Texas – September 2026



Welcome to the community

UnitedHealthcare Community Plan STAR+PLUS Member Handbook

Member Services: 1-888-887-9003, TDD/TTY: **7-1-1,** for deaf and hard of hearing

United Healthcare® Community Plan

TEXAS STAR PLUS Your Health Plan ★ Your Choice

TEXAS Health and Human Services

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Member Services

1-888-887-9003, TDD/TTY: **7-1-1,** for deaf and hard of hearing

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

What to do in an emergency

Call **9-1-1** or go to the nearest hospital/emergency facility if you think you need emergency care. You can call **9-1-1** 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 **9-1-1** 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 **1-888-887-9003** as soon as possible.

In case of emergency call 9-1-1

If you think that it is not an Emergency, but you need help, call the NurseLine at 1-877-839-5407.

If you have questions about your health plan, please call us. Our toll-free Member Services number is **1-888-887-9003,** TDD/TTY: **7-1-1,** for deaf and hard of hearing. There will be people who can speak to you in English and Spanish when you call.

If you need access to free and confidential support for anyone experiencing behavioral health-related distress – whether it is thoughts of suicide, mental health or substance crisis, or any other kind of emotional distress – call **9-8-8.**

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.

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Toll-free telephone numbers

Member Services **1-888-887-9003**
How to access covered services, information and Interpreters are available in many languages from 8:00 a.m.–8:00 p.m., Monday–Friday excluding state-approved holidays (see page 5). After-hours, please contact NurseLine. Call **9-1-1** or go to the nearest hospital/emergency facility if you think you need emergency care. TDD/TTY (for deaf and hard of hearing). **7-1-1**

Service Coordination. **1-800-349-0550**
(8:00 a.m.–5:00 p.m., Monday–Friday)

NurseLine (available 24 hours a day, 7 days a week) . . . . . **1-877-839-5407,** TTY: **7-1-1**
- Se habla Español
- Interpreter services available

For Dental Services, Call Your Child's Medicaid Dental Plan
DentaQuest **1-800-516-0165**
MCNA Dental. **1-855-691-6262**
UnitedHealthcare Dental **1-877-901-7321**

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

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

For Hearing Services, Call Member Services **1-877-597-7799**

Nonemergency Medical Transportation (NEMT) Services – Where's My Ride Hotline. . . . . **1-888-462-6050,** TTY: **711**
How to access NEMT services:
Available 8:00 a.m.–5:00 p.m., Monday–Friday, se habla Español.
Information and Interpreters are available in many languages.

Mental Health and Substance Abuse Services **1-888-887-9003**
Optum Behavioral Health; available 24 hours a day, 7 days a week.
How to access covered services, information and Interpreters are available in many languages. **For a crisis and you have trouble with the phone line, call 9-1-1 or go to the nearest emergency room.**

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

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

Pharmacy Benefits **1-888-887-9003**

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

Questions? Visit **UHCCommunityPlan.com**, or call Member Services at **1-888-887-9003,** TDD/TTY: **7-1-1.**

Health plan highlights

Thank you for choosing UnitedHealthcare Community Plan as your health plan

Welcome to UnitedHealthcare Community Plan

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

Your guide to good health

Please read this Member Handbook. It will tell you about your benefits. It will help you use your health plan right away. If you feel you need this handbook in Braille, larger print, another language or in audio, you can call us at **1-888-887-9003.** UnitedHealthcare Community Plan Member Services is always ready to help you.

Look at your UnitedHealthcare Community Plan identification card. Make sure all the information is right. We want to make it easy for you to use your health plan. We can answer any questions you have about getting started. If you have questions, please call us. Our toll-free Member Services number is **1-888-887-9003.** We are here to help you 8:00 a.m.–8:00 p.m., Monday–Friday. After-hours and weekend coverage is available via an automated telephone system.

Note: References to "you," "my," or "I" apply if you are a STAR+PLUS member. References to "my child" apply if your child is a STAR+PLUS member.

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

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

Want to access your information from a mobile app?

Download the UnitedHealthcare app® in the App Store or Google Play. It offers many of the same features as the secure member website – and you use the same user name and password. It's great for when you're on the go.

Your health providers

My primary care provider's name: _____

My primary care provider's phone number: _____

Other doctor's name: _____

Other doctor's phone number:_____

Pharmacy: _____ Phone: _____

If you need help with finding a provider or have questions about your health plan, please call us. Our Member Services in Texas can be reached toll-free at 1-888-887-9003, TDD/TTY: 7-1-1, 8:00 a.m.–8:00 p.m., Monday–Friday.

Our office locations

UnitedHealthcare Community Plan

Main Office
2950 North Loop W., Suite 200
Houston, TX 77092-8843

Or visit our website at: **UHCCommunityPlan.com**.

What is Member Services?

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

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

Member Services
1-888-887-9003, TDD/TTY: **7-1-1**

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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Questions? Visit **UHCCommunityPlan.com**, or call Member Services at **1-888-887-9003,** TDD/TTY: **7-1-1.**

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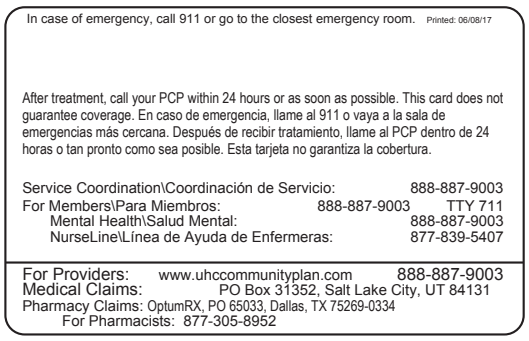
When and where do I use my UnitedHealthcare Community Plan ID card?

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

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

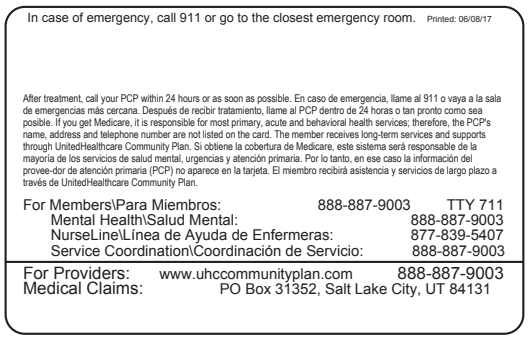
Members with Medicaid only ID card


UnitedHealthcare Community Plan
TEXAS STAR PLUS
Health Plan/Plan de salud (80840) 911-87726-04
Member ID/ID del Miembro: 999994197 Group/grupo: TXSTPL
Member/Miembro: Payer ID/ID del Pagador : 87726
NEW A ENGLISH
DOB/Fecha de nacimiento: 04/01/1955
PCP Name/Nombre del PCP:
DOUGLAS GETWELL
PCP Phone/Teléfono del PCP:
(361)883-1177
Effective Date/ Fecha de vigencia 11/01/2011
OPTUMRx
Rx Bin: 610494
Rx GRP: ACUTX
Rx PCN: 9999
0709 Administered by UnitedHealthcare Community Plan of Texas, LLC


In case of emergency, call 911 or go to the closest emergency room. Printed: 06/08/17
After treatment, call your PCP within 24 hours or as soon as possible. This card does not guarantee coverage. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible. Esta tarjeta no garantiza la cobertura.
Service Coordination\Coordinación de Servicio: 888-887-9003
For Members\Para Miembros: 888-887-9003 TTY 711
Mental Health\Salud Mental: 888-887-9003
NurseLine\Línea de Ayuda de Enfermeras: 877-839-5407
For Providers: www.uhccommunityplan.com 888-887-9003
Medical Claims: PO Box 31352, Salt Lake City, UT 84131
Pharmacy Claims: OptumRX, PO 65033, Dallas, TX 75269-0334
For Pharmacists: 877-305-8952

Members with Medicaid and Medicare ID card


UnitedHealthcare Community Plan
TEXAS STAR PLUS
Health Plan/Plan de salud (80840) 911-87726-04
Member ID/ID del Miembro: 999994201 Group/grupo: TXSTPL
Member/Miembro: Payer ID/ID del Pagador : 87726
NEW C ENGLISH
DOB/Fecha de nacimiento: 12/25/1945
PCP Name/Nombre del PCP:
USE MEDICARE
Effective Date/ Fecha de vigencia 01/01/2012
Long term care services only
Solo servicios de atención a largo plazo
0709 Administered by UnitedHealthcare Community Plan of Texas, LLC


In case of emergency, call 911 or go to the closest emergency room. Printed: 06/08/17
After treatment, call your PCP within 24 hours or as soon as possible. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible. If you get Medicare, it is responsible for most primary, acute and behavioral health services; therefore, the PCP's name, address and telephone number are not listed on the card. The member receives long-term services and supports through UnitedHealthcare Community Plan. Si obtiene la cobertura de Medicare, este sistema será responsable de la mayoría de los servicios de salud mental, urgencias y atención primaria. Por lo tanto, en ese caso la información del provee-dor de atención primaria (PCP) no aparece en la tarjeta. El miembro recibirá asistencia y servicios de largo plazo a través de UnitedHealthcare Community Plan.
For Members\Para Miembros: 888-887-9003 TTY 711
Mental Health\Salud Mental: 888-887-9003
NurseLine\Línea de Ayuda de Enfermeras: 877-839-5407
Service Coordination\Coordinación de Servicio: 888-887-9003
For Providers: www.uhccommunityplan.com 888-887-9003
Medical Claims: PO Box 31352, Salt Lake City, UT 84131

If you have Medicare and Medicaid, your UnitedHealthcare ID card will not show a doctor's name or phone number. Your ID card will show USE MEDICARE.

How to read your UnitedHealthcare Community Plan ID card

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

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

How to replace your card if it is lost

If you lose your UnitedHealthcare Community Plan ID card, call Member Services right away at **1-888-887-9003.** Member Services will send you a new one. Call TDD/TTY: **7-1-1** for deaf and hard of hearing.

Remember to take your card with you and show it whenever you visit the doctor, dentist, or drug store.

Your Texas Benefits (YTB) Medicaid Card

When you are approved for Medicaid, you will get a YTB Medicaid Card. This plastic card will be your everyday Medicaid Card. You should carry and protect it just like your driver's license or a credit card. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.

You will be issued only one card and will receive a new card only if your card is lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free 1-800-252-8263, or by going online to order or print a temporary card at **www.YourTexasBenefits.com**.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 1-800-252-8263. You can also call 2-1-1. First pick a language and then pick option 2.

Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your medical and dental information through the secure online network, call toll-free at 1-800-252-8263 or opt out of sharing your health information at **www.YourTexasBenefits.com**.

The YTB Medicaid Card has these facts printed on the front:

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

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

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

The YourTexasBenefits.com Medicaid Client Portal

You can use the Medicaid Client Portal to do all of the following for yourself or anyone whose medical or dental information you are allowed to access:

- View, print, and order a YTB Medicaid card
- See your medical and dental plans
- See your benefit information
- See STAR and STAR Kids Texas Health Steps alerts
- See broadcast alerts
- See diagnoses and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see your available medical and dental information

To access the portal, go to **www.YourTexasBenefits.com**.

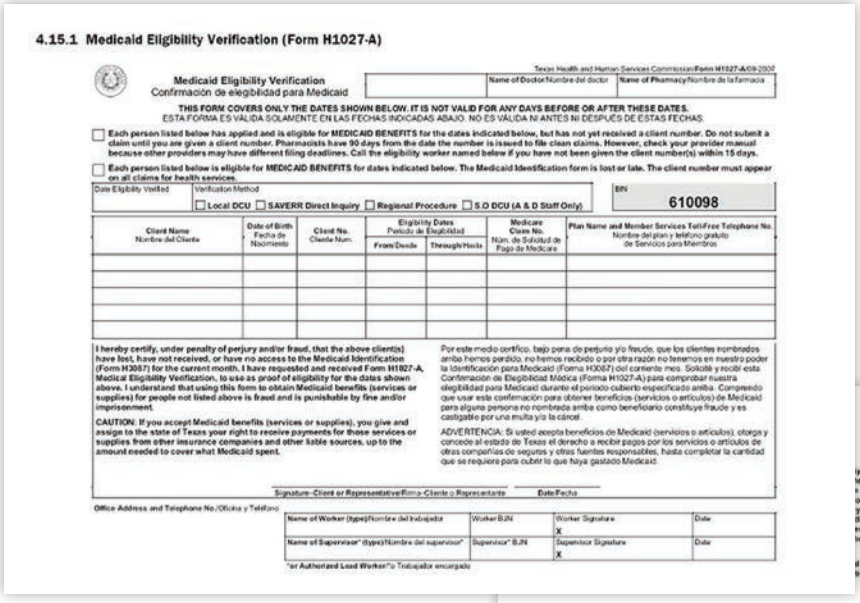
- Click **Log In**
- Enter your User name and Password. If you don't have an account, click **Create a new account.**
- Click **Manage**
- Go to the "Quick links" section
- Click **Medicaid & CHIP Services**
- Click **View services and available health information**

Note: The **YourTexasBenefits.com** Medicaid Client Portal displays information for active clients only. A Legally Authorized Representative may view the information of anyone who is a part of their case.

Your temporary Medicaid verification form (Form 1027-A)

You can request a temporary Medicaid verification form if you lose your Your Texas Benefits Medicaid Card. You need to contact your local Eligibility office or call 2-1-1 for information on getting the Temporary Medicaid verification form.

- Take your temporary verification form with you to the doctor and to get other medical care
- Show your UnitedHealthcare Community Plan ID card and your Your Texas Benefits Medicaid Card every time you go to a doctor's office or clinic
- If you move or change your phone number, call 2-1-1 or visit your local HHSC benefits office. Also call Member Services at **1-888-887-9003** so we can update our records. Call TDD/TTY: **7-1-1** for deaf and hard of hearing.



4.15.1 Medicaid Eligibility Verification (Form H1027-A)

Medicaid Eligibility Verification
Confirmación de elegibilidad para Medicaid

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

Each person listed below has applied and is eligible for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacists have 90 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filing deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.

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

BIN 610098

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

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form H3067) for the current month. I have requested and received Form H1027-A, Medical Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

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

Por este medio certifico, bajo pena de perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la Identificación para Medicaid (Forma H3067) del corriente mes. Solicité y recibí esta Confirmación de Elegibilidad Médica (Forma H1027-A) para comprobar nuestra elegibilidad para Medicaid durante el período cubierto especificado arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude y es castigado por una multa y/o la cárcel.

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

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

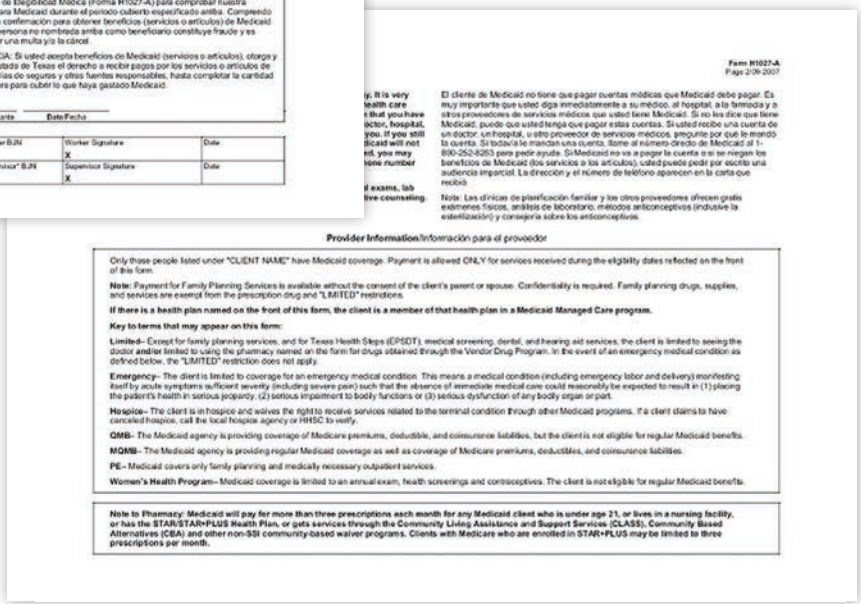
Office Address and Telephone No./Oficina y Teléfono

Name of Worker (type)/Nombre del trabajador | Worker BJN | Worker Signature X | Date

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

*or Authorized Lead Worker/o Trabajador encargado

Temporary Medicaid verification form sample – back



Form H1027-A
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El cliente de Medicaid no tiene que pagar cuentas médicas que Medicaid debe pagar. Es muy importante que usted diga inmediatamente a su médico, al hospital, a la farmacia y a otros proveedores de servicios médicos que usted tiene Medicaid. Si no les dice que tiene Medicaid, puede que usted tenga que pagar estas cuentas. Si usted recibe una cuenta de un doctor, un hospital, u otro proveedor de servicios médicos, pregunte por qué le mandó la cuenta. Si todavía le mandan una cuenta, llame al número directo de Medicaid al 1-800-252-8263 para pedir ayuda. Si Medicaid no va a pagar la cuenta o si se niegan los beneficios de Medicaid (los servicios o los artículos), usted puede pedir por escrito una audiencia imparcial. La dirección y el número de teléfono aparecen en la carta que recibió.

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

Provider Information/Información para el proveedor

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

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

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

Key to terms that may appear on this form:

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

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

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

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

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

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

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

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

Temporary Medicaid verification form sample – front

Going to the doctor

What is a Primary Care Provider (PCP)?

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

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

Always talk to your PCP when you want to visit another doctor. Your PCP will give you a referral form if you need one. Your relationship with your PCP is important. Get to know your PCP as soon as possible. It is important to follow the PCP's advice. A good way to build a relationship with your PCP is to call and schedule a checkup. You can meet your PCP then. He or she will get to know your medical history, any medications you are taking and any other health problems.

Can a specialist ever be considered a Primary Care Provider?

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

Don't forget that your PCP is the first one you call with any health problems or questions.

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

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

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

Going to the doctor

How do I pick a Primary Care Provider?

Call Member Services for help in choosing a PCP. All members of UnitedHealthcare Community Plan must pick a PCP.

You can also request a UnitedHealthcare Community Plan Provider Directory by calling Member Services at **1-888-887-9003,** or you can look online at **UHCCommunityPlan.com**.

Can a clinic be my Primary Care Provider?

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

If your doctor is a specialist, he or she might be allowed to be your PCP. If your doctor is NOT in the UnitedHealthcare Community Plan network, please call Member Services to select a PCP. If you do not pick a doctor, one will be assigned for you. UnitedHealthcare Community Plan will send you a UnitedHealthcare Community Plan ID card with your PCP's name and phone number.

What if I choose to go to another doctor who is not my Primary Care Provider?

Except in emergencies, always call your PCP before you go to another doctor or the hospital. You can reach your PCP or back-up doctor 24 hours a day, seven days a week. If you go to another doctor who is not your PCP, you may need to pay the bill.

How do I know who pays?

- If you have Medicaid and go to a Medicaid doctor, you do not have to pay the deductible or copay
- If you have Medicaid, but don't go to a Medicaid doctor, you must pay the deductible and copay, if required

What if I have another insurance?

- You can select a provider of your choice that is in network with your primary coverage, however, if that provider is not enrolled in Medicaid, you would be responsible for copays and deductibles

Please contact us at **1-888-887-9003,** TDD/TTY: **7-1-1** if you need assistance locating a provider that accepts all of your insurance coverage.

Questions about seeing a provider?

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

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

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

How can I change my Primary Care Provider?

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

How many times can I change my/my child's Primary Care Provider?

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

UnitedHealthcare Community Plan
2950 North Loop W., Suite 200
Houston, TX 77092-8843

When will my Primary Care Provider change become effective?

The PCP change will become effective the day following the change. Reasons you might change your PCP:

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

Are there any reasons why a request to change a Primary Care Provider may be denied?

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

Can a Primary Care Provider move me to another Primary Care Provider for non-compliance?

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

STAR+PLUS coverage and Medicare

How does my UnitedHealthcare Community Plan STAR+PLUS coverage affect me if I have both Medicare and STAR+PLUS?

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

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

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

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

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

Physician incentive plans

UnitedHealthcare Community Plan cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to members. 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.

What is Service Coordination?

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

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

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

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

How can I talk with a Service Coordinator?

To contact a Service Coordinator, look on your UnitedHealthcare Community Plan ID Card for the phone number. You can also call Member Services at **1-888-887-9003** to help you reach your Service Coordinator. Call TDD/TTY: **7-1-1** for deaf and hard of hearing.

What other programs are available to help me manage my chronic illness?

We have disease management programs that help members with chronic illnesses such as:

- Asthma
- COPD
- Coronary artery disease
- Diabetes
- Heart failure
- Obesity

Members in these programs receive reminders about their care and advice from a nurse. If you have a special need or need help managing a chronic illness, call **1-888-887-9003** to get in contact with your Service Coordinator.

Housing support

Safe and affordable housing can put your goals within reach. We're here to help.

- Help applying for housing help programs that may be available
- Get rental information
- Referral to shelters and prevention services
- Explain documents
- Help with landlord problems
- Learn what to do if you're going to be evicted

Make your life better with help finding food, jobs, clothing, childcare, education, legal aid and money management.

We connect you with quality services in your community

We're always here with answers to your questions. Call **1-888-887-9003.**

United Healthcare® Community Plan

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the state Medicaid program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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Did you know that you might be able to pick your own health caregiver?

UnitedHealthcare Community Plan can help you manage your home services

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

If you pick the CDS choice, you are the employer. You can hire, fire and manage your own health service providers. This can include your attendant(s), back-up attendant(s), in-home and out-of-home respite providers and habilitation providers. You have control over how your program funds are spent on salary and benefits for your employee(s). You pick a CDS agency to assist you. Your CDS agency will provide training and support to help with your employer responsibilities, pays your employees based on your budget, and files taxes for you.

Why would I want to pick CDS?

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

How does CDS work?

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

Which services can be self-directed in which programs?

Program	Services
STAR+PLUS Waiver Program (formerly known as Community-Based Alternatives)	Personal Assistance Services, Respite, Physical Therapy, Occupational Therapy, Speech/Hearing Therapy
Primary Home Care/Community Attendant Services	Personal Assistance Services

Contact your UnitedHealthcare Community Plan Service Coordinator to help you pick the best choice. He or she can tell you what services you can get. Call **1-888-887-9003** or TDD/TTY: **7-1-1** for deaf and hard of hearing.

What if I need to see a special doctor (specialist)?

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

What is a referral?

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

What services do not need a referral?

You do NOT need a referral for:

- Emergency services
- OB/GYN care
- Behavioral Health services
- Routine vision services
- Routine dental services

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

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

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

How can I ask for a second opinion?

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

Prior authorization

In some cases your provider must get permission from the health plan before giving you a certain service. This is called prior authorization. This is your provider's responsibility. If they do not get prior authorization, you will not be able to get those services.

You do not need prior authorization for advanced imaging services that take place in an emergency room, observation unit, urgent care facility or during an inpatient stay. You do not need a prior authorization for emergencies. You do not need prior authorization to see a women's health care provider for women's health services or if you are pregnant or receiving Texas Health Steps medical checkups for members under the age of 21. Emergency services do not require a prior authorization.

A prior authorization may be needed

Some services that need prior authorization include:

- Hospital admissions
- Certain outpatient imaging procedures, including PET scan imaging procedures
- Some Durable Medical Equipment services
- Some prescription medications
- Weight loss surgery
- Physical, speech and occupational therapy
- Cardiology
- Non-emergency ambulance transportation

All non-par services require a prior authorization.

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

UnitedHealthcare Community Plan covers medically necessary Substance Abuse and Behavioral Health Care services. If you have a drug problem or are very upset about something, you can get help. Call **1-888-887-9003** 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: **7-1-1,** for deaf and hard of hearing.

If it is a crisis and you have trouble with the phone line, call **9-1-1** or go to the nearest emergency room and contact UnitedHealthcare Community Plan within 24 hours.

What are Mental Health Rehabilitation Services and Mental Health Targeted Case Management? How do I get these services?

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

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

How do I find a network drug store?

Please contact Member Services for assistance at **1-888-887-9003** or look for a pharmacy on our website at **UHCCommunityPlan.com**.

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

This may affect your ability to get the medications you need. Please contact Member Services for assistance at **1-888-887-9003** or to find an in-network pharmacy. You can also look on our website at **UHCCommunityPlan.com**.

What do I bring with me to the drug store?

You will need your prescription, your UnitedHealthcare Community Plan member ID card, a Medicare card if you have one, and your Your Texas Benefits Medicaid Card. If you have coverage with another insurance plan, bring your other insurance card, too.

What if I need my medications delivered to me?

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

For a list of network pharmacies that deliver, go to this web address: **https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/findapharmacy/Texas_Listing_of_Delivery_Pharmacies.pdf**

Or

https://www.uhccommunityplan.com/tx/medicaid/star_kids > Pharmacy > Find a Pharmacy > Search for a Pharmacy > Filters and advanced search > (Select Filter) Retail pharmacy delivery.

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

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

What is a prior approval (authorization) of prescription drugs?

UnitedHealthcare Community Plan has built a pharmacy network to make getting your prescriptions easier. Your plan covers a long list of prescription medicines. For certain prescriptions, you may need prior approval. Prior approval means we need to give permission before you get a specific drug. We'll let you know if you need prior approval from us for any of your prescriptions. If you have a prescription to fill, be sure to:

- Check that your prescribed drug is on the Texas Vendor Drug Program (VDP) Medicaid Formulary, which is a list of all covered products. The Formulary, also known as the Texas Drug Code Index, is a list of all covered products, including prescription and over-the-counter drugs. The Formulary is listed on the Texas Vendor Drug website at **txvendordrug.com/formulary**. You can use the searchable formulary to search for drugs by name or type (class). Within the VDP Medicaid Formulary, there is also a Preferred Drug List (PDL), which shows which drugs the VDP recommends that your doctor try first when writing a prescription for you. See state-specific PDL here: **https://www.txvendordrug.com/formulary/prior-authorization**.

  Note: PDL for UnitedHealthcare Community Plan of Texas is managed by the Texas Health and Human Services Commission (HHSC), not UnitedHealthcare.

- HHSC develops and maintains the Medicaid PDL, and MCOs must adhere to the Medicaid PDL, which comprises medications in various therapeutic classes that are designated as either "preferred" or "non-preferred." The Medicaid PDL contains a subset of many, but not all, drugs that are on the Medicaid formulary. The Medicaid formulary is a listing of drugs, vitamins and minerals, and home health supplies available to Medicaid members as pharmacy benefits. Prescription drugs on the formulary, including the PDL, are covered at no cost to you.
- Show your member ID card at the pharmacy when you get your prescriptions filled
- If you have other primary insurance, show both your primary insurance and your Medicaid insurance at the drug store. The drug store should bill the primary insurance first, then your Medicaid insurance. Medicaid is the payer of last resort and should not be the only card presented to the pharmacy. This confirms your eligibility and helps the pharmacy in processing your claim.

If you have questions about your prescription drugs, ask your PCP or call member services at the number on the back of your member ID card.

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

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. For a list of covered medications, please visit **UHCCommunityPlan.com**.

What if I lose my medications?

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

How do I get my medications if I am in a Nursing Facility?

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

What if I also have Medicare?

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

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

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

For more information about these benefits or questions about whether your pharmacy provides DME or other supplies, call UnitedHealthcare Community Plan at **1-888-887-9003.**

What if I need Durable Medical Equipment (DME) that requires Prior Authorization?

DME must be medically necessary to help improve daily life activities or improve a health condition due to an illness, injury, or disability. First, discuss the need with your doctor. Your doctor can help determine if it is medically necessary and prepare the documents needed. Next, you will need to select an In-Network DME provider of choice. Your DME provider will work with your doctor to gather information to submit to the health plan for review. Lastly, the health plan will determine if medical necessity criteria has been met for approval. For more information, call Member Services at **1-888-887-9003** or your Service Coordinator at **1-800-349-0550.**

Please note: Durable Medical Equipment must be safe for use in the home.

What is the Medicaid Lock-in Program?

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

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

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

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

Who do I call if I have special health care needs and I need someone to help me?

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

What if I need OB/GYN care? Will I need a referral?

Attention female members: UnitedHealthcare Community Plan allows you to pick any OB/GYN, whether that doctor is in the same network as your Primary Care Provider or not. The OB/GYN you pick must be in the UnitedHealthcare Community Plan Provider Network.

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

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

Going to the doctor

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

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

Do I have the right to choose an OB/GYN as my Primary Care Provider?

If your OB/GYN is willing to be your Primary Care Provider, have them contact our Member Services team at **1-888-887-9003.**

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

If you are past the 24th week of your pregnancy, you can keep seeing your current OB/GYN through the postpartum checkup, even if the provider is Out-of-Network. If you want to change to an in-network OB/GYN, you are allowed to do so if the Provider agrees to accept you in the last trimester of your pregnancy. For questions, please contact UnitedHealthcare Community Plan Member Services at **1-888-887-9003.** UnitedHealthcare Community Plan will arrange for you to continue treatment with the OB/GYN doctor you have been seeing. The doctor may also contact UnitedHealthcare Community Plan to see if they can become one of our providers.

If you are not pregnant or are not in the last 3 months of your pregnancy, you may choose any OB/GYN within the UnitedHealthcare Community Plan network. If you see a doctor who is not in our Network, you may be responsible for any charges. If you need a provider list, please call Member Services. You can call us for help in picking an OB/GYN doctor at **1-888-887-9003.**

How do I choose an OB/GYN?

Call Member Services at **1-888-887-9003** for help choosing an OB/GYN. You can also request a UnitedHealthcare Community Plan Provider Directory by calling Member Services at **1-888-887-9003,** or you can look online at **UHCCommunityPlan.com**.

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

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

Will I need a referral for OB/GYN services?

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

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

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

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

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

If you are or may be pregnant:

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

Here's how:

- Make an appointment with an OB/GYN. You should try to visit in the next 10 days (or as soon as possible) for your first prenatal visit.
- The OB/GYN you select MUST be in our provider network
- It is important for pregnant women to see their doctor many times while pregnant, even if this is not your first child
- If you do not have an OB/GYN already, please call Member Services at **1-888-887-9003**

Where can I find a list of birthing centers?

To find a birthing center, call UnitedHealthcare Community Plan at **1-888-887-9003.**

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

Pregnant women not only get Case Management Services through our Healthy First Steps Program, but they get special services too. Pregnant women will be sent a book that is a guide to pregnant members and offers information on several pregnancy topics. You do not need prior authorization to see a women's health care provider for women's health services or if you are pregnant or receiving Texas Health Steps medical checkups for members under the age of 21. Emergency services do not require a prior authorization. All pregnant women will also be invited to attend our Baby Showers. Members and their guests are invited to join us for the Baby Showers where we offer prizes, refreshments, and educational information on pregnancy subjects such as the Healthy First Steps Program, Texas Health Steps, common discomforts of pregnancy and pre-term labor.

Can I pick a Primary Care Provider for my baby before the baby is born?

Yes. You can pick a PCP for your baby from the list of UnitedHealthcare Community Plan STAR doctors at any time before your baby is born. It is a good idea so you can get to know the doctor. Call Member Services if you want help picking a PCP for your baby.

How and when can I switch my baby's Primary Care Provider?

You can change your baby's PCP the same way you change your PCP. Call Member Services at **1-888-887-9003** if you want to change your baby's PCP.

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

Call UnitedHealthcare Community Plan Member Services at **1-888-887-9003** and let us know about your new baby as soon as your baby is born. In addition, ask for a Healthy First Steps Nurse. Call the Texas Health and Human Services Commission (caseworker) at 1-800-252-8263 to apply for Temporary Assistance for Needy Families (TANF) if you need help with buying food for you and your baby.

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

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

Healthy Texas Women Program

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

Healthy Texas Women Program
P.O. Box 14000
Midland, TX 79711-9902

Phone: 1-800-335-8957
Website: **https://www.healthytexaswomen.org/**
Fax (toll-free): 1-866-993-9971

DSHS Primary Health Care Program

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

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

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

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

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at **https://www.dshs.texas.gov/services-near-you**.

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

Website:
https://www.hhs.texas.gov/services/health/primary-health-care-services-program
Phone: 512-776-7796
Email: **PPCU@dshs.state.tx.us**

DSHS Expanded Primary Health Care Program

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

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at **https://www.dshs.texas.gov/services-near-you**.

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

Phone: 512-776-7796
Fax: 512-776-7203
Email: **PPCU@dshs.state.tx.us**

DSHS Family Planning Program

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

To find a clinic in your area, visit the DSHS Family and Community Health Services Clinic Locator at **https://www.dshs.texas.gov/services-near-you**.

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

Website:
https://www.healthytexaswomen.org/healthcare-programs/family-planning-program/
Phone: 512-776-7796
Fax: 512-776-7203
Email: **PPCU@dshs.state.tx.us**

How do I make appointments?

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

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

When you go to your appointment, always take your UnitedHealthcare Community Plan member ID Card, your Your Texas Benefits Medicaid Card, any other medical, insurance cards you may have, a list of problems you are having, and a list of all drugs or herbal medications you are taking.

How do I get medical care after my Primary Care Provider's office is closed?

If your PCP's office is closed, your PCP will have a number you can call 24 hours a day and on weekends. It is best to call your PCP as soon as you need health care. Do not wait until the evening or a weekend to call your PCP if you can get help during the day. Your illness might get worse as the day goes on. If you get sick during the night or on a weekend and cannot wait for help, call your PCP at the phone number on the front of your ID card. If you cannot reach your PCP or want to talk to someone while you wait for the PCP to call you back, call NurseLine at 1-877-839-5407 to talk to a nurse. Our nurses are ready to help you 24 hours a day, 7 days a week. If you think you have a real emergency, call **9-1-1** or go to the nearest Emergency Room.

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

If you need medical care when traveling, call us toll-free at **1-888-887-9003** and we will help you find a doctor. If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-888-887-9003.**

What if I am out of the state?

If you have an emergency out-of-state, go to the nearest emergency room for care. If you get sick and need medical care while you are out-of-state, call your UnitedHealthcare Community Plan PCP. Your PCP can tell you what you need to do if you are not feeling well.

If you visit a doctor or clinic out-of-state, they must be enrolled in Texas Medicaid to get paid. Please show your Your Texas Benefits Medicaid Card and UnitedHealthcare Community Plan ID card before you are seen. Have the doctor call UnitedHealthcare Community Plan for an authorization number. The phone number to call is on the back of your UnitedHealthcare Community Plan card.

What if I am out of the country?

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

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office by calling 2-1-1, and UnitedHealthcare Community Plan Member Services at **1-888-887-9003.** Before you get Medicaid services in your new area, you must call UnitedHealthcare Community Plan, unless you need emergency services. You will continue to get care through UnitedHealthcare Community Plan until HHSC changes your address.

What if I want to change health plans?

You can change your health plan by calling the Texas STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want.

Who do I call?

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

How many times can I change health plans?

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

When will my health plan change become effective?

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

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

Can UnitedHealthcare Community Plan ask that I get dropped from their health plan (for non-compliance, etc.)?

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

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

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

Language and interpreter services

UnitedHealthcare Community Plan has staff that speaks English and Spanish. If you speak another language or are deaf and hard of hearing and need help, call Member Services at **1-888-887-9003** or TDD/TTY: **7-1-1** for deaf and hard of hearing. You can also contact your Service Coordinator by calling **1-888-887-9003.**

Can someone interpret for me when I talk with my doctor? Who do I call for an interpreter? How far in advance do I need to call?

It is your right to talk with your doctor in the language you prefer. UnitedHealthcare Community Plan can arrange interpreter services for you. Please call **1-888-887-9003** if you need a translator. Call TDD/TTY: **7-1-1** for deaf and hard of hearing. Please call as soon as you make your appointment or at least 24 hours in advance.

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

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

What does Medically Necessary mean?

1. For members birth through age 20, the following Texas Health Steps services:
   a. Screening, vision, and hearing services; and
   b. Other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
      (i) Must comply with the requirements of the Alberto N., et al. v. Traylor, et al. partial settlement agreements; and
      (ii) May include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.
2. For members over age 20, non-behavioral health-related health care services that are:
   a. Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
   b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
   c. Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
   d. Consistent with the diagnoses of the conditions;
   e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   f. Are not experimental or investigative; and
   g. Are not primarily for the convenience of the member or provider; and
3. For members over age 20, behavioral health services that:
   a. Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
   b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
   c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
   d. Are the most appropriate level or supply of service that can safely be provided;

e. Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;

f. Are not experimental or investigative; and

g. Are not primarily for the convenience of the member or provider.

What is emergency medical care?

Emergency medical care

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

Emergency medical condition means:

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

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

Emergency behavioral health condition means:

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

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

Emergency services and emergency care means:

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

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

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

What is post-stabilization?

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

What is urgent medical care?

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

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

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

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes UnitedHealthcare Community Plan Medicaid. For help, call us toll-free at **1-888-887-9003.** You also can call our 24-hour Nurse HelpLine at **1-888-887-9003** for help with getting the care you need.

How soon can I expect to be seen?

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

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

If you need a physical checkup, then the visit is **routine**. Your doctor should see you within 14 days. UnitedHealthcare Community Plan will be happy to help you make an appointment, just call us at **1-888-887-9003.**

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

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

Are emergency dental services covered by UnitedHealthcare Community Plan?

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

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

UnitedHealthcare Community Plan also covers dental services your child gets in a hospital or ambulatory surgical center including other services your child might need, like anesthesia.

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

During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, call us toll-free at **1-888-887-9003** or call **9-1-1.**

What dental services does UnitedHealthcare Community Plan cover for children?

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

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

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

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

How do I get dental services for my child?

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

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

DentaQuest: 1-800-516-0165

MCNA Dental: 1-855-691-6262

UnitedHealthcare Dental: 1-877-901-7321

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

How do I get eye care services?

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

Benefits and services

What are my health care benefits?

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

- Ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral health services
- Birthing services
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Counseling services for adults
- Dialysis
- Drugs and biologicals provided in an inpatient setting
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency services
- Family planning services
- Home health care services
- Hospital services, inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures
- Medical checkups and Comprehensive Care Program (CCP) Services for children through the Texas Health Steps Program
- Optometry, glasses, and contact lenses, if medically necessary
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Outpatient drugs and biologicals
- Physical, occupational and speech therapies
- Podiatry

- Prenatal care
- Preventive services including an annual adult well check for patients 21 years of age and over
- Primary care services
- Psychiatry services
- Radiology, imaging, and X-rays
- Specialty physician services
- Substance use disorder treatment services
- Transplantation of organs and tissues
- Vision

How do I get these services?

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

Are there any limits to any covered services?

There may be limitations to some of the covered services. If you would like more details, contact Member Services at **1-888-887-9003.**

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

People covered by Medicaid who are eligible for STAR+PLUS and live in a Nursing Facility will get their basic health services (acute care) and long-term care services through STAR+PLUS. People who get both Medicaid and Medicare (dual eligible) will get their basic health services through Medicare and their long-term care services through STAR+PLUS Medicaid.

What services am I eligible for as a Medicaid Breast and Cervical Cancer (MBCC) member?

MBCC members are eligible for all benefits under the STAR+Plus program, including specialty care, oncology and Service Coordination.

What are LTSS and how do I get these services?

Long-Term Services and Supports (LTSS) are services provided by health care professionals who offer direct in-home and community-based services for elderly people and persons with disabilities. Contact Member Services at **1-888-887-9003** to ask for these services.

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

Long-term services and supports can include:

- Day Activity and Health Services (DAHS)
- Primary Home Care (PHC)
- Community First Choice (attendant care, habilitation, emergency response services and support management)

Other services under the STAR+PLUS Home and Community-Based Services Waiver include:

- Personal assistance services
- Adaptive aids
- Adult foster care home services
- Assisted living
- Emergency response services
- Home delivered meals
- Medical supplies
- Minor home modifications (making changes to your home so you can safely move around)
- Nursing services
- Respite care (short-term care to provide a break for caregivers)
- Therapies (occupational, physical, and speech-language)
- Transitional assistance services

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

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

What are my acute care benefits?

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

Hospital care inpatient:

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

Outpatient hospital care:

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

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

Walk-in surgery centers:

- Minor surgery not requiring a hospital stay

Professional services:

- Office visits for regular care including:
  - Care to prevent illness (annual physical for adults)
  - Regular medical care
  - Shots to prevent sickness (immunization)
  - 12 Chiropractic service visits per year
  - Podiatry services
- Laboratory and X-ray services, including tests to prevent birth defects
- Genetic services
- Hearing examinations and medically necessary hearing aids
- Emergency dental services
- Dialysis for kidney problems
- Family planning services
- Licensed professional counselors, social workers, and mental health services
- Eye doctor services – Children under 21 years old can get one eye exam each state fiscal year (September 1 through August 31)

Other services:

Rural health clinic services, including:

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

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

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

Call Member Services at **1-888-887-9003** for questions on how to get these services or visit **myuhc.com** for a comprehensive and most up-to-date benefits offerings.

What services are not covered?

If you want to know if a procedure or medication is covered under STAR+PLUS, ask your PCP or call Member Services at **1-888-887-9003.** Call TDD/TTY: **7-1-1**, for deaf and hard of hearing.

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

What are my prescription drug benefits?

Contact Member Services for more information on your prescription benefits.
For more information, please refer to page 29 of this Member Handbook.

Family planning

How can I get family planning services? Do I need a referral for this?

You can go to your PCP or any doctor or Family Planning clinic that takes Medicaid to help you with family planning. You do not need a referral. Tell your PCP where you are going so your records can be kept up to date. Family Planning Services are very private. You do not have to worry about anyone else knowing that you are going there.

Providers and family planning agencies cannot require parental consent for minors to receive family planning services.

Where do I find a family planning services provider?

You can find the locations of family planning providers near you online at **https://www.healthytexaswomen.org/find-a-doctor**, or you can call UnitedHealthcare Community Plan Member Services at **1-888-887-9003** for help in finding a family planning provider.

What if I am a migrant farmworker?

Children of Migrant Farmworkers can receive a Texas Health Steps medical checkup before it is due. You can get your checkup sooner if you are leaving the area. The appointment should be made and the exam done before leaving the area. You can call **1-888-887-9003** for help setting up the appointment. This is a benefit only to children of Migrant Farmworkers and is considered an "accelerated" service under Texas Health Steps, or one that is given before it is actually due. Please call us and let us know if anyone in your family works as a Migrant Farmworker.

Other plan details

What extra benefits do I get as a member of UnitedHealthcare Community Plan?

Value-added services

As a member of UnitedHealthcare Community Plan, you can also receive value-added services. These unique services are offered, in addition to the required Medicaid services, starting September 1 through August 30, to benefit your health and everyday life. For a comprehensive and the most up-to-date Value-added services offerings please go to **myuhc.com**. Some of the value-added services that UnitedHealthcare Community Plan offers are:

Help getting a ride

As a part of your UnitedHealthcare transportation benefits, you may also be eligible for additional transportation assistance to health needs not currently covered by Medicaid. For example, rides to grocery stores, housing and utility offices.

Terms: Get 4 round-trip rides for non-Medicaid health needs. Like grocery, housing, or utility visits. Ages 0–17 ride with an adult. Book with SafeRide at **1-888-462-6050.**

Tips for when you call to schedule a ride:

- Call to schedule at least 2 days before the appointment
- UnitedHealthcare member ID
- Provider's name
- Provider's address
- Provider's phone number
- Appointment time

Extra dental services for adults

Up to $500 annually for members ages 21–120.

- Two routine exams/cleanings
- One set of X-rays
- One scaling/root planning (if medically necessary)

Terms: Must use in-network provider. Excludes Dual Eligible members and members in Medicaid waivers.

Extra vision services

Get $105 every 24 months. For frames, lenses, or contacts not covered by Medicaid.

Terms: Must use in-network provider March Vision. Up to $105 every 24 months if not covered by the Medicaid benefit. Cannot be used for a second or spare pair. Excludes Dual Eligible members.

Diabetes and other disease management

OTC Diabetic reward

$15 Rewards Card. Get OTC items such as diabetic insoles.

Terms: Member must have a diagnosis of Diabetes. One time per year.

Text reminders for medicine

Access to the Optum Member Portal. Schedule text reminders for your meds online.

Terms: Members need a computer, tablet or smartphone to access the site.

*Each state fiscal year, 9/1-8/31.

Daily health reward

$20 Rewards Card to be used on items like pill organizer and notebook to keep track of health.

Terms: One time per year.* Excludes Dual Eligible members.

Body weight scale

One body weight scale per year* for members under disease management with a diagnosis of congestive heart failure.

Terms: Members under active disease management with a diagnosis of congestive heart failure. Excludes Dual Eligible members.

Help for members with asthma or COPD

Pest control reward

$20 Rewards Card to be used on home improvement items, such as pest control plug-ins.

Terms: Limited to members who are under case management for asthma or COPD. Excludes Dual Eligible members. One time per year.*

Assistance for asthmatics or COPD

$25 Rewards Card for indoor air quality items such as fans, air filters, or humidifiers.

Terms: Members must be under disease management program for asthma or COPD. One $25 Rewards Card per year.* Excludes Dual Eligible members.

*Each state fiscal year, 9/1-8/31.

Community living assistance

Emergency Response Services (ERS)

Eligible members may have access to an electronic monitoring system, which includes 24 hours a day, seven days a week monitoring that helps ensure the appropriate person or service agency is contacted in emergencies.

Terms: 24/7 ERS. Up to 6 months after discharge from a hospital or nursing facility. Excludes members who are not in a waiver program, Community First Choice members and Dual Eligible members.

Respite care services (home visits)

Up to 8 hours per calendar year of in-home respite services for members who are not in the STAR+PLUS Waiver.

Terms: Must use in-network provider.

$60 Healing food help

$60 Rewards Card to be used on healthy food.

Terms: For members who get out of a hospital stay of 2 or more days. Excludes STAR+PLUS Waiver members. One time per year.*

Welcome home kit

One Welcome Home Kit upon returning home from a Nursing Facility stay.

Terms: Includes 1 Welcome Home Kit per year.* Excludes Dual Eligible members.

*Each state fiscal year, 9/1-8/31.

Healthy living and exercise

Online wellness coaching program

Members can get weight loss and exercise tips, and resources. Available online at **myuhc.com**.

Terms: Need a computer, tablet or smartphone to access.

Food fitness reward

$40 Rewards Card to be used on healthy food and fitness items.

Terms: One time per year.* Excludes Dual Eligible members.

Behavioral Health

Online mental health resources

LiveandWorkWell.com has news, videos, legal resources, and you can find doctors and other care.

Terms: Need a tablet, computer, or smartphone to access. In English and Spanish.

CALM Health app

Get help anytime for stress and wellbeing. Available 24/7 on a website you can use at your own pace.

Terms: Need a computer, tablet or smartphone to access.

Inpatient follow-up incentive

$20 Rewards Card. For members who follow-up with a mental health practitioner.

Terms: Must be within 7 days of discharge from an inpatient mental health hospital. Excludes Dual Eligible members. One $20 gift card per year.*

*Each state fiscal year, 9/1-8/31.

Mindfulness journal

One mental health journal per year. Includes a list of resources related to mental health where members can write down and work on their feelings using writing ideas.

Terms: One per year.*

Gift programs

Creative Fun Kit

Creative Fun Kit with word search, crossword, and Sudoku activity books. Includes colored pencils, and coloring books.

Terms: Limited to one set per year.*

NOAA/FM/AM emergency radio

A NOAA/FM/AM radio that helps you stay connected during bad weather or a disaster. Includes cellphone charger and flashlight.

Terms: One radio per year.*

Menopause book

A "Generation M" menopause book. For members 31–65 who have symptoms of perimenopause or menopause.

Terms: One book per year.*

Online enrollment reward

$15 Rewards Card for new members who sign up for **myuhc.com**.

Terms: Must sign up within the first 30 days of enrollment with UHC. One time per year.*

*Each state fiscal year, 9/1–8/31.

Extra help for pregnant members

Prenatal mom support

Members can use **myuhc.com** or app to get info and tools to learn about their pregnancy. May earn rewards for doctor visits.

- $25 for going to a prenatal visit

Postpartum mom support

Members can use **myuhc.com** or app to get info and tools to learn about their postpartum care. May earn rewards for doctor visits.

- $25 for going to a postpartum visit

Wellhop

Wellhop for Mom & Baby helps moms-to-be with similar due dates. They can chat online, learn new things, and support each other from pregnancy to early motherhood.

Terms: Pregnant members can enroll in Wellhop online.

Blood pressure monitor

One electronic Blood Pressure cuff for pregnant members.

Terms: Eligible pregnant members with or at risk of high blood pressure. Service coordinators check need. Excludes Dual Eligible members. One per pregnancy.

Health and wellness services

Sensory products

$35 gift certificate for sensory goods.

Terms: For eligible members with sensory processing disorder. Service coordinator checks need. One $35 gift card per year.* Excludes Dual Eligible members.

*Each state fiscal year, 9/1-8/31.

Vaping programs

Members who vape can get help to stop. Education and support are available through an online program.

Terms: Need a computer, tablet, or smartphone to access.

Second hearing aid

Members ages 21–120 with a Medicaid hearing aid can get a second one at no cost.

Terms: Members 21–120. Available every 5 years. A prescription is needed. Excludes Dual Eligible members.

Online health information chats

Online health information chats. Staffed by health professionals who answer your questions 24 hours a day, 7 days a week, for every day of the year.

Help for members with intellectual or developmental disabilities (IDD)

Location assistance

$30 gift certificate for ID bracelets and other items to help members who may get lost, confused, or cannot ask for help.

Terms: Service Coordinator checks need. One $30 gift card per year.*

Washable period underwear

Three pairs of washable period underwear.

Terms: Members with Intellectual or Developmental Disability (IDD) diagnosis. One set per year*

How do I get these benefits?

Call Member Services at **1-888-887-9003,** TDD/TTY: **7-1-1,** for questions on how to get these services.

*Each state fiscal year, 9/1–8/31.

What health education classes does UnitedHealthcare Community Plan offer?

UnitedHealthcare Community Plan can refer you to Health Education classes such as parenting courses and classes to help you quit smoking. Please call your Service Coordinator at **1-888-887-9003** for more information about Health Education.

What other services can UnitedHealthcare Community Plan help me get?

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

- Case Management for children and pregnant women – Visit the website below to learn more: **https://www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women**
- Prescription drugs
- Texas Health Steps dental services
- Tuberculosis (TB) clinics
- Women, Infants and Children Services (WIC)
- Early Childhood Intervention (ECI)
- Services by federal or state hospital doctors
- Mental Health and Mental Retardation (MHMR) Case Management
- Mental Retardation Diagnostic Assessment (MRDA)
- Mental health rehabilitation
- Texas School Health and Related Services (SHARS)
- Texas Commission for the Blind (TCB)

What is Case Management for children and pregnant women?

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

Who can get a Case Manager?

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

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

What do Case Managers do?

A Case Manager will visit with you and then:

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

What kind of help can you get?

Case Managers can help you:

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

How can you get a Case Manager?

For more information contact Member Services at **1-888-887-9003,** TDD/TTY: **7-1-1,** go online by visiting **UHCCommunityPlan.com**, or call Texas Health Steps at 1-877-847-8377 (toll-free), 8:00 a.m.–8:00 p.m., Monday–Friday.

To learn more, go to: **https://www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women**.

Early Childhood Intervention (ECI)

What is Early Childhood Intervention?

ECI means Early Childhood Intervention, a federally mandated program for infants and toddlers under the age of three (0–36 months) with developmental delays or disabilities. ECI services are unique because:

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

Do I need a referral for this?

Anyone can make a referral (a parent, family member, health care professional, social worker, caregiver, friend or neighbor). To find an ECI provider, visit **https://www.hhs.texas.gov/services/disability/early-childhood-intervention-services** or contact your Service Coordinator for assistance at **1-877-352-7798**. A child who already has a medically diagnosed condition, which has a high probability of resulting in a developmental delay, automatically qualifies for ECI. Contact your Service Coordinator for assistance at **1-877-352-7798.**

Where do I find an ECI provider?

All of the professionals in ECI have expertise in working with babies, toddlers and their families. To find an ECI provider, visit **https://www.hhs.texas.gov/services/disability/early-childhood-intervention-services** or contact your Service Coordinator for assistance at **1-877-352-7798.** Licensed and/or credentialed specialties include:

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

If I do not have a car, how can I get a ride to the doctor's office? Who do I call for a ride to a medical appointment?

Transportation

Non Emergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provide transportation to nonemergency health care appointments for members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

What services are part of NEMT Services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus
- Commercial airline transportation services
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services

If you need an attendant to travel to your appointment with you, NEMT services will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15–17 years old must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adults on file to travel alone. Parental consent is not required if the health care service is confidential in nature.

How to get a ride?

Your MCO will provide you with information on how to request NEMT services. You should request NEMT Services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances you may request the NEMT service with less notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours. You must notify your MCO prior to the approved and scheduled trip if your medical appointment is canceled.

Call the **Where's My Ride Hotline** at **1-888-462-6050,** TTY **711,** 8:00 a.m.–5:00 p.m., Monday–Friday to discuss your NEMT transportation needs.

Additional member responsibilities while using NEMT Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT Services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT Services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets o tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

What are in-lieu-of services and settings?

In-lieu of services are services that are provided to you in place of other services that you may not need nor want. In this section, we will explain what in-lieu of services are and how they may benefit you.

In-lieu of services are different services that can be provided to you in a setting, approved by Health and Human Services, instead of a hospital. These alternative services may be more convenient for you and better suited to your individual needs. For example, a Partial Hospitalization Program, or PHP for short, is like a middle step between staying in the hospital and going home. It's a special program that happens during the day at a psychiatric hospital. The program is very organized and follows a set schedule typically between 9 a.m. until 3 p.m. Furthermore, Intensive Outpatient Services, also called IOP, are a bit like a smaller version of a PHP. They're still very structured but reduced to 10 hours a week for a 4- to-12-week period. This is considered more intensive and structured than normal outpatient psychiatric services.

It is important to note that in-lieu of services are not a replacement for regular services covered by your plan. If you have a medical condition that requires a certain type of treatment, you should still receive that treatment through your plan. However, if you feel that an in-lieu of service would be a better fit for you, please do not hesitate to contact us to discuss.

What happens if I lose my Medicaid coverage?

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

What do I have to do if I need help with completing my renewal application?

Call UnitedHealthcare Community Plan or 2-1-1 for help with renewing an application.

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

What if I get a bill from my doctor? Who do I call? What information will they need?

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

If you still get a bill, call Member Services at **1-888-887-9003** 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 do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and UnitedHealthcare Community Plan Member Services at **1-888-887-9003.**

Before you get Medicaid services in your new area, you must call UnitedHealthcare Community Plan, unless you need emergency services. You will continue to get care through UnitedHealthcare Community Plan until HHSC changes your address.

What if I have other health insurance in addition to Medicaid?

Medicaid and private insurance

You are required to tell Medicaid staff about any private health insurance you have.

You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

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

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

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

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

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

Complaints and appeals

What should I do if I have a complaint?

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

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

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you can get on the Internet, you can submit your complaint at: **https://www.hhs.texas.gov/contact/complaints-appeals/hhs-office-ombudsman/ombudsman-frequently-asked-questions**.

Who do I call?

Call UnitedHealthcare Community Plan Member Services for help at **1-888-887-9003,** TDD/TTY: **7-1-1,** for deaf and hard of hearing.

Where can I mail a complaint?

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

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

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

There is no time limit on filing a complaint with UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan will send you a letter telling you what we did about your complaint.

How long will it take to process my complaint?

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

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

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

What can I do if my doctor asks for a service or medicine that is covered but UnitedHealthcare Community Plan denies or limits it?

UnitedHealthcare Community Plan will send you a letter if a covered service that you requested is not approved or if payment is denied in whole or in part. If you are not happy with our decision, call UnitedHealthcare Community Plan within 60 days from when you get our letter.

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

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

How will I find out if services are denied?

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

What are the time frames for the appeal process?

UnitedHealthcare Community Plan must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a member; or the MCO shows that there is a need for more information and how the delay is in the member's interest. If the MCO needs to extend, the member must receive written notice of the delay.

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

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

Does my appeal request have to be in writing?

Your request does not have to be in writing. If you would like to send in a written appeal you can mail written requests to:

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

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

Member Services is available to help you file a complaint or an appeal. You can ask them to help you when you call **1-888-887-9003.**

What happens after my appeal?

You will get a letter telling you what the appeal decided, if your services will change and when, and any other choices you may have. Member's option to request an External Medical Review and State Fair Hearing no later than 120 Days after the date the MCO mails the appeal decision notice. Member's option to request only a State Fair Hearing Review no later than 120 Days after the MCO mails the appeal decision notice. You may have to pay for the services you get while your appeal is being decided if you do not win the appeal. UnitedHealthcare will not recover costs for services you received without written permission from HHSC.

What is an emergency appeal?

An emergency 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 emergency 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 emergency appeal," or "I feel my health could be hurt by waiting for a standard decision." To request a quick decision by phone, call UnitedHealthcare Community Plan Member Services at **1-888-887-9003.**

Does my request have to be in writing?

We can record your verbal request. Your request does not have to be in writing. Your request will then be made into a written request. If you would like to mail in your appeal request you can mail written requests to:

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

What are the time frames for an emergency appeal?

UnitedHealthcare Community Plan must decide this type of appeal within 1 Business Day or 72 hours from the time we get the information and request. If your appeal is for ongoing emergency or you were denied continued stay in the hospital, we must complete the appeal within 1 Business Day.

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

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

Who can help me file an emergency appeal?

If you are in the hospital, ask someone to help you mail, fax, or call in your request for this type of appeal. You may also call UnitedHealthcare Community Plan Member Services at **1-888-887-9003** and ask someone to help you start an appeal or ask your doctor to do it for you. If you go through this process, and the services you asked for after appeal and State Fair Hearing is denied, you may have to pay for those services.

State Fair Hearing

Can I ask for a State Fair Hearing?

If you, as a member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative.

If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter with the internal appeal decision.

If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should call UnitedHealthcare Community Plan at **1-800-288-2160** or send a letter to the health plan at:

UnitedHealthcare Community Plan
Attn: Fair Hearings Coordinator
2950 North Loop W., Suite 200
Houston, TX 77092-8843

You have the right to keep getting any service, including an in-lieu-of service and settings, the health plan denied or reduced, based on previously authorized services, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of: (1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or (2) the day the health plan's internal appeal decision letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped.

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

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

If you go through this process, and the services you asked for after appeal and fair hearing is denied, you may have to pay for those services.

If you lose the State Fair Hearing appeal, UnitedHealthcare Community Plan might be able to recover the costs of the service or benefit you received while the appeal was pending. UnitedHealthcare will not recover costs for services you received during the appeal or State Fair Hearing without written permission from HHSC.

Can I ask for an emergency State Fair Hearing?

If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling UnitedHealthcare Community Plan. To qualify for an emergency State Fair Hearing through HHSC, you must first complete UnitedHealthcare Community Plan's internal appeals process.

External Medical Review information

Can a member ask for an External Medical Review?

If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the member can take to get the case reviewed before the State Fair Hearing occurs. The member may name someone to represent them by contacting the health plan and giving the name of the person the member wants to represent him or her. A provider may be the member's representative.

The member or the member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the External Medical Review within 120 days, the member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the member or the member's representative may either:

- Fill out the "State Fair Hearing and External Medical Review Request Form" that came with the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to:

  UnitedHealthcare Community Plan
  Attn: Fair Hearings Coordinator
  2950 North Loop W., Suite 200
  Houston, TX 77092-8843

  Fax: 1-855-322-0672

- Or call UnitedHealthcare by using the address or fax number at the top of the form
  - Call UnitedHealthcare at **1-800-288-2160**
  - Email UnitedHealthcare at **uhctx_fairhearings_appeals@uhc.com**

If the member asks for an External Medical Review within 10 days from the time the member gets the appeal decision from the health plan, the member has the right to keep getting any service, including an in-lieu-of service and setting, the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the member does not request an External Medical Review within 10 days from the time the member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The member may withdraw the member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the member has the right to withdraw the State Fair Hearing request. The member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling UnitedHealthcare Community Plan. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete UnitedHealthcare's internal appeals process.

Advance Directives

What are Advance Directives?

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

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

How do I get an Advance Directive?

Contact your PCP or call Member Services at **1-888-887-9003.** Call TDD/TTY: **7-1-1,** for deaf and hard of hearing.

Who has the right to make health care decisions?

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

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

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

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

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

What are my options for making an Advance Directive?

Under Texas law, you can make the following directives:

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

Must my Advance Directive be followed?

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

Must a lawyer prepare my Advance Directive?

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

Who should have a copy of my Advance Directive?

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

Do I have to make an Advance Directive?

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

Can I change or cancel my Advance Directive?

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

What if I already have an Advance Directive?

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

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

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

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

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

a. You have appointed that person to make health care decisions for you in a Durable Power of Attorney for Health Care.

b. A court has appointed that person as your guardian to make health care decisions for you.

c. You have stated in an Advance Directive that you do not want this specific treatment. If you need any help in learning about Advance Directives, or to order a copy of a Living Will, call Member Services at **1-888-887-9003.**

Member rights and responsibilities

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

Member rights:

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

5. If your MCO offers in-lieu-of services and settings, you have the right to:
   a. Be given information about the in-lieu-of services and settings you can get and how to request them.
   b. Be told why any in-lieu-of services and settings were reduced or denied.
   c. Choose to refuse to receive in-lieu-of services and settings instead of other Covered Services.
6. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for a an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
7. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
8. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.

9. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
10. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
11. You have a right to make recommendations to your health plan's member rights and responsibilities.

Member responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a Primary Care Provider quickly.
   c. Make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your Primary Care Provider first for your non-emergency medical needs.
   g. Be sure you have approval from your Primary Care Provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your Primary Care Provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.
   f. Must follow agreed upon plans and instructions for care

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

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

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

- Information about network providers – at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients and, when applicable, professional qualifications, specialty, medical school attended, residency completion and board certification status.
- Member has a right to receive info about the organization, its services, its practitioners and providers and member rights
- Any limits on your freedom of choice among network providers
- Your rights and responsibilities
- Information on complaint, appeal, External Medical Review and State Fair Hearing procedures
- Information about benefits available under the Medicaid program, including amount, duration and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- Information about in-lieu-of services and settings, if offered by your MCO, including amount, duration and scope of benefits and the policy on referrals.

- How you get benefits including authorization requirements
- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits
- How you get after hours and emergency coverage and limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services and post-stabilization services
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services
  - How to get emergency services, including instructions on how to use the **9-1-1** telephone system or its local equivalent
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid
  - A statement saying you have a right to use any hospital or other settings for emergency care
  - Post-stabilization rules
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider
- UnitedHealthcare Community Plan practice guidelines

UnitedHealthcare Community Plan must provide information to members on how it evaluates new technology for inclusion as a covered benefit. UnitedHealthcare reviews new procedures and devices to decide if they are safe and effective for members. If they are found to be safe and effective, they may become covered. If new technology becomes a covered service, it will follow plan rules, including medical necessity. It may publish this information in newsletters, member handouts or other member materials. If a newsletter is the chosen method, UnitedHealthcare Community Plan must publish this information annually.

You have the right to respect and dignity, including freedom from abuse, neglect, and exploitation

What are abuse, neglect, and exploitation?

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

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

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

Reporting abuse, neglect, and exploitation

The law requires that you report suspected abuse, neglect, or exploitation, including unapproved use of restraints or isolation that is committed by a provider.

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

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

Report to the Health and Human Services Commission (HHSC) by calling **1-800-458-9858** if the person being abused, neglected, or exploited lives in or receives services from a:

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

Suspected abuse, neglect or exploitation by an HCSSA must also be reported to the Department of Family and Protective Services (DFPS). Report all other suspected abuse, neglect, or exploitation to DFPS by calling 1-800-252-5400.

Report electronically (non-emergency)

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

Helpful information for filing a report

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

Fraud and abuse

Do you want to report waste, abuse, or fraud?

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit **https://oig.hhs.texas.gov/** and click on "Report Fraud" to complete an online form; or
- You can report directly to your health plan:

  UnitedHealthcare Community Plan Compliance
  2950 North Loop W., Suite 200
  Houston, TX 77092-8843
  1-888-887-9003

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

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

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

When reporting about someone who gets benefits, include:

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

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Glossary of managed care terminology

Appeal: A request for your managed care organization to review a denial or a grievance again.

Complaint: A grievance that you communicate to your health insurer or plan.

Durable Medical Equipment (DME): Equipment ordered by a health care provider for everyday or extended use. Coverage for DME may include but is not limited to: oxygen equipment, wheelchairs, crutches, or diabetic supplies.

Emergency Medical Condition: An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.

Emergency Medical Transportation: Ground or air ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you get in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint to your health insurer or plan.

Habilitation Services and Devices: Health care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.

Home Health Care: Health care services a person receives in a home.

Other plan details

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Medically Necessary: Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Participating Provider: A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.

Participating Provider: A Provider who has a contract with your health insurer or plan to provide covered services to you.

Physician Services: Health-care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit, like Medicaid, which provides and pays for your health-care services.

Pre-Authorization: A decision by your health insurer or plan that a health-care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision or approval, sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health-care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health-care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health-care professional, or health-care facility licensed, certified, or accredited as required by state law.

Rehabilitation Services and Devices: Health-care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Health Plan Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2025

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

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

By law, we must follow the terms of our current notice.

HI is information about your health or medical services. We have the right to make changes to this notice of privacy practices. If we make important changes, we will notify you by mail or e-mail. We will also post the new notice on our website. Any changes to the notice will apply to all HI we have. We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

How We Collect, Use, and Share Your Information

We collect, use and share your HI with:

- You or your legal or personal representative.
- Certain Government agencies. To check to make sure we are following privacy laws.

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

- **For Payment.** To process payments and pay claims. For example, we may tell a doctor whether we will pay for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment or Managing Care.** To help with your care. For example, we may share your HI with a hospital you are in, to help them provide medical care to you.
- **For Health Care Operations.** To run our business. For example, we may talk to your doctor to tell him or her about a special disease management or wellness program available to you. We may study data to improve our services.

- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** If you receive health insurance through your employer, we may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** To make health insurance underwriting decisions. We will not use your genetic information for underwriting purposes.
- **For Reminders on Benefits or Care.** We may send reminders about appointments you have and information about your health benefits.
- **For Communications to You.** We may contact you about your health insurance benefits, healthcare or payments.

We may collect, use, and share your HI as follows.

- **As Required by Law.** To follow the laws that apply to us.
- **To Persons Involved with Your Care.** A family member or other person that helps with your medical care or pays for your care. This also may be to a family member in an emergency. This may happen if you are unable to tell us if we can share your HI or not. If you are unable to tell us what you want, we will use our best judgment. If allowed, after you pass away, we may share HI with family members or friends who helped with your care or paid for your care.
- **For Public Health Activities.** For example, to prevent diseases from spreading or to report problems with products or medicines.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with certain 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,** for example, 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.** To public health agencies or law enforcement, for example, in an emergency or disaster.
- **For Government Functions.** For military and veteran use, national security, or certain protection services.
- **For Workers' Compensation.** If you were hurt at work or to comply with employment laws.
- **For Research.** For example, to study a disease or medical condition. We also may use HI to help prepare a research study.

- **To Give Information on Decedents.** For example, to a coroner or medical examiner who may help identify the person who died, why they died, or to meet certain laws. We also may give HI to funeral directors.
- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissues.
- **To Correctional Institutions or Law Enforcement.** For persons in custody, for example: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates.** To give you services, if needed. These are companies that provide services to us. They agree to protect your HI.
- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
  1. Alcohol and Substance Use Disorder
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive or Sexual Health
  11. Sexually Transmitted Diseases

We will only use or share your HI as described in this notice or with your written consent. We will get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your health insurance ID card.

Your Rights

You have the following rights for your medical information.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.** Your request to limit our use or sharing must be made in writing.

- **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 as allowed by state and federal law. We take verbal requests but may ask you to confirm your request in writing. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy of certain HI.** You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. 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. We will respond to your request in the time we must do so under the law. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of when we shared your HI in the six years prior to your request. This will not include when we shared HI for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website.
- **In certain states, you may have the right to ask that we delete your HI.** Depending on where you live, you may be able to ask us to delete your HI. We will respond to your request in the time we must do so under the law. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

Using Your Rights

- **To Contact your Health Plan.** If you have questions about this notice, or you want to use your rights, **call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at 1-866-633-2446, or TTY/RTT 711.
- **To Submit a Written Request.** Mail to:
  UnitedHealthcare Privacy Office
  MN017-E300, P.O. Box 1459, Minneapolis MN 55440
- **To File a Complaint or Grievance.** If you think your privacy rights have been violated, you may send a complaint or grievance at the address above.

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

[1] This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Financial Information Privacy Notice

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

Effective January 1, 2025

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

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

Questions About This Notice

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

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Health Care Solutions, Inc.; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Notice of Availability of Language Assistance Services and Alternative Formats: https://www.uhc.com/communityplan/non-discrimination-notice

Notice of nondiscrimination

Our Companies comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member identification card (TTY **711**).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

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

UHC_Civil_Rights@uhc.com

Optum Civil Rights Coordinator
1 Optum Circle
Eden Prairie, MN 55344

Optum_Civil_Rights@Optum.com

If you need help filing a complaint, call the toll-free number on your member identification card (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

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

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

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

This notice is available at: **https://www.uhc.com/nondiscrimination-med**
https://www.optum.com/en/language-assistance-nondiscrimination.html

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Notice of availability of language assistance services and alternate formats

ATTENTION: Free language assistance services and free communications in other formats, such as large print, are available to you. Call enrollee services 1-888-887-9003, TTY 711 (STAR+PLUS, STAR & CHIP), or 1-877-597-7799, TTY 711 (STAR Kids).

ATENCIÓN: Si habla **español** (**Spanish**), tiene acceso a servicios gratuitos de asistencia lingüística y a materiales gratuitos en otros formatos, como letra grande. Llame a servicios para afiliados al 1-888-887-9003, TTY 711 (STAR+PLUS, STAR & CHIP), o al 1-877-597-7799, TTY 711 (STAR Kids).

CHÚ Ý: Nếu quý vị nói tiếng **Việt** (**Vietnamese**), quý vị sẽ nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí và nhận các tài liệu truyền thông miễn phí ở các định dạng khác như chữ in lớn. Hãy gọi dịch vụ cho người ghi danh theo số 1-888-887-9003, TTY 711 (STAR+PLUS, STAR & CHIP), hoặc 1-877-597-7799, TTY 711 (STAR Kids).

注意：如果您說中文 (Chinese)，您可以獲得免費語言協助服務和其他格式（例如大字版）的免費通訊。
請撥打投保人服務專線，電話：1-888-887-9003，聽障專線 (TTY) 711 (STAR+PLUS, STAR & CHIP)，或1-877-597-7799，TTY 711 (STAR Kids)。

참고: 귀하가 **한국어** (**Korean**) 를 구사하시는 경우, 무료 언어 지원 서비스와 다른 형식의 무료 커뮤니케이션(예, 큰 활자체로 된 정보)을 이용하실 수 있습니다 가입자 서비스 1-888-887-9003, TTY 711 (STAR+PLUS, STAR & CHIP) 또는 1-877-597-7799, TTY 711 (STAR Kids) 로 전화하십시오.

تنبيه: إذا كنت تتحدث اللغة العربية (**Arabic**)، الترجمة العربية للغة فتتوفر لك خدمات مساعدة لغوية مجانًا ورسائل مجانية بتنسيقات أخرى، مثل الطباعة بحروف كبيرة. اتصل بخدمات المُسجّل على الرقم 1-888-887-9003، الهاتف النصي 711 (STAR+PLUS, STAR & CHIP)، أو 1-877-597-7799، الهاتف النصي 711 (STAR Kids).

توجہ فرمائیں: اگر آپ **Urdu** بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات اور دیگر فارمیٹس، جیسے بڑے پرنٹ، میں مفت مواصلات دستیاب ہیں۔ ممبران کی خدمات کو 1-888-887-9003، TTY 711 (STAR+PLUS, STAR & CHIP)، یا 1-877-597-7799، TTY 711 (STAR Kids) پر کال کریں۔

ATTENTION : si vous parlez **Français** (**French**), des services d’assistance linguistique gratuits et des communications gratuites dans d’autres formats, tels que du texte en gros caractères, sont à votre disposition. Appelez les services aux inscrits au 1-888-887-9003, TTY 711 (STAR+PLUS, STAR & CHIP) ou au 1-877-597-7799, TTY 711 (STAR Kids).

ATENSYON: Kung nagsasalita ka ng (**Tagalog**), may makukuha kang mga serbisyong libreng tulong sa wika at mga libreng komunikasyon sa mga ibang anyo, tulad ng malaking print. Tawagan ang mga serbisyo sa nagpatala sa 1-888-887-9003, TTY 711 (STAR+PLUS, STAR & CHIP), o sa 1-877-597-7799, TTY 711 (STAR Kids).

ध्यान दें: यदि आप **हिन्दी** (**Hindi**) बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। नामांकित सेवाओं के लिए 1-888-887-9003, TTY711 (STAR+PLUS, STAR & CHIP), या 1-877-597-7799, TTY 711 (STAR Kids) पर कॉल

ध्यान दिनुहोस्: यदि तपाईं **नेपाली** (**Nepali**) बोलुहुन्छ भने, तपाईंलाई निःशुल्क भाषा सहायता सेवा दिइनेछ र ठूलो अक्षरजस्ता अन्य ढाँचामा पनि सूचना उपलब्ध गराइनेछ। भर्ना सेवा (Enrollee Services) मा फोन गर्नुहोस्:1-888-887-9003, TTY 711 (STAR+PLUS, STAR & CHIP), वा 1-877-597-7799, TTY 711 (STAR Kids).

लक्ष द्याः तुम्ही **मराठी** (**Marathi**) बोलत असाल, तर मोफत भाषा सहाय्य सेवा आणि मोठ्या प्रिंटसारखे इतर स्वरूपातील मोफत संप्रेषण तुमच्यासाठी उपलब्ध आहे. enrollee services यांना 1-888-887-9003, TTY 711 वर (STAR+PLUS, STAR & CHIP) किंवा 1-877-597-7799, TTY 711 वर (STAR Kids) वर कॉल करा.

توجه: اگر به **فارسی** (**Farsi**)، صحبت نمی کنید، خدمات رایگان کمکی زبان و مطالب رایگان در قالب های دیگر، مانند پرینت درشت، برای شما فراهم است. با شماره خدمات ثبتنام شدگان 1-888-887-9003،
TTY 711 (STAR+PLUS, STAR & CHIP)، یا 1-877-597-7799،
TTY 711 (STAR Kids)تماس بگیرید.

ધ્યાન આપો: જો તમે **ગુજરાતી** (**Gujarati**) બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ અને મોટા પ્રિન્ટ જેવા અન્ય ફોર્મેટમાં નિઃશુલ્ક સંદેશાવ્યવહાર તમારા માટે ઉપલબ્ધ છે. નોંધણી કરાવનાર સેવાઓ 1-888-887-9003, TTY711 (STAR+PLUS, STAR & CHIP), અથવા 1-877-597-7799, TTY 711 (STAR Kids) પર કૉલ કરો.

గమనిక: ఒకవేళ మీరు **భాష** (**Telugu**) మాట్లాడుతుంటే, ఉచిత భాషా సహాయక సేవలు అలాగే పెద్ద ప్రింట్ వంటి వేరే ఫార్మాట్లలలో ఉచిత కమ్యూనికేషన్స్ మీకు అందుబాటులో ఉంటాయి. ఎన్రోల్ సేవలకు కాల్ చేయండి 1-888-887-9003, TTY 711 (STAR+PLUS, STAR & CHIP), లేదా 1-877-597-7799, TTY 711 (STAR Kids).

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: **7-1-1,** for deaf and hard of hearing. You can also visit our website at **UHCCommunityPlan.com**.

UnitedHealthcare Community Plan
Regional Service Delivery Area Office
2950 North Loop W., Suite 200
Houston, TX 77092-8843

UHCCommunityPlan.com

1-888-887-9003, TDD/TTY: **7-1-1,** for deaf and hard of hearing
8:00 a.m.–8:00 p.m., Monday–Friday

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