help you get those services at a discount or through community organizations that might be able to help you. Call our Member Services staff at **1-888-887-9003** for help.

What are my unborn child's prescription drug benefits?

CHIP Perinatal covers most of the medicine your unborn child's doctor says you need. Your doctor will write a prescription so that you can take it to the drug store, or may be able to send the prescription for you.

There are no copayments required for CHIP Perinate Members.

How do I find a network drug store?

Please contact Member Services for assistance at **1-888-887-9003**.

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

This may affect your ability to get the medications you need. Please contact Member Services for assistance at **1-888-887-9003**.

What do I bring with me to the drug store?

You will need your UnitedHealthcare Community Plan Member ID card.

What if I need my medications delivered to me?

Please contact Member Services for assistance at **1-888-887-9003**.

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

All prescriptions you get from your doctor can be filled at any drug store that takes your UnitedHealthcare Community Plan ID card. If you need help finding a drug store, call UnitedHealthcare Community Plan at **1-888-887-9003**. Remember — always take your UnitedHealthcare Community Plan ID card with you to the doctor and to the drug store.

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

If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication. Call UnitedHealthcare Community Plan at **1-888-887-9003** for help with your medications and refills.

What if I lose my medications?

Please contact Member Services for assistance at **1-888-887-9003**.

What if I need an over-the-counter medication?

The pharmacy cannot give you an over-the-counter medication as part of your CHIP Perinate benefit. If you need an over-the-counter medication, you will have to pay for it.

What services are NOT covered by CHIP Perinatal?

- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Transplant services.
- Tobacco cessation programs.
- Chiropractic services.
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor and delivery or postpartum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to, artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.

Benefits and Services

- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor and delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Corrective orthopedic shoes.
- Convenience items.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care. (Care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ.

How much do I have to pay for my unborn child's health care under CHIP Perinatal?

No copayments are paid for preventive care such as well-child or well-baby visits or immunizations. CHIP Perinate and Newborn members, American Indian members and Alaskan Native members do not pay any enrollment fees or copayments.

CHIP Perinate Members may have to pay for non-covered services.

Will I have to pay for services that are not covered?

CHIP Perinatal only pays for covered benefits under the Program. If you get services that are not covered, you may have to pay for these services. When you go to the hospital, you may need to apply for Emergency Medicaid to pay for your hospital stay. If you do not apply for Emergency Medicaid and CHIP Perinatal does not cover your hospital stay, you may have to pay for your hospital stay.

Health Education Classes and Other Resources for CHIP, CHIP Perinate Newborn and CHIP Perinatal Members

Early Childhood Intervention (ECI)

What is ECI?

ECI, or Early Childhood Intervention, is a program for babies and children under age 3 who may have a handicap or a delay in their growth. The ECI program may offer special services through ECI providers that are close to your home or your child's day care.

How do I get ECI services for my child?

You do not need a referral from your PCP for your child to be in an ECI program.

An ECI provider can test your child for a medical problem that may cause a delay in his or her growth. Also, your child may be tested if your doctor or family thinks your child has a disability or handicap.

What does ECI provide?

- Activities to help your child play or to help your child with daily functions.
- Counseling for your child and family.
- Education on your child's handicap or delay in development.
- Services to help with your child's nutrition needs.
- Transportation to help get you and your child to and from ECI services.

Are ECI services free?

Yes. Services are free to those who qualify, up to the age of 3. After age 3, ECI providers will help you get services from other programs if your child still needs them.

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

Women, Infants, and Children (WIC)

What is WIC?

WIC is a program for pregnant women, new moms and children age 5 and under. The WIC program helps teach pregnant women and new moms how to eat well and stay healthy.

How do I apply for WIC?

Call toll-free at 1-800-942-3678 or call UnitedHealthcare Community Plan Member Services at **1-888-887-9003**.

Who can get WIC services?

- Pregnant women.
- Women who are breastfeeding a baby who is 1 year old or younger.
- Women who have had a baby in the last 6 months.
- Children 5 years or younger who meet the income requirements.
- Parents (including single women and men), stepparents, guardians, and foster parents of infants and children.

Are services free?

Yes. Services are free to those who qualify.

What are the requirements?

- Must meet income guidelines set by WIC.
- Have poor eating habits or iron-deficiency anemia.
- Live in Texas.

What does WIC provide?

- Education on eating food that is good for you.
- Healthy foods such as baby formula, baby cereal, adult cereal, fruit and vegetable juices, milk, eggs, cheese, beans and peanut butter. Moms who are breastfeeding may also get tuna and carrots.
- Help on breastfeeding.
- Referrals for additional services such as food stamps, CHIP, Medicaid.
- Immunizations (at some clinics).

What Extra Benefits Does a Member of UnitedHealthcare Community Plan Get?

Value-added services.

Value-added services are extra services UnitedHealthcare Community Plan offers. As a member of UnitedHealthcare Community Plan, in addition to the standard CHIP services, you or your child can also receive:

- Access to 24-hour NurseLine.
- Non-emergent transportation assistance (as approved by your Health Plan Care Manager).
- Assistance for asthmatics.
- Infant Care book for pregnant CHIP Members.
- Baby Showers.
- Diaper Rewards program.

How can I get these benefits/How can I get these benefits for my unborn child?

To get these services, call Member Services at **1-888-887-9003**.

What health education classes does UnitedHealthcare Community Plan offer?

UnitedHealthcare Community Plan can refer you to Health Education classes such as parenting courses and classes to help you quit smoking. Call Member Services at **1-888-887-9003** for more information about Health Education classes and meetings.

Health Care and Other Services for CHIP Members and CHIP Perinate Newborn Members

Note: References to “you,” “my,” or “I” apply if you are a CHIP Members. References to “my child” or “my daughter” apply if your child is a CHIP Member or a CHIP Perinate Newborn Member.

What does “Medically Necessary” mean?

Covered services for CHIP Members, CHIP Perinate Newborn Members, and CHIP Perinate Members must meet the CHIP definition of “Medically Necessary.” A CHIP Perinate Member is an unborn child.

Medically Necessary means:

1. **Health Care Services** that are:
 - a. Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
 - b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member’s health conditions;
 - c. Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
 - d. Consistent with the member’s diagnoses;
 - e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
 - f. Not experimental or investigative; and
 - g. Not primarily for the convenience of the member or provider; and
2. **Behavioral Health Services** that:
 - a. Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
 - b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
 - c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
 - d. Are the most appropriate level or supply of service that can safely be provided;

- e. Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
- f. Are not experimental or investigative; and
- g. Are not primarily for the convenience of the member or provider.

What is routine medical care and how soon can I/my child expect to be seen?

If you or your child needs a physical checkup, then the visit is ROUTINE. Your doctor should see you within four weeks. UnitedHealthcare Community Plan will be happy to help you make an appointment, just call us at **1-888-887-9003**.

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

You/your child must see a UnitedHealthcare Community Plan provider for routine and urgent care. You can always call UnitedHealthcare Community Plan at 1-888-887-9003 if you need help picking a UnitedHealthcare Community Plan provider.

What is urgent medical care and how soon can I/my child expect to be seen?

If you/your child needs medical care for things such as minor cuts, burns, infections, nausea or vomiting, then your visit is URGENT. Call your doctor. He/she can usually see you within one day. If you have trouble getting an appointment for an urgent medical need, call Member Services for assistance at **1-888-887-9003**.

What is an Emergency, an Emergency Medical Condition, and an Emergency Behavioral Health Condition?

Emergency care is a covered service. Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

"Emergency Medical Condition" is a medical condition characterized by sudden acute symptoms, severe enough (including severe pain), that would lead an individual with average knowledge of health and medicine, to expect that the absence of immediate medical care could result in:

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

“Emergency Behavioral Health Condition” means any condition, without regard to the nature or cause of the condition, which in the opinion of an individual possessing average knowledge of health and medicine:

- Requires immediate intervention or medical attention without which the member would present an immediate danger to himself/herself or others; or
- Renders the member incapable of controlling, knowing, or understanding the consequences of his/her actions.

What is Emergency Services or Emergency Care?

“Emergency Services” and “Emergency Care” mean health care services provided in an in-network or out-of-network hospital emergency department, free-standing emergency medical facility, or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize Emergency Medical Conditions or Emergency Behavioral Health Conditions. Emergency services also include any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency Medical Condition or an Emergency Behavioral Health Condition exists.

How soon can I/my child expect to be seen in an emergency?

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

Are emergency dental services covered?

UnitedHealthcare Community Plan will pay for some emergency dental services provided in a hospital, urgent care center, or ambulatory surgical center setting, such as services for:

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

UnitedHealthcare Community Plan also covers other dental services your child gets in a hospital, urgent care center, or ambulatory surgical center setting. This includes services from the doctor and other services your child might need, like anesthesia.

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

During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call us toll-free at **1-888-887-9003**.

What is post-stabilization?

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

How do I get health care after my/my child's PCP's office is closed?

It is best to call your/your child's PCP as soon as you/your child needs health care. Do not wait until the evening or a weekend to call your/your child's PCP if you can get help during the day. Your/your child's illness might get worse as the day goes on. If you/your child gets sick during the night or on a weekend and cannot wait for help, call your/your child's PCP at the phone number on the front of your child's ID card.

If you cannot reach your/your child's doctor or want to talk to someone while you wait for the doctor to call you back, call NurseLine, UnitedHealthcare Community Plan's nurse helpline, at 1-800-850-1267. Our nurses are ready to help you 24 hours a day, 7 days a week. If you think you have a real emergency, call 911 or go to the nearest Emergency Room.

What if I get sick when I am out of town or traveling?

What if my child gets sick when he or she is out of town or traveling?

What if I am out of the state?

If you/your child needs medical care when traveling, call us toll-free at **1-888-887-9003** and we will help you find a doctor.

If you/your child needs emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-888-887-9003**.

What if I am/my child is out of the country?

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

What if I/My Child Needs to See a Special Doctor (Specialist)?

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

What is a referral?

Your/your child's PCP will talk to you about your/your child's needs and will help make plans for you to see the specialist that can provide the best care for you/your child. This is called a referral. Your/your child's doctor is the only one that can give you a referral to see a specialist. If you/your child has a visit, or receives services from a specialist without your doctor's referral, or if the specialist is not a UnitedHealthcare Community Plan provider, you might be responsible for the bill. In some cases, an OB/GYN can also give you a referral for related services.

What services do not need a referral?

You do NOT need a referral for:

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

Contact your/your child's PCP or Member Services at **1-888-887-9003** to determine if you need a referral.

How soon can I/my child expect to be seen?

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

How can I ask for a second opinion?

You have the right to a second opinion from a UnitedHealthcare Community Plan provider if you are not satisfied with the plan of care offered by the specialist. Your primary care doctor should be able to give you a referral for a second opinion visit. If your doctor wants you to see a specialist that is not a UnitedHealthcare Community Plan provider, that visit will have to be approved by UnitedHealthcare Community Plan. You can call Member Services at **1-888-887-9003** for help with getting a second opinion.

How do I get help if I have/my child has behavioral (mental) health or alcohol or drug problems? Do I need a referral for this?

UnitedHealthcare Community Plan covers medically necessary Substance Abuse and Behavioral Health Care services. If you/your child has a drug problem or is very upset about something, you can get help. Call 1-800-495-5660 for help. You do not need a referral for these services.

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

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

Who do I call if I/my child has special health care needs and I need someone to assist me?

If you/your child have special health care needs, like a serious ongoing illness, disability, or chronic or complex conditions, please contact UnitedHealthcare Community Plan Member Services at **1-888-887-9003** to request help with your/your child's special health care needs.

What are my/my child's prescription drug benefits? How do I get my/my child's medications?

CHIP covers most of the medicine your/your child's doctor says you need. Your/your child's doctor will write a prescription so that you can take it to the drug store, or may be able to send the prescription for you.

Exclusions include: contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain.

You may have to pay a copayment for each prescription filled, depending on your income.

All prescriptions you get from your doctor can be filled at any drug store that takes your UnitedHealthcare Community Plan ID card. If you need help finding a drug store, call UnitedHealthcare Community Plan at **1-888-887-9003**. Remember — always take your UnitedHealthcare Community Plan ID card with you to the doctor and to the drug store.

How do I find a network drug store?

Please contact Member Services for assistance at **1-888-887-9003**.

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

This may affect your ability to get the medications you need. Please contact Member Services for assistance at **1-888-887-9003**.

What do I bring with me to the drug store?

You will need your UnitedHealthcare Community Plan Member ID card and your prescription(s).

What if I need my/my child's medications delivered to me?

Please contact Member Services for assistance at **1-888-887-9003**.

Benefits and Services

What if I need/my child needs an over-the-counter medication?

The pharmacy cannot give you an over-the-counter medication as part of your/your child's CHIP benefit. If you need/your child needs an over-the-counter medication, you will have to pay for it.

Who do I call if I have problems getting my/my child's prescriptions?

Please contact Member Services for assistance at **1-888-887-9003**.

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

If your/your child's doctor cannot be reached to approve a prescription, you/your child may be able to get a three-day emergency supply of your/your child's medication.

Call UnitedHealthcare Community Plan at **1-888-887-9003** for help with your medications and refills.

What if I lose my/my child's medication?

Please contact Member Services for assistance at **1-888-887-9003**.

What if I need/my child needs birth control pills?

The pharmacy cannot give you/your child birth control pills to prevent pregnancy. You/your child can only get birth control pills if they are needed to treat a medical condition.

How do I get eye care services?/How do I get eye care services for my child?

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

How do I get dental services for my child?

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

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

Can someone interpret for me when I talk with my/my child's doctor?

Who do I call for an interpreter? How far ahead of time do I need to call?

It is your right to talk with your/your child's doctor in the language you prefer. UnitedHealthcare Community Plan can arrange interpreter services for you. Please call **1-888-887-9003** if you need a translator. Call **TDD/TTY 711** for hearing impaired. Please call as soon as you make your/your child's appointment or at least 24 hours in advance.

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

Translators can meet you at your/your child's doctor's office and help you talk to your/your child's doctor face-to-face in the language you prefer. Please contact Member Services at **1-888-887-9003** for more information.

What if I Need/My Daughter Needs OB/GYN Care?

You/your daughter can get OB/GYN services from your doctor. You can also pick an OB/GYN specialist to take care of your/your daughter's female health needs. An OB/GYN can help with pregnancy care, yearly checkups or if you/your daughter have female problems. You DO NOT need a referral from a doctor for these services. Your/your child's OB/GYN and doctor will work together to make sure you get the care you need.

Do I have the right to choose an OB/GYN?

ATTENTION MEMBERS: You have the right to pick an OB/GYN for yourself/your daughter without a referral from your/your daughter's Primary Care Provider. An OB/GYN can give you:

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

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

How do I choose an OB/GYN?

Call Member Services at **1-888-887-9003** or pick one from the provider directory.

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

Yes.

Will I need a referral for OB/GYN services?

No.

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

You/your daughter can be seen within two weeks of contacting your/her doctor to request a prenatal visit.

If you or your daughter is pregnant, call your daughter's doctor and UnitedHealthcare Community Plan Member Services at **1-888-887-9003**.

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

If you/your daughter is pregnant and you are/she is in the last 3 months of your/her pregnancy, please contact UnitedHealthcare Community Plan Member Services at **1-888-887-9003**. UnitedHealthcare Community Plan will arrange for you/her to continue treatment with the OB/GYN doctor you/she has been seeing. The doctor may also contact UnitedHealthcare Community Plan to see if they can become one of our providers.

If you/your daughter is not pregnant or is not in the last 3 months of your/her pregnancy, you/she may choose any OB/GYN within the UnitedHealthcare Community Plan network. If you need a provider list, please call Member Services.

You can call us for help in picking an OB/GYN doctor at **1-888-887-9003**.

What if I am pregnant?/What if my daughter is pregnant? Who do I need to call?

If you think or know you/your daughter are pregnant, make an appointment to see your doctor or an OB/GYN. They will be able to confirm if you are/she is pregnant or not and discuss the care you/she and your/her unborn child will need. When you know that you are pregnant, call UnitedHealthcare Community Plan at **1-888-887-9003**. UnitedHealthcare Community Plan will enroll you/her in the Healthy First Steps program to make sure you/your daughter and your/your daughter's unborn child get medical care you/your daughter need during your/your daughter's pregnancy.

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and UnitedHealthcare Community Plan Member Services Department at **1-888-887-9003**. Before you get CHIP services in your new area, you must call UnitedHealthcare Community Plan, unless you need emergency services. You will continue to get care through UnitedHealthcare Community Plan until HHSC changes your address.

Other Plan Details

Member Rights and Responsibilities for CHIP Members and CHIP Perinate Newborn Members

Member rights.

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's PCP and any specialist doctor that you might like to see are part of the same "limited network."
3. You have the right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's PCP. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment depending on your income. Copayments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

Other Plan Details

15. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member responsibilities.

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. You must talk to your provider about your medications that are prescribed.

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

What Does “Medically Necessary” Mean?

Covered services for CHIP Members, CHIP Perinate Newborn Members, and CHIP Perinate Members must meet the CHIP definition of “Medically Necessary.” A CHIP Perinate Member is an unborn child.

Medically Necessary means:

1. Health Care Services that are:

- a. Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
- b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member’s health conditions;
- c. Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
- d. Consistent with the member’s diagnoses;
- e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- f. Not experimental or investigative; and
- g. Not primarily for the convenience of the member or provider; and

2. Behavioral Health Services that:

- a. Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
- b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
- d. Are the most appropriate level or supply of service that can safely be provided;
- e. Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered;
- f. Are not experimental or investigative; and
- g. Are not primarily for the convenience of the member or provider.

Other Plan Details

What is routine medical care and how soon can I expect to be seen?

If you need a checkup, then the visit is ROUTINE. Your doctor should see you within four weeks. UnitedHealthcare Community Plan will be happy to help you make an appointment, just call us at **1-888-887-9003**.

You must see a UnitedHealthcare Community Plan provider for routine and urgent care. You can always call UnitedHealthcare Community Plan at **1-888-887-9003** if you need help picking a UnitedHealthcare Community Plan provider.

What is urgent medical care and how soon can I expect to be seen?

If you/your child needs medical care for things such as minor cuts, burns, infections, nausea or vomiting, then your visit is URGENT. Call your doctor. He/she can usually see you within one day. If you have trouble getting an appointment for an urgent medical need, call Member Services for assistance at **1-888-887-9003**.

What is an Emergency and an Emergency Medical Condition?

A CHIP Perinate Member is defined as an unborn child. Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth. Emergency care is provided for the following Emergency Medical Conditions:

- Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child;
- Stabilization services related to the labor with delivery of the unborn child;
- Emergency ground, air and water transportation for labor and threatened labor is a covered benefit;
- Emergency ground, air, and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.

Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

What is Emergency Services or Emergency Care?

“Emergency Services” or “Emergency Care” are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition, including post-stabilization care services related to labor and delivery of the unborn child.

How soon can I expect to be seen in an emergency?

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

How do I get health care after my doctor's office is closed?

Please call your pregnancy doctor. If you cannot reach your doctor or want to talk to someone while you wait for the doctor to call you back, call NurseLine, UnitedHealthcare Community Plan's nurse helpline, at 1-800-850-1267. Our nurses are ready to help you 24 hours a day, 7 days a week. If you think you have a real emergency, call 911 or go to the nearest emergency room.

What if I get sick when I am out of town or traveling? What if I am out of the state?

If you need medical care when traveling, call us toll-free at **1-888-887-9003** and we will help you find a doctor.

If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-888-887-9003**.

What if I am out of the country?

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

What is a referral?

Your Perinate Provider will talk to you about your unborn baby's needs and will help make plans for you to see the specialist that can provide the best care for your unborn baby. This is called a referral. Your doctor is the only one that can give you a referral to see a specialist. If you have a visit, or receive services from a specialist without your doctor's referral, if the specialist is not a UnitedHealthcare Community Plan provider, or if the service is not a covered service, you might be responsible for the bill.

What services do not need a referral?

You do NOT need a referral for:

- Emergency Services.
- OB/GYN Care.

Contact Member Services at **1-888-887-9003** to determine if you need a referral.

What if I need services that are not covered by CHIP Perinatal?

CHIP Perinatal only pays for covered benefits under the Program. If you get services that are not covered, you may have to pay for these services.

When you go to the hospital, you may need to apply for Emergency Medicaid to pay for your hospital stay. If you do not apply for Emergency Medicaid and CHIP Perinatal does not cover your hospital stay, you may have to pay for your hospital stay.

Other Plan Details

How do I get my medications?

CHIP Perinatal covers most of the medicine your unborn child's doctor says you need. Your doctor will write a prescription so that you can take it to the drug store, or may be able to send the prescription for you.

There are no copayments required for CHIP Perinate Members.

How do I find a network drug store?

Please contact Member Services for assistance at **1-888-887-9003**.

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

This may affect your ability to get the medications you need. Please contact Member Services for assistance at **1-888-887-9003**.

What do I bring with me to the drug store?

You will need your UnitedHealthcare Community Plan Member ID card and your prescription(s).

What if I need my medications delivered to me?

Please contact Member Services for assistance at **1-888-887-9003**.

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

All prescriptions you get from your doctor can be filled at any drug store that takes your UnitedHealthcare Community Plan ID card. If you need help finding a drug store, call UnitedHealthcare Community Plan at **1-888-887-9003**. Remember — always take your UnitedHealthcare Community Plan ID card with you to the doctor and to the drug store.

What if I can't get my prescription approved?

If your/your child's doctor cannot be reached to approve a prescription, you/your child may be able to get a three-day emergency supply of your medication. Call UnitedHealthcare Community Plan at **1-888-887-9003** for help with your medications and refills.

What if I lose my medication?

Please contact Member Services for assistance at **1-888-887-9003**.

What if I need/my child needs an over-the-counter medication?

The pharmacy cannot give you an over-the-counter medication as part of your/your child's CHIP benefit. If you/your child needs an over-the-counter medication, you will have to pay for it.

Can someone interpret for me when I talk with my perinatal provider?

Who do I call for an interpreter? How far ahead of time do I need to call?

It is your right to talk with your doctor in the language you prefer. UnitedHealthcare Community Plan can arrange interpreter services for you. Please call **1-888-887-9003** if you need a translator. Call **TDD/TTY 711** for hearing impaired. Please call as soon as you make your appointment or at least 24 hours in advance.

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

Translators can meet you at your doctor's office and help you talk to your doctor face-to-face in the language you prefer. Please contact Member Services at **1-888-887-9003** for more information.

How do I choose a perinatal provider? Will I need a referral for this?

If you need help choosing a perinatal provider, please contact Member Services at **1-888-887-9003**. You will not need a referral for this service.

How soon can I be seen after contacting a perinatal provider for an appointment?

You should be able to see your perinatal provider within two weeks of calling them. If you have any problem getting an appointment within two weeks of contacting your/your child's provider, please call UnitedHealthcare Community Plan at **1-888-887-9003**.

Can I stay with a CHIP Perinatal Provider if they are not with my health plan?

You should try to choose a CHIP Perinatal Provider that is in your health plan's CHIP Perinatal Provider Network. If you have 12 weeks or less remaining before the expected delivery date of your baby, you can stay under your current Perinatal Provider through your postpartum checkup, even if the Perinatal Provider is, or becomes, out of network. Please contact Member Services.

What if I get a bill from a perinatal provider? What information will they need? Who do I call?

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

*If you still get a bill, call Member Services at **1-888-887-9003** for help.*

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

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and UnitedHealthcare Community Plan Member Services Department at **1-888-887-9003**. Before you get CHIP services in your new area, you must call UnitedHealthcare Community Plan, unless you need emergency services. You will continue to get care through UnitedHealthcare until HHSC changes your address.

Member Rights and Responsibilities for CHIP Perinate Members

Member rights.

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member responsibilities.

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Program Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. You must talk to your provider about your medications that are prescribed.

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

When Does CHIP Perinatal Coverage End?

You will be able to get CHIP Perinatal coverage until you deliver your baby. Once you have your baby, you will no longer be able to get these services.

Will the state send me anything when my CHIP Perinatal coverage ends?

The State will send you a letter telling you that you no longer have benefits.

How Does Renewal Work for CHIP Perinatal?

Your CHIP Perinatal coverage is for twelve months. The coverage begins when you enroll the unborn baby when you are pregnant, and continues for the baby only, after the baby is born for a total of twelve months of coverage. In the 10th month of coverage you will receive a CHIP renewal form. You must fill it out and send it to the State. The State will determine if your child is eligible for Medicaid or CHIP.

Can I Choose My Baby's Primary Care Provider Before My Baby Is Born?

Who Do I Call?

What Information Do They Need?

Yes, you can choose your baby's PCP before your child is born. It is important for you to select a Primary Care Provider for your baby. You can find a CHIP Primary Care Provider for your newborn by calling Member Services at **1-888-887-9003**, or going to www.UHCCommunityPlan.com or by looking in UnitedHealthcare Community Plan's CHIP Provider Directory. Have your Member ID card available.

Complaints and Appeals

What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call us toll-free at **1-888-887-9003** to tell us about your problem. A UnitedHealthcare Community Plan Member Services Advocate can help you file a complaint. Just call **1-888-887-9003**. Most of the time, we can help you right away, or at the most within a few days.

If I am not satisfied with the outcome, who else can I contact?

If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll-free to 1-800-252-3439. If you would like to make your request in writing, send it to:

Texas Department of Insurance
Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091

If you can get on the Internet, you can send your complaint in an email to <http://www.tdi.texas.gov/forms/consumer/cp012complform.pdf>.

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

Yes, a UnitedHealthcare Community Plan Member Services representative can help you file a complaint, just call **1-888-887-9003**. Most of the time, we can help you right away, or at the most within a few days.

How long will it take to process my complaint?

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

What are the requirements and timeframes for filing a complaint?

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

Do I have the right to meet with a Complaint Appeal Panel?

If you make a complaint for you/your child and it is not worked out the way you thought it should, you have the right to appeal. When you appeal, you will get information about having your concern heard by a Complaint Appeal Panel. This panel is made up of doctors, other providers, and UnitedHealthcare Community Plan members.

Other Plan Details

Where can I mail a complaint?

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

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

Ombudsman program.

UnitedHealthcare Community Plan members can access a UnitedHealthcare Community Plan Independent Ombudsman to assist them with resolving their complaint.

UnitedHealthcare Community Plan contracts with several non-profit organizations to provide this service to you. You can be referred to a UnitedHealthcare Community Plan Independent Ombudsman through our Member Services department by calling **1-888-887-9003**.

What Can I Do if My Child's Doctor Asks for a Service for My Child That Is Covered But UnitedHealthcare Community Plan Denies or Limits It?

UnitedHealthcare Community Plan will send you a letter if a covered service requested by your child's PCP is denied, delayed, limited or stopped. If you are not happy with the decision, you can call Member Services at **1-888-887-9003** and ask for an appeal. We will record your verbal request. Your recording will then be made into a written request. We will send a form to you to complete, sign and return as soon as possible.

How will I find out if services are denied?

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

What are the timeframes for the appeal process?

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

When do I have the right to request an appeal?

You may request an appeal whenever you do not agree with UnitedHealthcare Community Plan's decision to deny services or care for you/your child.

Does my request have to be in writing?

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

No retaliation is allowed.

UnitedHealthcare Community Plan will not punish a member, doctor or provider for filing a complaint against UnitedHealthcare Community Plan.

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

Member Services is available to help you file an appeal. You can ask them to help you when you call **1-888-887-9003**. They will send you an appeal request form and ask that you return it before your appeal request is taken.

What Is an Expedited Appeal?

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

How do I ask for an expedited appeal?

You may ask for this type of appeal in writing or by phone. Make sure you write "I want a quick decision or an expedited appeal," or "I feel my child's health could be hurt by waiting for a standard decision."

To request a quick decision by phone, call UnitedHealthcare Community Plan Member Services at **1-888-887-9003**.

Does my request for an expedited appeal have to be in writing?

We can accept your request orally or in writing. Mail written requests to:

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

Other Plan Details

What are the timeframes for an expedited appeal?

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

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

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

Who can help me in filing an appeal or an expedited appeal?

If you/your child is in the hospital, ask someone to help you mail or call in your request for this type of appeal. You may also call UnitedHealthcare Community Plan Member Services at **1-888-887-9003** and ask someone to help you start an appeal or ask your/your child's doctor to do it for you.

What Is an Independent Review Organization (IRO)?

An Independent Review Organization (IRO) is an outside organization that the Texas Department of Insurance (TDI) picks to review your health plan's denial of a service you and your doctor feel is medically necessary. This organization is not related to your doctor or your health plan. There is no cost to you for this independent review.

You can ask for a review by an IRO after you complete the appeal process. An IRO is the final level of appeal for an Adverse Determination.

How do I request an IRO?

If you choose an IRO, you may contact UnitedHealthcare Community Plan Member Services at **1-888-887-9003**.

What are the timeframes for this process?

When UnitedHealthcare Community Plan gets your request, we send it to the Texas Department of Insurance (TDI) within 5 calendar days.

We work with TDI and the IRO to give them all the information about your case. The IRO will let UnitedHealthcare Community Plan and YOU know what they decide. This decision is final and UnitedHealthcare Community Plan will work with you and your child's providers to do what the IRO says must be done.

Each Year You Have the Right to Ask UnitedHealthcare Community Plan to Send You Certain Information

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

- Names, addresses, phone numbers, and languages spoken (other than English) by network providers, and identification of providers who are not accepting new patients. The information given will be, at a minimum, on primary care doctors, specialists, and hospitals in the member's service area.
- Any restrictions on the member's freedom of choice among network providers.
- Member rights and responsibilities.
- Information on complaint, appeal, and fair hearing procedures.
- The amount, duration, and scope of benefits under the contract in sufficient detail to ensure that members know about the benefits to which they are entitled.
- How to get benefits including authorization requirements.
- How members might get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
- How afterhours and emergency coverage are provided and/or limits to those benefits, including:
 - What makes up emergency medical conditions, emergency services and post-stabilization services;
 - The fact that prior authorization is not required for emergency care services;
 - How to get emergency services, including use of the 911 system or its local equivalent;
 - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services covered under the contract;
 - The member has a right to use any hospital or other settings for emergency care; and
 - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits not furnished by the member's PCP.
- UnitedHealthcare Community Plan practice guidelines.

Important changes in payments made to physicians and providers.

UnitedHealthcare Community Plan will tell our members in writing if any important changes are made in how we pay our physicians and providers. The members will be told within 30 days of the change. The announcement will include how the payment was changed and what the new payment will be.

Do You Want to Report CHIP Waste, Abuse, Or Fraud?

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit <https://oig.hhsc.state.tx.us/> in the box labeled "I WANT TO," click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
UnitedHealthcare Community Plan
14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478
1-888-887-9003

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

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

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

When reporting about someone who gets benefits, include:

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

HEALTH PLAN NOTICES OF PRIVACY PRACTICES.
THIS NOTICE SAYS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED.
IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2016.

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

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

We must by law follow the terms of this notice.

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

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

How we use or share your information.

We must use and share your HI with:

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

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

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

Other Plan Details

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

We may use or share your HI as follows:

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

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

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

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

Your rights.

You have a right:

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

Other Plan Details

- **To get a paper copy of this notice.** You may ask for a copy at any time. Even if you agreed to get this notice electronically, you have a right to a paper copy. If we maintain a website for your health plan, 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 **1-888-887-9003** or **TTY 711**.
- **To Submit a Written Request.** Mail to:
UnitedHealthcare Government Programs Privacy Office
MN017-E300
P.O. Box 1459
Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

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

Effective January 1, 2016.

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

Information we collect.

We get FI about you from:

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

Sharing of FI.

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

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

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

Confidentiality and security.

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

Questions about this notice.

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-888-887-9003** or **TTY 711**.

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

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

Other Plan Details

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

Revised: January 1, 2016.

The first part of this Notice (pages 78 – 82) says how we may use and share your health information (“HI”) under federal privacy rules. Other laws may limit these rights. The charts below:

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

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

SUMMARY OF FEDERAL LAWS

Alcohol and Drug Abuse Information

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

Genetic Information

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

SUMMARY OF STATE LAWS

General Health Information

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

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

Other Plan Details

HIV/AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

We're here for you.

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-888-887-9003**, **TDD/TTY 711**, for hearing impaired. You can also visit our website at www.UHCCommunityPlan.com.

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

www.UHCCommunityPlan.com

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

