Minnesota – January 2023

Welcome to the community

UnitedHealthcare Community Plan of Minnesota Families and Children Member Handbook

This is also known as the Prepaid Medical Assistance Program (PMAP).
This booklet contains important information about your health care services.

Member Services:
1-888-269-5410, TTY **711**, or use your preferred relay services. This call is free.
8:00 a.m.–6:00 p.m., Monday–Friday

UnitedHealthcare
9800 Health Care Lane
Mail Code: MN006-W900
Minnetonka, MN 55343

myuhc.com/CommunityPlan

CSMN22MD0085146_000

UnitedHealthcare Community Plan

United Healthcare Community Plan

Civil Rights Notice

Discrimination is against the law. UnitedHealthcare Community Plan of Minnesota does not discriminate on the basis of any of the following:

- Race
- Color
- National origin
- Creed
- Religion
- Sexual orientation
- Public assistance status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital status
- Political beliefs
- Medical condition
- Health status
- Receipt of health care services
- Claims experience
- Medical history
- Genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UnitedHealthcare Community Plan of Minnesota. 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, UTAH 84130
Toll Free: **1-888-269-5410**, TTY **711**
Email: **UHC_Civil_Rights@uhc.com**

Auxiliary Aids and Services: UnitedHealthcare Community Plan of Minnesota provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact Member Services at 1-888-269-5410.**

Language Assistance Services: UnitedHealthcare Community Plan of Minnesota provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact Member Services at 1-888-269-5410.**

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Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UnitedHealthcare Community Plan of Minnesota. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: **ocrmail@hhs.gov**

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Religion
- Creed
- Sex
- Sexual orientation
- Marital status
- Public assistance status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104

Voice: 651-539-1100
Toll free: 800-657-3704
MN Relay: 711 or 800-627-3529
Fax: 651-296-9042
Email: **Info.MDHR@state.mn.us**

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National origin
- Religion (in some cases)
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
Voice: 651-431-3040 or use your preferred relay service

American Indian Health Statement

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

1-888-269-5410, TTY **711**

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအား အခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။*

កំណត់សម្គាល់៖ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះ ដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သး. နမ့်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီနၤလၢ တၢ်ကကွဲးကျိးထံဝဲဒဉ် လံာ်တီလံာ်မီတခါအံၤအဃိ ကိးလီတဲစိနီဉ်ဂံၢ် လၢထးအံၤန့ဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

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Welcome to UnitedHealthcare

We are pleased to welcome you as a member of UnitedHealthcare Community Plan of Minnesota (referred to as "UnitedHealthcare," "Plan" or "the Plan"). UnitedHealthcare (referred to as "we," "us," or "our") is part of the Families and Children program. We coordinate and cover your medical services. You will get most of your health services through the Plan's network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which doctor to go to.

If you are new to UnitedHealthcare, you will be receiving a New Member survey to complete by phone or online. This is a voluntary survey. It will take only a few minutes to fill out. We encourage you to complete this survey. The survey will help us connect you to health care services or other services available to you as a member. Based on your answers, we may contact you for additional information. If you have questions about this survey, please call Member Services.

This Member Handbook is our contract with you. It is an important legal document.

This Member Handbook includes:

- Contact information
- Information on how to get the care you need
- Your rights and responsibilities as a member of the Plan
- Information about cost sharing
- A listing of covered and non-covered health care services
- When to call your county worker
- Using the Plan coverage with other insurance or other sources of payment
- Information on what to do if you have a grievance (complaint) or want to appeal a Plan action, as defined in Section 13
- Definitions

The counties in the Plan service area are as follows:

- Anoka
- Carver
- Dakota
- Hennepin
- Ramsey
- Scott
- St. Louis
- Washington

Please tell us how we're doing. You can call us at any time. Contact Member Services at **1-888-269-5410**, TTY **711**. Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with us. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Section 1: Telephone numbers and contact information

How to contact our Member Services

If you have any questions or concerns, please call Member Services. We will be happy to help you. Member Services hours of service are 8:00 a.m.–6:00 p.m., Monday–Friday.

Call	**1-888-269-5410**, TTY **711**
Website	**myuhc.com/CommunityPlan/MN**
Mobile website	**UnitedHealthcare app**
Appeals and Grievances	Fax: **801-994-1082**

Address for submitting written appeal or grievance:

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

Refer to Section 13 for more information.

Chiropractic Services	**1-888-269-5410**, TTY **711**
Dental Services	**1-888-269-5410**, TTY **711**
Durable Medical Equipment Coverage Criteria	**1-888-269-5410**, TTY **711**
NurseLine	**1-800-718-9066**, TTY **711**

NurseLine's Registered Nurses give eligible consumers access to the immediate clinical support twenty-four hours a day, seven days a week using a toll-free number or internet chat.

Interpreter Services:	
American Sign Language (ASL)	**1-888-269-5410**, TTY **711**
Spoken Language	**1-888-269-5410**, TTY **711**
Mental Health and Behavioral Health Services	**1-888-269-5410**, TTY **711**
Prescriptions	**1-888-269-5410**, TTY **711**
Substance Use Disorder Services	**1-888-269-5410**, TTY **711**
Transportation	**1-888-444-1519**, TTY **711**

Other important contact information

People with hearing loss or a speech disability may call the following numbers to access the resources listed in this Member Handbook: **711**, Minnesota Relay Service at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service). Calls to these numbers are free.

For information and to learn more about health care directives and how to exercise an advance directive, please contact UnitedHealthcare Member Services at **1-888-269-5410**, TTY **711**. More information about health care directives can be found: **myuhc.com/CommunityPlan**. You may also visit the Minnesota Department of Health (MDH) website at: **https://www.health.state.mn.us/facilities/regulation/infobulletins/advdir.html**.

To report fraud and abuse UnitedHealthcare by telephone at 1-844-359-7736 or online at **https://www.uhc.com/fraud**. To report fraud or abuse directly to the State, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at 651-431-2650 or 1-800-657-3750 (toll free) or TTY 711; or use your preferred relay services; by fax at 651-431-7569; or by email at **DHS.SIRS@state.mn.us**. This call is free.

Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS) is a state agency that helps people meet their basic needs. It provides or administers health care, financial help, and other services. DHS administers the Medical Assistance (Medicaid) program through counties. If you have questions about your eligibility for Medical Assistance (Medicaid), contact your county worker.

Ombudsman for Public Managed Health Care Programs

The Ombudsman for Public Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving access, service, and billing problems. They can help you file a grievance or appeal with us. The ombudsman can also help you request a State Appeal (Fair hearing with the state). Call 651-431-2660 or 1-800-657-3729 or TTY 711. This call is free. Hours of service are Monday through Friday, 8:00 a.m. to 4:30 p.m.

Section 2: Important information on getting the care you need

Each time you get health services, check to be sure that the provider is a Plan network provider. In most cases, you need to use Plan network providers to get your services. Members have access to a Provider Directory that lists Plan network providers. You may ask for a print copy of this at any time. To verify current information, you can call Member Services at **1-888-269-5410**, TTY **711**.

When you are a member or become a member of UnitedHealthcare you chose or were assigned to a Primary Care Provider (PCP). Your Primary Care Provider (PCP) can provide most of the health care services you need and will help coordinate your care. This provider will also advise you if you need to go to specialists. You may change your Primary Care Provider (PCP). Please Contact Member Services to change a provider.

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

- Cardiologist — for problems with the heart
- Pulmonologist — for problems with the lungs and breathing

You do not need a referral to see a provider. However, your primary care clinic can provide most of the health care services you need and will help coordinate your care.

Contact your primary care clinic for information about the clinic's hours, prior authorizations, and to make an appointment. If you cannot go to your appointment, call your clinic right away.

You may change your Primary Care Provider or clinic. To find out how to do this, call Member Services at **1-888-269-5410**, TTY **711**.

Out-of-plan specialty services

Sometimes members need to see a very specialized type of doctor. We will work with your PCP to make sure you get the specialist or service when you need it, for as long as you need it, even if the provider is not currently a network provider. There is no cost to you when we authorize the care or service before you see the provider.

Transition of care

If you are a newly enrolled member who is currently receiving care from a provider who is not a Plan network provider, we will help you transition to a network provider.

If a drug you are currently taking is not covered under your new plan, you may be able to receive up to a 90-day temporary supply. For more information, call Member Services.

Utilization management

UnitedHealthcare Community Plan wants you to get the right amount of quality care. We want to make sure that the health care services provided are medically necessary, right for your condition and are provided in the best care facility. We also need to make sure that the care you get is a covered benefit. The process to do this is called utilization management (UM).

We follow policies and steps to make decisions about approving medical services. We do not reward providers or staff for denying coverage. We do not give incentives for UM decisions. We do not reward anyone for saying no to needed care.

Prior authorizations

Our approval is needed for some services to be covered. This is called prior authorization. The approval must be obtained before you get the services or before we pay for them. Many of these services are noted in Section 7. Please work with your primary care provider to get a prior authorization when required. For more information, call Member Services at **1-888-269-5410**, TTY **711**.

In most cases, you need to use Plan network providers to get your services. If you need a covered service that you cannot get from a Plan network provider, you must get a prior authorization from us to go to an out-of-network provider. Exceptions to this rule are:

- Open access services: family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for acquired immune deficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related conditions. You can go to any doctor, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- Emergency and post-stabilization services

If we are unable to find you a qualified Plan network provider, we must give you a standing prior authorization for you to go to a qualified specialist for any of the following conditions:

- A chronic (on-going) condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first three months (first trimester)

If you do not get a prior authorization from us when needed, the bill may not be paid. For more information, contact Member Services **1-888-269-5410**, TTY **711**. If a provider you choose is no longer in our Plan network, you must choose another Plan network provider. You may be able to continue to use services from a provider who is no longer a part of our Plan network for up to 120 days for the following reasons:

- An acute condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first three months (first trimester)
- A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year or is likely to result in death.
- A disabling or chronic condition that is in an acute phase

If your doctor certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

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

UnitedHealthcare Community Plan reviews the service request from you, your PCP, or your specialist. Your doctor will tell you if the service is approved. If the service has been denied, UnitedHealthcare Community Plan will send you a letter, called a Denial, Termination or Reduction (DTR) Letter.

In urgent, life-threatening situations we will usually make decisions no later than 72 hours following the receipt of the request from your doctor.

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. Refer to the Appeals section of this handbook for detailed information about the appeals process

There are some services we need to review before you can get them. Refer to **Prior authorizations** above.

If you have questions about UM, expedited decisions, or the criteria used in our decision-making, call Member Services at **1-888-269-5410**, TTY **711**. Language help is available.

At UnitedHealthcare, we have staff who can help you figure out the best way to use health care services. If you have questions about things like where to get services, getting authorization for services, or restrictions on prescription drugs, we can help. Contact Member Services at **1-888-269-5410**, TTY **711**. If you need language assistance to talk about these issues, UnitedHealthcare can give you information in your language through an interpreter. For sign language services, call TTY **711**. For other language assistance, contact Member Services **1-888-269-5410**, TTY **711**.

Covered and noncovered services

Enrollment in the Plan does not guarantee that certain items are covered. Some prescription drugs or medical equipment may not be covered. This is true even if they were covered before.

Some services and supplies are not covered. All health services must be medically necessary for them to be covered services. Read this Member Handbook carefully. It lists many services and supplies that are not covered. Refer to Sections 7 and 8.

Some services are not covered under the Plan but may be covered through another source. Refer to Section 9 for more information. If you are not sure whether a service is covered, contact Member Services **1-888-269-5410**, TTY **711**.

We may cover additional or substitute services under some conditions.

Cost sharing

You may be required to contribute an amount toward some medical services. This is called cost sharing. You are responsible to pay your cost sharing amount to your provider. Refer to Section 6 for more information.

Billing for services

Sometimes you will get a bill that should have been sent to us. If you get a bill you believe we should pay, do not throw it away. Call Member Services at **1-888-269-5410**, TTY **711**. We will work with you to find out if you need to pay the bill or if you should send it to us.

Payments to providers

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. If you paid for a service that you think we should have covered, call Member Services.

You may get health services or supplies not covered by the Plan if you agree to pay for them. Providers must have you sign a form acknowledging that you will be responsible for the bill. Providers must have a signed form before providing services or supplies that are not covered by the Plan.

Cultural awareness

We understand that your beliefs, culture, and values play a role in your health. We want to help you maintain good health and good relationships with your doctor. We want to ensure you get care in a culturally sensitive way.

Interpreter services

We will provide interpreter services to help you access services. This includes spoken language interpreters and American Sign Language (ASL) interpreters. Face-to-face spoken language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. Please contact Member Services **1-888-269-5410**, TTY **711** to find out which interpreters you can use.

Other health insurance

If you have other health or dental insurance, tell us **before** you get care. We will let you know if you should use the Plan network providers, or the health care providers used by your other insurance. We will coordinate with your other insurance plan. If your other health or dental insurance changes, tell your county worker.

If you have Medicare, you need to get most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services. The Plan does not pay for prescriptions that are covered under the Medicare Prescription Drug Program.

Private information

We, and the health care providers who take care of you, have the right to get information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

Restricted Recipient Program

The Restricted Recipient Program (RRP) is for members who have misused health services. This includes getting health services that members did not need, using them in a way that costs more than they should, or in a way that may be dangerous to a member's health. UnitedHealthcare will notify members if they are placed in the Restricted Recipient Program.

If you are in the Restricted Recipient Program, you must get health services from one designated Primary Care Provider, one clinic, one hospital used by the Primary Care Provider and one pharmacy. UnitedHealthcare may designate other health services providers. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options, or consumer directed services.

You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your Primary Care Provider and received by the UnitedHealthcare Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to go to a non-designated provider who is the same provider type as one of their designated providers.

Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program. At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. You must file an appeal within 60 days from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. A member may request a State Appeal (Fair Hearing with the state) after receiving our decision that we have decided to enforce the restriction. Refer to Section 13.

Cancellation

Your coverage with us will be canceled if you are not eligible for Medical Assistance (Medicaid) or if you enroll in a different health plan.

If you are no longer eligible for Medical Assistance (Medicaid), you may be eligible to purchase health coverage through MNsure. For information about MNsure, call 1-855-3MNSURE or 1-855-366-7873, use your preferred relay services, or visit **www.MNsure.org**. This call is free.

Section 3: Member Bill of Rights

You have the right to:

- Be treated with respect, dignity, and consideration for privacy
- Get the services you need 24 hours a day, seven days a week. This includes emergencies.
- Be told about your health problems
- Get information about treatments, your treatment choices, and how treatments will help or harm you
- Participate with providers in making decisions about your health care
- Have a candid discussion about appropriate or medically necessary treatment options for conditions, regardless of cost or benefit coverage
- Refuse treatment and get information about what might happen if you refuse treatment
- Refuse care from specific providers
- Know that we will keep your records private according to law
- Ask for and get a copy of your medical records. You also have the right to ask to correct the records.
- Get notice of our decisions if we deny, reduce, or stop a service, or deny payment for a service
- File a grievance or appeal with us. You can also file a complaint with the Minnesota Department of Health.
- Request a State Appeal (Fair Hearing with the state) with the Minnesota Department of Human Services (also referred to as "the state"). You must appeal to us before you request a State Appeal. If we take more than 30 days to decide your plan appeal and we have not asked for an extension, you do not need to wait for our decision to ask for a State Appeal.
- Receive a clear explanation of covered home care services
- Give written instructions that inform others of your wishes about your health care. This is called a "health care directive." It allows you to name a person (agent) to make decisions for you if you are unable to decide, or if you want someone else to decide for you.

- Choose where you will get family planning services, diagnosis of infertility, sexually transmitted disease testing and treatment services, and AIDS and HIV testing services
- Get a second opinion for medical, mental health, and substance use disorder services
- Be free of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request a written copy of this Member Handbook at least once a year
- Get the following information from us, if you ask for it. Call Member Services at **1-888-269-5410**, TTY **711**.
  - Whether we use a physician incentive plan that affects the use of referral services, and details about the plan if we use one
  - Results of an external quality review study from the state
  - The professional qualifications of health care providers
- Make recommendations about our rights and responsibilities policy
- Exercise the rights listed here
- Get information about UnitedHealthcare, its services, its providers, and member rights and responsibilities

Section 4: Member responsibilities

You have the responsibility to:

- Read this Member Handbook and know which services are covered under the Plan and how to get them
- Show your health plan member ID card and your Minnesota Health Care Program card every time you get health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.
- Establish a relationship with a Plan network Primary Care Provider before you become ill. This helps you and your Primary Care Provider understand your total health condition.
- Give information asked for by your Primary Care Provider or health plan so the right care or services can be provided to you. Share information about your health history.
- Work with your Primary Care Provider to understand your total health condition. Develop mutually agreed-upon treatment goals when possible. Follow plans and instructions for care that you have agreed to with your doctor. If you have questions about your care, ask your Primary Care Provider.
- Know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems
- Practice preventive health care. Have tests, exams and vaccinations recommended for you based on your age and gender.

Contact us if you have any questions, concerns, problems, or suggestions. Contact Member Services **1-888-269-5410**, TTY **711**.

Section 5: Your health plan member identification (ID) card

Each member will receive a Plan member ID card.

Always carry your Plan member ID card with you.

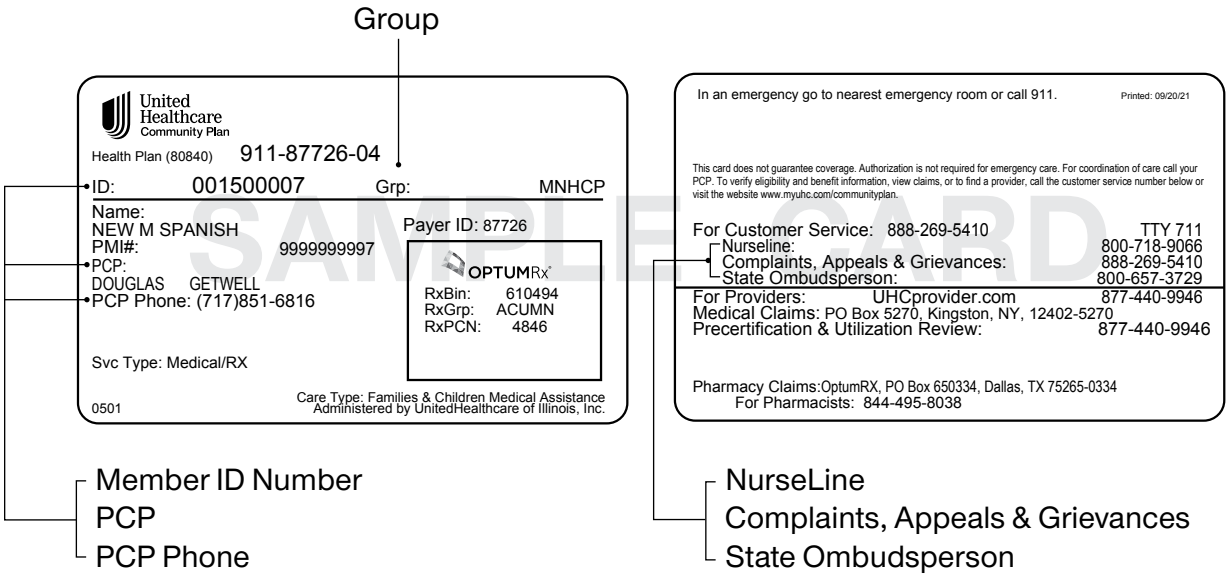
You must show your Plan member ID card whenever you get health care.

You must use your Plan member ID card along with your Minnesota Health Care Program card. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Contact Member Services **1-888-269-5410**, TTY **711** right away if your member ID card is lost or stolen. We will send you a new card.

Call your county worker if your Minnesota Health Care Program card is lost or stolen.

Here is a sample Plan member ID card to show what it looks like:



Section 6: Cost sharing

Cost sharing refers to your responsibility to pay an amount towards your medical costs. For people in the Families and Children program, cost sharing consists only of copays.

You will pay no more than five percent of your monthly family income for cost sharing. This may reduce the copay amount to less than the amounts listed here. DHS will tell us each month if you have a reduced cost sharing amount.

Copays

The members listed here **do not** have to pay copays for medical services that are covered by Medical Assistance (Medicaid) under the Plan:

- Pregnant women (if you become pregnant, tell your county worker right away)
- Members under age 21
- Members receiving hospice care
- Members residing in a nursing home, hospital, or other long-term care facility for more than 30 days
- American Indians who receive or have ever received a service(s) from an Indian Health Care Provider, or through Indian Health Service Contract Health Services (IHS CHS) referral from an IHS facility

Some services require copays. A copay is an amount that you will be responsible to pay to your provider.

Copays are listed in the following chart:

Service	Copay amount
Non-preventive visits (such as visits for a sore throat, diabetes checkup, high fever, sore back, etc.) provided by a physician, physician assistant, advanced practice nurse, certified professional midwife, chiropractor, acupuncturist, podiatrist, audiologist, or eye doctor. There are no copays for mental health services.	$3.00
Diagnostic procedures (for example, endoscopy, arthroscopy)	$3.00
Emergency room visit when it is not an emergency	$3.50
Brand name prescriptions The most you will have to pay in copays for prescriptions is $12.00 per month.	$3.00
Generic prescriptions The most you will have to pay in copays for prescriptions is $12.00 per month.	$1.00

The most you will have to pay in copays for prescriptions is $12.00 per month. Copays will not be charged for some mental health drugs and most family planning drugs.

If you have Medicare, you must get most of your prescription drugs through a Medicare Prescription Drug Program (Medicare Part D) plan. You may have different copays with no monthly limit for some of these services.

You must pay your copay directly to your provider. Some providers require that you pay the copay when you arrive for the medical service. The hospital may bill you after your non-emergency visit to the emergency room.

If you are unable to pay the copay, the provider must still provide services. This is true even if you have not paid your copay to that provider in the past or if you have other debts to that provider. The provider may still bill you for the unpaid copays.

We get information from the state about which members do not have copays. You may need to pay a copay until you are listed in our system as a person who does not have to pay copays.

Examples of services that **do not** have copays:

- Dental services
- Emergency services
- Eyeglasses
- Family planning services and supplies
- Home care
- Immunizations
- Inpatient hospital stays
- Interpreter services
- Medical equipment and supplies
- Medical transportation
- Mental health services
- Preventive care visits, such as physicals
- Rehabilitation therapies
- Repair of eyeglasses
- Services covered by Medicare, except for Medicare Part D drugs
- Some mental health drugs (antipsychotics)
- Some preventive screenings and counseling, such as cervical cancer screenings and nutritional counseling
- Substance use disorder treatment
- Tests such as blood work and X-rays
- Tobacco use counseling and interventions
- 100% federally funded services at Indian Health Services clinics

This is not a complete list. Contact Member Services at **1-888-269-5410**, TTY **711** if you have questions.

Section 7: Covered services

This section describes the major services that are covered under the Plan for Medical Assistance (Medicaid) members. It is not a complete list of covered services. If you need help understanding what services are covered, contact Member Services at **1-888-269-5410**, TTY **711**. Some services have limitations. Some services require a prior authorization. Make sure there is a prior authorization in place before you get the service. A service marked with an asterisk (*) means a prior authorization is required or may be required. Some services require a prior authorization. All health care services must be medically necessary for them to be covered. Contact Member Services at **1-888-269-5410**, TTY **711** for more information.

Some services require cost sharing. Cost sharing refers to your responsibility to pay an amount toward your medical costs. Refer to Section 6 for information about cost sharing and exceptions to cost sharing.

Acupuncture services

Covered services:

Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing.

Up to 20 units of acupuncture services are allowed per calendar year without authorization. Ask for prior authorization if additional units are needed.*

* Requires or may require prior authorization.

Acupuncture services are covered for the following:

- Acute and chronic pain
- Depression
- Anxiety
- Schizophrenia
- Post-traumatic stress syndrome
- Insomnia
- Smoking cessation
- Restless legs syndrome
- Menstrual disorders
- Xerostomia (dry mouth) associated with the following:
  - Sjogren's syndrome
  - Radiation therapy
- Nausea and vomiting associated with the following:
  - Postoperative procedures
  - Pregnancy
  - Cancer care

Child and Teen Checkups (C&TC)

Covered services:

Child and Teen Checkups (C&TC) preventive health visits include:

- Growth measurements
- Health education
- Health history including nutrition
- Developmental screening
- Social-emotional or mental health screening
- Head-to-toe physical exam
- Immunizations
- Lab tests
- Vision checks
- Hearing checks
- Oral health, including fluoride varnish application

Notes:

C&TC is a health care program of well-child visits for members under age 21. C&TC visits help keep kids healthy and can provide more support, if needed. How often a C&TC is needed depends on age:

- Birth to 2 1/2 years: 0–1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months
- 3 to 21 years: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20 years

Starting at age 11, each visit may include one-on-one time with the healthcare provider. This gives time for questions and discussion about health needs and goals and helps children and young adults learn to manage their own health.

Contact your Primary Care Clinic to schedule your C&TC well child and preventive health visits.

* Requires or may require prior authorization.

Chiropractic care

Covered services:

- One evaluation or exam per calendar year
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine — up to 24 visits per calendar year, limited to six per month. Visits exceeding 24 per calendar year or six per month require a prior authorization.
- X-rays when needed to support a diagnosis of subluxation of the spine

Not covered services:

- Other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor

Dental services (for adults except pregnant women)

Covered services:

Diagnostic services:

- Comprehensive exam (once every five years) (cannot be performed on same date as a periodic or limited evaluation)
- Periodic exam (once per calendar year) (cannot be performed on same date as a limited or comprehensive evaluation)
- Limited (problem-focused) exams (once per day) (cannot be performed on same date as a periodic or comprehensive oral evaluation or dental cleaning service; documentation must include notation of the specific oral health problem or complaint)
- Teledentistry for diagnostic services
- Imaging services, limited to:
  - Bitewing (once per calendar year)
  - Single X-rays for diagnosis of problems (four per date of service)
  - Panoramic (once every five years and as medically necessary; once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure)
  - Full mouth X-rays (once every five years and only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery)

* Requires or may require prior authorization.

Preventive services:

- Dental services (for adults except pregnant women)
- Dental cleaning (limited to two per calendar year; up to four times per year if medically necessary with Prior Authorization)
- Fluoride varnish (once per calendar year)
- Cavity treatment (once per tooth per six months) (cannot be performed on same date as fluoride varnish service or emergency treatment of dental pain service)

Restorative services:

- Fillings (limited to once per tooth per 90 days).
  Please confirm details of coverage limits and distinguish from cavity treatments allowed once per tooth per 6 months.*
- Sedative fillings for relief of pain (cannot be performed on same date as emergency treatment of dental pain service)

Endodontics (root canals) (on anterior teeth and premolars only and once per tooth per lifetime; retreatment is not covered).

- Oral surgery(limited to extractions, removal of impacted teeth or tooth roots, biopsies, and incision and drainage of abscesses)

Periodontics:

- Gross removal of plaque and tartar (full mouth debridement) (once every five years) (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluation service)
- Scaling and root planing (cannot be performed on same day as dental cleaning or full mouth debridement) (once every 2 years for each quadrant)
- Periodontal maintenance (once every 3 months for up to 2 years) following the completion of scaling and root planing

* Requires or may require prior authorization.

Prosthodontics:

- Removable appliances (dentures and partials) (one appliance every six years per dental arch); partials always require a prior authorization
- Adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials) (repairs to missing or broken teeth are limited to five teeth per 180 days)
- Replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances
- Replacement of partial appliances if the existing partial cannot be altered to meet dental needs
  - Tissue conditioning liners (once per appliance)
  - Precision attachments and repairs

Additional general dental services:

- Emergency treatment for pain (once per day)
- General anesthesia, deep sedation (when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery)
- Extended care facility/house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMDs), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), nursing facilities, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital) (cannot be performed on same date as oral hygiene instruction service)
- Behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
- Oral or IV sedation (only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)

Notes:

If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance (Medicaid).

Refer to Section 1 for Dental Services contact information.

* Requires or may require prior authorization.

Dental services (for children and pregnant women)

Covered services:

Diagnostic services:

- Comprehensive exam (once per five years) (cannot be performed on same date as a periodic or limited evaluation)
- Periodic exam (cannot be performed on same date as a limited or comprehensive evaluation)
- Limited (problem-focused) exams (cannot be performed on same date as a periodic or comprehensive oral evaluation or dental cleaning
- Oral evaluation for patients under age three (3) (once per lifetime) (cannot be performed on same date as oral hygiene instruction service)
- Detailed oral evaluation (cannot be performed on same date as full mouth debridement)
- Periodontal evaluation (cannot be performed on same date as full mouth debridement)
- Teledentistry for diagnostic services
- Imaging services, limited to:
  - Bitewing (once per calendar year) (pregnant women limited to once per five years)
  - Single X-rays for diagnosis of problems (four per date of service) (pregnant women limited to once per five years)
  - Panoramic (once in a five-year period except when medically necessary; once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure)
  - Full mouth X-rays (once in a five-year period)

Preventive services:

- Dental cleaning (limited to twice per calendar year; up to four per year as medically necessary)
- Fluoride varnish (once every six months) (cannot be performed on same date as emergency treatment of dental pain service)
- Sealants for children under age 21 (one every five years per permanent molar)
- Cavity treatment (once per tooth per six months) (cannot be performed on same date as emergency treatment of dental pain service or fluoride varnish application)
- Oral hygiene instruction service (cannot be performed on same date as oral evaluation for children under age three)

* Requires or may require prior authorization.

Restorative services:

- Fillings (limited to once per 90 days, per tooth). Individual crowns must be made of prefabricated stainless steel or resin with prior authorization.
- Sedative fillings for relief of pain (cannot be performed on same date as emergency treatment of dental pain service)

Endodontics (root canals) (anterior and premolar are limited to once per tooth per lifetime).

Periodontics:

- Gross removal of plaque and tartar (full mouth debridement) (once per five years) (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluation service)
- Scaling and root planing (cannot be performed on same day as dental cleaning or full mouth debridement) (once every 2 years for each quadrant)
- Periodontal maintenance (once every 3 months for up to 2 years) following the completion of scaling and root planing

Prosthodontics:

- Removable appliances (dentures, partials, overdentures) (one appliance every six years per dental arch)
- Adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials) (repairs to missing or broken teeth are limited to five teeth per 180 days)
- Replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances
- Replacement of partial appliances if the existing partial cannot be altered to meet dental needs
- Tissue conditioning liners
- Precision attachments and repairs

Oral surgery

- Including extractions

Orthodontics (only when medically necessary for very limited conditions for members age 20 and younger).

* Requires or may require prior authorization.

Additional general dental services:

- Emergency treatment of dental pain
- General anesthesia, deep sedation
- Nitrous oxide
- Extended care facility/house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMDs), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), nursing facilities, school or Head Start program, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital) (cannot be performed on same date as oral hygiene instruction service)
- Medications (only when medically necessary for very limited conditions)
- Behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
- Oral bite adjustments (complete adjustments with Prior Authorization) (limited to once per day)

Notes:

If you begin orthodontia services, we will not require completion of the treatment plan in order to pay the provider for services received.

If you are new to our health plan and have already started a dental service treatment plan (ex. Orthodontia care), please contact us for coordination of care.

Refer to Section 1 for Dental Services contact information.

Diagnostic services

Covered services:

- Lab tests and X-rays
- Other medical diagnostic tests ordered by your doctor

* Requires or may require prior authorization.

Doctor and other health services

Covered services:

- Doctor visits including:
  - Allergy immunotherapy and allergy testing
  - Care for pregnant women
  - Family planning — **Open access service**
  - Lab tests and X-rays
  - Physical exams
  - Preventive exams
  - Preventive office visits
  - Specialists
  - Telehealth consultation
  - Vaccines and drugs administered in a Primary Care Provider's office
  - Visits for illness or injury
  - Visits in the hospital or nursing home
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral. **Please call Member Services if you need assistance with referrals to Indian Heath Care Providers.**
- Behavioral Health Home: coordination of behavioral and physical health services
- Blood and blood products
- Clinical trial coverage: Routine care that is: 1) provided as part of the protocol treatment of a Clinical Trial; 2) is usual, customary, and appropriate to your condition; and 3) would be typically provided outside of a Clinical Trial. This includes services and items needed for the treatment of effects and complications of the protocol treatment.

* Requires or may require prior authorization.

- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Clinical services
- Community health worker care coordination and patient education services
- Community Medical Emergency Technician (CMET) services
  - Post-hospital or post-nursing home discharge visits ordered by your Primary Care Provider
  - Safety evaluation visits ordered by Primary Care Provider (PCP)
- Community Paramedic Services: certain services are provided by a community paramedic. The services must be a part of a care plan by your Primary Care Provider. The services may include:
  - Health assessments
  - Chronic disease monitoring and education
  - Help with medications
  - Immunizations and vaccinations
  - Collecting lab specimens
  - Follow-up care after being treated at a hospital
  - Other minor medical procedures
- Counseling and testing for sexually transmitted diseases (STDs), AIDS and other HIV-related conditions — **Open access service**
- Enhanced asthma care services (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma, when specific criteria are met)
  - Home visits to determine if there are asthma-triggers in the member's home
  - Must be provided by a registered environmental health specialist, healthy homes specialist, and lead risk assessor. You must contact one of these health care professionals to help you or you can contact Member Services.
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Hospital In-Reach Community-Based Service (IRSC) Coordination: Coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services.
- Immunizations

* Requires or may require prior authorization.

- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Respiratory therapy
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Treatment for AIDS and other HIV-related conditions — **Not** an open access service. You must go to a provider in the Plan network.
- Treatment for sexually transmitted diseases (STDs) — **Open access service**
- Tuberculosis care management and direct observation of drug intake

Not covered services:

- Artificial ways to become pregnant (artificial insemination, including in-vitro fertilization and related services, fertility drugs and related services)

Early Intensive Developmental and Behavioral Intervention (EIDBI) services (for children under age 21)

The purpose of the EIDBI benefit is to provide medically necessary, early and intensive intervention for people with Autism Spectrum Disorder (ASD) and related conditions. The benefit is also intended to:

- Educate, train and support parents and families
- Promote people's independence and participation in family, school and community life
- Improve long-term outcomes and the quality of life for people and their families

EIDBI services are provided by enrolled EIDBI providers who have expertise in the approved modalities which include:

- Applied Behavior Analysis (ABA)
- Developmental, Individual Difference, Relationship-Based (DIR)/Floortime Model
- Early Start Denver Model (ESDM)
- PLAY Project
- Relationship Development Intervention (RDI)
- Early Social Interaction (ESI)

* Requires or may require prior authorization.

Covered services:

- Comprehensive Multi-Disciplinary Evaluation (CMDE) which is needed yearly to access EIDBI services
- Individual Treatment Plan (ITP) development (initial)*
- Individual Treatment Plan (ITP) development and progress monitoring*
- Direct intervention: Individual and/or group*
- Observation and direction*
- Family/Caregiver training and counseling: Individual and/or group*
- Coordinated Care Conference (one per year without authorization)*
- Travel time*

Emergency medical services and post-stabilization care

Covered services:

- Emergency room services
- Post-stabilization care
- Ambulance (air or ground includes transport on water)

Not covered services:

Emergency, urgent, or other health care services delivered, or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Notes:

If you have an emergency and need treatment right away, call 911 or go to the closest emergency room. Show them your member ID card and ask them to call your Primary Care Provider

In all other cases, call your Primary Care Provider, if possible. The clinic's phone number is also on your member ID card.

* Requires or may require prior authorization.

If you are out of town, go to the closest emergency room or call 911. Show them your member ID card and ask them to call your Primary Care Provider.

You must call Member Services **1-888-269-5410**, TTY **711** within 48 hours or as soon as you can after getting emergency care at a hospital that is not a part of the Plan network.

Family planning services

Covered services:

- Family planning exam and medical treatment — **Open access service**
- Family planning lab and diagnostic tests — **Open access service**
- Family planning methods (for example, birth control pills, patch, ring, Intrauterine Device (IUD), injections, implants) — **Open access service**
- Family planning supplies with prescription (for example, condom, sponge, foam, film, diaphragm, cap) — **Open access service**
- Counseling and diagnosis of infertility, including related services — **Open access service**
- Treatment for medical conditions of infertility — **Not** an open access service. You must go to a provider in the Plan network. Note: This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS, and other HIV-related conditions — **Open access service**
- Treatment for sexually transmitted diseases (STDs) — **Open access service**
- Voluntary sterilization — **Open access service**
  Note: You must be age 21 or over and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.
- Genetic counseling — **Open access service**
- Genetic testing — **Not** an open access service. You must go to a provider in the Plan network.
- Treatment for AIDS and other HIV-related conditions — **Not** an open access service. You must go to a provider in the Plan network.

* Requires or may require prior authorization.

Not covered services:

- Artificial ways to become pregnant (artificial insemination, including in vitro fertilization and related services; fertility drugs and related services)
- Reversal of voluntary sterilization
- Sterilization of someone under conservatorship or guardianship

Notes:

Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency to get **open access services**, even if they are not in the Plan network.

Hearing aids

Covered services:

- Hearing aid batteries
- Hearing aids*
- Repair and replacement of hearing aids due to normal wear and tear, with limits

Home care services

Covered services:*

- Skilled nurse visit
- Rehabilitation therapies to restore function (for example, speech, physical, occupational, respiratory)
- Home health aide visit

* Requires or may require prior authorization.

Hospice

Covered services:*

Hospice benefits include coverage for the following services, when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

Notes:
Medicare election

You must elect hospice benefits to receive hospice services.

If you are both Medicare- and Medicaid-eligible and elect hospice, you must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit you from choosing hospice care through one program and not the other when you are eligible for both.

Members age 21 and under can still receive treatment for their terminal condition in addition to hospice services.

If you are interested in using hospice services, please contact Member Services **1-888-269-5410**, TTY **711**.

* Requires or may require prior authorization.

Hospital – Inpatient

Covered services:*

Inpatient hospital services are covered if determined to be medically necessary. Inpatient services require you to be admitted to the hospital. The hospital will contact us and ask for authorization for your care. You should go to the hospital only if you need emergency care or if your doctor told you to go. If the doctor who admits you to the hospital is not your PCP, you should call your PCP and let them know you are being admitted to the hospital.

This includes:

- Inpatient hospital stay
- Your semi-private room and meals
- Private room when medically necessary
- Tests and X-rays
- Surgery
- Drugs
- Medical supplies
- Professional services
- Therapy services (for example, physical, occupational, speech, respiratory)

Not covered services:

- Personal comfort items, such as TV, phone, barber or beauty services, guest services
- Charges related to hospital care for investigative services, plastic surgery, or cosmetic surgery are not covered unless determined medically necessary through the medical review process

Notes:

For further information on different types of inpatient admissions including inpatient behavioral health or substance use disorder (SUD), please refer those specific sections in this member handbook.

Non-emergency care received at a hospital may require a prior authorization. Please work with your primary care doctor to get a prior authorization when required. You can also call Member Services at the phone number in Section 1 for more information.

* Requires or may require prior authorization.

Hospital – Outpatient

You can receive outpatient services without a referral from your PCP. Your PCP can help you determine if you need outpatient services. Your doctor's office can help you schedule them.

Covered services:

- Urgent care for conditions that are not as serious as an emergency
- Outpatient surgical center
- Tests and X-rays
- Dialysis
- Emergency room services
- Post-stabilization care
- Observation services — If you're not admitted as an inpatient to the hospital, you may enter "outpatient observation" status until your provider determines your condition requires an inpatient admission to the hospital or a discharge home. Observation services are covered up to 48 hours. UnitedHealthcare will consider observation services up to 72 hours for unusual circumstances when submitted with additional documentation.*

Notes:

Non-emergency care received at a hospital may require a prior authorization. Please work with your primary care doctor to get a prior authorization when required. You can also call Member Services at the phone number in Section 1 for more information.

Housing stabilization services
(for members 18 years old and older)

Covered services:

The plan will pay for the following services for members eligible for Housing Stabilization Services:

- Housing consultation services: to develop a person-centered plan for people without Medical Assistance case management services
- Housing transition services: to help you plan for, find, and move into housing

* Requires or may require prior authorization.

- Housing sustaining services: to help you maintain housing
- Transportation to receive Housing Stabilization Services (within a 60 mile radius)

Notes:

You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. If you need Housing Stabilization Services, you can ask for an assessment or be supported by your provider or case manager. If you have a targeted case manager or waiver case manager, that case manager can support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you.

Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to receive this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.

Interpreter services

Covered services:

- Spoken language interpreter services
- Sign language interpreter services

Notes:

Interpreter services are available to help you get services.

Refer to Interpreter Services in Section 1 for contact information and to find out which interpreters you can use.

* Requires or may require prior authorization.

Medical equipment and supplies

Covered services:

- Prosthetics or orthotics
- Durable medical equipment (for example, wheelchairs, hospital beds, walkers, crutches, and wigs for people with alopecia areata). Contact Member Services for more information on coverage and benefit limits for wigs.
- Repairs of medical equipment
- Batteries for medical equipment
- Some shoes, when custom molded or part of a leg brace
- Oxygen and oxygen equipment
- Medical supplies you need to take care of your illness, injury, or disability
- Diabetic equipment and supplies
- Nutritional or enteral products, when specific criteria are met
- Incontinence products
- Family planning supplies — **Open access service**. Refer to Family Planning Services in this section.
- Augmentative communication devices, including electronic tablets
- Allergen-reducing products (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma)

Not covered services:

- Constructive modifications to home, vehicle, or workplace, including bathroom grab bars
- Environmental products (such as air filters, purifiers, conditioners, dehumidifiers) unless covered as allergen-reducing products for eligible members
- Exercise equipment

Notes:

You will need to go to your doctor and get a prescription in order for medical equipment and supplies to be covered. Please call the durable medical equipment coverage criteria phone number in Section 1 if you need more information on our durable medical equipment coverage criteria.

* Requires or may require prior authorization.

Mental health and behavioral health services

Covered services:

- Certified Community Behavioral Health Clinic (CCBHC)
- Clinical Care Consultation
- Crisis response services including:
  - Screening
  - Assessment
  - Intervention
  - Stabilization including residential stabilization
  - Community intervention (for members age 18)
- Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorders
- Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP) (for adult members age 18 or older and adolescent members age 12–17 who meet certain criteria)
- Forensic Assertive Community Treatment (ACT) (for members age 18 or older)
- Inpatient psychiatric hospital stay, including extended inpatient psychiatric hospital stay
- Mental health provider travel time
- Mental Health Targeted Case Management (MH-TCM)
- Outpatient mental health services including:
  - Explanation of findings
  - Family psychoeducation services (for members under age 21)
  - Mental health medication management
  - Neuropsychological services
  - Psychotherapy (patient or family, family, crisis, and group)
  - Psychological testing
- Physician Mental Health Services including:
  - Health and behavior assessment and intervention
  - Inpatient visits
  - Psychiatric consultations to Primary Care Providers
  - Physician consultation, evaluation, and management

* Requires or may require prior authorization.

- Rehabilitative Mental Health Services including:
  - Assertive Community Treatment (ACT) (for members age 18)
  - Adult day treatment (for members age 18)
  - Adult Rehabilitative Mental Health Services (ARMHS) is available to members 18 or over
  - Certified family peer specialists (for members under age 21)
  - Certified Peer Specialist (CPS) support services in limited situations
  - Children's mental health residential treatment services (for members under age 21)
  - Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment (for members under age 21)
  - Family psychoeducation services (for members under age 21)
  - Intensive Residential Treatment Services (IRTS) (for members over age 18)
  - Intensive Treatment Foster Care Services (for members under age 21)
  - Partial Hospitalization Program (PHP)
  - Intensive Rehabilitative Mental Health Services (IRMHS) (for members ages 16 through 20)
- Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services (for members ages eight (8) through 25)
- Psychiatric Residential Treatment Facility (PRTF) for members age 21 and under
- Telehealth

Not covered services:

- Conversion therapy

The following services are not covered under the Plan but may be available through your county. Call your county for information. Also refer to Section 9.

- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Treatment and room and board services at certain children's residential mental health treatment facilities in bordering states

* Requires or may require prior authorization.

Notes:

Refer to Mental Health and Behavioral Health Services in Section 1 for information on where you should call or write.

Use a Plan network provider for mental health services.

If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to go to any qualified health professional that is not in the Plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision.

We will not determine medical necessity for court-ordered mental health services. Use a Plan network provider for your court-ordered mental health assessment.

Obstetrics and gynecology (OB/GYN) services

Covered services:

- Prenatal, delivery, and postpartum care
- Childbirth classes
- Hospital services for newborns
- HIV counseling and testing for pregnant women — **Open access service**
- Treatment for HIV-positive pregnant women
- Treatment for newborns of HIV-positive mothers
- Testing and treatment of sexually transmitted diseases (STDs) — **Open access service**
- Pregnancy-related services received in connection with an abortion (does not include abortion-related services)
- Doula services by a certified doula supervised by either a physician, nurse practitioner, or certified nurse midwife and registered with the Minnesota Department of Health (MDH)
- Services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives

* Requires or may require prior authorization.

Not covered services:

- Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 or TTY 711. Also refer to Section 9. This call is free.
- Planned home births

Notes:

You have "direct access" to OB-GYN providers for the following services: annual preventive health exam, including follow-up exams that your doctor says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as **open access**, you can go to any doctor clinic, hospital, pharmacy, or family planning agency.

Optical services

Covered services:

- Eye exams
- Initial eyeglasses, when medically necessary
- Replacement eyeglasses, when medically necessary
  - Identical replacement of covered eyeglasses for loss, theft, or damage beyond repair
- Repairs to frames and lenses for eyeglasses covered under the Plan
- Tinted, photochromatic (for example, Transition® lenses) or polarized lenses, when medically necessary
- Contact lenses, when medically necessary

Not covered services:

- Extra pair of glasses
- Progressive bifocal or trifocal lenses (without lines)
- Protective coating for plastic lenses
- Contact lens supplies

* Requires or may require prior authorization.

Out-of-area services

Covered services:

- A service you need when temporarily out of the Plan service area. Please contact Member Services for questions on covered services out of the Plan service area.
- A service you need after you move from our service area while you are still a Plan member
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- Medically necessary urgent care when you are outside of the Plan service area. (Call Member Services at **1-888-269-5410**, TTY **711** as soon as possible.)
- Covered services that are not available in the Plan service area

Not covered services:

- Emergency, urgent, or other health care services or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Out-of-network services

Covered services:

- Certain services you need that you cannot get through a Plan network provider
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- A second opinion for mental health and substance use disorder
- Open access services
- Pregnancy-related services received in connection with an abortion (does not include abortion-related services)
- A non-emergency medical service you need when temporarily out of the network or plan service area that is or was prescribed, recommended, or is currently provided by a network provider

* Requires or may require prior authorization.

Prescription drugs
(for members who do **not** have Medicare)

Covered services:

- Prescription drugs
- Medication therapy management (MTM) services
- Certain over-the-counter drugs (when prescribed by a qualified health care provider with authority to prescribe)

Not covered services:

- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved by the FDA
- Medical cannabis

Notes:

The drug must be on our list of covered drugs (formulary).

The list of covered drugs (formulary) includes the prescription drugs covered by UnitedHealthcare. The drugs on the list are selected by the Plan with the help of a team of doctors and pharmacists. The list has to be similar to the list covered by Fee-for-Service Medical Assistance (Medicaid). The list also must include drugs listed in the Department of Human Services' Preferred Drug List (PDL).

In addition to the prescription drugs covered by UnitedHealthcare, some over-the-counter drugs are covered for you under your Medical Assistance (Medicaid) benefits. You can search for prescription drugs using our online search tool at **myuhc.com/CommunityPlan**. A list of covered drugs (formulary) is also posted on the website. You can also call Member Services and ask for a written copy of our list of covered drugs (formulary).

If a drug you are currently taking is not covered under your new plan, you may be able to receive up to a 90-day temporary supply. For more information, call Member Services.

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* Requires or may require prior authorization.

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior authorization (PA):** UnitedHealthcare requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval from UnitedHealthcare before you fill your prescriptions. If you don't get approval, UnitedHealthcare may not cover the drug.
- **Quantity limits (QL):** For certain drugs, UnitedHealthcare limits the amount of the drug that UnitedHealthcare will cover.
- **Preferred and non-preferred (P/NP):** For some groups of drugs, UnitedHealthcare requires you to try the preferred drugs before paying for the non-preferred drugs. In order to receive a non-preferred drug, your doctor or health care provider will have to get prior authorization.
- **Age requirements:** In some cases, there are age requirements for you to try certain drugs. A prior authorization is needed depending on your age and the specific drug prescribed.
- **Brand-name drugs:** Brand-name version of the drug will be covered by UnitedHealthcare only when:
  1. Your prescriber informs UnitedHealthcare in writing that the brand name version of the drug is medically necessary; **or**
  2. UnitedHealthcare prefers the dispensing of the brand-name version over the generic version of the drug; **or**
  3. Minnesota Law requires the dispensing of the brand-name version of the drug.

You can find out if your drug requires prior authorization, has quantity limits, has Preferred or Non-Preferred status, or has an age requirement by contacting Member Services or visiting our website at **myuhc.com/CommunityPlan**. A drug restriction or limit can be removed if your doctor submits a statement or documentation supporting the request. You can also get more information about the restrictions applied to specific covered drugs by contacting Member Services or visiting our website at **myuhc.com/CommunityPlan**.

If UnitedHealthcare changes prior authorization requirements, quantity limits, or other restrictions on a drug you are currently taking, UnitedHealthcare will notify you and your prescriber of the change at least 10 days before the change becomes effective.

We will cover a non-formulary drug if your Primary Care Provider shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your doctor is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.

* Requires or may require prior authorization.

We will cover an antipsychotic drug, even if it is not on our drug list, if your provider certifies this is best for you. There is no copay for antipsychotic drugs. In certain cases, we will also cover other drugs used to treat a mental illness or emotional disturbance even if the drug is not on our approved drug list. We will do this for up to one year if your provider certifies the drug is best for you and you have been treated with the drug for 90 days before: 1) we removed the drug from our drug list; or 2) you enrolled in the Plan.

For most drugs, you can get only a limited day supply at one time

Most drugs and certain supplies are available up to a 34-day supply. Certain drugs you take on a regular basis for a chronic or long-term condition are available up to a 90-day supply and are listed here: **https://mn.gov/dhs/assets/90-day-supply-list_tcm1053-490928.pdf**.

If UnitedHealthcare does not cover your drug or has restrictions or limits on your drug that you don't think will work for you, you can do one of these things:

- You can ask your health care provider if there is another covered drug that will work for you
- You or your health care provider can ask UnitedHealthcare to make an "exception" and cover the drug for you or remove the restrictions or limits. If your exception request is approved, the drug will be covered at the appropriate generic or brand name copay level.

Are there any restrictions on my coverage?

Some drugs on this list may have additional requirements or limits on coverage. These requirements and limits may include the following:

- **Prior authorization:** UnitedHealthcare requires your doctor to get prior authorization for certain drugs. This means that you will need to get approval from UnitedHealthcare before you fill your prescription. If you don't get approval, UnitedHealthcare may not cover the drug.
- **Quantity limits:** For certain drugs, UnitedHealthcare limits the amount of the drug that we will cover.
- **Age requirements:** Some drugs have age requirements. A prior authorization may be needed depending on your age and the specific drug prescribed.

  You can find out if your drug requires prior authorization, has quantity limits, or has an age requirement by looking in this list of covered drugs. An exception to a drug restriction or limit can be made if your doctor submits a statement or documentation supporting the request. Refer to Section 7: Covered Services (Prescription Drugs) in your Member Handbook for more information You can also get more information about the restrictions applied to specific covered drugs by calling Member Services at **1-888-269-5410**, TTY **711** or by visiting our website at **myuhc.com/CommunityPlan**. Also see "Can I ask for an exception to the coverage restrictions?"

* Requires or may require prior authorization.

- **Excluded drugs:** Some drugs are excluded from the list of covered drugs. This means they are not covered. Excluded drugs include the following:
  - Drugs used to treat sexual or erectile dysfunction
  - Drugs used to enhance fertility
  - Drugs used for cosmetic purposes, including drugs to treat hair loss
  - Drugs not clinically proven to be effective
  - Investigational or experimental drugs
  - Medical cannabis

  If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by us under the Plan. If the pharmacy won't call your doctor, you can. You can also call Member Services at **1-888-269-5410**, TTY **711** for help.

Specialty drugs are used by people with complex or chronic diseases. These drugs often require special handling, dispensing, or monitoring by a specially-trained pharmacist. Call Member Services at the number on the back of your Member Identification (ID) card.

If you are prescribed a drug that is on the UnitedHealthcare Specialty Drug List, your prescriber will need to send the prescription of that specialty drug to UnitedHealthcare's Specialty Pharmacy.

Name of Specialty Pharmacy: Optum Specialty Pharmacy

Phone and TTY: 1-855-427-4682, TTY 711

Fax: 1-877-342-4596

Hours of Operation: Available 24 hours a day, seven days a week

Website: **specialty.optumrx.com**

The Specialty Pharmacy will contact you to set up your account after you have authorized your prescriber to send the prescription to the Specialty Pharmacy and receive authorization from UnitedHealthcare Community Plan of Minnesota.

* Requires or may require prior authorization.

Prescription drugs
(for members who have Medicare)

Covered services:

- Some over-the-counter products, some prescription cough and cold products, and some vitamins that are not covered under the Medicare Prescription Drug Program (Medicare Part D)

Not covered services:

- Prescription drugs that are eligible to be covered under the Medicare Prescription Drug Program (Medicare Part D)
- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved by the FDA
- Medical cannabis

Notes:

Medicare pays for most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). **You must enroll in a Medicare prescription drug plan** to receive most of your prescription drug services. You will get your prescription drug services through your Medicare prescription drug plan — not through our Plan. You may have to pay a copay for prescriptions covered by your Medicare prescription drug plan.

* Requires or may require prior authorization.

Rehabilitation

Covered services:

- Rehabilitation therapies to restore function: physical therapy, occupational therapy, speech therapy
- Audiology services including hearing tests

Not covered services:

- Vocational rehabilitation
- Health clubs and spas

School based community services
(for members under age 21)

Covered services:

- Audiology
- Occupational therapy
- Outpatient mental health services
- Physical therapy
- Public health nursing
- Speech language pathology

Not covered services:

- Personal care assistance
- Assistive technology
- Special transportation
- Individualized Education Plan (IEP) services that are required to be covered through the school

* Requires or may require prior authorization.

Substance Use Disorder services (SUD)

Covered services:

- Screening, assessment and diagnosis
- Outpatient treatment
- Inpatient hospital
- Residential non-hospital treatment
- Outpatient methadone treatment
- Detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification)
- SUD treatment coordination
- Peer recovery support
- Withdrawal management

Not covered services:

Payment for room and board determined necessary by substance use disorder assessment is the responsibility of the Minnesota Department of Human Services.

Notes:

Refer to Section 1 for Substance Use Disorder Services contact information.

A qualified assessor who is part of the Plan network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor. We will do this within five working days of when we get your request. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment. You have the right to appeal. Refer to Section 13 of this Member Handbook.

* Requires or may require prior authorization.

Surgery

Covered services:

- Office, clinic visits and surgery
- Removal of port wine stain birthmarks
- Reconstructive surgery (for example, following mastectomy, following surgery for injury, sickness or other diseases; for birth defects)
- Anesthesia services
- Circumcision when medically necessary
- Gender confirmation surgery

Not covered services:

- Cosmetic surgery

Telehealth services

Covered services:

- Telehealth services cover medically necessary services and consultations delivered by a licensed health care provider by telephone or video call with the member. The member's location can be their home. Telehealth is defined as the delivery of health care services or consultations through the use of real time, two-way interactive audio and visual communications. The purpose of telehealth is to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment education, and care management of a patient's health care while the patient is at an originating site and the licensed health care provider is at a distant site.

* Requires or may require prior authorization.

Telemonitoring

Telemonitoring is the use of technology to provide care and support to a member's complex health needs from a remote location such as in a member's home. Telemonitoring can track a member's vital signs using a device or equipment that sends the data electronically to their provider for review. Examples of vital signs that can be monitored remotely include heart rate, blood pressure, and blood glucose levels.

Covered services:

- Telemonitoring services for members with high-risk, medically complex conditions like congestive heart failure, chronic obstructive pulmonary disease (COPD) or diabetes (when medically necessary or when certain criteria are met)

Transplants

Covered services:

- Organ and tissue transplants, including bone marrow, cornea, heart, heart-lung, intestine, intestine-liver, kidney, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, stem cell, and other transplants
- Ventricular Assist Device: inserted as a bridge to a heart transplant or as a destination therapy treatment

Notes:

The type of transplant must be: 1) listed in the Minnesota Department of Human Services Provider Manual; 2) a type covered by Medicare; or 3) approved by the state's medical review agent.

Transplants must be done at a transplant center that is a Medicare approved transplant center.

Stem cell or bone marrow transplants centers must meet the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT).

* Requires or may require prior authorization.

Transportation to and from medical services

Covered services:

- Ambulance (air or ground includes transport on water)
- Volunteer driver transport
- Unassisted transport (taxicab or public transit)
- Assisted transport
- Lift-equipped or ramp transport
- Protected transport
- Stretcher transport

Not covered services:

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking also including out of state travel. These services are not covered under the Plan but may be available through the local county or tribal agency. Call your local county or tribal agency for more information.

Notes:

If you need transportation to and from health services that we cover, call the transportation phone number in Section 1. We will provide the most appropriate and cost-effective form of transportation.

The Plan is not required to provide transportation to your primary care clinic if it is more than 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Call the transportation phone number in Section 1 if you do not have a primary care clinic that is available within 30 miles of your home or if you do not have a specialty provider that is available within 60 miles of your home.

* Requires or may require prior authorization.

Urgent care

An urgent condition is not as serious as an emergency. This is care for a condition that needs prompt treatment to stop the condition from getting worse.

Covered services:

- Urgent care within the Plan service area
- Urgent care outside of the Plan service area

Not covered services:

- Urgent, emergency, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Access to Urgent Care

Urgent care clinics are there for you when you need to see a doctor for a non-life-threatening condition, but your PCP isn't available or it's after clinic hours. Urgent care is available 24 hours a day. Common health issues ideal for urgent care include:

- Sore throat
- Ear infection
- Minor cuts or burns
- Flu
- Low-grade fever
- Sprains

If you have an urgent problem, call your PCP first. Your doctor can help you get the right kind of care. Your doctor may tell you to go to urgent care or the emergency room. You may also call NurseLine at 1-800-718-9066, TTY 711. NurseLine provides clinical support 24 hours per day, 7 days a week.

Planning ahead

It's good to know what in-network urgent care clinic is nearest to you. You can find an urgent care clinic in the Find-A-Doctor search tool at **myuhc.com/CommunityPlan**. Or you can call Member Services.

Call Member Services at **1-888-269-5410**, TTY **711** as soon as possible if you get urgent care outside the Plan service area.

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* Requires or may require prior authorization.

Section 8: Services we do not cover

If you get services or supplies that are not covered, you may have to pay for them yourself. Some "not covered" services and supplies are listed under each category in Section 7. The following is a list of other services and supplies that are not covered under the Plan. This is not a complete list. Call Member Services for more information.

- Autopsies (exams that are done on the bodies of people who have died to find out the cause of death)
- Cosmetic procedures or treatments
- Emergency, urgent, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.
- Experimental or investigative services
- Health care services or supplies that are not medically necessary
- Homeopathic and herbal products
- Hospital inpatient and nursing home incidental services, such as TV, phone, barber and beauty services, and guest services
- Supplies that are not used to treat a medical condition

Section 9: Services that are not covered under the Plan but may be covered through another source

These services are not covered under the Plan, but may be covered through another source, such as the state, county, federal government, tribe, or a Medicare prescription drug plan. To find out more about these services, call the Minnesota Health Care Programs (MHCP) Member Helpdesk at 651-431-2670 or 1-800-657-3739 or TTY 711, or use your preferred relay services. This call is free.

- Abortion services
- Case management for members with developmental disabilities
- Child welfare targeted case management
- Day training and habilitation services
- HIV case management
- Home Care Nursing (HCN): To learn more about HCN services, contact a home care agency for an assessment. To find a home care agency in your area, call the MHCP Member Helpdesk number listed in the first paragraph.
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Job training and educational services
- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance (Medicaid)
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays
- Personal Care Assistance (PCA). Community First Services and Supports (CFSS) will replace PCA services, upon federal approval. Contact your county of residence intake for long-term care services and supports to learn more about PCA services and to arrange for an assessment.
- Post-arrest Community-Based Services Coordination

Section 9: Services that are not covered under the Plan but may be covered through another source

- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Room and board associated with treatment services at children's residential mental health treatment facilities. Room and board may be covered by your county. Call your county for information.
- Services provided by federal institutions
- Services provided by a state regional treatment center, a state-owned long term care facility unless approved by us or the service is ordered by a court under conditions specified in law
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Home and Community-Based Services waivers

Section 10:
When to call your county worker

Call your county worker to report these changes:

- Name changes
- Address changes including moving out of Minnesota
- Pregnancy begin and end dates
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID card
- New insurance or Medicare — begin and end dates
- Change in income including employment changes

Section 11: Using the Plan coverage with other insurance

If you have other insurance, tell us before you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate our payments with them. This is called "coordination of benefits." Examples of other insurance include:

- No-fault car insurance
- Workers' compensation
- Medicare
- Tricare
- Other Health Maintenance Organization (HMO) coverage
- Other commercial insurance

When you become a member of the Plan, you agree to:

- Let us send bills to your other insurance
- Let us get information from your other insurance
- Let us get payments from your other insurance instead of having payments sent to you
- Help us get payments from your other insurance

If your other insurance changes, call your county worker.

Section 12: Subrogation or other claim

This first paragraph applies to certain noncitizens in the Families and Children program:

You may have other sources of payment for your medical care. They might be from another person, group, insurance company, or other organization. If you have a claim against another source for injuries, we will make a claim for medical care we covered for you. State law requires you to help us do this. The claim may be recovered from any settlement or judgment received by you from another source. This is true even if you did not get full payment of your claim. The amount of the claim will not be more than state law allows.

This second paragraph applies to members in the Families and Children program except certain noncitizens:

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and state laws provide that Medical Assistance (Medicaid) benefits pay only if no other source of payment exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than federal and state laws allow.

Section 13: Grievance, Appeal and State Appeal (Fair Hearing with the state) process

This section tells you about the grievance and appeal system including notices, grievances (complaints), health plan appeals, and State Appeals (Fair Hearing with the state) It tells you how and when to use the grievance and appeal system if you are not satisfied with your health care or service or disagree with a decision we made. It tells you about your rights when using the grievance and appeal system.

Please call Member Services at **1-888-269-5410**, TTY **711** if you have questions or want help filing a grievance or appeal.

Grievance and appeal system terms to know

A grievance is when you are not satisfied with the services you have received and may include any of the following:

- Quality of care or services provided
- Failure to respect your rights
- Rudeness of a provider or health plan employee
- Delay in appropriate treatment or referral
- Not acting within required time frames for grievances and appeals

A denial, termination, or reduction (DTR) (notice of action) is a form or letter we send you to tell you about a decision we made on a request for service, payment of a claim, or any other request. The notice will tell you how to file an appeal with the health plan or request a State Appeal (Fair Hearing with the state) if you disagree with our decision.

A health plan appeal is your request for us to review a decision we made. You may ask for an appeal if you disagree with our decision in any of the following **actions** (decisions):

- Denial or limited authorization of the type or level of service requested by your provider
- Reduction, suspension, or stopping of a service that was approved before
- Denial of all or part of payment for a service
- Not providing services (including transportation) in a reasonable amount of time
- Denial of a member's request to get services out of network for members living in a rural area with only one health plan
- Not providing a response to your grievance or appeal in the required timelines
- Denial of your request to dispute your financial liability including copayments and other cost sharing

Your provider may Appeal on your behalf with your written consent. Your treating provider may Appeal a Prior Authorization decision without your consent.

A State Appeal (Fair Hearing with the state) is your request for the state to review a decision we made. You must appeal to UnitedHealthcare before asking for a State Appeal. If we take more than 30 days to decide your appeal and we have not asked for an extension, you do not need to wait for our decision to ask for a State Appeal. You may appeal any of these actions (decisions):

- Denial or limited authorization of the type or level of service
- Reduction, suspension, or stopping of a service that was approved before
- Denial of all or part of a payment for a service
- Not providing services in a reasonable amount of time
- Our failure to act within required timelines for prior authorizations and appeals
- Financial liability including copayments or other cost sharing
- Any other action

Important timelines for appeals

You must follow the timelines for filing health plan appeals, and State Appeals (Fair Hearings with the state). If you go over the time allowed, we may not review your appeal and the state may not accept your request for an appeal.

You must appeal to us **within 60 days** from the date of the DTR (notice of action). We can give you more time if you have a good reason for missing the deadline. You must file an appeal with us **before** you request a State Appeal. If we take more than 30 days to decide your appeal and we have not asked for an extension, you can request a State Appeal without waiting for us.

You must request a State Appeal **within 120 days** of our appeal decision.

If we are stopping or reducing a service, you can keep getting the service if you file a health plan appeal **within 10 days** from the date on the notice, or before the service is stopped or reduced, whichever is later. **You must ask to keep getting the service when you file an appeal.** The service can continue until the appeal is decided. If you lose the appeal, you may be billed for these services, but only if state policy allows it.

If you lose the appeal, you may keep getting the service during a State Appeal if you request a State Appeal within 10 days from the date of the decision on your plan appeal.

For the Restricted Recipient Program, a member who receives a notice of restriction may file an appeal with us. You must file an appeal **within 60 days** from the date on the notice. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. You may request a State Appeal after receiving our decision.

To file an oral or written appeal with us:

You may appeal by phone, writing, fax, or in person. The contact information and address is found in Section 1 under "Appeals and Grievances."

Your appeal will need to include the following information:

- Your name
- The number on your UnitedHealthcare Plan card
- The kind of care you want
- The reason you want to appeal
- Your mailing address
- The name of the person we should call if we have questions about your appeal
- A daytime phone number

If you call us with your appeal, it must be followed by a written appeal, unless you are requesting a fast resolution. We will help you complete a written appeal. We will ask you to sign and return the written appeal.

Fast appeals are for urgently needed services. If we agree that it is urgent, we will give you a decision within 72 hours. We will try to call you with the decision before we send the decision in writing.

We may take up to 14 extra days if we need more information and it is in your best interest or if you request extra time. We will tell you why we are taking the extra time.

If your appeal is not urgent, we will tell you within 10 days that we received it. We will give you a written decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest or if you request extra time. We will tell you we are taking the extra time and why.

The person making the decision will not be the same person who was involved in the prior review or decision-making.

If we are deciding an appeal about a service that was denied because it was not medically necessary, the decision will be made by a health care professional with appropriate clinical expertise in treating your condition or disease.

You or your representative may present your information in person, by telephone, or in writing.

If you appeal, we will send you or your representative the case file upon request, including medical records and any other documents and records considered by us during the appeal process.

To file a State Appeal (Fair Hearing with the state) with the Minnesota Department of Human Services:

You must file a health plan Appeal with us **before** you ask for a State Appeal. You must ask for a State Appeal **within 120 days** from the date of our appeal decision (resolution).

Your appeal to the state must be in writing. You can write to the Minnesota Department of Human Services to request a State Appeal.

Write to:	Minnesota Department of Human Services Appeals Office P.O. Box 64941 St. Paul, MN 55164-0941
File online at:	**https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG**
Or fax to:	651-431-7523

Tell the state why you disagree with the decision we made. You can ask a friend, relative, advocate, provider, or lawyer to help you. Your provider must have your written permission to request a State Appeal for you.

A human services judge from the State Appeals Office will hold a hearing. You may ask to attend the hearing by telephone, by video, or in person. You can ask your providers or others to give testimony. You can provide documents for the judge to consider.

The process can take 90 days. If your hearing is about an urgently needed service, tell the Judge or the Ombudsman when you call or write to them.

If your hearing is about a service that was denied because it was not medically necessary, you may ask for review by a medical expert. The medical expert is independent of both the state and UnitedHealthcare. The state pays for this review. There is no cost to you.

If you do not agree with the human service judge's decision, you may ask the state to reconsider their decision. Send a written request for reconsideration to the Minnesota Department of Human Services Appeals Office within 30 days from the date of the decision. The contact information is listed earlier in this section.

If you do not agree with the state's decision, you may appeal to the district court in your county.

Grievances (complaints)

You may file a Grievance with us **at any time**. There is no timeline for filing a grievance with us.
To file an oral grievance with us: Call Member Services at **1-888-269-5410**, TTY **711** and tell us about the problem.

We will give you a decision within 10 days. We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 10 days that we are taking extra time and the reasons why.

If your grievance is about our denial of a fast appeal or a grievance about urgent health care issues, we will give you a decision within 72 hours.

To file a written grievance with us:

Send a letter to us about your grievance. Write to the address listed in Section 1 under "Appeals and Grievances."

We can help you put your grievance in writing. Call Member Services at **1-888-269-5410**, TTY **711** if you need help.

We will tell you that we received your grievance within 10 days.

We will give you a written decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest or if you or your provider requests extra time. We will tell you we are taking the extra time and why.

If you do not agree with our decision, you can file your complaint with the Minnesota Department of Health.

Write to: Minnesota Department of Health
Health Policy and Systems Compliance Monitoring Division
Managed Care Systems
P.O Box 64882
St. Paul, MN 55164-0882

Call: 1-800-657-3916 (This call is free.) or 651-201-5100, TTY 711, or use your preferred relay services

Visit: **https://www.health.state.mn.us/facilities/insurance/clearinghouse/complaints.html**

You can also call the Ombudsman for Public Managed Health Care Programs for help. The contact information is listed after this section.

Important information about your rights when filing a grievance, appeal, or requesting a State Appeal (Fair Hearing with the state):

If you decide to file a grievance or appeal, or request a State Appeal, it will not affect your eligibility for medical services. It will also not affect your enrollment in our health plan.

You can have a relative, friend, advocate, provider, or lawyer help with your grievance, appeal, or a State Appeal.

There is no cost to you for filing a health plan appeal, grievance, or a State Appeal. We may pay for some expenses such as transportation, childcare, photocopying, etc.

If you ask for your medical records or other documents, we used to make our decision or want copies, we or your provider must provide them to you at no cost. If you ask, we must give you a copy of the guidelines we used to make our decision, at no cost to you. You may need to put your request in writing.

If you need help with your grievance, appeal, or a State Appeal, you can call or write to the Ombudsman for Public Managed Health Care Programs. They may be able to help you with access, service, or billing problems. They can also help you file a grievance or appeal with us or request a State Appeal.

Call: 651-431-2660
1-800-657-3729 or TTY 711, or use your preferred relay services. This call is free.
Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m.

Or

Write to: Ombudsman for Public Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249

Fax to: 651-431-7472

Section 14: Definitions

These are the meanings of some words in this Member Handbook.

Action: This includes:

- Denial or limited authorization of the type or level of service
- Reduction, suspension, or stopping of a service that was approved before
- Denial of all or part of payment for a service
- Not providing services in a reasonable amount of time
- Not acting within required time frames for grievances and appeals
- Denial of a member's request to get services out-of-network for members living in a rural area with only one health plan

Anesthesia: Drugs that make you fall asleep for an operation.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing a written or oral appeal.

Child: Member under age 21.

Child and Teen Checkups (C&TC): A special health care program of well-child visits for members under age 21. It includes screening to check for health problems. It also includes referrals for diagnosis and treatment, if necessary.

Clinical Trial: A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

Coinsurance: An amount you may be required to pay as your share of the cost for services or items. Coinsurance is usually a percentage (for example, 10%).

Copay/Copayment: A fixed amount you may pay as your share of the cost each time you get certain services, supplies, or prescription drugs. Copays are usually paid at the time services, supplies, or prescription drugs are provided. For example, you might pay $1 – $3.50 for services, supplies or prescription drugs.

Section 14: Definitions

Cost Sharing: Amounts you may be responsible to pay toward your medical services. Refer to Section 6 for information on cost sharing.

Covered Services: The health care services that are eligible for payment.

Cultural Competency: Cultural and language competence is the ability of managed care organizations and the providers within their network to provide care to members with diverse values, beliefs, and behaviors, and to tailor the delivery of care to meet members' social, cultural, and language needs. The ultimate goal is a health care delivery system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, sexual orientation, disability, religion, or socioeconomic status.

Denial, Termination or Reduction (DTR) (Notice of Action): A form or letter we send you to tell you about a decision on a claim, service, or any other action taken by us.

Direct Access Services: You can go to any provider in the Plan network to get these services. You do not need a referral or prior authorization from your PCP or PCC before getting services.

Durable Medical Equipment (DME): Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, oxygen equipment and supplies.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part or could cause serious physical or mental harm. The medical symptoms may be a serious injury or severe pain. This is also called Emergency Medical Condition.

Emergency Care/Services: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. This is also called Emergency Room Care.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Excluded Services: Services the Plan does not pay for. Medical Assistance (Medicaid) will not pay for them either.

Experimental Service: A service that has not been proven to be safe and effective.

External Quality Review Study: A study about how quality, timeliness and access of care are provided by UnitedHealthcare. This study is external and independent.

Families and Children: The name of the prepaid medical assistance program (PMAP) you are in.

Family Planning: Information, services, and supplies that help a person decide about having children. These decisions include choosing to have a child, when to have a child, or not to have a child.

Fee-for-Service (FFS): A method of payment for health services. The medical provider bills the Minnesota Department of Human Services (DHS) directly. DHS pays the provider for the medical services. This method is used when you are eligible for Minnesota Health Care Programs but are not enrolled in a health plan.

Formulary: The list of drugs covered under the Plan.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Home Health Care: Health care services for an illness or injury given in the home or in the community where normal life activities take the member.

Hospice: A special program for members who are terminally ill and not expected to live more than six months to live comfortably for the rest of the member's time. It offers special services for the member and his or her family. This is also known as Hospice Services.

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

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

Housing Stabilization Services: Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person's transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

Inpatient Hospital Stay: A stay in a hospital or treatment center that usually lasts 24 hours or more.

Investigative Service: A service that has not been proven to be safe and effective.

Section 14: Definitions

Medically Necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and behavioral health (including Mental Health and Substance Use Disorder). It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

- Be the services, supplies and prescription drugs other providers would usually order
- Help you get better or stay as well as you are
- Help stop your condition from getting worse
- Help prevent or find health problems

Medicare: The federal health insurance program for people age 65 or over. It is also for some people under age 65 with disabilities, and people with End-Stage Renal Disease.

Medicare Prescription Drug Plan: An insurance plan that offers Medicare Prescription Drug Program (Medicare Part D) drug benefits.

Medicare Prescription Drug Program: The prescription drug benefit for Medicare members. It is sometimes called Medicare Part D. Drug coverage is provided through a Medicare prescription drug plan.

Member: A person who is receiving services through a certain program, such as a Minnesota Health Care Program or Medicare.

Member Handbook: This is the document you are reading. This document tells you what services are covered under the Plan. It tells what you must do to get covered services. It tells your rights and responsibilities. It also tells our rights and responsibilities.

Network: Our contracted health care providers for the Plan.

Network Providers: These are providers who agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called plan providers or participating providers.

Ombudsman for Public Managed Health Care Programs: A person at the Minnesota Department of Human Services who can help you with access, service or billing problems. The ombudsman can also help you file a grievance or appeal or request a State Appeal (Fair Hearing with the state).

Open Access Services: Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency — even if not in our network — to get these services.

Outpatient Hospital Services: Services provided at a hospital or outpatient facility that are not at an inpatient level of care. These services may also be available at your clinic or another health facility.

Out-of-Area Services: Health care provided to a member by an out-of-network provider outside of the Plan service area.

Out-of-Network Provider or Out-of-Network Facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. This is also known as a non-participating provider.

Out-of-Network Services: Health care provided to a member by a provider who is not part of the Plan network.

Physician Incentive Plan: Special payment arrangements between us and the doctor or doctor group that may affect the use of referrals. It may also affect other services that you might need.

Physician Services: Services provided by an individual licensed under state law to practice medicine or osteopathy. Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: An organization that has a network of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you.

Prepaid Medical Assistance Program (PMAP): A program in which the state contracts with health plans to cover and manage health care services for Medical Assistance (Medicaid) enrollees.

Post-Stabilization Care: A hospital service needed to help a person's conditions stay stable after having emergency care. It starts when the hospital asks for our approval for coverage. It continues until: the person is discharged; our Plan network doctor begins care; or we, the hospital, and doctor agree to a different arrangement.

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prepaid Medical Assistance Program (PMAP): A program in which the state contracts with health plans to cover and manage health care services for Medical Assistance (Medicaid) enrollees.

Prescriptions: Medicines and drugs ordered by a medical provider.

Section 14: Definitions

Prescription Drug Coverage: A health plan that helps pay for prescription drugs and medications. Also refer to "Medicare Prescription Drug Program."

Preventive Services: Services that help you stay healthy, such as routine physicals, immunizations, and well-person care. These services help find and prevent health problems. Follow-up on conditions that have been diagnosed (like a diabetes checkup) are **not** preventive.

Primary Care Clinic: The primary care clinic (PCC) you choose for your routine care. This clinic will provide most of your care.

Primary Care Provider: Your Primary Care Provider (PCP) is the doctor or other qualified health care provider you go to at your primary care clinic. This person will manage your health care.

Prior Authorization: Our approval that is needed for some services before you get them. This is also known as preauthorization or service authorization.

Provider: A qualified health care professional or facility approved under state law to provide health care.

Quality of Care Complaint: For purposes of this handbook, "quality of care complaint" means an expressed dissatisfaction regarding health care services resulting in potential or actual harm to a member. Quality of care complaints may include: access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that could impact the quality of health care services.

Referral: Written consent from your primary care provider that you may need to get before you go to certain providers, such as specialists, for covered services. Your primary care provider must write you a referral.

Rehabilitation Services and Devices: Treatment and equipment you get to help you recover from an illness, accident or major operation.

Restricted Recipient Program (RRP): A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated Primary Care Provider, one pharmacy, one hospital or other designated health care provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

Second Opinion: If you do not agree with an opinion you get from a Plan network provider, you have the right to get an opinion from another provider. We will pay for this. For mental health services, the second opinion may be from an out-of-network provider. For substance use disorder services,

the second opinion will be from a different qualified assessor who does not need to be in the Plan network. We must consider the second opinion but do not have to accept a second opinion for substance use disorder or mental health services.

Service Area: The area where a person must live to be able to become or remain a member of the Plan. Contact Member Services at **1-888-269-5410**, TTY **711** for details about the service area.

Service Authorization: Our approval that is needed for some services before you get them. This is also known as preauthorization or prior authorization.

Skilled Nursing Care: Care or treatment that can only be done by licensed nurses.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Standing Authorization: Written consent from us to see an out-of-network specialist more than one time (for ongoing care).

State Appeal (Fair Hearing with the State): A hearing at the state to review a decision made by us. You must request a hearing in writing. Your provider may request a State Appeal with your written consent. You may ask for a hearing if you disagree with any of the following:

- A denial, termination, or reduction of services
- Enrollment in the Plan
- Denial of part or all of a claim for a service
- Our failure to act within required timelines for prior authorizations and appeals
- Any other action

Subrogation: Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this Plan for a service that is covered by another source or third-party payer.

Substance Use Disorder: Using alcohol or drugs in a way that harms you.

United States: For the purpose of this Member Handbook, the United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, The Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Urgently Needed Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. This is also known as Urgent Care.

Section 15: Additional information

You can learn information about network doctors, at **myuhc.com/CommunityPlan**, or by calling Member Services.

We can tell you the following information:

1. Name, address, phone number
2. Professional qualification
3. Specialty
4. Board certification
5. Languages spoken by the provider
6. Information about medical school attended and residency program
7. Board certification status

New medical procedures

Requests to cover new medical procedures, devices, or drugs are reviewed by the UnitedHealthcare Community Plan Technology Assessment Committee. This group includes doctors and other health care experts. The team uses national guidelines and scientific evidence from medical studies to help decide whether UnitedHealthcare Community Plan should approve new equipment, procedures, or drugs.

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 **1-888-269-5410**, TTY **711**. You can also visit our website at **myuhc.com/CommunityPlan**.

UnitedHealthcare Community Plan of Minnesota
Families and Children

Member Services:
1-888-269-5410, TTY **711**
8:00 a.m.–6:00 p.m., Monday–Friday

UnitedHealthcare
9800 Health Care Lane
Mail Code: MN006-W900
Minnetonka, MN 55343

myuhc.com/CommunityPlan

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Healthcare
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