Indiana – October 2023

Welcome to the community

Hoosier Care Connect Member Handbook

United Healthcare Community Plan

CSIN23MD0095188_000 (09/2023)

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Getting started

New member checklist

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

Call Member Services at **1-800-832-4643**, TTY **711**, if you need help completing any of these tasks.

✔	Task	Notes
	Register for your online portal account	Visit **myuhc.com/CommunityPlan/IN** to sign up.
	Complete your Health Needs Survey	If you take the survey during your first 90 days as a new member, you will earn a $35 gift card. There are three ways to take the survey: • Access the survey through your online portal account • Complete a paper form. This form will come in the mailing that includes your member ID card. There is a prepaid envelope with that packet so that you do not need to pay for postage when you return the survey. • If you do not have internet access or have not received your member ID card mailing, you may complete the survey over the phone with Member Services
	Get the UnitedHealthcare app	Download the UnitedHealthcare app to your Apple® or Android™ smartphone or tablet to stay connected. This gives you access to your member ID card, Member Services, NurseLine, Doctor Chat, and more. We can also help you get a free smartphone with unlimited talk, text, and data so that you can use this app.

✔	Task	Notes
	View or print your member ID card	If you have your member ID card, check to make sure your details are accurate. If any of the information is wrong, call Member Services at **1-800-832-4643**. If you have not received your member ID card in the mail, you can print one online using your portal account.
	Choose or change your PMP (Primary Medical Provider)	Choose a Hoosier Care Connect registered provider. You can follow this link directly to the Doctor Lookup feature: **https://www.uhccommunityplan.com/IN**.
	Make an appointment with your PMP	Your PMP is the main doctor you see. When you see the same PMP over time, it's easier to develop a relationship with them. Your PMP is available to assist you 24/7 to address your health concerns.
	Connect with your Member Services Navigator	Having trouble with any of these to-do list tasks? Your Member Services Navigator is here to help. Call Member Services at **1-800-832-4643**, TTY **711**, to meet your Navigator. This is your main support person while you are our member.

Your Hoosier Care Connect quick reference guide

I want to:	You can contact:
Find a doctor, specialist or health care service	Your PMP. If you need help choosing your PMP, call Member Services at **1-800-832-4643**.
Get the information in this handbook in another format or language	Member Services at **1-800-832-4643**.
Get a ride to and from my health care appointments	Member Services at **1-800-832-4643**. You can also find more information on transportation services in this handbook.
Get help to deal with my stress or anxiety	**911** if you are in danger or need immediate medical attention. Behavioral health hotline 24/7 at 1-855-780-5955. You may also call the number on the back of your member ID card.

I want to:	You can contact:
Get answers to basic questions or concerns about my health, symptoms, or medicines	• Your PMP • NurseLine, available 24/7 at 1-800-801-4407 • Doctor Chat, available 24/7 at **myuhc.com/CommunityPlan**
Understand a letter, bill, or notice about my health care	Your Navigator. To connect with your Navigator, call Member Services at **1-800-832-4643**.
Get help with social needs. These are things like housing, getting food every day, getting to the grocery, or feeling safe.	Your Navigator. To connect with your Navigator, call Member Services at **1-800-832-4643**. You can also visit **UHCHealthierLives.com**.
Update my address	Family and Social Services Administration (FSSA). Update in your FSSA Portal at **https://fssabenefits.in.gov/bp/#/**. Member Services can offer more options.
Find a Provider Directory or other general information about my health plan	Online at **UHCCommunityPlan.com**
Replace a lost member ID card	Online at **myuhc.com/CommunityPlan/IN** to print a new card. You can also call Member Services at **1-800-832-4643**.
Tell my health plan how I want to be contacted (i.e., mail, email, large print, braille, Spanish)	Online at **myuhc.com/CommunityPlan/IN**. Or call your Navigator. To connect with your Navigator, call Member Services at **1-800-832-4643**.
Allow another person to talk to my health plan (authorized representative, power of attorney)	Online at **myuhc.com/CommunityPlan/IN**. You can also call Member Services at **1-800-832-4643**.
Contact the State enrollment broker (to change health plans, to ask questions during open enrollment)	Maximus by phone at **1-866-963-7383**.

Important phone numbers

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

Emergencies (available 24/7)

Medical Emergency	**911**
Behavioral Health Crisis Line	**1-855-780-5955**
National Poison Control Center	**1-800-222-1222**
National Suicide Prevention Lifeline	**988**
Senior Help Line	**1-602-264-4357**

UnitedHealthCare Community Plan resources

Member Services (8:00 a.m.–8:00 p.m. EST, Monday–Friday)	**1-800-832-4643**, TTY **711**
NurseLine (24/7 health advice from a nurse)	**1-866-801-4407**
Transportation (call 3+ business days ahead)	**1-800-832-4643**, TTY **711**
Prior Authorization	**1-800-832-4643**, TTY **711**
Substance Abuse Helpline	**1-855-780-5955**

State of Indiana resources

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

Your personal details

My UnitedHealthcare Community Plan ID number is: _____

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

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

If you think fraud, waste, or abuse is going on, please report it. Call the UHC Fraud Hotline at **1-844-359-7736**. You can also call Member Services at **1-800-832-4643**. We will not use your name in your report. You will not get in trouble for reporting this. We will look into the matter for you. The State of Indiana also has a fraud, waste, and abuse toll-free hotline. You can call **1-800-403-0864**. Reports can be made anonymously. TTY users may dial **711** for all options.

Welcome to UnitedHealthcare Community Plan

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

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

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

How our health plan works

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

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

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

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

Member ID card

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

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

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

Quick tips

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

Lost your member ID card?

If you or a family member loses a card, you can print a new one at **myuhc.com/CommunityPlan/IN**. If you need a new card sent to you, call Member Services. You can also download the UnitedHealthcare mobile app on your smartphone. The mobile app includes a digital member ID card that can be used at any time. We offer free smartphones that come with the mobile app loaded on it. Call us or apply at **mybenefitphone.com**.

Member Services

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

- Answer questions about your physical and behavioral health benefits
- Help solve a problem or concern you might have with your doctor or any part of the health plan
- Help you find a doctor or dentist
- Tell you about our doctors, their backgrounds, and the care facilities in our network
- Help you if you get a medical bill for a covered service
- Tell you about community resources available to you to help with things like, food, transportation, housing, clothing, and safety
- Help you if you speak another language, are visually impaired, need interpreter services, or sign language services
- Help you connect with your Navigator and/or Care Manager
- Help answer other questions you may have
- Help you get materials in an alternate format, such as braille, large print, or audio file
- Assist with scheduling doctor, dental, and vision appointments
- Schedule transportation
- Provide you with a copy of the Member Handbook at no cost to you

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

When you call us ...

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

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

Member Services is here to help you

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

Discover your plan online

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

Great reasons to use myuhc.com/CommunityPlan/IN

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

Mobile app

Our UnitedHealthcare® app is available for use on your smartphone. Just search **UnitedHealthcare** in the App Store or Google Play to download. You can access your digital member ID card, review health benefits, access claims information, locate doctors, and more. When you get a free phone from us, the mobile app will be pre-loaded. Call Member Services or apply at **mybenefitphone.com**.

NurseLine

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

Our NurseLine can answer your questions and help you make an informed decision whether to call your doctor, visit an urgent care center, or go to the emergency room (ER). If NurseLine tells you to go to the ER, this is called a waiver.

Renew your coverage

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

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

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

Native Americans and Alaskan Natives

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

How to get services

How can I be involved in my health care?

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

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

Take advantage of these materials

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

- **Preventive care** — Preventive Services Reminder, Immunizations, Glaucoma Screenings
- **Chronic conditions** — Asthma, diabetes, chronic obstructive pulmonary disease, heart failure, coronary artery disease, taking charge of blood pressure, spinal stenosis, dementia, depression, dysrhythmia, peripheral vascular disease, deep vein thrombosis and pulmonary embolisms, neuropathic foot care, tooth decay, gum disease
- **Ways to keep your living area safe**
- ***You Can Quit Smoking*** **brochure**
- **Flu and pneumonia vaccination information** — Signs and Symptoms of the Flu, Caring for the Flu, Flu Guide – Q and A, ***No More Excuses*** brochure
- **Live and Work Well** — **Liveandworkwell.com** delivers helpful articles and tools to improve well-being. This includes:
  - Online mental behavioral health provider directory
  - Self-help, assessment, and prevention programs
  - Educational articles, guides, and resources
- **Self Care app** — On-demand mobile app that helps with stress, anxiety, and depression

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

Culturally competent services

Culturally competent care is having knowledge and skills for positive outcomes. This includes language, lifestyles, values, beliefs, and attitudes. Ask for culturally sensitive, translated materials, or printed materials in alternate formats. Contact your Navigator at **1-800-832-4643**, TTY **711**.

Materials in alternate formats

Materials in alternate formats are services or devices to help people with impaired sensory, manual, or speaking skills have an equal opportunity to participate in the health plan. They are free upon request. These alternate formats include materials with large print, materials in other languages, braille, and audio formats. Call your Navigator at **1-800-832-4643**, TTY **711**.

Interpretation services

If English is not your main language, we can provide you with an interpreter. If you are deaf or hard of hearing, we can provide you with an American Sign Language interpreter. You can also find a provider who speaks languages other than English. Ask your Navigator if you need help when you choose your PMP.

Choose your PMP

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

Your PMP may be any of the following:

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

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

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

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

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

Your Navigator can also help you choose providers from within its provider network. If you'd like to select a provider based on convenience, location, or cultural preference, you can tell your Navigator.

You can receive a paper or emailed copy of the Provider Directory by contacting Member Services at **1-800-832-4643**, TTY **711**.

Change your PMP

Your PMP knows you, has your records, and knows what medications you take. Your PMP is the best person to make sure you get good care. There may be a time you want to change PMPs. If so, you need to call Member Services. We can answer your questions and help you find a new PMP. We can also send or email a list of UnitedHealthcare Community Plan providers to pick from.

You can also use the Provider Lookup tool at **UHCCommunityPlan.com**. Your PMP change will happen within one business day. Your new member ID card may take up to 10 days to reach you by mail. You will be able to use your digital member ID card until your replacement card arrives.

Some reasons you may change your PMP:

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

Some reasons you may not change your PMP:

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

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

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

Member Services is here to help you

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

How to get regular health care

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

If you need help making an appointment, call your Navigator.

PMP appointments

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

Specialist appointments, including dental specialty appointments

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

Canceling or changing appointments

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

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

How to get specialty care – referrals

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

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

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

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

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

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

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

We want to make sure you are living in the best place for your situation. We have Care Managers available to help you meet your personal care and medical needs. We will ask you questions and will let you make all decisions about your health care. This is called person-centered planning. If you want a friend or family member to be involved, that is okay. We will work with those people who are important to you. This process:

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

If you have questions, contact your Navigator and ask to connect with a Care Manager. Your Care Manager can help you:

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

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

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

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

Self-referral services

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

Self-referral benefit	Covered service
Chiropractor	Office visits, X-rays, and physical treatments are covered when you see any chiropractor that is in the Indiana Medicaid Network.
Diabetes Self-Management Training (Self-Care)	Diabetes self-management training and education includes things like blood glucose (blood sugar) self-monitoring, or medication counseling. These services can be given by any type of provider in the Indiana Medicaid Network.
Emergency Care	Emergency room (ER) visits are covered at any hospital in the Indiana Medicaid Network. See **Emergency care** for details.
Family Planning	Family planning covers: • Pap smear tests, including screening for cervical cancer and human papillomavirus (HPV) • Any service to temporarily or permanently prevent or delay pregnancy for members who are within childbearing age, including birth control and sterilization • Diagnosis and treatment of sexually transmitted infections (STIs) and the screening, testing, and counseling for members at risk for human immunodeficiency virus (HIV) The provider must be in the Indiana Medicaid Network.
Immunizations	Immunizations (shots) are covered for babies, children, and adults by any Indiana Medicaid Network Provider.
Podiatrist (Foot Doctor)	Office visits, X-rays, surgical services, and corrective shoes and inserts are covered when you see any podiatrist in the Indiana Medicaid Network.

Self-referral benefit	Covered service
Psychiatric Services	Evaluation and counseling services are covered when provided by any psychiatrist in the Indiana Medicaid Network.
Urgent Care	Urgent care visits are covered at any facility in the Indiana Medicaid Network. See **After-hours care/Urgent care** for more information.
Vision (Eye) Care	Routine vision exams and eyeglasses (frames and lenses) are covered when you see any vision provider in the Indiana Medicaid Network. See **Vision care** for details.

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

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

Out-of-network providers

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

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

Emergency care

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

If you have an emergency, call **911** or go to the nearest emergency room (ER).

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

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

- Sudden loss of feeling, or not being able to move
- Chest pain
- Severe pain in your stomach area
- Poisoning
- A serious accident
- Severe shortness of breath
- Severe burns
- Severe wound or heavy bleeding
- Damage to your eyes
- Severe spasms/convulsions
- Broken bones
- Choking or being unable to breathe
- Throwing up (vomiting) blood
- Strong feeling that you might hurt yourself or another person
- Faint or pass out for no reason (will not wake up)
- Danger of losing life or limb
- Loss of speech

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

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

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

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

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

While you are at the ER, you will get all the services you need. The doctors and nurses will let you know when you are stable enough to leave. Post-stabilization services are also covered. This is any care you get after the emergency is over. If you need more tests or services, the ER staff will call UnitedHealthcare to request approval. This only happens once your condition is stable.

When not to use the ER

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

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

If you are unsure if you need to go to the ER, call your PMP or NurseLine at **1-866-801-4407**, which is available 24/7, 365 days a year.

After-hours care/Urgent care

If it is not an emergency but your PMP is not available, you can get services at an urgent care center.

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

- Contact NurseLine at **1-866-801-4407**, TTY **711** 24 hours a day, seven days a week, 365 days a year
- Call your PMP
- Visit **UHCDoctorChat.com** to get a virtual visit. You can use your smartphone, tablet, or laptop to talk to a doctor by video chat.

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

Behavioral health crisis services

What if I am experiencing a behavioral health crisis?

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

Crisis line:

If you are experiencing a behavioral health or substance abuse crisis, call 1-855-780-5955. The crisis line is available 24 hours a day, seven days a week, 365 days a year. Crisis calls are answered by a live trained crisis specialist.

National 24-hour crisis hotlines:

Phone:
National suicide prevention lifeline **988**

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

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

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

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

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

Telehealth (virtual visits)

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

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

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

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

Care outside Indiana

If you are out of town and need to get approval for medical care, contact Member Services at **1-800-832-4643**. All providers must be registered as an Indiana Medicaid provider to get paid for services that are not considered an emergency. This is true for medical and pharmacy services. If you plan to be out of the state, please make sure you have enough of your medications with you.

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

Covered services and benefits

Covered services

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

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

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

Covered services and benefits

Benefit	Coverage
Emergency room	Covered See **Transportation** for details.
Vision (optical) care	Covered See **Self-referral services** for details.
Hearing aids	Covered (once every five years)
Home health care	Covered
Hospice care	Covered
Hospital stays	Covered
Immunizations	Covered See **Self-referral services** for details.
Labs and X-rays	Covered
Maternity services	Covered
Medical equipment and supplies	Covered
Office visits	Visits with a: • PMP (Primary Medical Provider) • Specialist (for adults and children) • OB/GYN (for women)
Orthotics – leg braces, orthopedic shoes, prosthetics	Covered
Outpatient surgeries and follow-up care	Covered
Physical therapy Occupational therapy Speech therapy Respiratory therapy	Covered in an office, outpatient, or inpatient hospital setting
Prescriptions and medication therapy management	Covered

Benefit	Coverage
Routine foot care by a podiatrist (foot doctor)	Covered See **Self-referral services** for details.
Skilled nursing facility services	Covered, based on the condition, up to 30 days for short-term stay or up to 60 days for long-term stays
Transportation	Covered See **Transportation** for details.
Urgent care	Covered See **Self-referral services** for details.
Well-child checkups (Early Periodic Screening, Diagnosis, and Treatment)	Covered

Services not covered

These services are not covered:

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

Other programs offered by the State of Indiana

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

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

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

Copayments

The Hoosier Care Connect program no longer includes a copayment for services. Please contact Member Services if you are asked to pay for a covered service.

Can a provider bill me?

I received a bill for medical services

Tell your provider you are a Hoosier Care Connect member. Show them your ID card. You do not have to pay bills or copays for any service covered by IHCP-registered providers. The provider is not allowed to bill you. If you do get a bill, call the provider and tell them to stop billing you and to send a claim to UnitedHealthcare Community Plan. If the provider continues to bill you, file a grievance (complaint) by calling Member Services. We will send a letter to your provider to stop the billing.

My provider asked me for a copay

The Hoosier Care Connect program no longer requires a copay. Call us if you are asked to pay for any medication or covered service.

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

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

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

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

Transportation

Emergency transportation

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

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

Transportation (non-emergency)

If you need a ride to an appointment, ask a friend, family member, or neighbor first. If you cannot get a ride, UnitedHealthcare Community Plan will help you. Members may receive non-emergency transportation services through UnitedHealthcare Community Plan for Hoosier Care Connect covered services. You are responsible for setting up your own transportation. Members and/or family may schedule non-emergency transportation.

You get unlimited transportation to doctor visits. We also cover trips for Women, Infants, and Children (WIC) appointments, the food pantry, and Medicaid eligibility appointments. Your Navigator can help you schedule transportation. If you need a ride and cannot schedule three or more days ahead, call for assistance.

Following these rules will help you get a ride:

- Call at least **three business days** ahead of time
- Call **1-800-832-4643**, TTY **711** to set up your ride
- If you cancel your visit, call **1-800-832-4643** to cancel your ride
- Have your Medicaid ID card available

- Know the address of your health care provider and the date and time of your appointment
- After your visit, call for a ride home
- If your doctor gives you a prescription, you can stop at the pharmacy to get it
- Let us know if you have special needs like a wheelchair
- Members under age 16 must have a parent or guardian with them
- Bus passes or friends and family mileage reimbursement may be an option. Call Member Services for details.
- A member who is pregnant may be accompanied by anyone
- Both parents may go with a child to attend a scheduled appointment

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

Our programs

Care coordination

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

- Complex care management
- Care management
- Disease management

Complex care management

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

Disease and care management

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

A team of registered nurses, community health workers, and social workers will work with you, your family, caregiver, PMP, other health care providers, and community resources. Your Care Manager will design a plan of care to meet your needs in the most appropriate setting. They can also help you with other things like weight loss, stopping use of tobacco products, making appointments with your doctor, and reminding you about special tests you might need.

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

Individuals with special needs

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

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

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

Foster care members

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

All foster children have an assigned UnitedHealthcare Care Manager. To connect with your Care Manager, call Member Services.

You may coordinate and schedule appointments, learn about covered benefits, including special therapy services, enhanced programs and, if needed, a customized plan of care. There are certain changes to your foster child's record that can only be made by your state-assigned Family Case Manager and/or Department of Children's Services (DCS). Make sure you share your Family Case Manager's contact information with us so that we can more easily help you get the services and support your foster child needs.

All foster children need regular care from their PMP, dentist, and vision providers. Talk to your Family Case Manager to understand when the child next needs to be seen by a provider.

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

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

HealthWatch

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

To learn more, contact your Care Manager.

UnitedHealthcare On My Way

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

Quit using tobacco and vaping products

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

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

- Reach out to the Indiana Quit Line for coaching and counseling. They offer additional support for pregnant members and teens who use tobacco. This program is free to all Indiana residents. Call 1-800-QUIT-NOW (1-800-784-8669). You can also visit **quitnowindiana.com**.
- Visit your doctor to get advice and medicines that can help you quit. We can help you schedule an appointment.

- Medicines come in different forms like patches, gum, lozenges, and pills. Most of these are covered by your benefits. We can help you understand your other benefits too.
- Get access to educational materials and other resources. We offer a wide variety of resources and links to valuable material.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

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

Early: Assessing and identifying problems early,

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

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

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

Treatment: Control, correct, or reduce health problems found.

Well-child visits (EPSDT)

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

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

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

- Eating
- Sleeping
- Behavior
- Physical activity

Well-child visits (checkup) schedule

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

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

AAP (American Academy of Pediatrics, 2018, 2023)

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

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

Treatment, including:

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

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

Immunizations

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

Here are some facts you should know about each immunization:

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

HepA — Protects against hepatitis A. Two doses are given between ages 1 and 2.

HepB — Protects against hepatitis B (infection of the liver). HepB is given in three shots, the first given at birth.

Hib — Protects against Haemophilus influenzae type b. This infection used to be the main cause of bacterial meningitis. Hib shots are given in three to four doses.

HPV — Protects against cancers caused by the human papillomavirus. Children 11 or 12 years old should get two shots of HPV, six to 12 months apart.

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

IVP — Protects against polio and is given in four doses.

Meningococcal — Protects against the bacteria that causes meningococcal disease. Children should get this shot at 11 to 12 years of age.

MMR — Protects against measles, mumps, and rubella (German measles). MMR is given in two doses. The first dose is given between 12 and 15 months of age. The second dose is usually given between ages 4 and 6. However, it can be given as soon as 28 days after the first dose.

PCV — Protects against pneumococcal disease, which includes pneumonia. PCV is given in a series of four doses.

RV — Protects against rotavirus, a major cause of diarrhea. RV is given in two to three doses, depending on the type of vaccine that is used.

Tdap — Protects your child from diphtheria, tetanus, and whooping cough. Children should get this at 11 to 12 years of age.

Varicella — Protects against chickenpox. Varicella is recommended for all healthy children and is given in two doses.

Lead screening in children

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

- Paint
- Soil
- Dust
- Air
- Pottery

A special blood test is ordered by your doctor to check for lead poisoning. The test is usually given at the child's one- and two-year checkups. If your child has not been tested, your doctor might want to test up to the age of 6. For more information, contact your Navigator.

Adult care

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

Adult care schedule

Type of service	21–64 years old	65 years old and over
Blood pressure check	Every year (additional tests based on your health history)	Every year (additional tests based on your health history)
Breast exam	Every year	Every year
Cholesterol check	Once (additional tests based on history)	Based on history
Colorectal cancer	Starting at age 45; talk to your doctor if you are at risk	Based on history

Type of service	21–64 years old	65 years old and over
Flu vaccine	Every year	Every year
Health education	Every doctor visit	Every doctor visit
HIV screening	Ask your doctor if you are at risk	Ask your doctor if you are at risk
Immunizations (shots)	Ask your doctor if you are at risk	Ask your doctor if you are at risk
Mammogram	Every year starting at age 45 or based on medical need; every other year starting at age 55	Every other year or based on medical need
Pap smear	Annually for sexually active women	See your PMP or GYN
Physical exam (unclothed)	Every year	Every year
Pneumonia vaccine		Once on or after age 65
Prostate screening	Every year after age 50 (additional tests based on your health history)	Every year
Sexually Transmitted Infection screening	At least once during pregnancy (additional tests based on your health history)	Ask your doctor if you are at risk
Tdap (tetanus/diphtheria/ acellular pertussis)	Every 10 years	Every 10 years
Testicular exam	Every two years from age 18–39	Not required
Tuberculosis screening	Once (additional tests based on your health history)	Ask your doctor if you are at risk

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

Women's health and pregnancy services

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

Female members, or members assigned female at birth, have direct access to preventive and well-care services from a gynecologist within our provider network without a referral from a PMP.

As a member, UnitedHealthcare Community Plan will help you:

- Choose a primary care obstetrician (PCO), nurse practitioner, physician assistant, or certified nurse midwife (CNM) for pregnancy care
- Get information about BabyScripts, a maternity program for you and your baby
- Schedule appointments and exams
- Choose a pediatrician (child's doctor) for your new baby
- Choose a PMP for you after the birth or return to the PMP you had before your pregnancy. Call Member Services after your delivery.
- Get information on community programs such as SNAP (Supplemental Nutritional Assistance Program) and WIC (Women, Infants, and Children). Call WIC at 1-800-522-0874.

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

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

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

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

At your postpartum checkup, your doctor will:

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

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

BabyScripts

Earn gifts by participating in this healthy pregnancy program. Call Member Services for more information.

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

Substance use disorder helpline

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

Get help for yourself today

Call the Substance Use Disorder Helpline toll-free at **1-855-780-5955**. Available 24/7.

Family planning services

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

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

Vision care

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

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

- One routine eye exam per year — no referral is necessary
- One pair of prescription eyeglasses every 12 months

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

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

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

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

Dental care

Getting a yearly dental checkup is important to your health. Good oral health is key to good overall health. Painful, broken, and missing teeth can make eating healthy more difficult. Gum disease can cause swelling or infection, and that can impact the health of your whole body. Your Hoosier Care Connect coverage includes these dental services:

- Two exams and cleanings per year
- Bitewing X-ray once every 12 months and one complete set of X-rays every three years
- Restorations such as fillings
- Needed services after a traumatic injury
- Orthodontics, only if other issues are present, such as a cleft palate or other facial deformity
- Periodontal care, which includes deep cleanings and surgical treatment for gum disease
- Partial, full dentures, and repairs to partials, and dentures
- Sedation and nitrous oxide, if medically necessary

Dental care for children

For young children, their first dental visit with a pediatric or family dentist should happen as soon as the first tooth comes in, but not later than their first birthday. Your coverage includes these dental services. It is important for everyone to see a dentist regularly.

If your family dentist does not see children who are under the age of 3, please contact us. We can help you find a pediatric dentist. These dentists are trained to work with younger children.

Members with special needs

Sometimes people have a hard time going to the dentist. They may be sensitive to touch. They might need extra time or gentle care. Let us help you find the right dentist for you or your family.

The dangers of gum disease

- People with gum disease are two to three times more likely to have a heart attack or stroke
- Diabetes increases the chance of gum disease. Gum disease plus diabetes increases the danger for other health issues.
- Some germs related to gum disease can cause blood clots
- Gum disease increases bacteria in your mouth. It can make heart conditions worse. It can cause swelling of the heart muscle.

Getting dental care

The good news is that dental problems can be treated. See your dentist two times a year for a cleaning and a checkup. Learn the right way to care for your teeth and gums. Even people who do not have teeth need to get a yearly oral cancer screen. Catching oral cancer early improves the chances to stop it or cure it completely.

Some dental services require prior authorization. This means your dentist must get an approval before the service is performed. Your dentist must make the prior authorization request.

You may see any dentist who is registered with the IHCP as a Medicaid provider. Your dentist does not have to be part of the UnitedHealthcare network. **You should not be asked to pay for any services that are part of your Hoosier Care Connect coverage.** If you have trouble finding a dentist, call Member Services. Your Navigator can help you.

If you have a dental emergency, go to the nearest emergency room. If you are not sure if your dental need is an emergency, call our NurseLine. You can reach NurseLine by calling **1-800-832-4643**. You can also go to **UHCDoctorChat.com** for a virtual visit. Both of these services are free and are available 24 hours a day, seven days a week.

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

Social needs

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

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

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

Extra programs to help you stay healthy

Call Member Services to learn more about:

One Pass fitness

One Pass goes beyond a gym membership. With One Pass, you can visit many fitness locations with one easy program. You can also join online workouts from home. This program is free. You must be 18 years or older to join One Pass. All members can get one free at-home fitness kit. We will send it to your home.

Free rewards programs

Get rewards when you complete healthy activities, like getting a needed checkup or screening. Our rewards are subject to change. For a current list of rewards, visit our website or call Member Services.

Member Services call center

Every Hoosier Care Connect member has a personal Navigator. This person can help resolve issues with coordinating care and issues with your prescriptions, providers, behavioral health, and home and social supports. Member Services Navigators can also assist with challenges due to insurance and payment, care delivery, and family welfare.

Community health workers

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

Caregiver support

Caring for others is difficult. It can also be rewarding. Being a caregiver can cause stress and burnout. We have a program to help you cope. We offer monthly calls. Topics include:

- Understanding care options
- Home safety
- Pain management
- Staying connected
- Living with grieving and loss

Anyone can join a monthly caregiver call:

- When: Third Tuesday of each month
- Time: 3:00 p.m. EST
- How: Dial 1-844-767-5679. Enter access code 1893910.

Low-cost internet resources

The Affordable Connectivity Program is a federal program that offers these discounts:

- Up to $30 per month toward internet service
- Up to $75 per month for households on qualifying Tribal lands
- One-time discount of up to $100 to buy a laptop, desktop computer, or tablet from participating providers

Internet access has many benefits. You can get virtual visits, take classes, and stay connected with your health plan. All Hoosier Care Connect members qualify for this program.

- To learn more about this program, visit **fcc.gov/acp**
- To apply, visit **acpbenefit.org**

Mom's Meals

This program provides 14 home-delivered meals for you if you need them. One example includes getting meals right after you are discharged from the hospital. Your Care Manager can coordinate this delivery service for you so that mealtime is easier while you heal.

Essentials box

If money is tight, it can be hard to spend money on groceries and cleaning supplies. Call your Navigator and take a social needs survey. We will send out a box of items like rice, chicken, fruit, vegetables, toilet paper, trash bags, and dish soap.

High School Equivalency (HSE)

It's not too late to finish high school. If you would like to get your HSE, we can help. Any member age 16 or older can be part of this program. Your Navigator can help you sign up for classes to help you get ready. We will send you a voucher so that you can take the test up to three times for free.

Doctor Chat

You can video chat with a provider online to ask about health care needs if your PMP is not available. Learn more at **UHCDoctorChat.com**.

24/7 NurseLine

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

Alternative healing

We offer options for some health items not covered by Medicaid. Talk to us about help getting items or services such as herbal medications/herbal remedies, vitamins and minerals, therapeutic massage, or acupuncture. If your provider asks you to buy something that is not covered by Medicaid, your Care Manager may be able to help.

HERO Council

We have a member advisory council called HERO Council. This group provides a forum for members and local community agencies to share opinions and give recommendations. HERO stands for Health, Empowerment, Resources, and Opportunities. At meetings, we discuss new and ongoing Hoosier Care Connect programs. It is a great opportunity for members to provide input about current processes and future changes to the Hoosier Care Connect program. All members and those who help them are welcome to attend meetings. We offer both in-person and meetings by phone. Would you like you to be a part of the HERO Council? Call Member Services to get invited to the next meeting.

Free smartphone

We offer a free mobile phone with UNLIMITED talk, text, and data. All members qualify for this free smartphone (one per household). Visit **mybenefitphone.com** to apply. Your Navigator can also help you with the application.

Sanvello app

Sanvello is a free app that can help you learn more about stress, anxiety, and depression. It has tools to track your progress. You can even connect with a large community of people and share advice, stories, and insights — anytime, anywhere. Upgrade to premium for free! Questions? Talk to your Care Manager. Please note that Sanvello will change its name to Self Care on Jan. 1, 2024.

Providers app (formerly Fresh EBT)

If you receive SNAP (Supplemental Nutrition Assistance Program) benefits, this app helps you make healthy choices on a budget. Check your balance quickly and easily, track spending, habits, find places that accept EBT, locate grocery deals, keep a shopping list, and get healthy low-cost recipes. On your phone, go to the App Store or Google Play. Search for EBT. Download the Providers app for free.

On My Way

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

Just Plain Clear Glossary

The Just Plain Clear® Glossary contains thousands of health care terms defined in plain, clear language to help you make informed decisions. Visit **justplainclear.com** to use this free and helpful tool.

Magnifier tool

We offer a free magnifier tool to our members who have trouble reading small print. It includes a light and allows you to see half a page at a time. We can also print and send out your letters in large font. Call your Navigator to request this tool. You can also set an email, large print, or braille preference for the mail you get from us.

Live and Work Well

Find support and resources that can help you and your family. This health and wellness website can be found at **LiveAndWorkWell.com**.

Pharmacy

Getting your prescriptions (medications)

Getting prescription medications is an important part of your health care. UnitedHealthcare Community Plan covers many prescription medications as well as over-the-counter medications, tobacco cessation drugs, and diabetes supplies. If your doctor prescribes a medicine that is listed on your plan's preferred drug list (PDL), it is covered. If your drug is not preferred, your health care provider may request a different drug for you that is preferred. They can also work with UnitedHealthcare Community Plan to get an approval (prior authorization) to allow for that medication. This includes contraceptives and supplies (i.e., birth control pills and condoms).

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

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

- View the PDL
- Find a pharmacy near you

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

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

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

Prior approval

Prior approval (authorization) of prescription drugs

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

90-day supply benefit

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

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

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

Medication therapy management

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

The Right Choices Program

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

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

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

Behavioral health services

Mental health and substance use treatment benefits

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

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

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

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

Substance Use Disorder (SUD) residential treatment

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

Peer Recovery Services

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

What to expect when getting help

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

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

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

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

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

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

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

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

Making a behavioral health appointment

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

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

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

If you feel you may harm yourself or others, call 911 for emergency help. If you need help finding a provider or scheduling an appointment, please call Member Services for support.

For referrals for psychotropic medications

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

Resources and support

Behavioral Health Help Line
1-855-780-5955

We are available 24/7 to answer your questions. These may include your personal health, care for a family member, coverage, cost of care, problems with drugs or alcohol, and more. We are committed to making it as easy as possible for you to access the services you or your loved one may need. Simply call us any time, day or night, and we'll be here. You can also reach us by calling the number on the back of your member ID card.

Sanvello app

Sanvello is a free mobile app that can help you learn more about stress, anxiety, and depression. It has tools to track your progress. You can even connect with a large community of people and share advice, stories, and insights — anytime, anywhere. Upgrade to premium for free! Questions? Talk to your Care Manager. Please note that Sanvello will change its name to Self Care on Jan. 1, 2024.

Crisis Text Line

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

KEY Warmline

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

Live and Work Well

Find support and resources that can help you and your family. This health and wellness website can be found at **LiveAndWorkWell.com**.

Plan procedures

Prior authorization process

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

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

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

Expedited (Rush) decisions in urgent, life-threatening situations should be made no later than 48 hours following the receipt of the authorization request unless an extension is in effect. For more information on Notice of Adverse Benefit Determination letters, call Member Services to talk about actions you can take. If you do not agree with a decision made by UnitedHealthcare Community Plan, you can ask us to review the request again. This request for a review is called an appeal.

Call Member Services for more information about filing an appeal

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

Prior approval for an out-of-network provider

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

Prior authorization medication

Some medications may require prior authorization. Prior authorization decisions for medications will be made within 24 hours from the receipt of the request. If additional information is needed, UnitedHealthcare will send a request to your provider and issue a final decision no later than seven working days from the date of the request. Please see UnitedHealthcare's drug list at **UHCCommunityPlan.com/IN**. **If you are asked to pay full price for your medications, call Member Services for help.** You should never be charged for a prescription.

Other insurance

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

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

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

Coordination of benefits/third party liability

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

New medical treatments and technology

If you or your doctor would like to use a new medical treatment, call your Navigator or Care Manager. We want you to be healthy. A group of doctors and specialists will review the request from your doctor. They will let your PMP or specialist know if the treatment is medically necessary and will share the reasons for the decision. Some medical services are not yet proven to be effective. New practices, treatments, tests, and technologies are reviewed nationally by UnitedHealthcare Community Plan. The information is reviewed by a committee of doctors, nurses, pharmacists, and guest experts.

Provider incentive program

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

Member complaints and grievances

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

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

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

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

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

We will send an acknowledgment letter within three business days from the day we receive your grievance.

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

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

Should you need help following a health plan process or understanding a decision, your Member Services Navigator will help you.

Notice of adverse benefit determination

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

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

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

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

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

Appeals

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

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

Send your written appeal to:

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

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

We will decide within 30 calendar days of receipt and notify you in writing within five business days of our decision. This is called a standard appeal.

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

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

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

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

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

External Review by an Independent Review Organization

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

The written appeal must be completed before asking for an external review by an IRO. If you do not agree with the IRO's decision, you may ask for a State Fair Hearing (SFH).

You may ask for an external review by writing a letter to:

UnitedHealthcare Community Plan
Attn: Indiana Grievance and Appeal Manager
P.O. Box 31364
Salt Lake City, UT 84131-0364

State Fair Hearing

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

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

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

Will my services continue during the appeal process?

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

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

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

Questions and answers on appeals

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

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

Q: How do I file an appeal?

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

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

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

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

Advance directives

It is your right to choose the medical care you receive. This includes life-saving measures in an emergency. It also includes your wishes during a mental health crisis. An advance health directive is a legal form. On it, you can list what health care you want in case you cannot talk or make decisions later on.

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

Ready to make your advance directive? You can visit the PREPARE for your care website (**prepareforyourcare.org**). You can get an advance directive form at drugstores, hospitals, law offices, and doctors' offices. You may have to pay for the form. You can ask your family, PMP, or someone you trust to help you fill out the form.

You have the right to have your advance directive placed in your medical records. You have the right to change or cancel your advance directive at any time. You have the right to learn about changes to advance directive laws. The **Indiana Department of Health** has a website that explains the law in Indiana. Go to **in.gov** and search for Advance Directives Resource Center.

UnitedHealthcare Community Plan is providing general advance directive information; always consult your lawyer or legal advisor before signing any legal document. If you would like more information, talk to your Care Manager or Navigator. You may also find information about advance directives at **UHCCommunityPlan.com/IN**.

Fraud, waste, and abuse

When you pay attention and report things that may be fraud, waste, or abuse, this helps protect the Hoosier Care Connect program. Members and providers can commit fraud, waste, or abuse. If you think a Hoosier Care Connect member or provider has committed fraud, waste, or abuse, it is your responsibility to let someone know.

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

Examples of fraud, waste, and abuse:

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

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

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

If you think fraud, waste, or abuse is happening, report it. Call the UnitedHealthcare Fraud Hotline at **1-844-359-7736**. You can also call Member Services at **1-800-832-4643**. We will not use your name in your report. You will not get in trouble for reporting this. We will look into the matter for you. The State of Indiana also has a fraud, waste, and abuse toll-free hotline. You can call **1-800-403-0864**. Reports can be made anonymously. TTY users may dial **711** for all options.

Life changes

Changes you should report to your Navigator include:

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

Changing health plans

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

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

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

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

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

If you are not happy with the outcome of a grievance or appeal, you have the right to request to change health plans for just cause. Requests can be made by phone or mail to Maximus. Maximus is the state enrollment broker. They process a just cause request only after a grievance has been completed. Maximus is the organization to contact about changing health plans. The phone number is 1-866-963-7383. You can also send a letter. The address is:

Maximus
101 W. Ohio Street
Indianapolis, IN 46204

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

Transition of care if you change plans

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

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

Recommendations for changes

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

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

  UnitedHealthcare Community Plan
  2955 N. Meridian Street, Suite 400
  Indianapolis, IN 46208

Other plan details

Member rights and responsibilities

Member rights

You have the right to:

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

Member responsibilities

You have the responsibility to:

Use services

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

Give information

- Tell your PMP and Navigator or Care Manager about your health and changes in your health
- Tell your Navigator about changes in your private insurance. This includes adding or ending other insurance.
- Talk to your providers and your Care Manager about your health care. Ask questions about the ways your health problems can be treated.
- Notify your Care Manager and the Indiana FSSA if your family size changes, if you move, or if your income changes
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care

Other plan details

“Healthier lives. Healthier you.”

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

Community resources

Behavioral health

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

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

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

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

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

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

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

National Suicide Prevention Lifeline
Toll-Free: 988
https://suicidepreventionlifeline.org/

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

Social needs

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

Find Help
https://UHCHealthierLives.com

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

AARP Friendly Voices
1-888-281-0145

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

Long-term medical conditions

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

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

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

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

American Stroke Association
www.stroke.org

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

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

Resources for children

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

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

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

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

WIC
1-800-522-0874

Other resources

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

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

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

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

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

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

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

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

Health plan definitions

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

Care Management — If you want help, you may work with a care coordinator, Care Manager, behavioral health, or complex case manager to help you set goals and get access to care. This can include covered services, community-based agency referrals, and coordination of non-covered services, like a waiver.

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

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

Cost Sharing — Money you pay out of pocket to get services, such as a copay for prescriptions or going to the emergency room for a reason that is not an emergency.

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

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

Emergency Services — Services to treat an emergency condition.

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

Hospitalization — Being admitted to or staying in a hospital.

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

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

Other plan details

Navigator — A person you can call for support and guidance about your Hoosier Care Connect coverage and benefits. Your Navigator will call you every few months to make sure you are getting the services you need.

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

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

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

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

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

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

Postpartum Care — Health care provided for a period of 12 months post-delivery. Family planning services are included.

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

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

Primary Medical Provider (PMP) — A person who is responsible for the management of the member's health care. A PMP may be a general or family doctor, physician assistant, internal medicine doctor, OB/GYN, nurse midwife, nurse practitioner, clinical nurse specialist, or pediatrician.

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

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

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

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

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

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

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

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

Discrimination is against the law. UnitedHealthcare Community Plan of Indiana complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, religion, or sex.

UnitedHealthcare Community Plan of Indiana provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

UnitedHealthcare Community Plan of Indiana provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

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

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by **UnitedHealthcare Community Plan of Indiana**. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

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

Email: **UHC_Civil_Rights@uhc.com**

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

Online: **hhs.gov/civil-rights/filing-a-complaint/index.html**

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

By phone: **1-800-368-1019** (TDD **1-800-537-7697**)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Plan Notices of Privacy Practices

THIS NOTICE 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, 2023

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

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

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

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

How we collect, use, and share your information

We collect, use, and share your HI with:

- You or your legal representative.
- Government agencies.

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

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

- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** We may collect, use, and share your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may collect, use and share your HI to send you appointment reminders and information about your health benefits.
- **For Communications to You.** We may use the phone number or email you gave us to contact you about your benefits, healthcare or payments.

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

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

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

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

Your rights

You have the following rights.

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

- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website **(www.uhccommunityplan.com)**.
- **To ask that we correct or amend** your HI. Depending on where you live, you can also ask us to delete your HI. 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. 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
- **Timing.** We will respond to your phone or written request within 30 days.
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

[1] This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; and UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. 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, 2023

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 the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus 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 ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Life Print Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, 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 Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; 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. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

We're here for you

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

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

UHCCommunityPlan.com/IN

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

United Healthcare
Community Plan