Texas – September 2026



Welcome to the community

UnitedHealthcare Community Plan
STAR+PLUS Nursing Facility Member Handbook

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

UnitedHealthcare® 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

Websites: **UHCCommunityPlan.com**
myuhc.com/CommunityPlan

What to do in an emergency

In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services. An emergency is a condition in which you think you have a serious medical condition, or not getting medical care right away will be a threat to your life, limb or sight.

What to do in a behavioral health emergency

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

If you have questions about your health plan, please call us. Our toll-free Member Services number is **1-888-887-9003,** TDD/TTY: **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. **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**
Information on how to access covered services and Interpreters are available in many languages from 8:00 a.m.–8:00 p.m., Monday–Friday, excluding state-approved holidays (see page 4).
After-hours, please contact NurseLine.
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. **1-877-839-5407**
(available 24 hours a day, 7 days a week)
• Se habla Español
• Interpreter services available

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

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

For Hearing Services, Call Member Services **1-888-887-9003**

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

Rides to Doctor visit. . . . . **1-888-462-6050,** TTY: **711**
(8:00 a.m.–5:00 p.m., Monday–Friday)

Mental Health and Substance Abuse Services **1-888-887-9003**
Optum Behavioral Health; available 24 hours a day, 7 days a week.
Information and Interpreters are available in many languages.
In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.

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.

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

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

Our office locations

UnitedHealthcare Community Plan

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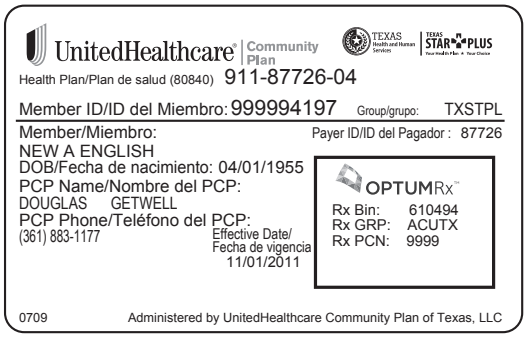
 Questions? Visit **UHCCommunityPlan.com**, or call Member Services at **1-888-887-9003,** TDD/TTY: **7-1-1.**

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.

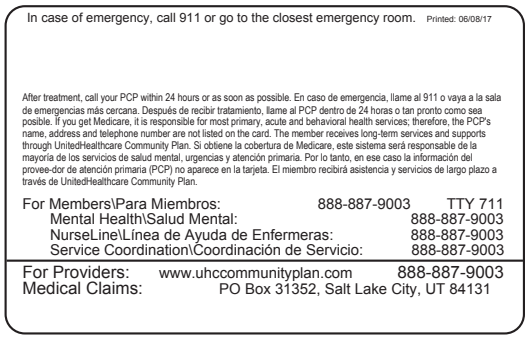
Members with Medicaid only ID card


UnitedHealthcare Community Plan
TEXAS Health and Human Services | 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: 888-887-9003
For Providers: www.uhccommunityplan.com 888-887-9003
Medical Claims: PO Box 31352, Salt Lake City, UT 84131
Pharmacy Claims: OptumRX, PO Box 65033, Dallas, TX 75269-0334
For Pharmacists: 877-305-8952

Members with Medicaid and Medicare ID card


UnitedHealthcare Community Plan
TEXAS Health and Human Services | 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: 888-887-9003
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 Your Texas Benefits 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 you 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.

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, or by going online to order or print a temporary card at **www.YourTexasBenefits.com**.

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

The Medicaid Client Portal lets you do all of the following for anyone who is part of your case:

- View, print, and order a Your Texas Benefits Medicaid card
- See your medical and dental plans
- See your benefit information
- See 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**.

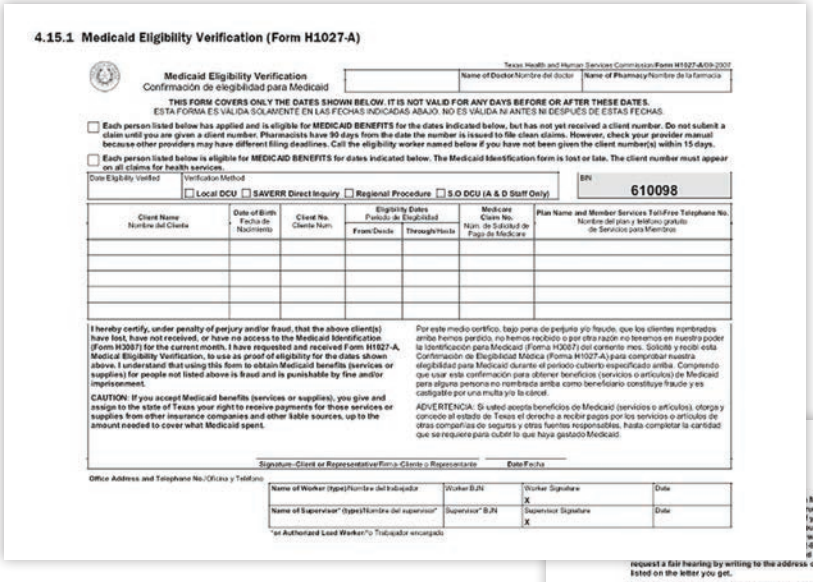
- Click **Log In**
- Enter your User name and Password. If you don't have an account, click **Create a new account.**
- Click **Manage**
- Go to the "Quick links" section
- Click **Medicaid & CHIP Services**
- Click **View services and available health information**

Note: The **YourTexasBenefits.com** Medicaid Client Portal displays information for active clients only. Legally authorized representatives can view 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 VALIDA SOLAMENTE EN LAS FECHAS INDICADAS ABAJO. NO ES VALIDA NI ANTES NI DESPUÉS DE ESTAS FECHAS.

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

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

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

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

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form H3007) 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 H3007) del corriente mes. Solicité y recibí esta Confirmación de Elegibilidad Médica (Forma H1027-A) para comprobar nuestra elegibilidad para Medicaid durante el período cubierto especificado arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude y es castigable por una multa y/o la cárcel.

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

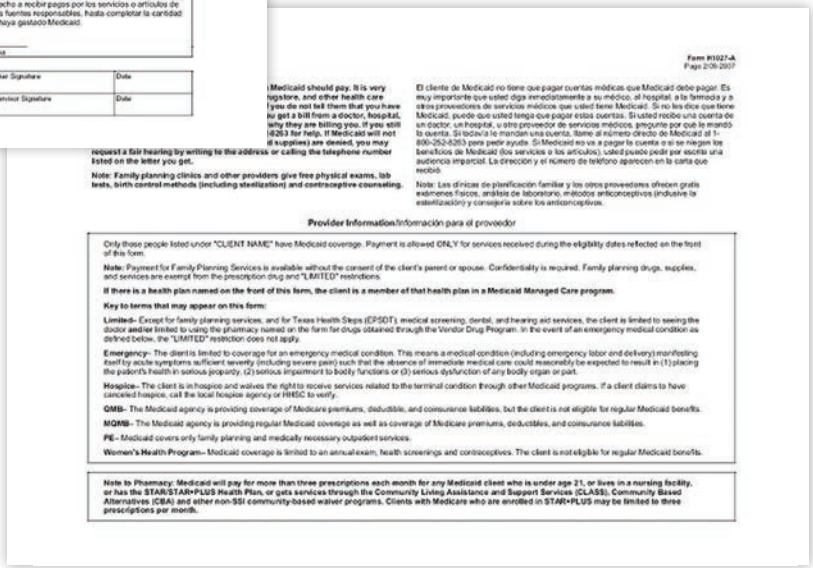
Signature-Client or Representative/Firma-Cliente o Representante | Date/Fecha

Office Address and Telephone No./Oficina y Teléfono

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

*or Authorized Load Worker/*o Trabajador encargado

Temporary Medicaid verification form sample – front



Medicaid should pay. It is very ...ngstore, and other health care ...) you do not tell them that you have ...u get a bill from a doctor, hospital, ...why they are billing you. If you still ...(263 for help. If Medicaid will not ...d supplies) are denied, you may request a fair hearing by writing to the address or calling the telephone number listed on the letter you get.

Note: Family planning clinics and other providers give free physical exams, lab tests, birth control methods (including sterilization) and contraceptive counseling.

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

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

Provider Information/Información para el proveedor

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

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

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

Key to terms that may appear on this form:

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

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

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

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

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

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

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

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

Temporary Medicaid verification form sample – back

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.

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.

Will I be assigned a Primary Care Provider if I have Medicare?

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

How do I see my Primary Care Provider if s/he does not visit my nursing home?

If you need to leave the Nursing Facility for a doctor visit, the Nursing Facility will provide transportation.

How do I pick a Primary Care Provider?

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

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

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.

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

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 rewards doctors for treatments that are cost-effective for people covered by Medicaid. You have the right to know if your Primary Care Provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call **1-888-887-9003** to learn more about this.

What is Service Coordination?

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

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

What is a Service Coordinator?

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

Did you know that you might be able to hire and manage the people who provide your services?

UnitedHealthcare Community Plan Can Help You Manage Your Home Services. Consumer-Directed Services (CDS) is a program for people receiving certain services available under the CDS option. With this program, you find, hire and train the people providing these specific services. You also review the budget for the services. You decide how much to pay these providers. You can pick the person to handle the services for you. If you pick this program, an agency will teach you what to do. The agency will also handle the payroll for your services.

If you pick the CDS choice, you are the employer. You can hire, fire and manage your own health service providers. This can include your attendant(s), back-up attendant(s), in-home and out-of-home respite providers and providers for services available under the CDS option. You have control over how your program funds are spent on salary and benefits for your employee(s). You pick a CDS agency to manage fiscal services for you. As an employer, you need to arrange payment of employment taxes. You need to pay your employees from your program funds. Your CDS agency will offer this service for you.

Why would I want to pick CDS?

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

How does CDS work?

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

Which services can be self-directed in which programs?

Program	Services
STAR+PLUS Waiver Program (formerly known as Community-Based Alternatives)	Personal Assistance Services/Protective Supervision, Respite, Physical Therapy, Occupational Therapy, Speech/Language Therapy, Nursing Services, Support Consultation, Supported Employment/ Employment Assistance, Cognitive Rehabilitation Therapy
Primary Home Care/Community Attendant Services	Personal Assistance Services Support Consultation

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

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

Do I need a referral?

You do not need a referral for these services.

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

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

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

How do I get my medications?

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

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

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

What if I also have Medicare?

Medicare or your Medicare Health Plan will pay for your services before UnitedHealthcare Community Plan will. UnitedHealthcare Community Plan might cover some services that are not covered by Medicare for STAR+PLUS members. Prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D.

What is the Medicaid Lock-in Program?

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

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

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

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

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

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

What if I need OB/GYN care? Do I have the right to choose an OB/GYN? 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.

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

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

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

How do I choose an OB/GYN?

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

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

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

Will I need a referral for OB/GYN services?

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

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

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

How do I make appointments?

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

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

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

How do I get medical care after my primary care provider's office is closed?

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

What if I get sick when I am out of the facility and traveling out of town?

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

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

What if I am out of the state?

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

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

What if I am out of the country?

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

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office by calling 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 STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want, but not more than once a month. If you are in the hospital, a residential Substance Use Disorder (SUD) treatment facility, or residential detoxification facility for SUD, you will not be able to change health plans until you have been discharged.

Who do I call?

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

How many times can I change health plans?

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

When will my health plan change become effective?

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

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

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

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

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

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

Language and interpreter services

UnitedHealthcare Community Plan has staff that speaks English and Spanish. If you speak another language or are 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 age 21 and over, non-behavioral health related health care services that are:
   a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, 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. not experimental or investigative; and
   g. not primarily for the convenience of the member or provider; and
2. For members age 21 and over, 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 a disorder;
   b. are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

c. are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

d. are the most appropriate level or supply of service that can safely be provided;

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

f. are not experimental or investigative; and

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

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

What is emergency medical care?

Emergency medical care

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

Emergency medical condition means:

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

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

Emergency behavioral health condition means:

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

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

Emergency services and emergency care means:

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

How soon can I expect to be seen?

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

Do I need a prior authorization?

You do not need a referral or prior authorization for emergency care.

What is post-stabilization?

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

What is 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?

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

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

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

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

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- Open or closed reduction of fracture of the maxilla or mandible;
- Repair of laceration in or around oral cavity;
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;

- Incision and drainage of cellulitis;
- Root canal therapy. Payment is subject to dental necessity review and pre- and post-operative X-rays are required; and
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Are non-emergency dental services covered?

UnitedHealthcare Community Plan is not responsible for paying for routine dental services provided to Medicaid members. UnitedHealthcare Community Plan is responsible, however, for paying for treatment and devices for craniofacial anomalies.

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
- Psychiatry services
- Counseling services for adults
- Substance use disorder treatment services
- Prenatal care
- Birthing services
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency services
- Family planning services
- Home health care services
- Hospital services, inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures
- Medical checkups and Comprehensive Care Program (CCP) Services for children through the Texas Health Steps Program
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Optometry, glasses, and contact lenses, if medically necessary
- Outpatient drugs and biologicals

- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Physical, occupational and speech therapies
- Transplantation of organs and tissues
- Vision

How do I get these services?

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

Are there any limits to any covered services?

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

What are Long-Term Services and Supports (LTSS)?

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 Nursing Facility LTSS benefits?

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

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

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

How would my benefits change if I moved into the community?

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

Community-based long-term care services for all members

- Personal Attendant Services
- Day Activity and Health Services

HCBS STAR+PLUS waiver services for those members who qualify for these services

- Personal attendant services (including the three service delivery options: self-directed; agency model, self-directed; and agency model)
- In-home or out-of-home respite services
- Nursing services (in home)
- Emergency response services (emergency call button)
- Home-delivered meals
- Adaptive aids and medical equipment
- Medical supplies not available under the Texas Medicaid State Plan/Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver
- Physical therapy, occupational therapy, speech therapy
- Day Activity Health Services (DAHS)
- Adult foster care
- Assisted living
- Transition assistance services
- Dental services
- Cognitive rehabilitation therapy
- Financial management services
- Support consultation
- Employment assistance
- Supported employment

What are my acute care benefits?

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

- Ambulance services
- Audiology services, including hearing aids
- Behavioral Health Services, including:
  - Inpatient mental health services for adults and children. The MCO may provide these services in a freestanding psychiatric hospital in lieu of an acute care inpatient hospital setting.
  - Outpatient mental health services for adults and children
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
  - Substance use disorder treatment services
- Outpatient services, including:
  - Assessment
  - Detoxification services
  - Counseling treatment
  - Medication-assisted therapy
  - Residential services, which may be provided in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting, including detoxification services
  - Substance use disorder treatment (including room and board)
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
- Birthing services provided by a physician and CNM in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services

- Emergency services
- Family planning services
- Home health care services
- Hospital services, inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - Outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - Surgery and reconstruction on the other breast to produce symmetrical appearance;
    - Treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - Prophylactic mastectomy to prevent the development of breast cancer.
  - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
- Medical checkups and Comprehensive Care Program (CCP) Services for children (birth through age 20) through the Texas Health Steps Program
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational, and speech
- Transplantation of organs and tissues

- Vision. (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
- Telemedicine
- Telemonitoring
- Telehealth

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

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

Call Member Services at **1-888-887-9003** for questions on how to get these services.

What services are not covered?

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

- Dentures
- 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
- 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)

What services can I still get through regular Medicaid but are not covered by UnitedHealthcare Community Plan?

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

What are my prescription drug benefits?

Contact Member Services for more information on your prescription benefits. For more information, please refer to page 24 of this Member Handbook.

Note: For Non-Dual members only.

Family planning

How do 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/healthcare-programs/family-planning-program**, or you can call UnitedHealthcare Community Plan Member Services at **1-888-887-9003** for help in finding a family planning provider.

Other plan details

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

Value-added services

As a member of UnitedHealthcare Community Plan, you can also receive value-added services in addition to the required Medicaid services starting September 1 through August 30. 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:

Adult dental services
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. Members ages 21–120. 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. 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.

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 1 set per year.*

Lap blanket

One personal blanket for lap or bed.

Terms: Includes 1 blanket per year.*

Nursing facility welcome kit

One Welcome Kit upon admission into an in-network Nursing Facility.

Terms: Includes 1 welcome kit per year* upon admission to an in-network facility. Excludes Skilled Nursing Facility (SNF) admissions. Nursing Facility must be an in-network provider.

Cozy and comfort kit

The kit comes with a backscratcher, a soft knit hat, and a pair of legwarmers for warmth.

Terms: For members who have trouble moving, walking or bending during daily activities. One per year.*

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

Online resources

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.

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.

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.

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.

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.

Second hearing aid

Members ages 21–120 with a Medicaid covered 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.

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 certificate per year.*

Alzheimer's care
Robopet or doll

A robopet or doll for comfort and company. Promotes rest and lowers stress.

Terms: For members with dementia or Alzheimer's. One per member lifetime.

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.

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.

*Each state fiscal year, 9/1–8/31.

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:

- Prescription drugs
- Texas Health Steps dental services
- Tuberculosis (TB) clinics
- Women, Infants and Children Services (WIC)
- Early Childhood Intervention (ECI)
- Services by federal or state hospital doctors
- Mental Health and Mental Retardation (MHMR) Case Management
- Mental Retardation Diagnostic Assessment (MRDA)
- Mental health rehabilitation
- Texas School Health and Related Services (SHARS)
- Texas Commission for the Blind (TCB)

UnitedHealthcare Community Plan transportation services for Nursing Facility residents

What transportation services are offered?

The Nursing Facility is responsible for providing routine non-emergency transportation services. If medically necessary, UnitedHealthcare Community Plan provides non-emergency ambulance transportation. Non emergency transportation is also covered for trips to dialysis treatment and trips to the home for members after being discharged from a Nursing Facility.

How do I get this service?

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

What happens if I lose my Medicaid coverage?

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

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

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

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

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

What is applied income?

It is the member's personal income that the member must provide to the Nursing Facility as part of their cost sharing obligation as a Medicaid beneficiary.

What are my responsibilities?

Any time Medicaid is billed by the Nursing Facility, the member must give their applied income to the facility. The amount is determined by the total amount of monthly income divided by the number of days the member resides in the facility each month. The member is allowed to keep $60 themselves for personal needs.

What do I have to do if I move?

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

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

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

Medicaid and private insurance

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

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

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

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

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

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

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

Complaints and appeals

What should I do if I have a complaint about my health care, my provider, my Service Coordinator, or my health plan?

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

Once you have gone through the UnitedHealthcare Community Plan complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 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:
hhs.texas.gov/managed-care-help.

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 signa 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 in whole or in part. If you ask for an appeal within 10 days from the time you get the denial notice from the health plan, you have the right to keep getting any service the health plan denied or reduced at least until the final appeal decision is made. If you do not request an appeal within 10 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.

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?

You can ask for an emergency appeal verbally or in writing. We can record your verbal request. 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.

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 contacting to name 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 internal appeal decision letter being challenged.

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 either 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

or call UnitedHealthcare Community Plan at **1-800-288-2160**

You have the right to keep getting any service 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 notice of the Action, or (2) the day the health plan's letter says your service will be reduced or end.

If you do not request a 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 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.

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's internal appeals process.

External Medical Review information

Can I ask for an External Medical Review?

If you, as a member of the health plan, disagrees with the health plan's Internal Appeal decision, you have the right to ask for an External Medical Review with State Fair Hearing. An External Medical Review is an optional, extra step you can take to get the case reviewed for free before your State Fair Hearing. You, your parent, your authorized representative or your legally authorized representative (LAR) must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the decision. If you do not ask for the External Medical Review within 120 days, you may lose your right to an External Medical Review. To ask for an External Medical Review, you, your parent, your representative or your legally authorized 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**

You have the right to keep getting any service the health plan denied or reduced, at least until the External Medical Review and final State Fair Hearing decision is made if you ask for an External Medical Review with State Fair Hearing by the later of: (1) 10 calendar days following the MCO's mailing of the notice of the Action, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request 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.

You may withdraw your 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, you have the right to withdraw the State Fair Hearing request. You may withdraw your 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.
   c. Be given information about your health plan, services, and providers.
   d. Be told about your rights and responsibilities.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, 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 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.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have a right to make recommendations to your health plan's member rights and responsibilities policy.

Member responsibilities:

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

3. You must share information about your health with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your Primary Care Provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.
   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.
- 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 emergency coverage and limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services and post-stabilization services
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services
  - In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid
  - A statement saying you have a right to use any hospital or other settings for emergency care
  - Post-stabilization rules
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider
- UnitedHealthcare Community Plan practice guidelines

UnitedHealthcare Community Plan must provide information to members on how it evaluates new technology for inclusion as a covered benefit. UnitedHealthcare reviews new procedures and devices to decide if they are safe and effective for members. If they 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.

Abuse, neglect, and exploitation

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 a person for personal or monetary benefit. 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 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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What are abuse, neglect, and exploitation?

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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 Department 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.

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.

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.

Other plan details

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
Main 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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